108. Dr J Cullen & J O'Keeffe

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* Current aged care assessment programs are predominately assessment programs and do not have the capacity to respond to elder abuse situations as currently briefed by the ACAT funding body ie. their ‘official’ role currently is minimal.
* Assessors do have extensive training and knowledge in identifying people at risk of elder abuse. The initial comprehensive psycho-social assessment is vital in detecting people at risk of elder abuse therefore assessors have a good understanding of risk factors and signs and symptoms of abuse.
* Assessors should be able to provide clear information and education to people at risk as to the supports and options available to them and have clear referral pathways to appropriate services, which at present time do not exist.
* Assessors can refer to the NSW Elder Abuse Hot line however this is only an advocacy/Information service, with no case management service at the grass roots level that can support a victim of abuse or a person at risk. The NSW Elder Abuse hot line often refers to ACAT for advice and guidance.
* Unless the role of assessment services is extended to longer term case management, the ability of assessment teams to contribute further to responding to the risk of elder abuse is limited to this process of identifying and referring appropriately for support for the client.

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* Insufficient evidence as yet. It is unclear how this data would be captured, if ever, in any transitioned sites or by the NDIA which is of concern.

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* No. accreditation against the National Disability Standards only provides a snapshot of the way services undertake their business as present at that time.
* There is anecdotal evidence that suggests the way in which NDIS service providers charge clients for services differs immensely, e.g. travel time, note taking, phone calls, etc. due to the lack of standardisation (or the ability to manipulate these tasks, people with increased vulnerability are at greater risk of being taken advantage of).
* The lack of tertiary qualifications needed to become a NDIS planner is also of concern, as this limits the planners experience, knowledge and ability to identify risk factors of elder abuse, which increases the likelihood of instances of abuse not being identified.

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* As older people present to all clinical areas of health, not just designated Aged Care Services, all health professionals from all clinical areas, inpatient and community based staff, need to be able to identify signs of abuse, and be aware of the escalation or referral process. This includes all inpatient, ED, ambulatory care and community based staff.
* For specific staff who have been identified as needing to respond to abuse, training on assessing risk and appropriate questions to ask to formulate their assessment and response is required. Health professionals may shy away from any intervention due to lack of knowledge and confidence, fear of placing the victim in further dangerand the understanding there are no appropriate referral pathways to support their interventions.
* Mandatory training throughout all health districts is important to ensure all health professionals have the knowledge, skills and confidence to identify a victim of elder abuse or a person that may be at risk of abuse and how to best respond. Most health professionals lack specific knowledge about elder abuse, its prevalence, how to identify risk factors including signs and symptoms, how to best respond and work with perpetrators. Health professionals need a high standard of clinical and communication skills to work with elder abuse victims.
* Each LHD should have a specific, localised Elder Abuse Policy.
* Health Professionals should be able to respond in accordance to the Local Health District policy with the support of police and other community services.
* Form strong partnerships with local police, Family and Domestic Violence officers, so health professionals have the support of legal and health services in their interventions. There is a need for collaboration between NSW Health and the Justice system.
* A large part of health professional’s role should be to provide education and raise awareness on elder abuse.
* The current responses to elder abuse are variable from police and services .This may be due to the justice system and community services lack of training in identifying abuse such as signs and symptoms, risk factors associated and how to best respond. Although Elder abuse is a form of Family Violence, training needs to be specific to elder abuse looking at risk factors, the impact of dementia, cognitive impairment and capacity issues and specifically at POA and guardianship issues.
* There are a limited number of resources available to health professional to access and implement to support victims of elder abuse.
* A specialised elder abuse case management service would be beneficial, where services are accessible, with partnerships between health and the Justice and Legal system in order to best support victims or vulnerable adults at risk of elder abuse.
* Within the reformed aged care environment, with much more of a ‘user pays’ focus, there is potential for increased financial abuse. There are recent examples of family members declining needed services for their family member because of the cost of services, leaving older people at risk ie family members with conflicts of interest protecting the inheritance
* While consumer directed care is generally supported, there is potential for abuse in situations where the person lacks cognitive capacity. The awareness and use of independent advocates for the impaired older person is low. Again family members could be perceived as having conflict of interest, if they are the ones deciding whether to engage an advocate or not.

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Other comments?