

**ADA Australia (ADA) Response to Australian Law Reform Commission Elder Abuse Issues Paper**

**QUESTION 1**

**Definitions of Elder Abuse**

Definitions need to be broad enough to include the controlling nature of most aspects of a person’s life and denying communication with others. This is a common theme that ADA Australia witnesses.

There are already quite sophisticated behaviours occurring that would qualify as elder abuse.

The following scenario highlights how people are able to manipulate systems, including independent processes, to achieve outcomes in their interests and not in the interests of the elder person.

Concepts involved in the following scenario include: presumption of gifting from older person to younger family member, insufficient understanding by health professionals of older person’s support network (presumption of family being supportive), de-personalisation within aged care, and lack of remedies for administrator to remove son from her home so that this older person can return home.

**Case Scenario 1**

*June: 77 year old widow, and lives alone. Admitted to hospital after a fall, after short stay, the hospital wished to transfer her to aged care, against her wishes, and worked only with her children to organise aged care. While in hospital she was diagnosed with early dementia. Hospital educated children re QCAT processes and children sought appointment as decision makers. While awaiting QCAT hearing, the children signed a contract for placement and transferred June in to an Aged Care secure dementia unit. The Aged Care Facility assisted the children and neither group would communicate with June. Both the children and the organisations (hospital and Aged Care Facility) agreed to dishonestly advise June that her time in the Aged Care Facility was temporary while she rehabilitated from her fall. June’s friends sought ADA Australia’s assistance for June. ADA Australia assisted June to obtain further medical evidence, educated her about QCAT processes, connected her with services, negotiated with service providers, and attended and advocated for June at her two QCAT hearings. Ultimately June has decision makers – Public Trustee Qld (PTQ) and Office of Public Guardian (OPG). Her children remain in possession of her assets without her consent – home + contents, and car, and she has not had any contact with any children since their initial QCAT application was made. June now lives in the community with her friend and pays her friend for rent and board. Some 15 months later and June is still prevented from returning home as her son still resides in her house, and he spuriously claims she owes him money and living in her house rent free is her way of paying him back. June has been advised by PTQ that she will be liable for all legal costs incurred in forcing his eviction. An oral loan agreement from June to her son prior to the hospital admission has been disputed as a gift and consequently her pension has been reduced.*

**QUESTION 2**

Key elements of best practice responses are:

A Multi-disciplinary approach, including embedding lawyers/advocates, within teams or networks.

For example, each ACAT team should include a lawyer to triage responses to criminal or civil agencies, assist with Tribunal applications, and provide advice on services.

Replicating localised Child At Risk networks: involving Police, Elder Abuse Services, Health, CLC’s, Primary Health Networks, My Aged Care. Model MOU’s could be developed to support information sharing and contacting people of concern. Queensland Health has developed numerous guidelines and protocols to support collaborative networking across agencies.[[1]](#footnote-1)

Ethical tensions acknowledged for medical and allied health staff working in the area to promote ethical education team discussions about:

* Who is my client?
* How do we relate with clients who have a decision maker appointed?
* What alternative dispute mechanisms are available and are they suitable for this client?

**OLDER PEOPLE FROM PARTICULAR COMMUNITIES**

**Aboriginal and Torres Strait Islander**

**Case Scenario 2**

*Aunty Ruth attended an ADA Australia education session at a respite centre. She asked to speak privately to the advocate at the end of the session.*

*Aunty Ruth explained that she had always been an independent woman but she no longer had a driver’s license and it was harder to be independent. She explained that some of her family had moved in with her a few months ago to help out. Aunty Ruth said that she still pays the rent and the bills.*

*Aunty Ruth said that she does not see any of her pension money anymore and that the family was not really helping out. She advised that she did not want to upset her family, but she would like to have some money for herself. Aunty Ruth said that she would like to know what options might be available to her.*

*The advocate explained ADA Australia’s role and that an advocate could assist her to look at her options. Aunty Ruth asked if an advocate could meet with her at respite on a Monday or Friday so that her family would not know. The advocate told Aunty Ruth they would not do anything without her permission.*

*ADA Australia’s Indigenous advocate met with Aunty Ruth. The advocate explained that Aunty Ruth had a right to make her own decisions and explained that she could ask someone she trusted to make decisions for her if she was unable to make them for herself by appointing them as her Enduring Power of Attorney (EPOA) for personal matters or financial matters. Aunty Ruth decided that her eldest daughter Karen would be the best person to make decisions for her if she could no longer make her own decisions.*

*The advocate provided Aunty Ruth the forms and with the assistance of ADA Australia’s Guardianship Team Aunty Ruth was able to make her EPOA. Aunty Ruth said that she was relieved to know, that if she could no longer make her own decisions, Karen would be her EPOA. Karen helped her talk to the family members who had moved in with her and they had since moved out of her home. Aunty Ruth said that she was happier now that she understood her options and rights.*

**Case Scenario 3**

*Uncle Bill was receiving respite in an Aged Care Facility. With Uncle Bill’s permission the manager of the Aged Care Facility Robyn contacted ADA Australia to speak with one of the Indigenous advocates.*

*Robyn told the advocate that Uncle Bill was worried about going home. Robyn said that they had told Uncle Bill ADA Australia may be able to assist him. Robyn explained that Uncle Bill finds it difficult to speak on the phone and would prefer that the advocate visit him. Robyn explained that they believe Uncle Bill is being abused financially and physically by his son Michael.*

*The Indigenous advocate met with Uncle Bill. Uncle Bill explained that the Public Trustee used to make his financial decisions however Michael had made an application to QCAT a few years ago and had been appointed to make Uncle Bill’s guardianship and administration decisions.*

*Uncle Bill said that this was ok for the first couple of years, but Michael was not doing the right thing anymore.*

*Uncle Bill said that Michael goes out a lot now and does not always buy enough food. Uncle Bill said that if he asks Michael to help him with things like showering or to buy more food so he can have something to eat, Michael shouts at him and calls him ‘useless’. Uncle Bill said that he is afraid of Michael and does not want to go home.*

*Uncle Bill said that he thinks if he had someone to help him and if Michael moved out he would be ok. Uncle Bill said that he goes to respite a couple of times a week and that he used to get meals on Wheels. Uncle Bill said that he just wants to be happy in his home.*

*With Uncle Bill’s permission the Indigenous advocate made a referral to ADA Australia’s Guardianship Team. The Guardianship Team and the Indigenous advocate supported Uncle Bill through the QCAT process.*

*QCAT determined that Uncle Bill could make his own guardianship decisions. Uncle Bill requested that the Public Trustee assist him with his financial decisions as he felt that he could do some things for himself but needed support with others. Uncle Bill asked if he could have the same Public Trustee Officer that he had had previously, as the officer was still with the Public Trustee - this was arranged.*

*Uncle Bill was happy with the outcome and is pleased to be back home and feeling safe.*

**Culturally and Linguistically Diverse**

**Case Scenario 4**

*Belvie: ADA Australia’s CALD advocate was contacted by a migrant settlement service regarding a client, Belvie, who had recently arrived in Australia. The advocate was informed that Belvie arrived in Australia on a Woman at Risk visa with her daughter, Aicha, and several grandchildren.*

*ADA Australia was informed that Belvie was living in an Aged Care Facility and was now unable to walk or speak. Belvie’s family was learning English but speak Swahili and Congolese. ADA Australia made contact with Belvie’s daughter via an interpreter and arranged to meet to discuss the concerns about her mother’s care.*

*Aicha expressed concerns about her mother living in a nursing home without any staff who can speak either of the languages her mother can understand. There were also concerns regarding the food being provided.*

*ADA Australia’s advocate contacted the Aged Care Facility and requested that the resident records be updated to ensure that Belvie’s meals included fruit but no pork products. Belvie’s family also requested that she receive her food cut up so she could eat with her hand, and no cutlery be provided.*

*The CALD advocate requested that staff learn simple words of greeting in either Swahili or Congolese for Belvie. Historically the Aged Care Facility had used interpreters for meetings with Aicha but not for communication with Belvie.*

*The resident had experienced severe trauma prior to her arrival in Australia. During October staff at the Aged Care Facility dressed in ghoulish costumes for Halloween – red splashed clothing etc. As a result Belvie, who has Post Traumatic Stress Disorder (PTSD), had a severe reaction but was unable to communicate this to staff. Photos of the Halloween celebration were seen by the CALD advocate and the matter was raised with managers, who were unaware that this had taken place. The managers undertook to speak to the staff to ensure this type of behavior was not repeated.*

*Belvie’s family has ongoing concerns about the lack of bilingual staff to communicate with Belvie and the impact of this on her health and wellbeing. The Aged Care Facility still does not have any staff who can communicate with her, nor has there been any training for the staff on working with women who are survivors of war. As a result Belvie continues to experience isolation and remains at significant risk of experiencing episodes of PTSD.*

**Case Scenario 5**

*Jose, aged 78, rang ADA Australia Intake and advised that he was from a CALD background, uses a wheelchair, and was in receipt of a home care package. He lives with his wife, Anna, who provides his personal care but also has a mental health condition. Jose raised concerns with ADA Australia’s CALD advocate regarding Anna’s behaviour including that she threatens him with violence.*

*The CALD advocate made contact with the service providing the home care package as ADA Australia had concerns regarding Jose’s wellbeing. The response from the home care provider appeared to dismiss the concerns as they considered the behaviour ‘typical’ of the couple. The advocate was concerned with the service’s response. The advocate provided Jose with information about services that could provide him with support and guidance in developing a plan to protect him from violence.*

*The advocate then re-contacted the service provider and requested that they try to access Respite for Jose so he could have some time away from home when Anna was home. The advocate further requested that the service provide support to Jose to try to resolve the situation at home.*

*The service provider held an unscheduled meeting with Jose and Anna. Jose was very upset as the worker came to their home unannounced which caused an escalation in his wife’s behaviour. He requested that the specific worker never come to their home again.*

*Ultimately Jose chose not to take further action in relation to his wife’s violence. He was concerned with the potential of himself or his wife becoming homeless or financially disadvantaged. ADA Australia offered to assist him to access other support but he refused. The police were called on one occasion but the client was unwilling to provide information and therefore the police were unable to take any further action. The client chose to continue living in the violent situation as he did not want to be placed in residential aged care.*

**LGBTI**

**Case Scenario 6**

*Wendy: Wendy is a lesbian woman, aged 75. Wendy ‘re-closeted’ upon entry into aged care following the passing of her long term partner. Wendy had only spoken with four other residents about her sexual identity over 5 years in the Aged Care Facility. Two of these residents outed Wendy after an argument regarding dining room seating arrangements. Wendy was then repeatedly rejected from multiple tables in the dining room by other residents, receiving verbal insults, sometimes the diners would stop talking when she sat down, or spare chairs would be removed.*

*Wendy reported this to the Aged Care Facility and was told:*

*The ACF is not required to engage in resident-to-resident ‘spats’;*

*‘Everyone has the same rights here, other residents have the right to not like you’ and she should just ‘forget about it’;*

*She was not respecting the religious and personal views of others;*

*‘Don’t listen to them‘/ ’what other people say is about you is none of your business’*

*Residents at one table continued to move and hide the spare chair that Wendy was to use. The ACF Facility Manager identified that it was ‘their way of showing that she should be treating these things as a joke’. Wendy was eventually told that eating in her own room would be a better option.*

*ADA Australia provided assistance to locate new accommodation but Wendy now refuses to share information about her previous life. Wendy is self-isolating due to the broken trust with service providers in general. ADA Australia provided access to LGBTI identified staff with training in use of a communications board to allow Wendy to express her views. ADA Australia set up a LGBTI visitor scheme access. There was an absence of appropriate dispute mediation services and cultural education for residents.*

*ADA Australia referred the Aged Care Facility to the Aged Care Complaints Commissioner but was advised by Intake that no action would be taken as there is no requirement for Aged Care Facilities to be involved in resident-to-resident disputes. Wendy was subject to systemic abuse and was not protected by existing discrimination legislation.*

**Case Scenario 7**

*Amy: Amy is a transwoman, aged 70. Amy was placed in an Aged Care Facility after a stroke by her children as joint Enduring Power of Attorneys. Her family consists of two sons, one daughter and 4 grandchildren.*

*The Attorneys instructed the Aged Care Facility that only family were able to visit and everyone else was to be turned away or told that the resident was not at the facility. Amy’s telephone was to be removed from her room and Amy was to be dressed as a man and no assistance was to be provided for Amy to dress as a woman. Amy was only to be referred to by her birth name and gender.*

*ADA Australia was contacted by the Aged Care Facility as they had concerns regarding the legitimacy of the directions. Further investigation identified the eldest son required Amy pay fortnightly amounts of money for access to her grandchildren (travel and trouble reimbursement).*

*ADA Australia provided assistance for Amy to access a GP who administered a Mini Mental State Examination identifying that Amy had cognitive capacity to make her own decisions. ADA Australia provided Amy with support to revoke the current Enduring Power of Attorney document and to change gender identity on her passport and access medical letters from a gender clinic to facilitate change of gender on Medicare and the Aged Care systems.*

*ADA Australia provided staff training regarding rights of transgender people under Australian Government Guidelines on the recognition of Sex and Gender.*

*ADA Australia provided Amy with referrals to Australian Transgender Association Qld chapter and the LGBTI visitor service.*

*The Aged Care Facility Lifestyle staff created a program that included LGBTI pop culture movie day (integrated with a program including all special needs groups under Aged Care Act 1997 in forms of movies and song/music), and provided assistance Amy to access clothing and personal items that supported her gender identity, including mobility assistance to access and try on clothing at the gender appropriate change rooms at the local Target. The Aged Care Facility Lifestyle staff provided safety and support for Amy to ‘transition’ to herself again. Three of Amy’s friends provided organic peer support for her to be herself and socialise as a woman. Amy had been subject to financial, social and personal disadvantage but refused to report criminal issues to police for fear of losing contact with her family.*

*This case highlighted systemic concerns such as: nowhere to refer the issue except police, and a lack of accessibility regarding the rights of Trans people to their identity under federal guidelines.*

**Case Scenario 8**

*Adam: Adam is a gay man, aged 73, living in the community. Adam was arrested and detained for 5 years in a Queensland institutional care facility due to being suspected of homosexuality while consuming alcohol under Liquor Act 1985 (QLD). This experience led to Post Traumatic Stress Disorder (PTSD), negative responses to female nursing staff, and cognitive impairment from Electro Convulsive Therapy. Adam’s ‘step son’ had been his Enduring Power of Attorney however refused to continue after his biological father passed away.*

*Adam was referred to ADA Australia’s LGBTI advocate as Adam is identified as LGBTI special needs and his approved provider wished to terminate care due to refusal of female service staff and a lack of an alternative decision maker following death of Adam’s partner.*

*ADA Australia requested male clinical staff however this was declined by the service provider. Service provider records contained information regarding Adam’s personality but no assessment of his care needs.*

*ADA Australia provided Adam a referral to the Aged Care Complaints Commissioner however it was determined that the service provider did not need to explain to Adam how his needs exceeded their resources.*

*Adam has no Enduring Power of Attorney, has no understanding of his finances, and is now in hospital and being forced into an Aged Care Facility without support. There are concerns for Adam regarding being LGBTI and his special needs status.*

**Case Scenario 9**

*Jane: Jane is a TransWoman, aged 67, living in the community, receiving in home assistance. Following Jane’s transition she requested a break from old staff and the amendment of her data to fit her identified gender. The Service Provider reported that ‘the system will not allow for the change of client gender’ and that they are not required to do this as they are not a LGBTI service provider. The service provider claimed that ‘LGBTI’ needs to be on Jane’s file and the Trans status is required information for the provision of care and must be shared with direct care staff. Jane’s file has both names listed, and her gender is listed as ‘OTHER’ without clarification of her preferred name, pronouns or gender identity. Staff are ‘encouraged to remember’ to address her as Jane.*

*ADA Australia provided copies of the Australian Government Guidelines on the recognition of Sex and Gender, and a flow chart outlining process for change. ADA Australia assisted Jane to change her passport and details with Medicare and Centrelink.*

*A complaint was made to the Aged Care Complaints Commissioner (ACCC) regarding the service provider’s failure to meet the needs of a special needs group, and failure to provide confidentiality. The ACCC enquiry found that there is no requirement for an approved provider to change client details regarding gender. The ACCC staff was unaware of the Australian Government Guidelines on the recognition of Sex and Gender, and its application is out of the scope of the ACCC. Jane is forced to respond to her birth name and gender if she wishes support services to continue. There was an 18 month wait for a vacant home care package with another provider and the client is developing a fear of Residential Aged Care due to her treatment in the community.*

**Case Scenario 10**

*Cheryl is a 70 year old lesbian woman with 2 estranged children. Cheryl entered into a Family Agreement where she deeded her home to her daughter as collateral for a business loan, under the Oral terms that the home would be returned to her after the business became profitable, she would have monthly access to her grandchildren, and her daughter would provide ‘care and support’. Cheryl signed an agreement that the daughter’s solicitor would also act on her behalf.*

*The signed Agreement did not list visitation, or completion dates, and only that ‘reasonable care and support’ be provided in terms of free rent, but Cheryl must cover rates. Cheryl’s partner of 6 years has now been requested by family to move out or pay rent as she is not covered by the agreement.*

*As Cheryl does not pay rent she is not eligible for rent assistance with her pension and as the Centrelink system considers that the home was ‘gifted’ Cheryl receives only a partial pension.*

*As the property is now owned by person under 65 the rates are at full price. For Cheryl to remain living with her partner she will have to locate a private rental property.*

**Suggestions:**

1. Ongoing sustainable training:
   * Ensure consistent understanding of what is elder abuse

* Understanding of abuse in terms of life long trauma and refusal to recognise/respect trauma triggers in special needs groups
* Engage with special needs groups/ how to plan with regard to unseen need

1. Creation of central national investigation and referral gateway for elder abuse. A telephone line as intake to listen and refer appropriately (or report gaps)

* Investigation team:
  + A non penal/punitive investigatory organisation with a focus on dispute resolution to avoid reticence of seniors to speak out about their treatment and allows them to know that they are supported
  + Referral mechanism from investigation: police and non police
  + Investigation of financial and personal decision making on behalf of Adults through an Enduring Power of Attorney (whether they are deemed to have capacity or not)

1. Increased powers and legislative direction of the Aged Care Complaints Commissioner to investigate rather than desk review complaints
2. Vulnerable groups received legislative recognition for a reason, and it is not always due to discrimination or vilification (automatic referral to Human Rights or state anti discrimination commission is inappropriate and patronising).
3. Rejection of special needs clients from services on the basis of ‘we aren’t a specialist organisation’ or ‘don’t have the resources’ increases an adult’s reliance on unregulated and untrained support and increases the risk of financial, physical and psychological abuse

**SOCIAL SECURITY**

**QUESTIONS 5 & 6**

The role of Centrelink could be pivotal to practical resolutions and responses to elder abuse. However, there seems to be no practical way of contacting Centrelink on behalf of someone else because of privacy concerns. For example, we receive many complaints about people taking their pension, often under some type of authorisation (Nominee, Attorney, and Administrator). There should be some mechanism to raise abuse concerns directly with Centrelink (for organisations who are members of an Elder Abuse Network) so that rectification of the Adult’s own pension occurs swiftly and is not to be re-directed without authority from GP or ACAT.

The pension is obviously necessary to the older person, but certainly the amount taken is often not sufficient to pursue through other legal means.

For Nominees who abuse their powers, there needs to be a civil penalty pursued through the Magistrates courts, as with other Centrelink breaches.

**QUESTION 7**

In relation to provision of care by people receiving a carer’s pension, it would be very useful for standards or guidelines of care to be written, so that expectations are clear for care that is expected.

These standards of care would be written in consultation with many organisations, and informed by health professions.

This could also assist Police and Prosecution agencies.

**AGED CARE**

**QUESTION 12**

Aged care assessment programs or teams (eg ACATs) are one of the more common service points that elderly people access (besides a GP).

Aged Care Assessment Teams (with a lawyer as part of the multi-disciplinary team), in conjunction with Primary Health Networks, would provide the basis for an Elder Abuse outreach network model that could triage responses to Police, Tribunals, QCAT, Public Guardian, Advocates, Health, and Service sectors.

**QUESTION 13**

Wendy Lacey’s article[[2]](#footnote-2) that outlines the assumption that all things to do with older persons are a Commonwealth responsibility provides some insight regarding the current fractured approach to elder abuse. By way of analogy it may be useful to look to reforms between state based child protection systems and improved linkages with Commonwealth Family Law system.

The Commonwealth Aged Care System has not developed a sophisticated understanding of ‘capacity’ and ‘substituted or alternative decision making’. Too often we witness aged care services and health professionals casually observing Attorneys, Guardians or Administrators ‘doing the wrong thing’, yet providing no response.

When we have provided targeted training to aged care workers and encouraged them to challenge inhumane directions from Attorneys (such as no phone calls, no visitors, etc), as a breach of the resident’s rights, they have become quite empowered and invigorated. Commonwealth agencies need to develop a sophisticated understanding of the state based Guardianship regime. We would recommend intensive training on state based Guardianship frameworks for all Commonwealth agencies.

**QUESTION 15**

Besides training on state based Guardianship systems, we strongly recommend that as part of the accreditation system at a minimum all residential aged care providers need to demonstrate that their residents have been able to participate in a ‘rights based’ education system, including how to access advocacy services and complaint services. As can be seen in earlier case scenarios, education sessions can be an avenue where people can access an advocate without fear of retribution.

**QUESTION 16**

The beginning of a regulated restrictive practice regime involves an understanding that consent for restrictive practices is required. This is either from the person themselves, their Guardian or Attorney.

Restrictive practice also includes chemical restraint, and there has been much research done on this area (use of anti-psychotic medications in aged care) recently. If there is uncertainty, then it should be referred to a Tribunal, however Tribunals need access to experts (such as psycho-geriatricians to advise them of current best practice medication administration). Consent for medications is a personal healthcare matter. If the person lacks capacity to consent for themselves consent needs to be documented by the service provider.

**QUESTION 20**

As detailed in our earlier case scenarios, and response to Question 15, we have received many referrals from very isolated individuals who have attended an education session and spoken to our advocate after the session about the abuse they feel they have been suffering, and how to make contact with the advocate following the session, so that the abuser does not interrupt the connection or relationship with the advocate, and subject the person to further abuse.

All Aged Care Facilities need to demonstrate that they have provided for an advocacy agency to run a ‘residents’ rights training program’ annually as part of their accreditation. Access to advocacy and complaints services should be part of literature readily available to residents on noticeboards etc.

**FINANCIAL INSTITUTIONS**

**QUESTION 25**

Although there has been an increased focus by financial institutions on understanding the role of Attorneys and Administrators (as evidenced by the Australian Banking Association Guidelines)[[3]](#footnote-3), the response required needs to be further embedded into the system.

Also required is a proactive approach by banks, or seniors associations, to encourage people to complete a financial care plan if there is unusual activity on their accounts. This activity can be identified or a particular sum identified requiring the bank to notify whomever you have nominated. Similar notification mechanisms are in place when we travel.[[4]](#footnote-4)

**APPOINTED DECISION MAKERS**

**QUESTION 29**

We receive many requests through our intake service to assist with concerns regarding the actions of an Attorney. We receive approximately the same number of complaints from people with capacity and those concerning people with impaired capacity.

There are strict duties outlined in the legislation that could be simply stated so that everyone is clear as to their role. Training needs to be mapped to these duties.

The training could be part of an online checklist/exam that Attorneys would have to pass to be able to be nominated for the role (also available in paper format at local Magistrates courts). If Attorney duties are clearly and simply put, and not overly dramatised, they should not deter people who are otherwise well suited to the role.

**QUESTION 30**

In order to facilitate correct use of Attorney documents there needs to be a national registry.

We are aware that there is a Commonwealth Electronic Health Record being trialled on an “opt-out basis” in NSW and Northern Queensland. Apparently there is an allowance made for uploading planning documents. This is one well suited place for storage of information.

The agency that is nominated needs to be national, not state-based, and searchable by services that operate remotely and after hours (such as health services).

**QUESTION 31**

From our perspective expanding powers of Attorneys would not assist in protecting older people.

**QUESTION 32**

Abuse by Administrators and Guardians does occur and it is something that we often witness. The main option is for removal of the appointed decision maker. This can be awkward when the Tribunal have placed them in the role. Often, the same Tribunal member will be called upon to ‘change their mind’ regarding the appointment, which can sometimes be a delicate matter.

On some occasions we have requested another tribunal member, particularly when there have been strong views expressed by them previously. Rarely are those requests granted.

Compensation Orders have been rarely granted by a Tribunal, who have had a tendency to narrowly construe these powers.[[5]](#footnote-5) Also, Tribunal orders are not enforceable, requiring a vulnerable person to navigate another jurisdiction to pursue restitution.

Many times it has been reported that all of the money has ‘gone’. Within the criminal justice system, there are orders for restitution for a total amount that could be paid in fortnightly instalments. This approach would be used if an employee has stolen from their employer, but not considered in relation to Elder Abuse.

**PUBLIC ADVOCATES**

**QUESTIONS 33 & 34**

In Queensland, we have a large Office of the Public Guardian (OPG), that holds broad ranging investigating powers (as well as powers as the Guardian of last resort) and the much smaller Office of the Public Advocate (which reports on systemic issues).

Both of these Offices have jurisdiction only when the person lacks capacity.

The OPG can also suspend an attorney and refer the matter to QCAT. It is not clear how often they refer matters to the Police.

The concerns raised by Wendy Lacey regarding expansion of powers for vulnerable people in jurisdictions where there is no Charter of Rights, is a real concern for us. We would endorse her conclusion that *‘any system must be framed from a rights perspective to ensure that ageist and paternalistic approaches are not adopted, thereby avoiding the erosion of the rights and freedoms of vulnerable adults under the guise of safeguarding or protecting those people’.*

The following case scenario highlights these concerns:

**Case scenario 11**

*John is an 84 year old gentleman. The OPG had an open investigation about the adult with numerous independent reports, including one from a police officer neighbor, of physical, emotional and verbal abuse from John’s adult son Peter.*

*Police attended premises on several occasions but were unable to progress matters as John refused to engage. Apparently the OPG and Police had tried several times to speak to the family, however, the property gates were locked and they were unable to gain access. There were no Domestic Violence Orders in existence.*

*John had a fall at home and was admitted to hospital. While there John was assessed as having complex and simple decision making capacity.*

*On John’s recovery, his wife Anne and son Peter refused to take him home.*

*John maintained that he wanted to return home, even though his family was unwilling.*

*John refused alternative accommodation options. The hospital would not discharge him to ‘no fixed address’. The hospital made applications for Guardianship and Administration (including an Interim Application) as John was at risk, despite having a positive capacity assessment from hospital. The Interim order was granted determining that John was in need of Guardianship and Administration. The Public Guardian (OPG) and Public Trustee (PTQ) were appointed however the Tribunal’s reasons were not known.*

*John now resides in a half-way house and has had very little contact from his family since the QCAT applications were made.*

*John has a QCAT review in the near future and has again been given a positive capacity assessment from his long term GP. John still maintains that he wants to return home even though the family isn’t receptive.*

*OPG have advised that they have been unable to ascertain things further due to a denial of access to the property. John is concerned for Peter but doesn’t want to make things official as he ‘loves his child unconditionally’.*

*The upcoming QCAT hearing will review the need for a decision maker, and the OPG do not feel that they are required, as the adult has capacity.*

This scenario shows an intersection with Family Law as John was forced to separate, leave his own home without a property settlement, and reside in a hostel.

Perhaps a domestic violence pathway may have been more suitable and less paternalistic, rather than treating him as if he had no capacity and appointing a decision maker for him.

**HEALTH JUSTICE PARTNERSHIPS**

**QUESTION 37**

Health Justice Partnerships are a useful model for working alongside other professionals in identifying and responding to elder abuse. This model has already been endorsed by us in requesting lawyers in Aged Care Assessment Teams and local networks. They will often be best placed to determine criminal activity at an early stage, assist in recovery of property and advising on the best course of action (guardianship/domestic and family violence/family court options).

**HOSPITALS**

**QUESTION 38**

The patient centred model developed by St Vincent’s Hospital Melbourne is highly recommended. It needs to be supported by appropriate laws, policy and information exchange protocols as exist in relation to Child at Risk networks, mentioned previously in note 1.

**FORUMS FOR REDRESS**

**QUESTION 39**

Without a Charter of Rights to guide the decisions of the Tribunals, we do not support an extension of Tribunal powers. As previously mentioned, there is an existing tendency to read down any existing powers for compensation. This tendency, along with the lack of enforceability of Tribunal decisions, leads to concerns about the futility of this approach.

Magistrates Courts, particularly a specialised Courts program, would be far better suited to an elder abuse approach.[[6]](#footnote-6) These courts are often supported by a range of directions aimed at a problem solving, rather than adversarial, approach.

**QUESTION 40**

While it is important to provide good access to people who may be subject to elder abuse (including listening loops and a whiteboard for prompting), the precursor to this step is to be concerned about welcoming the participation of the older person in this process.

As numbers of applications have grown each year, the drive to ensure communication occurs with the adult themselves seems to have dissipated. There is no publicly available data about whether the adult participates in their own hearing (either attends in person, via phone, or written statement).[[7]](#footnote-7)

When hearings are conducted in a paternalistic rather than problem-solving or rights-focused way, the participation of the older adult seemingly becomes less necessary.

For example, there are options on the forms for the applicant to state that the person is not well enough to be troubled with a hearing. We have certainly witnessed applicants who have used this provision to avoid notification of the adult about their hearing. There appears to be no mechanism to follow-up with the person just prior to the hearing, as their circumstances may have changed remarkably, and they are left uninformed (for example they may be discharged from hospital). The adult is left out of their own hearing, under the guise of concern for their welfare, find themselves with appointed decision makers, and have no idea how this had come about. It leaves us with the concern that it is not often convenient to have a vulnerable person attend a hearing, and therefore not addressed.

**Case Scenario 12**

*We attended a hearing as advocate for Marjory. The hospital had put in an application saying she lacked capacity and could not consent for ACAT, accommodation or finances.*

*At the hearing it was clear that Marjory had been paying her bills over the months that she was in hospital. The Allied Health Staff were insistent that Marjory did not understand what ACAT was and could not consent (even though she had services previously and was agreeable to more and understood an ACAT assessment was necessary for this to occur). The Tribunal member commented on the need to ask ACAT to talk to Marjory and to use QCAT as a last resort, only if there was a difficulty. Eventually after months in hospital, the QCAT applications were dismissed, and Marjory went home with services arranged by her advocates as the hospital had refused to make community support referrals.*

**QUESTION 41**

We have long considered that many matters could be best diverted to mediation, allowing for a better tailored outcome, suiting the needs of the parties, other than an appointment of a decision maker. It also leaves a ‘lighter footprint’ on families, as Orders can facilitate deeper rifts in family and support networks.

**Case Scenario 13**

*Stephen was an elderly gentleman who lived in a retirement village. He had been found to lack capacity for financial matters and all 3 children were appointed as his Administrators despite a long standing antagonistic relationship. Stephen was settled where he lived and the last job for the Administrators was to sell the house and distribute his belongings. The family was referred to mediation (Relationships Australia) and then the Tribunal also set the matter down for a Compulsory Conference. Stephen was too distressed to attend the conference but allowed his advocate to attend for him. A process for the sale of the house was agreed to and Stephen’s main concern was the distribution of his Art collection to his children. The advocate undertook to assist in this process. The Attorneys were left in place and an appointment of a government agency was avoided.*

**CRIMINAL LAW**

**QUESTION 42**

ADA Australia staff observe many abusive behaviours that would be classified as criminal in other settings. The softening of our language in response to Elder Abuse/Crimes is not helpful in educating the community in the longer term. Our language needs to reflect the types of abhorrent behaviours that we do not tolerate elsewhere, and which we label as crimes.

Perhaps, as a beginning step, where the victim of crime is in a relationship of trust (Attorney), and or is over 65, this could be seen as a circumstance of aggravation and result in harsher penalties, in order to change attitudes and increase awareness.

**QUESTION 43**

The laws regarding duties to provide the necessities of life have rarely been used to prosecute victims of severe neglect. This is in spite of meticulous coronial investigations.[[8]](#footnote-8)

Prosecution services would require training on standards of care (see earlier response) and access to experts (such as geriatricians) to guide them as to the precise particulars involved in failure to provide necessities.

By contrast, the Canadian Centre for Elder Law has developed a comprehensive set of guidelines based on prosecution of criminal neglect cases.[[9]](#footnote-9)

**QUESTION 45**

The professions, such as medical and nursing, who are already mandated to report child abuse, should be required to report suspected elder abuse. These professions are most commonly involved in providing services in a range of settings for older people.

The local area Elder Abuse Network including Aged Care Assessment Teams and Public Guardians should receive the notification that can be recorded and triaged to the relevant agencies. Protocols similar to the Counterpoint Project above (see note 8) should underpin the network.

1. See Queensland Health “*Information Sharing in Child Protection Guideline”* 2015 and Childrens’ Health Queensland Hospital and Health Service “*Sharing Relevant Information under the Child Protection Act 1999”* [↑](#footnote-ref-1)
2. Wendy Lacey “Neglectful to the Point of Cruelty” 36 Sydney L. Rev. 99 2014 [↑](#footnote-ref-2)
3. See Australian Bankers Association “Responding to Requests from an Attorney or a Court-Appointed Administrator” accessed on 24 August 2016 [↑](#footnote-ref-3)
4. See discussion surrounding “Saskatchewan Model” 2.1, in the House of Representatives Standing Committee on Legal and Constitutional Affairs *Older People and the Law,* 2007, p 41 [↑](#footnote-ref-4)
5. See SMD [2013] QCAT 350 for complex QCAT history of responding to requests for compensation orders. [↑](#footnote-ref-5)
6. See Department of Justice and Attorney General *Interim Evaluation of the Trial Specialist Domestic and Family Violence Court in Southport,* May 2016 [↑](#footnote-ref-6)
7. By way of contrast with other vulnerable persons, see Annual Report of the Mental Health Review Tribunal (Queensland), where they note that the adult is 10 times more likely to have an order revoked if they attend their own hearing. See Mental Health Review Tribunal *Annual Report 2014-15* p11. [↑](#footnote-ref-7)
8. See note 2 for discussion on Cynthia Thoresen [↑](#footnote-ref-8)
9. Canadian Centre for Elder Law *Counterpoint Project Discussion Paper,* 2011. See also individual factsheets:

   [Confidential Patient and Client Information (Brochure)](http://www.bcli.org/publications/counterpoint-brochure-confidential-patient-privacy-rights)

   [Mental Capacity and Consent: (Brochure)](http://www.bcli.org/publications/counterpoint-brochure-mental-capacity-and-consent)

   [Charting Sheet (Form)](http://www.bcli.org/publications/counterpoint-charting-sheet)

   [Factsheet for Administrators](http://www.bcli.org/publications/counterpoint-factsheet-administrators)

   [Factsheet for Doctors](http://www.bcli.org/publications/counterpoint-factsheet-doctors)

   [Factsheet for Nurses](http://www.bcli.org/publications/counterpoint-factsheet-nurses)

   [Factsheet for Personal Support Workers](http://www.bcli.org/publications/counterpoint-factsheet-personal-support-workers)

   [Guidelines for Developing Improved Practices](http://www.bcli.org/publications/counterpoint-guidelines-developing-improved-practices)[Table of key legislation in each Province and Territory](http://www.bcli.org/publications/counterpoint-table-legislation)

   [Video series](https://www.youtube.com/user/BCLawInstitute) accessed at <http://www.bcli.org/project/counterpoint-project> on 24 August 2011 [↑](#footnote-ref-9)