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### **Australian Law Reform Commission Inquiry: Elder Abuse**

Australian National University Elder Abuse Law Student Research Group (ANU EALSARG) welcomes the opportunity to provide a submission in response to the issues paper of the Australian Law Reform Commission (ALRC) on *Elder Abuse*.

The ANU Law Reform and Social Justice (LRSJ) is a program at the ANU College of Law that supports the integration of law reform and principles of social justice into teaching, research and study across the College. Members of the group are ANU law students, who are engaged with a broad range of projects with the aim of exploring law's complex role in society, and the part that lawyers play in using and improving law to promote both social justice and social stability.

A student research group (ANU EALSARG) was formed within the LRSJ program in surveying certain topics outlined in the issues paper. Among those, Aged Care, Financial Institutions and Health Services were focused upon.

#### **We make the following general comments:**

- The prevalence of elder abuse in aged care arises out of a power imbalance between the person committing the abuse and the victim. Changes are needed to the regulation of the quality of care in aged care homes, such as a public reporting on staffing levels, the use of report cards in assessing aged care homes, and review of accreditation process. Use of antipsychotics in aged care (rarely acknowledged as elder abuse despite its detrimental consequences) should also be reviewed at a regional and national level.
- Elder financial abuse is a serious and underreported problem in Australia and internationally. Thorough research should be conducted by a dedicated research body to examine the scope and causes of financial abuse in Australia.
- There are a number of barriers to elder abuse detection amongst health care professionals that need to be overcome to improve care to patients. Solutions to improving health care amongst the elderly include educating health practitioners, multidisciplinary treatment planning, improved continuity of care and developing a straightforward pathway of reporting elderly abuse.

If we can provide further information, please do not hesitate to contact us:  
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## 1. Aged Care

Elder abuse occurs when a power imbalance exists between the person committing the abuse and the victim. Changes to the requirements concerning quality of care in aged care homes, will improve safeguards against elder abuse.

### 1.1 Elder Abuse by other residents

Resident-to-resident abuse in Aged Care is an ‘urgent and persistent issue,’ often with fatal consequences.<sup>1</sup> The abusers in these cases are often residents with aggressive tendencies due to the influence of dementia. Without the intent to commit ‘ill will,’ it is difficult to hold cognitively impaired individuals accountable for their abusive acts.<sup>2</sup> Given the context of an ageing population, coupled with the numbers of Australians living with dementia expected to increase to 400,000 in less than 5 years, this issue will become increasingly prevalent.<sup>3</sup>

The *Aged Care Act 1997* (Cth) requires providers of residential aged care to report all allegations or suspicions of reportable assaults, as a means to increase safeguards for residents of aged care homes.<sup>4</sup> A reportable assault is defined in s 63-1AA of the Act as:

- (a) *unlawful sexual contact with a resident of an aged care home,*
- (b) *unreasonable use of force on a resident of an aged care home.*

Aged care workers are not required to report an incident of abuse by cognitively or mentally impaired residents. Without the safeguard that reporting provides, staff must shoulder the burden to identify trends in resident-to-resident abuse, in order to manage the behaviour of dementia-affected residents and to provide solutions. Ultimately, this calls for extra staffing and staff training.

### 1.2 Shortage of staff: application of staff-to-resident ratios

The *Aged Care Act 1997* (Cth) s 41-3(1)(a)(i) requires aged care facilities to provide an ‘adequate number of appropriately trained staff.’ However, a NSW Nurses and Midwives’ Association survey revealed that 76% of respondents found inadequate staffing to be a

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<sup>1</sup> NSW Nurses and Midwives' Association, *Who Will Keep Me Safe? Elder Abuse in Residential Aged Care* (February 2016) <<http://www.nswnma.asn.au/wp-content/uploads/2016/02/Elder-Abuse-in-Residential-Aged-Care-FINAL.pdf>> 7.

<sup>2</sup> Ibid.

<sup>3</sup> Alzheimer's Australia, *Key Facts and Statistics 2016* (February 2016) <<https://www.fightdementia.org.au/about-dementia/statistics>>.

<sup>4</sup> Aged Rights Advocacy Service Inc, *Mandatory Reporting* <[http://www.sa.agedrights.asn.au/residential\\_care/preventing\\_elder\\_abuse/elder\\_abuse\\_and\\_the\\_law/mandatory\\_reporting](http://www.sa.agedrights.asn.au/residential_care/preventing_elder_abuse/elder_abuse_and_the_law/mandatory_reporting)>.

precursor for elder abuse, a statistic reflected on a national level.<sup>5</sup> A minimum staff-to-resident ratio would be one effective safeguard to reduce resident-to-resident elder abuse.

Arguments have been made against the use of set staff to resident ratios, culminating in the Productivity Commission's 2011 report into Aged Care. As Leading Age Services Australia have similarly argued, 'ratios are not responsive to the changing acuity of residents or the varied models of care provided across the industry.'<sup>6</sup> The fluctuating trends within the residential aged care system include occupancy rates, lifetime risk and age of entry to residential aged care, and length of stay in residential aged care.<sup>7</sup> The likelihood a person will enter permanent residential aged care is increasing; between 1997 and 2007 a 3% increase was seen in the lifetime risk of a female aged 65 years old entering permanent aged care.<sup>8</sup> The Productivity Commission has expressed concerns about a rigid application of staff to resident ratios in light of such fluctuations and subsequent operational difficulties, especially for smaller facilities.<sup>9</sup> Leading Age Services Australia reflected these concerns, stating that future aged care in Australia requires a 'flexible, blended workforce.'<sup>10</sup>

The state of the law in Australia is currently silent with regards to staffing numbers and specific 'ratios,' other than the 'adequate number,' requirement in s 41-3 of *The Aged Care Act 1997* (Cth). Current staffing levels in aged care are reflected through a rostering system and onsite review and audits, conducted by the Australian Government through the Australian Aged Care Quality Agency (AACQA).<sup>11</sup> Despite the existence of these established systems, nursing homes are regularly failing to meet accreditation standards and falling short of basic safety, nutrition and hydration requirements. In August 2015, 371 nursing homes failed to meet accreditation standards.<sup>12</sup> Re-Accreditation audits are only checked every three

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<sup>5</sup> NSW Nurses and Midwives' Association, *Who Will Keep Me Safe? Elder Abuse in Residential Aged Care* (February 2016) <<http://www.nswnma.asn.au/wp-content/uploads/2016/02/Elder-Abuse-in-Residential-Aged-Care-FINAL.pdf>> 7.

<sup>6</sup> Australian Ageing Agenda, *PUP Senate leader makes the case for ratios in aged care* <<http://www.australianageingagenda.com.au/2015/02/11/pup-senate-leader-makes-case-ratios-aged-care/>>.

<sup>7</sup> The Department of Health and Ageing, 'Technical Paper on the changing dynamics of residential aged care prepared to assist the Productivity Commission Inquiry *Caring for Older Australians*,' (April 2011) 5.

<sup>8</sup> Ibid 15.

<sup>9</sup> Productivity Commission, *Caring for Older Australians: Productivity Commission Inquiry Report Volume* (No. 53, 28 June 2011), 206: 'An across-the-board staffing ratio is a fairly 'blunt' instrument for ensuring quality care because of the heterogeneous and ever changing care needs of aged care recipients — in the Commission's view it is unlikely to be an efficient way to improve the quality of care.'

<sup>10</sup> Australian Ageing Agenda, *PUP Senate leader makes the case for ratios in aged care* <<http://www.australianageingagenda.com.au/2015/02/11/pup-senate-leader-makes-case-ratios-aged-care/>>.

<sup>11</sup> Barry Ashcroft, 'Hospital and Health Boards (Safe nurse to patient and midwife to patient ratios) Amendment Bill 2015' Leading Age Services Australia, 7.

<sup>12</sup> Choice, *Failing Standards in nursing homes and aged care. Overstretched staff and regulation oversights continue to affect quality of care* <<https://www.choice.com.au/health-and-body/healthy-ageing/ageing-and-retirement/articles/nursing-home-problems>>.

years, and assessors only talk to ‘a “minimum of 10%” of residents during inspections,’ according to the Aged Care Standards and Accreditation Agency.<sup>13 14</sup> The Commonwealth inspection scheme clearly has not met its mandate of ensuring high quality care, with most of the oversight being left to the aged care businesses themselves, placing pressure on staff. An accreditation process relying on interviews with residents as the primary source of information, is failing to pick up the problems in the aged care sector. The accreditation process and the way audits are carried out under the *Quality Agency Principles 2013* must be reviewed and overhauled, described by academics as merely a ‘document audit,’ and ‘all about the paper work and not observing care.’<sup>15</sup>

Evidence of an effective but flexible application of staff-to-resident ratios can be seen overseas in the jurisdiction of New Jersey in the United States.<sup>16</sup> New Jersey utilises a flexible system wherein nursing homes are required to record and report details about the quantity of staff involved in direct patient care. The state of New Jersey Department of Health makes these records available online to the public quarterly.<sup>17</sup> By reporting these numbers to the public and the Department of Health, it is ensured that an optimal level of staff-to-patient ratio is maintained.<sup>18</sup> This operates on the principle that the data plays a role in informing consumer choices and providing incentives for quality improvement, which indirectly influences resident to staff ratios. A lower number would indicate the fewer residents a staff member would have to deal with.<sup>19</sup> In light of the fluctuating demographic trends in nursing homes, a reporting process on staffing levels may prove an effective solution in light of an inadequate accreditation procedure and staffing shortages. New Jersey nursing homes are ranked highly, 12<sup>th</sup> in the United States, due to their reporting requirements intertwined with regular inspection.<sup>20</sup>

The interest of consumers for maximum ‘quality of life’ in aged care facilities will inevitably extend beyond blunt measurements of ‘levels of staff,’ to the postulated use of ‘report cards.’ We wish to stress that ‘report cards,’ should not be the sole policy tool to improve nursing home care. Quality is a multifaceted construct. A satisfactory staff-to-patient ratio does not alter the requirements for other aspects of quality, such as the conditions of the facility, food quality or the competence of the staff.<sup>21</sup> For a ‘report card,’ to be effective in influencing consumers, it must provide information about many aspects of quality that a consumer can

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<sup>13</sup> Ibid.

<sup>14</sup> Parliamentary Committee, *Inquiry into Aged Care, Chapter 3 – the aged care standards and accreditation agency* 2004, 3.46.

<sup>15</sup> Ibid.

<sup>16</sup> Agedcarecrisis.com, *Staffing Issues* < <http://www.agedcarecrisis.com/resources/staffing>>.

<sup>17</sup> State of New Jersey, Department of Health, Health Care Quality Assessment, Nursing Home Staffing Reports. <<http://healthapps.state.nj.us/nhstaffing/public/selectreport.aspx>>.

<sup>18</sup> State of New Jersey, Department of Health, Health Care Quality Assessment, Nursing Home Staffing <<http://www.nj.gov/health/healthcarequality/patients-families/facility-staffing/>>.

<sup>19</sup> Dana Mukamel, William Spector, ‘Quality Report Cards and Nursing Home Quality,’ (2003) 43(Suppl 2) *The Gerontologist* 58-66.

<sup>20</sup> Nursing Home Abuse Guide.org, *Nursing Home Laws and Regulations in New Jersey*< <http://www.nursinghomeabuseguide.org/states/new-jersey>>.

<sup>21</sup> Ibid.

understand. However, there exists a potential for bias in these quality measures, and this may simply worsen the inequality amongst nursing homes; risk-adjusted measures may be distorted so that factors which contribute to the decline in quality of a nursing home are not included.<sup>22</sup>

We recommend that Australia should utilise a similar approach taken by New Jersey: a flexible approach to the staff-to-patient ratio, with a reliance on influencing consumer choices and public exposure. Although this is not a complete measure of quality it will provide an important impetus to ensuring that staff-to-patient ratios are adequate, which will act as a bare-bones safeguard against resident-to-resident and other forms of elder abuse. Although regular reporting may be seen as an unnecessary burden on residential services, shortcomings in the current accreditation process, in light of evident shortages in staff, must not be ignored.

### **1.2.1 Recommendations:**

1. The adoption of public reporting on staffing levels in aged care facilities on a quarterly basis, analogous to the New Jersey system
2. The adoption of report cards when assessing aged care homes, although attention must be taken to avoid bias, and must be intertwined with regular auditing.
3. A review of the accreditation process including:
  - a. Abolishing the requirement that assessors only talk to 'a 'minimum of 10%' of residents during inspections. Raising the required percentage of residents to be interviewed will provide more reliable information on the current quality of care.
  - b. Regular Re-accreditation audits (more frequently than ever 3 years)
  - c. Audits to be carried out after hours where staffing levels are lower and violations of standards are more likely to occur

### **1.3 Quality of staff: development of a national curriculum**

The quality of staff must be improved; highly trained and sufficient levels of staff will act as the ultimate safeguard to elder abuse.

We propose the development of a national curriculum for the development of the skills of doctors, nurses, and aged care assistants working in aged care homes. A national curriculum would prepare staff for the complexity and severity of the mental state disorder of those in aged care, particularly concerning dementia. Unlike the UK, Australia is yet to implement a National Dementia Strategy, and lacks a holistic plan to tackle dementia through risk reduction, prevention programs and better care and support. The implementation of a strategy which develops a national vocational curriculum in dementia care for people working in aged care must be considered. The content of this curriculum for GPs and aged care nurses should include:

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<sup>22</sup> Ibid.

1: The basics of geriatrics and old age psychology, which is a mandatory requirement for GPs working in nursing homes in the Netherlands.<sup>23</sup> There are few GPs with an interest in these fields and thus limited opportunities for carers to develop the required skills.

2: Training focussed on the basics of ‘person centred care’ in dementia that takes into account an individual's history, hobbies, interest and preferences. The ultimate goal would be for the carer to develop an individually tailored care plan for the resident and a stimulating social environment. Individual tailored care plans (with robust family participation) have proven to be successful to minimise and deal with dementia affected residents.<sup>24</sup>

#### 1.4 Antipsychotic medication abuse

Abuse by staff is the most publicised form of elder abuse. It can arise from frustration with dealing with violent and difficult dementia affected residents, neglect, or even staff with poor temperaments.<sup>25</sup>

Antipsychotics are often used as a first response to control dementia affected patients. There is a high level of inappropriate prescribing of antipsychotic medicine (i.e. the nurse requests prescription from the resident's GP). One third of dementia patients in aged care homes use antipsychotic medicine regularly.<sup>26</sup>

The use of antipsychotics is rarely considered elder abuse, however considering the detrimental impacts it can have, awareness must be improved. Carers should be trained to avoid these medications as a first response and to not overdose elderly patients with prescription medication.

Problems associated with antipsychotic medicines include:

- Serious adverse effects – particularly cerebrovascular events.<sup>27</sup>
- Continuing antipsychotic treatment for up to two years increases mortality (risk of harm correlates to length of treatment).<sup>28</sup>

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<sup>23</sup> Schols JM, Crebolder HF, van Weel C. ‘Nursing home and nursing home physician: The Dutch experience’ *Journal of the American Medical Directors Association*, 2004, 5(3), 207–12.

<sup>24</sup> Ervin K, Finlayson SE, Cross M. ‘Reducing antipsychotic use in residential aged care.’ *School of Rural health, The University of Melbourne*, 20 June 2011.

<sup>25</sup> Agedcarecrisis.com, *Elder Abuse* <<http://www.agedcarecrisis.com/care-issues/elder-abuse>>.

<sup>26</sup> Westbury JL, Jackson S, Peterson GM. Psycholeptic use in aged care homes in Tasmania, Australia. *J Clin Pharm Ther* 2010; 35:189-93.

<sup>27</sup> Ballard C, Waite J. The effectiveness of atypical antipsychotics for the treatment of aggression and psychosis in Alzheimer's disease. *Cochrane Database Syst Rev* 2006:CD003476.

- The medicines of olanzapine, risperidone, aripiprazole and quetiapine are associated with an increased risk of mortality.<sup>29</sup>

#### **1.4.1 Recommendations:**

1. There should be national leadership for reducing the level of prescription of antipsychotic medication for people with dementia. i.e. there should be the creation of a role of the National Clinical Director for Dementia (as seen in the UK)<sup>30</sup>
2. Use of antipsychotics only as a last resort.
3. Clear, realistic and ambitious goals regarding the size and speed of reduction of antipsychotic use – should be reviewed at a regional and national level with information published yearly.<sup>31</sup>
4. Further research on the effectiveness and cost of non-pharmacological methods of treating behavioural problems in dementia.<sup>32</sup>
5. The development of a curriculum for the development of the skills of doctors, nurses and aged care assistants working in aged care homes – prepare them for the complexity and severity of the mental state disorder of those in homes.
6. Development of a curriculum for the progress of the skills of staff in non-pharmacological treatment of dementia – a national vocational qualification in dementia care should be developed for nurses in aged care homes.
7. Australia has a Dementia Behaviour Management Advisory Service (DBMAS) that provides clinical support for people caring for someone who is demonstrating dementia symptoms - this may become more effective with the regular input of a pharmacist into homes.<sup>33</sup>
8. Doctors and specialist older people’s mental health services should meet and plan how to address the problem of people with dementia on antipsychotic medicine. They should use practice and patient level data from the completed audits on the use of these medications, and should agree on how best to review and manage existing cases.

<sup>28</sup> Banerjee S. *The use of antipsychotic medication for people with dementia: time for action. A report for the minister of state for care services by Professor Sube Banerjee*

2009. <<http://www.dementiapartnerships.org.uk/wp-content/uploads/time-for-action.pdf>> 7.

<sup>29</sup> United States Food and Drug Administration. *Deaths with Antipsychotics in Elderly Patients with Behavioural Disturbances*. 2005<

<http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/DrugSafetyInformationforHealthcareProfessionals/PublicHealthAdvisories/ucm053171.html>

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<sup>30</sup> Banerjee S. *The use of antipsychotic medication for people with dementia: time for action. A report for the minister of state for care services by Professor Sube Banerjee*

2009. <<http://www.dementiapartnerships.org.uk/wp-content/uploads/time-for-action.pdf>> 8.

<sup>31</sup> Ibid.

<sup>32</sup> Ervin K, Finlayson SE, Cross M. ‘Reducing antipsychotic use in residential aged care.’ *School of Rural health, The University of Melbourne*, 20 June 2011.

<sup>33</sup> Banerjee S. *The use of antipsychotic medication for people with dementia: time for action. A report for the minister of state for care services by Professor Sube Banerjee*  
2009 <<http://www.dementiapartnerships.org.uk/archive/wp-content/uploads/time-for-action.pdf>>.

## **2. Financial Elder Abuse**

### **2.1 Definition**

In order to fully address problems of financial elder abuse, it is evident that there must be a clear, concise definition. To this end, we will analyse both international and Australian interpretations of 'elder financial abuse' and ultimately confine the meaning to a suitable scope allowing for further discussions on this topic.

A leading source on a definition of the topic is the World Health Organisation, which defines elder financial abuse as: *'The illegal or improper exploitation or use of funds or other resources of the older person'*.<sup>34</sup>

We contend that this definition is useful for highlighting the necessity of an element of trust that must exist in the relationship between the elderly person and the abuser. Further it explains that the abuse need not be limited to illegal acts, and may also consist of acts of 'improper exploitation' of the trust held by the elderly person towards the abuser. However, despite its usefulness, it lacks the specificity paramount to addressing the issue at hand. For example, the definition fails to specify within which relationships the abuse may occur and if it is just limited to persons or if it includes institutions. Once one considers that financial abuse can be interpreted differently, this definition is too broad.

The Protecting Elders' Assets Study conducted by Monash University in 2009 demonstrated that elder financial abuse was not confined only to the abuser and the elder, but that institutions could also partake in the abuse. It also noted that the abuse does not have to be 'improper or illegal', as 'exploitation' itself is sufficient to cover the act. Their definition is as follows:

*[including] acts with adverse outcomes committed not only by people known to and in a trusting relationship with the victim, but also those perpetrated by strangers and by even institutions.*<sup>35</sup>

Similarly, the Queensland-based Elder Abuse Prevention Unit (EAPU) founded by *UntingCare* defines financial abuse as:

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<sup>34</sup> Etienne G. Krug, Linda L. Dahlberg, James A. Mercy, Anthony B. Zwi and Rafael Lozano, 'World Report on violence and health' (Report, World Health Organization, 2002) 127 <[http://apps.who.int/iris/bitstream/10665/42495/1/9241545615\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/42495/1/9241545615_eng.pdf)>.

<sup>35</sup> Peteris Darzins, Georgia Lowndes and Jo Wainer, 'Financial abuse of elders: a review of the evidence -Protecting Elders' Assets Study' (Study Paper, Monash University, 2009) 5 <[http://www.eapu.com.au/uploads/research\\_resources/VIC-Financial\\_Elder\\_Abuse\\_Evidence\\_Review\\_JUN\\_209-Monash.pdf](http://www.eapu.com.au/uploads/research_resources/VIC-Financial_Elder_Abuse_Evidence_Review_JUN_209-Monash.pdf)>.



*The illegal or improper use of a person's finances or property by another person with whom they have a relationship implying trust.*<sup>36</sup>

Though not as specific or well scoped as the Monash study, this definition replaces the wordy phrase 'people known to and in a trusting relationship' with the much more concise 'relationship implying trust'. As a result, the EAPU definition has been adopted and cited by a number of other agencies in their publications, including the Victorian Department of Human Services and Senior Rights Victoria. This testifies to its authority and value as a scope determinant of the topic.

Ultimately, from all of the above definitions, it is clear that 'elder financial abuse' has several key themes.

- Exploitation (of a relationship of trust with the elder person)
- Finances, property, funds, other resources
- By strangers, institutions, people in a relationship implying trust
- Of the elder
- In a manner detrimental to the elder person (be it through decreased value of the elder person's assets as the abuser has used it to pay their bills instead, etc.)

However, there is inherent complexity in examining when a well-intentioned act that fails to deliver financial benefit (such as investing in shares to get the elder person more money, that falls in price later on) becomes abuse.

Therefore, as the Monash Study suggested, these definitions raised problems in regards to intent (*mens rea*) and the distinction between 'thoughtless practice and outright theft'.<sup>37</sup>

As such, the Monash Study mentions two categories of elder financial abuse:

- Intentional financial abuse 'the separation of a person from the benefit of their assets for the benefit of another, involving deliberate intention'
- Unintended abuse 'the inadvertent or uninformed financial mismanagement or neglect of financial assets which causes the deprivation of benefits to be derived from those assets'

However, we contend that it is better to have one concise statement of the scope of the topic, and hence it is clear there is one final element in the definition:

- The intentional (deliberate) abuse and the unintended (neglect) of the elder.

Ultimately, we submit that the definition of 'financial elder abuse' to be:

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<sup>36</sup> Elder Abuse Prevention Unit, *Financial Abuse* < <http://www.eapu.com.au/elder-abuse/financial-abuse>>.

<sup>37</sup> Louise Kyle, 'Assets for Care: A guide for lawyers to assist older clients at risk of financial abuse' (Guide, Seniors Rights Victoria, 2012) 7.

**The intentional or negligent exploitation of finances, funds, property, or other resources belonging to the elder by strangers, institutions, or people in a relationship implying trust.**

## **2.2 How Prevalent is Financial Elder Abuse?**

### **2.2.1 Evidence of Financial Elder Abuse in Australia**

Before recommendations can be made as to how the law must be changed to prevent financial elder abuse, we must examine its current prevalence.

We draw the ALRC's attention to research compiled by the Australian Institute of Family Studies (AIFS) into elder abuse, which has explained that financial abuse is one of the most common types of elder abuse reported.

Firstly, although elder abuse is generally underreported, calls regarding elder abuse have increased substantially to the Elder Abuse Prevention Unit (EAPU) hotline to approximately 1200 in 2014-15.<sup>38</sup> Most of these calls were in regards to financial abuse, which constituted 40% of reports.<sup>39</sup> The prevalence of financial elder abuse has overtaken psychological abuse (at 35%), which was the former most common type in 2012-13.<sup>40</sup>

However, this figure may be higher than reported once it is considered that financial elder abuse may encompass a much broader sphere than considered in the study. Furthermore, one must consider the skew in gender that this study contained as calls were mostly in relation to female victims. Thus, although we believe that financial elder abuse is a serious issue that is growing in prevalence, more study must be undertaken in order to better understand its prevalence amongst the male elderly population.

The findings of this study are backed by a recent Victorian study by the National Ageing Research Institute.<sup>41</sup> Out of the 455 calls that raised elder abuse issues, 61% of calls related to issues of elder financial abuse.<sup>42</sup> However, similar demographical issues to the

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<sup>38</sup> Ceallaigh Spike 'The EAPU helpline: Results of an investigation of five years of call data' (Research Report, International Association of Gerontology and Geriatrics Asia & Oceania Regional Congress, 2015).

<sup>39</sup> Ibid.

<sup>40</sup> Ibid.

<sup>41</sup> Melanie Joosten, Briony Dow and Jenny Blakey *Profile of elder abuse in Victoria: Analysis of data about people seeking help from Seniors Rights Victoria. Summary report. Melbourne: National Ageing Research Institute & Seniors Rights Victoria* (March 2014) Senior Rights <[seniorsrights.org.au/wp-content/uploads/2014/03/Summary-Report\\_Profile-of-Elder-Abuse-in-Victoria\\_Final.pdf](http://seniorsrights.org.au/wp-content/uploads/2014/03/Summary-Report_Profile-of-Elder-Abuse-in-Victoria_Final.pdf)>.

<sup>42</sup> Ibid.

aforementioned EAPU hotline study arise, as there was a skew towards reporting of female victims as opposed to males.

Moreover, we draw the ALRC's attention to two years of call data to the NSW Elder Abuse Hotline (compiled by the NSW Elder Abuse Helpline and Resource Unit), which exhibited similar patterns to that of its Queensland and Victorian counterparts. Financial abuse constituted 46% of 3,388 calls in the NSW study to form the second most prevalent form of elder abuse.<sup>43</sup>

However, the AIFS has noted in its 2016 study that 'financial abuse is reported to occur at similar rates whether or not the victim has dementia'.<sup>44</sup> The ALRC should note however, that an elderly person with dementia allows for the possibility for an adult child (or someone else who is nominated a potential carer/decision maker) to abuse power of attorney privileges that may be necessary for the elderly person to obtain due to their condition.

### **2.2.2 Evidence of Elder Financial Abuse Internationally**

Though international evidence may be less relevant to the issues at hand, the analysis of countries with similar fiscal environments as Australia may provide insight into financial elder abuse on the global stage.

The WHO estimated the prevalence of rate of abuse in high or middle income countries. Financial abuse appeared as the form of abuse with the highest maximum (1-9%), which not only indicates its prevalence, but a lack of clarity as to its definition.<sup>45</sup> These estimates however, only take into account elderly people in private and community settings and not those with cognitive impairments or in institutional care. However, these are the elderly people most susceptible to abuse, which highlights that financial elder abuse may be well underreported. Even if these figures were taken to be accurate, it indicates financial abuse constitutes a major part of elder abuse. Moreover, in 2015, the WHO recently reported that estimated prevalence of elder abuse in high-or middle-income countries ranged from 2% to 14%, with financial abuse in particular ranging from 1-9%.<sup>46</sup>

In the US, a study, based on 5,777 respondents (aged 60 and over), contacted through random-digit dialling in 2008, found that one in ten respondents had experienced elder abuse

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<sup>43</sup> NSW Elder Abuse Helpline and Resource Unit, Submission to the Parliament of New South Wales, *Parliamentary Inquiry into Elder Abuse in New South Wales*. Sydney, 2015.

<sup>44</sup> Rae Kaspiew, Rachel Carson and Helen Rhoades 'Elder abuse: Understanding issues, frameworks and responses' (Melbourne: Australian Institute of Family Studies, 2015).

<sup>45</sup> World Health Organization, *World report on ageing and health* (2015)

<[www.who.int/ageing/publications/world-report-2015/en/](http://www.who.int/ageing/publications/world-report-2015/en/)>.

<sup>46</sup> Ibid.

in the past year.<sup>47</sup> The most common types of abuse were: financial abuse by a family member (5%).<sup>48</sup>

The UK Study of Abuse and Neglect of Older People was based on face-to-face interviews with 2,111 people aged over 66 years living in private settings across the UK in 2006.<sup>49</sup> The study measured whether the participants had experienced mistreatment in the preceding 12 months at the hands of a family member, friend or care worker. Overall, 4% of the sample reported mistreatment in the defined period, comprising 4% of women and 1% of men.<sup>50</sup> In this study, neglect (1%) and financial abuse (0.7%) were the most common forms of abuse.<sup>51</sup>

### **2.3 Recommendations:**

1. More research must be conducted, to provide an accurate estimate of the prevalence of financial abuse in Australia.
2. The research conducted should be done by a dedicated research body, which will also provide a holistic definition for financial elder abuse.
3. This research body should also conduct research into the financial elder abuse of males, to determine whether there is a serious underreporting problem, or if financial elder abuse towards females is equally as or more prevalent.
4. This research body should aim to provide recommendations to curb the level of financial elder abuse in Australia.

## **3. Health Services**

### **3.1 How can the role that health professionals play in identify and responding to elder abuse be improved?**

Many health care professionals treat the elderly; these include but are not limited to medical practitioners (physicians and surgeons), dental practitioners, and other allied health care

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<sup>47</sup> Ron Acierno, Melba Hernandez and Deane Kilpatrick 'Prevalence and correlates of emotional, physical, sexual and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study' (2010) 100 *American Journal of Public Health* 2, 292–297.

<sup>48</sup> Ibid.

<sup>49</sup> Madeleine O'Keeffe, Amy Hill, Melanie Doyle, Claudine McCreadie, Shaun Scholes and Rebecca Constantine, *UK Study of Abuse and Neglect of Older People: Prevalence survey report* (London: National Centre for Social Research, 2007).

<sup>50</sup> Ibid.

<sup>51</sup> Ibid.

professionals including nurses, physiotherapists, nutritionists, and occupational therapists. There are a number of barriers to elder abuse detection amongst health care professionals that need to be overcome in order to improve care to those patients.<sup>52</sup>

The first barrier is 'Professional Orientation'. It was found that nurses expressed passion about caring for patients and looked to explanations other than elder abuse to explain why their patients were not doing so well. In a study of Iowa, it was found that most nurses felt they should never report directly to the 'Iowa Department of Human Services,' the agency for investigating elder abuse; these nurses stated that they were unwilling to accuse people in the absence of 'strong suspicions.'<sup>53</sup> Studies have found that physicians or supervisors rather than the nurses should be dealing with the abuse.<sup>54</sup> Alternatively, physicians thought that social workers were the ones to deal with the suspected elderly abuse. It has been revealed however, that social workers are hesitant to talk to patients about abuse, due to the fear of alienating caregivers and patients, fear of identifying the wrong perpetrator, or triggering retaliation attacks on the patient. There is evidently a circular 'Professional Orientation,' problem in how health professionals identify and respond to elder abuse.

The second barrier to overcome is clinical assessment. All clinicians felt that a lack of time was the major problem in assessing an elderly person. 'Physicians were more focused on known diseases or physical conditions that they could treat and with which they were more familiar.'<sup>55</sup> Health practitioners also thought that there was a general lack of sensitivity in detecting abuse of the elderly, as one could only see what was in front of them, not what occurred before the practitioner arrived or after they left.

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<sup>52</sup> Schmeidel A, Daly J, Rosenbaum M, Schmuck G, Jogerst G, 'Healthcare Professionals' Perspectives on Barriers to Elder Abuse Detection and Reporting in Primary Care Settings.' (2012); 24(1) *J Elder Abuse Negl* 2.

<sup>53</sup> Ibid 5.

<sup>54</sup> Ibid 4.

<sup>55</sup> Ibid 6.

### **3.1.1 Recommendations:**

Improving detection of elder abuse by health care professionals requires the following:

1. *Education*: all health care practitioners should be educated in identifying elderly abuse. This would involve examining the educational parameters of under graduate and postgraduate health care degrees. By improving the ability to assess and identify abuse amongst the elderly would be the initial step in providing better care for those affected. Education also includes all nursing home staff so they are informed of the signs of elder abuse.<sup>56</sup>
2. *Multidisciplinary treatment planning*: all health practitioners treating the elderly should be encouraged to collaborate and discuss the patient's various problems with each other.
3. *Improved continuity of care*: continuity of care requires a practitioner to treat the patient over a period of time. Whether this is the medical practitioner or nurse, the longer a patient is looked after by the same clinician the more obvious changes in personality and physical traits can be diagnosed. Accordingly, elder abuse can be diagnosed at an earlier stage.
4. *Straightforward pathway for reporting elderly abuse*: providing a clear pathway for reporting elderly abuse would allow a health care practitioner to respond in an efficient manner.

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<sup>56</sup> Ibid 11.