

Submission to: Australian Law Reform Commission (ALRC)

Issues Paper

Protecting the Rights of Older Australians from Abuse

1. **What is Capacity Australia?**

Capacity Australia ([capacityaustralia.org.au](http://capacityaustralia.org.au)) is a-not-for-profit medico-legal organisation led by senior legal and medical/psychiatric academics, clinicians and practitioners. We are committed to supporting the rights of people with decision-making disability.

**How do we do this?**

One of the ways we do this is by providing education regarding capacity (decision making ability) across medical, allied health, legal, financial and community sectors across Australia and internationally.[[1]](#footnote-1) A major element of our mission is to ensure that people with decision making disability can make the decisions (especially financial) that they are capable of making, while preventing abuse.

We note that these dual, sometimes competing priorities are asserted in Articles 12 and 16 of the United Nations *Convention of the UN Rights of Persons with Disabilities (*CRPD*).*[[2]](#footnote-2) Another equally important priority is to ensure that when decisions are made, people with disability are afforded access to the highest attainable standard of health without discrimination on the basis of disability, as asserted in Article 25 of CRPD. This is extremely relevant when issues of abuse by neglect or with-holding of health or services arise.

We note that our objectives align with the principles that Senator the Hon George Brandis QC, Attorney-General of Australia, has given regard to in drafting this Issues paper, namely:

* *the principle that all Australians have rights, which do not diminish with age, to live dignified, self-determined lives, free from exploitation, violence and abuse*
* *the principle that laws and legal frameworks should provide appropriate protections and safeguards for older Australians, while minimising interference with the rights and preferences of the person, and*
* *relevant international obligations relating to the rights of older people under United Nations human rights conventions to which Australia is a party*.

In this submission Capacity Australia wishes to address the questions posed in the issues paper where we have particular expertise and which speak to the human rights principles outlined above.

In early 2016, Capacity Australia made oral and written submissions to the NSW Parliament Legislative Council. General Purpose Standing Committee No. 2 Elder abuse [[3]](#footnote-3) where many of these questions were addressed. Where relevant, we will refer to these.

1. **What is elder abuse ?**

**Question 1 To what extent should the following elements, or any others, be taken into account in describing or defining elder abuse: · harm or distress; intention; · payment for services?**

According to the World Health Organisation [[4]](#footnote-4) definition, elder abuse can be defined as:

*a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an* ***expectation of trust*** *which causes harm or distress to an older person. Elder abuse can take various forms such as physical, psychological or emotional, sexual and financial abuse. It can also be the result of intentional or unintentional neglect.[[5]](#footnote-5)*

This definition clearly includes harm and distress, with a clear link between harm and exploitation of trust and vulnerability, a key factor distinguishing harmful behaviours involving older adults from harmful behaviours involving other adults.[[6]](#footnote-6) More importantly, understanding the link between vulnerability and harm by undue influence [[7]](#footnote-7) is an important key to addressing elder abuse, recognised in both Articles 12 and 16 of the CRPD, and a central focus of Capacity Australia’s work locally and internationally.

Neglect resulting from failure of payment of services is a typical manifestation of elder abuse, resulting from sequestration of the older adults’ finances, limiting access of the older adult to their own finances, or use of the older adult’s finances in ways that do not benefit the older adult. This is financial abuse - the illegal or improper use or mismanagement of a person’s money, financial resources, or property or assets without the person’s knowledge or consent, for purposes other than to serve their wishes or needs.[[8]](#footnote-8)

**Question 3 The ALRC is interested in hearing examples of elder abuse to provide illustrative case studies, including those concerning: · people from culturally and linguistically diverse communities; people with disability.**

In regards to older people with disabilities, undue influence (a term usually referring to coercion in the context of will-making, but also relevant to other transactions) is an important causative factor in elder abuse, whereby the physical and cognitive vulnerability of older people is exploited by others seeking to gain advantage from the older person’s decisions.[[9]](#footnote-9) Undue influence can occur in all circumstances where one person can benefit from the decision making of another, commonly in the procurement of legal documents that favour, advantage or give power to the “influencer”. There is an onus on both lawyers and health care professionals to identify and recognise undue influence due to clearly articulated professional obligations in regards to elder abuse prevention and action.[[10]](#footnote-10) Undue influence may be unwittingly facilitated by legal and financial professionals engaged for the purposes of executing documents or assisting with the management of financial affairs.

This is often due to a failure to detect when people are struggling with the management of their financial affairs – i.e. when people lack financial capacity. Importantly, financial capacity includes, in addition to basic monetary skills, ability to conduct cash transactions, financial conceptual knowledge and knowledge of assets, *financial judgment.* Financial judgment involves the ability to withstand fraud, exploitation and abuse.[[11]](#footnote-11)

In regards to culturally and linguistically diverse (CALD) groups, cultural practises and beliefs often influence whether or not behaviour is considered abuse, and whether such abuse is even reported. Older people from CALD backgrounds may be at particular risk of abuse by virtue of isolation, lack of English proficiency, “familism” which emphasizes the needs of the family over the needs of the individual, and shame or stigma which leads to concealing mistreatment and inhibiting formal help-seeking.[[12]](#footnote-12) Capacity Australia has partnered with a variety of ethnic community groups to promote community education and awareness raising of these issues.

In Report 44 of the NSW Parliament Legislative Council. General Purpose Standing Committee No. 2 Elder abuse it was noted that Professor Peisah, speaking on behalf of Capacity Australia:

*drew attention to the challenges of reaching CALD communities, which are well known to access a disproportionately low share of services. She asserted that, ‘It is hard enough for culturally and linguistically diverse families to access many health services and many dementia services let alone to ring up a hotline and say, “My son just ripped me off”’. Thus she called for strategies that are integrated into ethnic communities and that address the stigma and shame of abuse. Capacity Australia’s submission recommended specific funding for Aboriginal and CALD communities to enable the development of culturally appropriate tools in collaboration with the communities themselves, which are then utilised in culturally respectful ways:*

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

Perhaps the largest study of the nature and prevalence of elder abuse in Australia has been conducted on behalf of State Trustees Limited by Eastern Health Clinical School, Monash University, Melbourne.[[13]](#footnote-13) [[14]](#footnote-14) Further research looking at prevalence and correlates (associations) of abuse in order to identify appropriate targets for intervention is needed. Particular areas where there is no data, include the banking and financial sector.

Given that many of the solutions to this problem lie in de-stigmatisation, awareness-raising and education of professionals across health, law and finance, more knowledge translation research (which goes beyond merely delivering a didactic session) such as has been undertaken by Capacity Australia is needed across all sectors. There have been clear processes developed for this type of research.

**AGED CARE**

**Question 11 What evidence exists of elder abuse committed in aged care, including in residential, home and flexible care settings?**

Using the above definition of elder abuse which encompasses lack of appropriate action and neglect of older people causing harm, there is evidence that elder abuse manifests in a number of ways in aged care settings.

More than 50% of residents in Australian Government-subsidised aged care facilities have dementia. [[15]](#footnote-15) Separately, approximately 25% of older people in residential care have depression.[[16]](#footnote-16) Many of these people are unable to communicate their needs (e.g. pain, loneliness, hunger, intimacy) due to expressive (speaking) or receptive (understanding) language disturbance, hopelessness or apathy. As a result, these needs are not met. This is neglect. Moreover, while depression screening is mandated in residential care, poor scores are not followed up.[[17]](#footnote-17) This is neglect.

Behavioral and psychological symptoms of dementia (BPSD) are symptoms of disturbed perception, thinking, mood and behaviour occurring in people with dementia, often an expression of these unmet needs.[[18]](#footnote-18) BPSD include agitation, aggression, calling out/ screaming, disinhibition (sexual), wandering, night time disturbance, shadowing, swearing, depression, anxiety, apathy, delusions, hallucinations, irritability and elation/euphoria. They occur so commonly as to be virtually ubiquitous in dementia, with up to 97% of people experiencing BPSD of variable severity during the course of their illness.[[19]](#footnote-19)

Very often, rather than meeting these needs, people are restrained chemically or physically (see Question 16). Both types of restraints cause harm.[[20]](#footnote-20) This is abuse by lack of action, neglect and harm.

**Question 12 What further role should aged care assessment programs play in identifying and responding to people at risk of elder abuse?**

Aged care assessment teams are often at the forefront of contact with older people who are at risk or victims of abuse, and as such have a duty of care in regards to identification and response. The following exchange during the Inquiry into Elder abuse, NSW Legislative Council. General Purpose Standing Committee No. 2 (Transcript Friday 20th November, 2015, p14), between the Manager of the Leader from the NSW Elder Abuse Helpline and Resource Unit and Hon Bronnie Taylor illustrates these issues perfectly:

*Ms MARSHALL: Mandatory education across all organisations that serve older people is essential. Further, this education needs to be supported by government and local policies and procedures that are compatible with the law and made explicit to staff, and provide explicit directions and responsibilities.*

*Hon. BRONNIE TAYLOR: One of your recommendations is looking at training and identifying responding to elder abuse for all front-line staff. In thinking about practising as a nurse and going into someone's home, I knew what to do if I thought something was not right. Do you think some front-line staff almost need to go through a checklist when someone contacts a service? Do we need to flag to people to start thinking more about elder abuse?*

*Ms MARSHALL: I think it is both. My understanding is that the new Regional Assessment Service [RAS] do actually have a box to tick to say that they have checked for elder abuse. But we are still going back to the question of whether they have a basic understanding of what they are looking for when it comes to elder abuse, because there are so many different symptoms or things that they could be checking for to know. There just does not seem to be an eyes wide open approach to the fact that this could be elder abuse (transcript, p14).*

Capacity Australia supports an “eyes wide open approach” facilitated by development of policies, procedures and mandatory training across the health sector, where there is often at present, “eyes wide shut”.

**Question 15 What changes to the requirements concerning quality of care in aged care should be made to improve safeguards against elder abuse?**

In order to address the harm caused by neglect of needs, higher staff ratios are needed, including higher ratios of experienced registered nurses. The current mandated minimum of registered nurses within facilities is insufficient to prevent elder abuse by neglect and overuse of restraint.

Training in identifying and meeting needs is also required, and a culture that promotes person centred care over task orientated care. Despite this rubric being touted for some ten years, abuse and overuse of restraint continues. Mandatory reporting of data relating to psychotropic use will address accountability in regards to overuse of psychotropics. Evidence - beyond a tick box approach – of person centred care in facilities will address abuse by neglect of needs.

**Question 16 In what ways should the use of restrictive practices in aged care be regulated to improve safeguards against elder abuse?**

Restrictive practices include both chemical and physical restraint. Chemical restraint is the intentional sedation or control of an individual’s behaviour through the use of medicines. Physical restraint is the restriction of an individual’s movement by physical means including bed boundary markers, chairs with deep seats or tables, rockers and recliners, lap belts, hand mitts and seat belts. Bed rails and removing mobility aids are considered “high risk restraints” and seclusion, leg, wrist or ankle restraint “extreme restraints”. “Environmental restraint” is the restriction of movement of the client without the client’s explicit and informed consent (eg. locked units, fenced areas). [[21]](#footnote-21)

Reliance on chemical restraint to “manage” BPSD symptoms occurs commonly and is increasing in Australia.[[22]](#footnote-22) These medication have a range of serious side effects and are associated with increased mortality for people with dementia, while the evidence supporting the effectiveness of chemical restraint in treating BPSD is modest at best. [[23]](#footnote-23) This is despite a growing body of evidence for non-drug interventions. [[24]](#footnote-24) [[25]](#footnote-25) [[26]](#footnote-26)

International consensus guidelines recommend the use of multidisciplinary, individualised (person-centred) psychological and social approaches as a first line approach to behavioural symptoms of dementia. Such person-centred care relies on assessment involving observation, measurement and monitoring of BPSD to assess the antecedents, triggers and consequences of behaviours – often a communication of unmet needs or a response to too much or not enough stimulation in the environment. Thought needs to be given into working out why the behaviour is occurring, not a phone call to the GP for a prescription of sedation.

One of the most common unmet needs in dementia is pain, the detection of which can be problematic in people who have language deficits, rendering may people with dementia in nursing homes “silent and suffering”.[[27]](#footnote-27) To ignore and neglect pain is elder abuse.

Finally, there is evidence that consent is often not obtained for the use of these medications by either the person or their authorised substitute decision-maker.[[28]](#footnote-28) To treat without consent is battery. There is both anecodotal and research evidence [[29]](#footnote-29)[[30]](#footnote-30) that family members who are designated decision makers are:

1. not consulted in regards to consent for chemical restraint;
2. not informed about the major side effects including mortality risk of chemical restraints; and
3. often subject to pressure by residential care facilities to accede to chemical restraint for fear of the resident with BPSD losing tenure in the facility;
4. fearful of deprescribing (reducing medications) because of misinformation about the efficacy of these medications and alternatives available.

Compliance with the Aged Care Act 1997 may be compromised when facilities transfer patients to hospital due to “unmanageable” BPSD, with threat of loss of a bed. This is not uncommon, although there is no data available regarding this. It is important to understand that there is scientific consensus that the acute hospital setting is associated with adverse outcomes for patients with dementia (high use of chemical restraint, infections, skin tears, functional decline, pressure injuries, under-nutrition; falls-related injuries; prolonged length of stay and mortality). [[31]](#footnote-31) Thus, while transferring a person with BPSD to hospital may benefit the facility who cannot manage the BPSD symptoms, it does not benefit the patient.

Drug use for treating BPSD symptoms of unmet need should and can be reduced, if not stopped.[[32]](#footnote-32) A recent Australian study “HALT” showed that 75% of patients were able to stop chemical restraint in facilities where residential care nurses and facility managers were educated on how to identify, manage and prevent BPSD. [[33]](#footnote-33) Additionally, general practitioners who care for patients in aged facilities need more training in the management of BPSD and the use and avoidance of use of chemical restraint, this being a recommendation of a Coronial Enquiry in South Australia some 5 years ago.[[34]](#footnote-34)

The use of restrictive practices in aged care can be regulated by monitoring psychotropic use and residential facilities graded on this and given incentives for demonstrated best practice. Transfers to the acute hospital setting need to be justified and in keeping with the person’s advance care plans or directives. This can be audited.

Additionally, audits of consent documentation should be encouraged. Families need to be educated about the adverse effects of chemical restraints and their role in consent in appropriate circumstances.

Finally, more scrutiny in regards to the compliance of facilities under the Aged Care Act 1997 in regards to obligations of care provision and tenure of accommodation is required. The Australian Residential Care Manual (2014) [[35]](#footnote-35) articulates these obligations with legislative references to Sections 23.5, 23.6, 23.15, User Rights Principles 1997. Further, in regards to the Aged Care Act 1997, there is agreement that the Charter of Care Recipients Rights and Responsibilities need to be prioritised in the legislative framework and elevated from schedules (where they are treated by many providers as optional) to the body of the Act.[[36]](#footnote-36) [[37]](#footnote-37)

1. **Financial institutions**

**Question 25 What evidence is there of elder abuse in banking or financial systems?**

There is no reporting of elder abuse in banking or financial systems. Thus, there is no evidence. Yet we know that at least 5% of older Australians are subject to financial abuse and that banking and financial systems provide the means of access to those exploiting them. [[38]](#footnote-38) This lack of transparency and accordingly, lack of data [[39]](#footnote-39) to truly enable us to prevent and deal with financial elder abuse compounds the problem.

**Question 26 What changes should be made to the laws and legal frameworks relating to financial institutions to identify, improve safeguards against and respond to elder abuse? For example, should reporting requirements be imposed?**

Capacity Australia was established to address elder abuse as one of its prime missions. It has been committed to doing so by educating the financial sector since the receipt of a UNSW Dementia Collaborative Research Centre Knowledge Translation Grant in 2013. Using that grant we developed a brief, user friendly education tool tailor-made to the Australian banking environment, tested with three of Australia’s major banks and proven to increase knowledge of banking staff [[40]](#footnote-40). We enclose a link for a demo to the tool to assist the ALRC <https://aelp.smartsparrow.com/v/open/jmhcghtf> and have appended the research paper to this submission. Despite its release 18 months ago, we have yet to have one Australian bank adopt this education tool. Moreover, although Capacity Australia has produced specific training on elder abuse for accountants and financial planners, we are struggling with engaging the interest of the industry in this issue.

The Australian banking and financial sector needs to align with other countries (who have been providing education on elder abuse in the sector for some 20 years) with a commitment to addressing its responsibilities in regards to elder abuse. The lack of transparency, reporting responsibilities, and resulting lack of data on elder abuse [[41]](#footnote-41) in this setting compounds this issue.

Capacity Australia noted Recommendation 9 of the NSW Legislative Council Report 44 on elder abuse:

*That the NSW Government fund the NSW Elder Abuse Helpline and Resource Unit to conduct information sessions with financial institutions to raise awareness of financial abuse and promote online training tools for staff such as Capacity Australia’s training program to identify financial abuse.*

This recommendation needs to be endorsed and enforced nationally. Capacity Australia recommends that both reporting AND education requirements be imposed.

**Appointed decision-makers**

**Question 29 What evidence is there of elder abuse committed by people acting as appointed decision-makers under instruments such as powers of attorney? How might this type of abuse be prevented and redressed?**

Regular applications to tribunals with jurisdiction to review the making or operation of enduring power of attorney shows this. We recommend that the approach set out in the new Victorian power of attorney legislation be adopted. We refer to Capacity Australia’s submission to the NSW inquiry and advise that our suggestion was recommended by the Standing Committee.[[42]](#footnote-42) Specifically, we note that Recommendation 7 stated:

*That the NSW Government, as a priority, introduce legislation to amend the Powers of Attorney Act 2003 consistent with Victoria’s Powers of Attorney Act 2014, thereby significantly enhancing safeguards in respect of enduring powers of attorney.*

**Question 30 Should powers of attorney and other decision-making instruments be required to be registered to improve safeguards against elder abuse? If so, who should host and manage the register?**

Recommendation at 29 will be a more effective solution. Registration will have a chilling effect on the making of enduring powers of attorney leading to the need for more financial management (administration) orders and an increase in the inappropriate misuse of elderly persons’ money. We note that in Victoria the attorney is advised of their obligations and has to agree to comply with these obligations before being appointed as an enduring attorney. Also the attorney becomes liable to pay compensation for losses of the principal’s property caused by the attorney.

**Question 31 Should the statutory duties of attorneys and other appointed decision-makers be expanded to give them a greater role in protecting older people from abuse by others?**

Enduring attorneys already have standing to sue on behalf of principals who have lost the capacity to intervene to stop them from doing so. There are risks as attorneys suing are suing personally as next friends and are personally liable for costs if they lose. Also there are chilling factors such as the person having to be sued is often a close relative of the attorney.

 **Question 32 What evidence is there of elder abuse by guardians and administrators? How might this type of abuse be prevented and redressed?**

Capacity Australia suggest that such information may be sought from the tribunals and court in each jurisdiction which have the relevant “guardianship” legislation.

**Public advocates**

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

The Public Advocates without this power should be given it together with the resources to carry out the necessary investigations. However, often the money will be unrecoverable, having been spent by persons without resources. Personal property may have been sold and the cash obtained spent and the purchaser may well be a bona fide purchaser for value without actual or constructive notice. Real property may be unrecoverable for the same sorts of reasons together with the indefeasibility protections for bona fide purchasers for value without notice and the law relating to fixtures.

**Health services**

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

In submissions to the NSW Parliament Legislative Council. General Purpose Standing Committee No. 2 Elder abuse NSW (e.g. see 5.11) Capacity Australia noted the lack of awareness shown by health professionals regarding their responsibilities in regards to identifying and responding to elder abuse. Few policies and guidelines exist, and there is little or no awareness of those policies that do exist. An example of such a Policy is the 2014 Family and Community Services Interagency Policy Preventing and Responding to Abuse of Older People which has articulated the responsibilities of government, non-government, community agencies and organisations to:

*ensure their workers: are alert to the risk of abuse and are appropriately trained to respond in a timely manner, at all times acting in the best interests of an older person who has been abused*

Yet, evidence to the Standing Committee No. 2 suggested that there is little awareness or promulgation of this policy. The Report 44 noted: *FACS must ensure that service providers actually utilise the document, develop their own policies and exercise their responsibilities under the policy.*

Recommendation 4 stated:

* *That in undertaking the three year review of the NSW Interagency policy for preventing and responding to abuse of older people, the NSW Government:*
* *explicitly consider the improvements to content recommended by stakeholders documented in our report, including with regard to duty of care, reporting requirements in respect of a crime, and privacy and confidentiality conduct further consultation on potential improvements with relevant government and non-government stakeholders*
* *develop a comprehensive strategy to ensure widespread promulgation of a revised policy*
* *ensure that service providers exercise their responsibilities under the policy.*

Health professionals have a key role in both identification of and response to elder abuse. As stated above, an **eyes wide open approach** is a must. As stated in our submission to the NSW LC, **eyes are currently shut.**

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

Codes must explicitly address the duty of care of owed to patients or clients by health professionals in regards to identifying and responding to elder abuse. Issues of confidentiality and privacy must be addressed here.

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

Both health-justice and health-legal partnerships are useful models for identifying and responding to elder abuse, and indeed Capacity Australia has led the way in establishing such a model.

**Question 38 What changes should be made to laws and legal frameworks, such as privacy laws, to enable hospitals to better identify and respond to elder abuse?**

Many health care professionals remain uncertain regarding appropriate actions in regards to duty of care, confidentiality and privacy in regards to elder abuse. This often confounds and hinders proper and necessary communication across care providers and agencies essential to dealing with elder abuse. Clarity is needed.

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10. Ibid. ref 8. Capacity Australia Submission. See also [↑](#footnote-ref-10)
11. For further detail about the matters set out in this paragraph see Chapter 8 “Administration” of the ebook, O’Neill and Peisah, *Capacity and the Law*, published by Sydney University Press, but available free access on the AustLII website austlii.edu.au [↑](#footnote-ref-11)
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