

Submission to the Royal Commission into Aged Care Quality and Safety, regarding:

# Sexual abuse/assault of older women

By Dr Catherine Barrett, Director of the OPAL Institute, 10<sup>th</sup> September 2019

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Cover image of Margarita Solis by Lisa White, The Social Photographer.

# 1. Context

This submission focuses on sexual abuse/assault of older women. It acknowledges that most sexual abuse/assaults are perpetrated by men and that most victims are women. This is an issue that has been largely ignored until recently.

In my current role as Director of the OPAL Institute<sup>1</sup> I am contacted regularly by family members and service providers seeking information on sexual abuse/assault. Family members often report that service providers in residential aged care minimize the sexual abuse/assault – and also report that perpetrators are not held to account. Some families tell me that they contact the media to share their stories, because they do not feel confident that anyone else is listening.

I am sure there are aged care services who are responding appropriately to sexual abuse/assault and that I do not hear from family members or service providers in these instances. I also believe that most aged care service providers want to better respond to and prevent sexual abuse/assault but do not have the resources, skills or confidence to do so.

This submission draws on my 35 years working with older people and 20 years preventing sexual abuse/assault of older women. I want to share with you the context of my work, so you understand that this submission draws on my experiences as a nurse in residential aged care, a researcher, educator and capacity builder.

My intention is not to summarise all the research and resources that have been developed; rather I want to lay these out for you, so that you can see the pressing need for leadership and change. There are a number of researchers, clinicians and service providers who are now also working to create change – but we need a systemic approach. While it is possible to call out the inadequacies of aged care service providers on this matter – I ask: how have we resourced aged care service providers to address this issue? Where is the explicit mandate for change on this issue? We gather data in residential aged care on ‘alleged unlawful sexual contact’ but it is not clear that aged care service providers are *supported* to do anything other than report. I believe leadership for change would include a national strategy and suite of resources, policy, guidelines and training to build the capacity of aged care service providers to better respond to and prevent sexual abuse/assault. This would send

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<sup>1</sup> The OPAL Institute is a social enterprise promoting the sexual rights of older people including their right to be free from sexual violence and coercion. See: <https://www.opalinstitute.org/>

the message that we not only expect services to report sexual abuse/assault – we also expect service providers to better respond to and prevent sexual abuse/assault.

The context for this submission begins in 1982, when I first started working in aged care. I was a Nurse Unit Manager in a residential aged care home for almost a decade and it was here that I first recognized the problem of sexual abuse/assault of older women. What struck me was how conversations about sexual abuse/assault were (and still are) shut down. It was during my time working in residential aged care that I began to address the sexual rights of older people through education to build the capacity of service providers to promote sexual wellbeing.

I left residential aged care to undertake a Ph.D. on improving the quality of health services by focusing on the experiences of the client/patient, and then worked in academia for 10 years. As a Senior Research Fellow at the Australian Research Centre in Sex, Health and Society at La Trobe University, I established Australia's first Sexual Health and Ageing Program. In this role I was Chief Investigator with a team that secured a Federal Grant for Norma's Project – Australia's first evidence base on sexual assault of older women<sup>2</sup>. I was also a coresearcher on a project called: Older Women's Right to be Safe at Home and in Care<sup>3</sup>. This project was an Appreciative Inquiry approach into aged care service provider's strategies for responding to and preventing sexual abuse/assault of older women. The research highlighted the important role that aged care service providers have in preventing sexual abuse/assault.

In 2016 I left academia to establish a social enterprise called Celebrate Ageing<sup>4</sup>, which focuses on building respect for older people. I also left build more momentum for preventing the sexual abuse/assault of older women. The more work I do preventing the sexual abuse/assault of older women – the more stories people share with me – the more I realise that we have an evidence base, but so little change. It is difficult to understand this inaction as reflecting anything other than ageism and sexism.

As part of the Celebrate Ageing Program I established the OPAL Institute<sup>5</sup>. The Institute works to empower service providers with resources and skills to address the sexual rights of older people. In 2017 I coedited a book on the sexual rights of older people, to help raise awareness of sexuality as a

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<sup>2</sup> See: <https://www.opalinstitute.org/uploads/1/5/3/9/15399992/researchreport.pdf>

<sup>3</sup> See: <https://www.opalinstitute.org/uploads/1/5/3/9/15399992/finalreport.pdf>

<sup>4</sup> See: <https://www.celebrateageing.com/>

<sup>5</sup> See: <https://www.opalinstitute.org/>

rights-based issue. The OPAL Institute includes a project called The Power Project<sup>6</sup>, focusing on the power of service providers (and community members) to transform the lives of older women who have been sexually abused/assaulted.

The Power Project is Australia's only resource portal/knowledge hub on preventing the sexual abuse/assault of older women. The Project was co led by Margarita Solis, a 97 year old woman who was sexually abused/assaulted by the acting manager of a Senior's Rental Service. While I recognize this setting is not within the scope of the Commission – there are many parallels between Margarita's experiences and those of older women who are sexually abused/assaulted in residential aged care or their own homes. When Margarita first reported her sexual abuse/assault she was discredited by the Manager of the service who told her that the sexual abuse/assault could not have occurred because the acting manager was a family friend. They proposed instead, that Margarita must have a urinary tract infection causing her to be confused. When Margarita called me after her sexual abuse/assault, she expressed interest in information about support services. I promised to find out what services she could access (we lived in different states). It took me three days of phone calls to identify services that she could access. Two elder abuse services told me they didn't deal with sexual abuse, several sexual assault services said they could not provide services to an older woman ... and so the list went on. The Power Project was set up to address this gap – to provide an information portal for older women and their families, as well as service providers.

Margarita is the only woman I know of in Australia who has been willing to publicly share her story of sexual abuse/assault as an older woman. That says much about the ways in which we silence older women.

In this submission I present a summary of the research and initiatives undertaken in Australia to date. I present them to you as a call for action. Older women experience sexual abuse/assault in residential aged care and at home – and there has been very little leadership on this issue. This is particularly concerning because aged care service providers have the power to prevent sexual abuse/assault of older women. In particular, service providers working in residential aged care need to be resourced to prevent sexual abuse/assault by coresidents and to better respond to/prevent sexual abuse/assault by other staff members/visitors, volunteers and strangers. Additionally, given the problem of sexual violence against women is not limited to young women – aged care service providers have a pivotal role to play in supporting older women who are experiencing sexual abuse/assault by an intimate

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<sup>6</sup> See: <https://www.opalinstitute.org/power-project.html>

partner, family member, stranger or service providers. Finally, there is a poorly recognised issue of sexual abuse/assault of older women in their own homes by aged care service providers that also needs to be addressed.

## 2. Definitions & reporting

The language used to refer to sexual abuse/assault is inconsistent, creates confusion and needs to be addressed. The OPAL Institute began using the term sexual abuse to make connections with the growing focus on Elder Abuse. The World Health Organisation includes sexual abuse in their definition of elder abuse<sup>7</sup> and defines sexual abuse as non-consensual sexual contact of any kind with an older person.<sup>8</sup> References to sexual contact are also included in the framework for compulsory reporting in residential aged care – however, a definition by the Queensland Government<sup>9</sup> encompasses sexual abuse/assault without physical contact. The NSW Elder Abuse Help Line and Resource Unit<sup>10</sup> expands the definitions to include consent obtained through coercion and 1800RESPECT<sup>11</sup> notes that sexual violence is anything sexual that makes a person feel scared or uncomfortable.

It is interesting to note that many sexual assault services frame sexual abuse/assault more broadly. The CASA Forum<sup>12</sup> (Centres Against Sexual Assault) in Victoria defines sexual assault as:

*any behaviour of a sexual nature that makes someone feel uncomfortable, frightened, intimidated or threatened. It is sexual behaviour that someone has not agreed to, where another person uses physical or emotional force against them. It can include anything from sexual harassment through to life threatening rape. Some of these acts are serious indictable crimes. Sexual assault is an abuse of power. Sexual assault is never the fault or responsibility of the victim/survivor.*

There is also a need for clarity related to the signs of sexual abuse/assault listed by a number of organisations and services. The Queensland Government<sup>13</sup> lists bruising of breasts or genital, urinary

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<sup>7</sup> See: [https://www.who.int/violence\\_injury\\_prevention/violence/elder\\_abuse/EA\\_infographic\\_EN\\_Jun\\_18\\_final.pdf](https://www.who.int/violence_injury_prevention/violence/elder_abuse/EA_infographic_EN_Jun_18_final.pdf)

<sup>8</sup> See: [https://www.who.int/violence\\_injury\\_prevention/violence/global\\_campaign/en/chap5.pdf](https://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap5.pdf)

<sup>9</sup> See: <https://www.communities.qld.gov.au/campaign/know-signs/what-elder-abuse>

<sup>10</sup> See: <http://www.elderabusehelpline.com.au/for-professionals/identifying-elder-abuse-types-signs>

<sup>11</sup> See: <https://www.1800respect.org.au/violence-and-abuse/sexual-assault-and-violence/>

<sup>12</sup> See: [http://www.casa.org.au/casa\\_pdf.php?document=what\\_is\\_SA](http://www.casa.org.au/casa_pdf.php?document=what_is_SA)

<sup>13</sup> See: <https://www.communities.qld.gov.au/campaign/know-signs/what-elder-abuse>

tract infections, bloody clothing, bruising thighs and difficulty walking. Information by The NSW Elder Abuse Help Line and Resource Unit<sup>14</sup> includes unexplained STDs or incontinence, human bite marks, torn bloody clothing and trauma including bleeding around the genitals, chest, rectum or mouth. These signs may be more likely to be present when sexual assault is perpetrated by a stranger – rather than a family member or service provider. In the latter, perpetrators may be careful to leave little or no evidence of the assault – in order to get away with their crime. In these instances, signs of sexual abuse/assault may be more likely to include emotional withdrawal, changes in mood, fearful responses to a particular staff or family member. An evidence-based approach to definitions and signs of sexual abuse/assault is a critical foundation to improving responses and prevention.

Regarding reporting of sexual abuse/assault, I encourage you to read the critique of compulsory reporting in the Norma's Project resource. My understanding is that data is collected and published in the Report on the Operation of the Aged Care Act – but there is no apparent evidence that this data is used to inform education or other strategies for prevention. The lack of strategies and resources for prevention contributes to a culture of inaction beyond reporting. Indeed, I am informed by numerous aged care service providers that the Limited Circumstances clause in reporting means that some aged care service providers do not understand sexual abuse/assault by a cognitively impaired person to be sexual abuse/assault. The guidance for service providers needs to be explicit and resourced.

### 3. Margarita Solis #SheToo

Margarita Solis shared her story of sexual abuse/assault to encourage reporting by older women and to communicate to older women that sexual abuse/assault is not their fault. She also wanted service providers to understand their power to improve the lives of older women who experience sexual abuse/assault. Margarita was a Fellow of the Elder Leadership Academy<sup>15</sup> (part of the Celebrate Ageing Program) and used her Fellowship to develop resources to prevent sexual abuse/assault. Margarita featured in a film<sup>16</sup> in which she shared the positive responses of service providers and community following her sexual abuse/assault. She also shared her story with the media and

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<sup>14</sup> See: <http://www.elderabusehelpline.com.au/for-professionals/identifying-elder-abuse-types-signs>

<sup>15</sup> See: <https://www.celebrateageing.com/academy.html>

<sup>16</sup> See: <https://www.opalinstitute.org/margarita.html>

delivered a plenary address to over 500 delegates at the National Elder Abuse Awareness Conference in 2019 – by video.

On International Women's Day 2019, at the age of 97, Margarita launched a campaign called #SheToo<sup>17</sup> which focused on strategies for listening to older women who experience sexual abuse/assault. Margarita reflected on her own experiences and shared the following 14 strategies for listening to older women:

1. *Use your eyes to listen as well as your ears. Don't just hear. You also need to notice signs if an older woman is not her usual happy self, or is not well.*
2. *Check in and ask: "are you alright?" And if she says: "I'm fine thank you." Check in again later and say: "you don't look like your usual self, you don't seem to be happy. Is there anything you want to talk to me about? Can I help you in some way?"*
3. *Show an interest. If an older woman knows that you care - she will feel safer to tell you how she is actually feeling.*
4. *Be respectful of older women - don't poke fun at them because they will think you won't be interested in listening to them. If you do things like telling stupid jokes about ageing, it may lead her to believe because she's old, she must be stupid, or because of how she looks, or dresses, or her frailties, she is somehow not worthy or you just won't believe her. To be sure, don't share cartoons, or post cards that are ageist making older people look silly or ugly, or saying ageist things.*
5. *Make sure your language is never ageist or mocking of older women – or any older people for that matter.*
6. *Make sure the older woman knows she is in the driver's seat - that you are there to listen and help if she wants help. Give her permission to talk about sexual abuse.*

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<sup>17</sup> See: <https://www.opalinstitute.org/shetoo.html>

7. *Your actions as you are listening can clearly communicate to an older women that you don't believe them. You must always believe that she is telling you the truth - until it is proved otherwise!*
8. *I know some older women who have told someone they have been sexually assaulted and have not been believed. This can make them reluctant to tell anyone else. But if you are encouraging, they might trust you to talk about what is, or has been, happening to them.*
9. *Some older women feel ashamed of sexual abuse and blame themselves - or are worried that others will blame them. Tell older women it's not their fault. That is essential.*
10. *Just because we are older women we are NOT stupid. Don't underestimate the intelligence or the resilience of older women. Talk to them and get to know them. They should not be relegated, but treated with respect for their intelligence, life experiences, and their education more generally.*
11. *Remember that Centres Against Sexual Violence have wonderful counsellors who can assist you – whether or not you want to make a complaint to police.*
12. *Remember too that police can help you to make your complaint so that it is dealt with in court.*
13. *Australian states and territories have support agencies that assist survivors or victims of crime through the court process.*
14. *Your own personal networks will also be very important. Social isolation can cause you to lose confidence. Try to keep engaged with other people where you live, or join a senior's group, or perhaps even say hello to or chat with people at the shops.*

Margarita's strategies for listening to older women highlight the importance of working in partnership with older women on this issue. They also highlight the lack of leadership – older women who have been sexually abused/assaulted should not need to campaign to be heard. It surely is not the responsibility of older women to educate us on sexual abuse/assault – so that we will listen. We need leadership and direction in order to achieve change.



## 4. Leadership

The Power Project website includes a Leadership page<sup>18</sup> with a chronological record of strategies to better respond to and prevent the sexual abuse/assault of older women. It is intended as a resource for service providers and others wishing to keep up to date with strategies for change. There is likely to be a small number of innovations that have been missed in this list – however, the page demonstrates how slow the pace of change has been, and how much work is still to be done. The key innovations are summarized in the following section to ensure the Royal Commission takes these into account in addressing the sexual abuse/assault of older women.

The earliest strategies were implemented by centers against sexual assault in Victoria and Queensland. In 2011, the Gold Coast Centre Against Sexual Violence<sup>19</sup> developed a booklet of information for older women – to clearly communicate that their service welcomed older women. In 2019 the same Centre received a small grant to facilitate training for residential aged care services on sexual assault. In 2012 South East Centre Against Sexual Assault, Melbourne<sup>20</sup> partnered with Monash University medical students to conduct a literature review and develop information for older women, their families and service providers.

The first research on sexual abuse/assault of older women was conducted by the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University in 2014 when Norma's Project was funded by the Australian Department of Social Services. The Director of the OPAL Institute was the Chief Investigator for the project. The research was conducted in partnership with the National Ageing Research Institute; the University of Melbourne, Alzheimer's Australia and the Council on the Ageing (COTA) Victoria.

Then, in 2016 Senior's Rights Victoria released research from a collaborative project with COTA and ARCSHS, that was funded by the Victorian Women's Benevolent Trust. This project documented aged care service providers strategies to respond to and prevent sexual abuse/assault of older women. The project steering group included representatives from many of the key stakeholder groups and the project developed a state wide strategy for preventing sexual abuse of older women.

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<sup>18</sup> See: <https://www.opalinstitute.org/leadership.html>

<sup>19</sup> See: <http://www.stopsexualviolence.com/>

<sup>20</sup> See: <https://www.secasa.com.au/pages/abuse-of-older-women/>

The strategy has not been implemented and highlights the need for leadership and resources to create sustainable change.

The Victorian Institute of Forensic Medicine/Monash University<sup>21</sup> have undertaken research on older women who are sexually abused and provide support for honors students to undertake research on this issue. They Institute is presenting a seminar on preventing sexual violence in residential aged care in August 2019.

The issue of sexual abuse/assault has been presented by the Director of the OPAL Institute /or a sexual assault service at every national elder abuse conference – with the exception of the first. The Director of the OPAL Institute coordinated an interdisciplinary panel at the Elder Abuse Conference hosted by Senior's Rights Service in 2017. A video from the panel is available online, alongside a video of an interview with Ellen Fanning that is also focused on sexual abuse/assault of older women.

The 2019 the Elder Abuse Awareness Conference in Brisbane, hosted by ADA Australia and Caxton Legal included a plenary presentation by 97 year old Margarita Solis on her experience of sexual abuse/assault and her suggestions for change.

The Australian Association of Gerontology (AAG) has undertaken a number of activities to build the capacity of its members to better respond to/prevent sexual abuse of older women. In 2018 they presented a webinar and an interdisciplinary preconference workshop was hosted prior to the 2018 Conference in Melbourne. At this workshop, participants were invited to identify recommendations for the Royal Commission into Aged Care Quality and Safety, and the National Plan to Respond to the Abuse of Older Australians. A report on the workshop<sup>22</sup> includes 30 recommendations. At the 2019 AAG Conference in Sydney a pre-conference workshop on Unlawful Sexual Contact - Compliance, Resourcing and Prevention will be hosted by the OPAL Institute and will include a presentation by the Aged Care Quality and Safety Commission.

The leadership shown in these and other initiatives is important – but does not go far enough. Change must be systemic and must come from Government.

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<sup>21</sup> See: [https://www.opalinstitute.org/uploads/1/5/3/9/15399992/smith\\_sexual\\_assault\\_2018\\_legal\\_medicine.pdf](https://www.opalinstitute.org/uploads/1/5/3/9/15399992/smith_sexual_assault_2018_legal_medicine.pdf)

<sup>22</sup> See: [https://www.opalinstitute.org/uploads/1/5/3/9/15399992/aag056\\_-\\_a\\_fair\\_future\\_for\\_older\\_women\\_who\\_experience\\_sexual\\_abuse.pdf](https://www.opalinstitute.org/uploads/1/5/3/9/15399992/aag056_-_a_fair_future_for_older_women_who_experience_sexual_abuse.pdf)

## 5. Conclusions and recommendations

There is a body of evidence on the sexual abuse/assault of older women that needs to be taken into account by the Commission and utilized to inform recommendations for preventing the sexual abuse/assault of older women. It is my hope, and the hope of many family members and good service providers, that the Commission will make recommendations to galvanize leadership on this important issue – and recommend the allocation of resources to make change possible.

To date, many of the responses to preventing sexual abuse/assault of older women have come from committed individuals and groups. We now need bipartisan support to address this issue from state and federal Governments. There are many relatively simple strategies that could be implemented to prevent the sexual abuse/assault of older women – all of these require Government leadership and resourcing. Aged care service providers in residential aged care need to be resourced with the skills and confidence to prevent sexual abuse/assault by other residents, staff, visitors, strangers and volunteers. Additionally, service providers in home care need to be resourced with the skills and confidence to identify older women who are at risk of sexual abuse/assault and understand how to offer women information about their choices.

In regard to how best to achieve this, I draw on seven years' experience working on the National LGBTI Ageing and Aged Care Strategy. I was cochair of the committee that developed the strategy; I was then a member of an evaluation committee. The Strategy responded to recognition that older LGBTI people were invisible and their needs not understood. The Strategy offered a system-based approach to reform and as such presents a useful model for better responding to and preventing the sexual abuse/assault of older women. Key points that could be adopted for a National Strategy to Prevent Sexual Abuse/Assault of Older Women are:

1. Establishing a national committee to oversee the Strategy
2. Consultation with stakeholders including: older women, families, communities, service providers etc
3. Drafting a Strategy and seeking feedback
4. Identifying areas of legislative reform
5. Developing policy and reviewing existing systems
6. Resourcing education – roll out of a national training program, online resource and champions model
7. Developing resources
8. Undertaking research
9. Promoting best practice
10. Evaluating the Strategy.

## 6. Research narratives

The final section of this Submission presents research narratives from Norma's Report – in participants own words (including typos and spelling errors). The narratives were published in an education resource and are presented here in to assist the Commission to understand that we have a problem that we can no longer ignore.

### Sexual abuse/assault in residential aged care

*I was called to a nursing home after a staff member had sexually assaulted four female residents. The male staff member had digitally raped the women in the shower. One resident had reported the assault to a family member and was believed. The facility manager and the police were called. The facility also called CASA to provide support for the older women. The staff were distressed by what had occurred. The facility manager wanted to know what other supports he could offer the residents (Interview 25-31: sexual assault service).*

*A 90 year old woman was sexually assaulted by a male nurse in a residential aged care facility. She had dementia and had difficulty communicating what had occurred. She told her son, but had difficulty communicating to police, others what had occurred. The woman was transferred to an acute hospital crisis centre – which had difficulty providing for her care needs and it may have been more useful for her to stay in her own facility (Interview 25-31: sexual assault service).*

*I was called to another nursing home where a male nurse had sexually assaulted a female resident. I was called to provide education to staff on how to respond (Interview 25-31: sexual assault service).*

*[At a local nursing home] ... a nurse working there, sexually assaulted a woman on two occasions and I think he also assaulted another person on a third occasion, it was only on the third instance that it actually was reported to the police and the Department of Health and Ageing. Anyway, he's been convicted of sexual assault. ... My understanding is that at least one of them was noticed or suspected, I think it was reported to management and management chose not to do anything with it and they therefore breached the mandatory reporting rules. And on the third occasion that's when it was escalated and reported to the police (Interview S24: aged care service provider).*

*I have done a crisis care unit at an aged care facility and it was an incredible challenge as you would be aware, for the staff to deal with that issue, that it was a male carer who had offended against a severely disabled and elderly woman. So there were huge challenges. And one of the other barriers, one of the complications was that her speech was really compromised because of a stroke, so she was only able to communicate that it had happened with sort of nods of her head and shakes and her level of distress alerted people. So there were lots of complications, lots of difficulties, with that particular CCU, or crisis care unit (Interview s17-22: sexual assault service)*

*Some work I did ... with a woman who had been severely sexually assaulted, shockingly sexually assaulted, and who suffered from dementia, and I guess there were discussions around, well, you know, just as well she has dementia, she probably didn't realise what was going on, however, how do I know, how do we know. And so fortunately she had a friend who was stayed with her in emergency and she was being prepared for surgery. So our role then was to advocate for her, that despite having dementia she has rights, and her son was contacted and he came into the hospital and he was going to follow up, but it was an interesting discussion between myself and her person who was with her, about the rights of people who have dementia. ... Fortunately, her son decided it needed to be reported to the police. And of course, you know, we know that people who may have dementia have times when they perhaps come in and out of that consciousness or whatever it is, and do remember things and they talk about experiences. ... [the perpetrator was a service provider or was believed to be a service provider. ... [she had surgery] ... because an object was used and she was - yeah, she needed quite extensive repair damage. And, you know, whether someone has dementia or not, they feel, everyone feels, and you know, it was really a shocking assault. And (indistinct) perpetrator (indistinct) hasn't been made accountable for that and who else has he assaulted (Interview s17-22: sexual assault service)*

*I [was asked to provide some support to a residential institution where a resident had reported sexual assault]. ... the staff were absolutely fantastic about it, again she had some level of dementia, she did have a history of early childhood sexual assault as well, which is ..., you know, there's a bit of weighing up ... but really they just went with, well, you know, this is what she said happened and she's obviously distressed so we're going to have to take that - we're going to believe it. But he was a reliever, so I went down, she by that stage had sort of retreated into, you know, not wanting to kind of go there, so it wasn't possible to kind of have a conversation about resident stuff or anything else about that, yeah, had a really nice conversation with her but, you know, kind of it had*

*happened, she'd said something and then, you know, but she didn't know me and I think that was an issue probably, although we did have the staff member that she felt most comfortable there with me. But anyway, he was a relieving staff so they made a decision they would never employ him again but, you know, off he went into the sector because there's absolutely no sort of [accountability]. But the police had been and everything as well so it was really handled very well and just recently we've been doing trainings with resi staff, SRS (Interview s17-22: sexual assault service).*

*... we had an allegation of sexual assault in the same dementia facility. ... When the police said something about: oh you know we'll need to take her - you know, we'll need to take her bedding and examine it. A very helpful care worker without being asked just went over - went and stripped the bed and brought the sheets back to the police. And they were horrified. ... So there was a long investigation, the allegations were against a specific member of staff ... (Interviewee S3: aged care services).*

*So the two cases that I have dealt with of - one the physical assault and one the allegation of sexual assault. ... [The staff] noticed that, you know, that this guy you know sort of, is you know showing far too much interest in the way that he was touching people under the shower and things. Not that they were alleging that he was touching genitals or anything but just a prurient interest and just - they felt a bit uncomfortable around him (Interviewee S3: aged care services).*

*Well, ... we were called out to a nursing home by a Nursing Unit Manager when one of the women in the nursing home disclosed that a staff member had sexually abused her a few nights earlier. She'd actually disclosed it to her son when he visited on the weekend. Now, she - it happened in the Dementia Unit but she didn't have dementia; she had been in the hostel. They didn't have a bed for her in the nursing home when she needed it so they popped her into the Dementia Unit for a couple of nights till a bed came. And she was able to disclose that this guy had sexually assaulted her. On record - or his staff record - showed that he'd already had an incident where he had indecently assaulted a young girl who worked in the complex with an intellectual disability. ... Now, the police decided not to proceed with charging because the woman had had a stroke previously; she had - she was [in her late 80s]. She didn't have good, you know, long-term recall and she had a lack of ability - physical frailty; that's why she was going to the nursing home. But she couldn't verbally describe very well what happened and the police just thought, "There's no way we'll this through the courts with that level of disability" not that they didn't believe her. The Nursing Unit Manager said to the Board, "We need to sack this guy. He's already got two marks against him" and they said, "Oh, no, he'll go*

*for unfair dismissal." She said, "You sack him or I'm going" and they said, "Oh, well, you better go." (Interviewee S1: sexual assault service).*

*I'll give you another example of a woman that we saw who - she was in her 90s and she became very unwell and confused suddenly. But she had been saying to the Nursing Home Manager that a man had come into her room in the night and raped her. And they sent her off to hospital saying, "She's confused." And she did; she had a [urinary tract infection]. But the nurse on the ward rang us and said, "This woman keeps telling me she's been sexually assaulted and I don't know what to believe, but I feel like she needs to be heard." So, our doctor and a counsellor went across and interviewed her and examined her, and she had occipital fractures of both hips, which showed - which was consistent with someone coming and lying on top of her (Interviewee S1: sexual assault service).*

*In early 2004, my brain injured mother was sexually assaulted by a carer in the aged care facility she resided in. the assault was not reported by staff of the facility and my mother was made to go through her allegations in front of the person who assaulted her (Survey 28: family member/carer)*

*An elderly incapacitated lady in a nursing home who was sexually assaulted by a female nurse. We charged the nurse and due to a technicality, she was not convicted. In the process, it was discovered that PCA's [personal care attendants] are not registered and there isn't a governing body for them (Survey 29: police).*

*We had a situation which we weren't able to prosecute where it was believed that a male PCA may have been sexually assaulting women in nursing homes and moving from home to home on work experience (Survey 29: police).*

*I previously worked in [names a residential aged care service] and often, we would come across sexual assault of older women whose partners/husband were the 'perpetrators'. The complexities of our experience is that their partners were victims of dementia, and would either not be able to control their actions or recall the assault. This made it particularly difficult for these carers to raise their concerns and often they would not speak to a professional, friend or family due to feelings of embarrassment, guilt and fear. Other experiences [relate to] longstanding assault throughout a marriage/relationship and how disempowered these women felt when 'no one listened to me or recognised it is really upsetting' (Survey 3: aged care services).*

*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 moved her to another separate room, and kept her safe from him. And reduced her social contact with him, as he had physical restrictions and was wheel chair bound (Survey 32: sexual assault service).*

*[We had] an elderly woman [who had an adult son with an intellectual disability]. ... One day, a staff member ... came into her room and found him in his mother's bed having sex with her. She did not appear distressed. Many questions arose... - Was it a continuation of a longstanding sexual relationship? - Had this happened before before at the ACF? - Is this a criminal offence? - What are the mother's rights and how does this change with her loss of ability to give consent? - What is the duty of the ACF to inform the managers of the son's accommodation? - Should the son's accommodation managers take action to protect other residents? (Survey 14: aged care service).*

*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).*

*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).*

*I believe it was an occurrence in a nursing home, yeah, and it was sort of another person with dementia coming into her room. ... I think he touched her on the breasts, (Interviewee S8: sexual assault service).*

*... we had a resident here who was in quite advanced dementia, essentially bedridden, and I had a phone call one evening from the staff here to say, "We've got a real problem here." There was a relative visiting and that relative was visiting his mother-in-law and you know, just spending time with her but then going - he was found in the room of this other resident, and he was sitting at the bedside and this lady had her breasts exposed. That shocked the staff in a big way. And of course this was our first experience about what we're going to do here. He denied that he had done anything and he was just*



*visiting, but I think the difficulty that we have is who in their right mind would still spend time sitting at a bedside with a lady who had her breasts exposed? You know, why would a man still continue to sit there and not be mortified and embarrassed and rush out of the room. We couldn't understand that (Interviewee S6 aged care service provider).*

*At one facility ... an elderly female patient was sexually assaulted by an intruder unknown to the facility who allegedly broke into the woman's single room during the night. This woman was non-ambulant, mentally incoherent and non-verbal due to advanced dementia. The assault was reported after a regular staff member noticed vaginal abrasions and police became involved. ... to my knowledge, no-one has been arrested for this crime (Survey 17: family member/carer).*

*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).*

## **Sexual abuse/assault at home**

The problem of sexual abuse/assault is not limited to residential aged care. The following narratives highlight how older women experience sexual abuse/assault in their own homes and how aged care service providers have such a powerful role in prevention in this context.

*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 - you know, 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?" ... The sons were going, "Well what's the problem with that," you know, and then kind of joking about the father's prowess at that age, "What's the problem with that?" And the reality is that the three sons and the husband were tied up in the property that they worked on, but two of the sons actually still lived at home, they were all drinkers, the males were all drinkers, and that was behaviour that had gone on for a very long time. 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. And the way in which they were able to handle that was to involve the doctor and look at the unintended outcomes of him continuing to have Viagra, and also by getting him regular respite so the woman could have some kind of life. ... And you know, eventually he went into care because of his dementia, the behavioural components weren't manageable at home and he actually went into care and the woman was able to carve out a bit of a safe life for herself at the home (Interviewee S9: sexual assault service).*

*[One of the] Elder Abuse Network members was telling us the story that was one of their clients, that it was her experience that she was basically, yeah, 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 S32: advocacy service).*

*... What is really tragic from I think our perspective is many of these people – and I'll say women, but it's not always women, are seeing this almost as therapeutic; that is, not for them, but what they're saying is that a lot of carers, especially where their partner is demented, that they're using sex as a means of calming the person down and to appease behavioural issues. So what we're – what I – what these people were telling me was that their partner, who obviously they once loved and once had a very good sexual relationship with, as part of their dementia process have become dis-inhibited or hyper sexual and wanting to have sex with them. And these women are saying – well, said to me that they – rather than say what would be appropriate which is no, they're actually agreeing to it because it's the quickest pathway to quieten the person down. (S33: aged care service provider).*

*I thought [one of the other staff was contacted by an older woman] about partner rape recently but it wasn't new, it was - really domestic violence that just essentially carried on into older age ... apparently 41 years' worth (Interviewee S32: advocacy service).*

*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 [us]*

*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).*

*One case has come back to me, where it was a woman who was receiving out of home care, I mean she was at home but she was having visiting outreach care and it was a woman with a sight impairment as well as other physical disabilities and she 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 come in - 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 the or talk to the woman without him being there (Interviewee S8: sexual assault service).*

*I spoke with one woman who literally walked in to find her mother in distress because her father was 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).*

*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).*

*I have had a couple of cases where a husband has had dementia [particularly when the dementia is mainly affecting the frontal lobes of the brain]. The husbands have 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).*

*Have met client whose son has assaulted her. More common husbands sexually assaulting their wives than most of society would think. Have met a number of women that has happened to (Survey 25: aged care service).*

*I remember 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).*

*Well this [woman] came in in October and it was 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).*

*Just recently I worked with an older woman who worked in a facility that was for children with disabilities and also older - I guess older children who perhaps were in their 20s but cognitively they were aged five, six or something. So she worked there as a carer, she was sexually assaulted by the manager of the service in her own home. Of course she wasn't believed. She also struggled with her mental health, .... Fortunately her GP believed her and was fantastic, but the manager of the service was a well-respected person: he's a manager of service, he wouldn't do this, you know, she's old, she's lost her husband, she probably approached him. So he wasn't charged ... , but the manner in which the police officer informed her, was even more - further traumatised*

*her, and he was advised to do it in a more sensitive way by myself and her GP, he decided to ignore that and he delivered this news over the telephone, well she, you know, immediately went into crisis and because of that, well couldn't pursue it any further. But she stopped counselling, she just stopped counselling because she thought the process is over, "I have no rights, I don't have rights to counselling, you know, I've lost everything." (Interview s17-22: sexual assault service).*

*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).*

*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).*

*Have met client whose son has assaulted her. More common husbands sexually assaulting their wives than most of society would think. Have met a number of women that has happened to (Survey 25: aged care service).*

*Very recently 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).*

*The other one that I dealt with was more serious, in home and community care, where the aged care worker was going out to the home to deliver service and a man who had full-blown dementia, she had started a sexual relationship with him. She was telling him that they were going to get married, she was taking his money, the daughter had found out and was the guardian and had said, you know, she is not coming anymore, had lodged a complaint with the aged care agency. But they hadn't fired her or anything, they just told her to stop going there but she didn't, she would sneak around there when she wasn't on shift; she would sneak around the back door to make sure the daughter wasn't there. And it was a very inappropriate situation. And as the care worker was saying, you know, "We're just friends, he wants me to be there," and the family was saying he actually had no idea who she was at all when she would arrive, he had no idea who she was, but she would sit on his knee and touch him inappropriately and all of a sudden he'd say, "Oh, it's you, of course, it's my wife" sort of thing, but it wasn't, she was just taking advantage of that situation to take what she could from him (Interviewee S12: aged care advocacy service).*

## Dedication

This submission is dedicated to Margarita Solis, who helped shape the document and died a few days before it was submitted.