**Submission to the Australian Law Reform Commission**

**Issues Paper on Elder Abuse**

**UnitingCare Australia**

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# UnitingCare Australia

## **1 Introduction**

UnitingCare Australia is the national body for the UnitingCare network, one of the largest providers of community services across the country. We provide services to children, young people and families, Indigenous Australians and people from culturally and linguistically diverse backgrounds, people with disabilities and older people in urban, rural and remote communities. With over 1,600 sites, the network has 40,000 employees supported by 30,000 volunteers and makes a significant social and economic contribution to our nation. UnitingCare Australia represents one of Australia’s largest not-for-profit providers of aged care services, including residential and home based care.

UnitingCare Australia works to advocate for policies and programs that will improve people’s quality of life. UnitingCare Australia is committed to speaking with and on behalf of those who are the most vulnerable and disadvantaged, for the common good.

UnitingCare Australia’s response to the Australian Law Reform Commission Issues Paper has been informed by data, evidence and experience from the Elder Abuse Prevention Unit (EAPU), including the Elder Abuse Helpline and UnitingCare Queensland’s EAPU Reference Group\*, Resthaven and the broader UnitingCare Aged Care Network. The EAPUprovides a free and confidential telephone service for anyone experiencing or witnessing abuse of an older person – the Elder Abuse Helpline. The EAPU is supported by a cross-sector reference group which includes representatives from the Queensland Public Advocate, Queensland Government, University of Queensland and other agencies that provide legal and community and aged care services to seniors.

UnitingCare Australia has provided responses to questions where we believe we can make a valuable contribution.

*\*It is important to note that data from the Elder Abuse Helpline and EAPU is representative of Queensland only.*

## **Executive Summary**

The UnitingCare network’s approach to older people is guided and informed by the United Nations Principles for Older Persons which focus on Independence, Participation, Care, Self-fulfilment and Dignity and by an overall safe church approach to ensure the protection of vulnerable people.

The UnitingCare network is concerned with the level of elder abuse across the community. Based on the available evidence we note that most abuse is perpetrated by family members, and that the mostly commonly reported forms of abuse are financial and psychological. While the evidence is varied across the nation, the levels of physical abuse and neglect are also of concern.

While we note that the reported incidence of elder abuse within the residential aged care sector is comparatively low, as major providers of aged care services we are always willing to explore to make our residential aged care services even safer, and to improve our capacity to support older people to remain safe at home.

Our Elder Abuse Prevention Unit and services, and the broader network, also stand ready to assist in the development of new approaches to better protect older people in all settings, and to raise community and worker awareness of elder abuse.

The UnitingCare network believes that ageism lies at the heart of elder abuse and effective elder abuse prevention can only be achieved with the support of education and awareness programs that deal with the negative perceptions and assumptions about ageing and older people. The network notes the Respect for Seniors program, run by Uniting, is one such program that focuses on building respect for older people, valuing their contributions and challenging common assumptions. The network is willing to share the experience and knowledge gained from developing and implementing this program.

## **Q1: 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**

There is so single agreed definition of elder abuse in use in Australia. In the absence of a single legal definition the majority of elder abuse is currently addressed within state/territory civil, criminal and domestic and family violence law; including for psychological and financial abuse and neglect.

The definition used to guide the work of the Uniting Care network, the UnitingCare Queensland’s Elder Abuse Prevention Unit (EAPU) and many other services, is the World Health Organisation’s (WHO) 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.*

The WHO further notes that:

*This type of violence constitutes a violation of human rights and includes physical, sexual, psychological, emotional; financial and material abuse; abandonment; neglect; and serious loss of dignity and respect.*

The EAPU is also guided in its work by the definition used in the Toronto Declaration on the Global Prevention of Elder Abuse:

*Elder Abuse is 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”. It can be of various forms: physical, psychological/emotional, sexual, financial or simply reflect intentional or unintentional neglect[[1]](#footnote-1).*

The Uniting Care network believes that harm, distress and intent are all important factors in reflecting upon the definition of elder abuse, its impact and the appropriate responses. The Uniting Care network does not believe that payment for services should be a factor taken into consideration when seeking to define elder abuse, and it should not to be used as an exclusionary factor as elder abuse can occur irrespective of whether a payment for service is involved. Older people can and do suffer abuse in circumstances that involve the payment for services and in relationships of trust, such as those that exist with paid carers, whether in the home or in residential aged care. (See also section on Relationships in which elder abuse occurs).

The experience of the Uniting Care network is that many older people have a broader definition of elder abuse which reflects how the actions of others impact on them. For example, some consider actions and factors such as the following to represent elder abuse:

* the capacity of the aged pension to enable individuals to live a decent life;
* poor communication and management practices at retirement villages and residential aged care facilities,
* the timing of meals and other services at a residential aged care facility;
* poor consultation on the design of services for older people; and
* public transport operators who do not allow sufficient time for an older person to be safely seated before moving a vehicle or train.

While UnitingCare Australia acknowledges the negative impacts of such actions, particularly on overall quality of life, we do not consider them to fit within the commonly accepted scope or definition of elder abuse.

The Uniting Care network concurs with the views expressed by the Australian Institute of Family Studies (AIFS) that the “absence of a precise agreed definition is considered problematic for a range of reasons, not the least of which is the difficulty in measuring elder abuse[[2]](#footnote-2)”. The AIFS goes on to observe that one important area is in relation to the age at which one is considered an elder, with differing definitions used depending upon context (ie pension access) and the range extending from 60 to 70. In some Aboriginal and Torres Strait Islander communities, an ‘older’ person may be considered to be significantly younger[[3]](#footnote-3).

The Uniting Care network also notes other issues associated with the definition of elder abuse including “the question of whether harmful behaviours involving older people are distinguishable from harmful behaviours involving other adults because they involved older people or because they involve the exploitation of vulnerability”[[4]](#footnote-4).

***Relationships in which elder abuse occurs***

In using the WHO definition, we have considered what constitutes a relationship where there is an expectation of trust. We have determined that in the context of elder abuse a more holistic approach and flexible interpretation is required beyond family. Data from the Elder Abuse Helpline shows that although the majority of elder abuse is perpetrated by sons or daughters, almost one in five calls to the Helpline are about abuse in non-familial relationships.

***Relationship of Perpetrator to Victim***



*Fig. 1 Relationships between perpetrators and victims in cases reported to the EAPU Helpline for the period 1 July 2010 to 30 June 2015, N=6433*

***Types of elder abuse***

Data gathered from calls to the Elder Abuse Helpline reflect the types of abuse that are most commonly being experienced by older people and can help to determine what actions constitute elder abuse. In collating this data, the EAPU adopts the definition the Toronto Declaration[[5]](#footnote-5) and also includes a sixth category of social abuse; referring to the behaviour of isolating or restricting the victim’s access to family/friends or activities that they enjoy. The categories of abuse used are:

* Physical – the infliction of pain, injury or force;
* Psychological – the infliction of mental anguish, fear, and feelings of shame and powerlessness;
* Financial – the illegal or improper use of an older person’s finances or assets;
* Social – preventing a person from having social contact or attending activities;
* Sexual – sexually abusive or exploitative behaviour; and
* Neglect – the failure of a carer to provide for an older person in their care.

At the broader network level we note that chemical or medication misuse (including the inappropriate use, underuse of overuse of prescribed medication) and the over or misuse of restrictive practices are also included in the definition of elder abuse: as reflected in both the ALRC Issues Paper and the WHO reports.

Further, the UnitingCare network aged care services notes the need for, and exercises, vigilance in relation to managing the risks of harm by cognitively impaired residents.

It is our experience that identifying the combination of primary and secondary abuse types provides a fuller picture of what occurs in elder abuse situations and can usefully inform responses.

Analysis of data from the Elder Abuse Helpline shows us that financial abuse has overtaken psychological abuse as the primary abuse type reported. When examining the combined abuse types we see that psychological abuse has remained relatively stable and financial abuse has increased to a similar level.

***Primary and combined abuse types***



*Fig. 2 Proportion of abuse types as a) primary abuse type recorded for cases where there is a relationship of trust N=5409, and 2) proportion of all cases where there is a relationship of trust in which abuse type is recorded, n=9028*

*Misunderstood Elder Abuse*

In many cases elder abuse is not understood as abuse by victims or perpetrators. In particular, with regard to financial abuse, we are concerned that the recent changes to aged care funding, which place a greater emphasis on those who can pay making a contribution, may place some older people at risk of conflict with family members who had expectations in relation in inheritance. Therefore, we believe that is important that the adoption of any new legal definition of elder abuse take this into account and be accompanied by a community wide awareness campaign.

## **Q2. What are the key elements of best practice legal responses to elder abuse?**

The Uniting Care network believes that the broad response to elder abuse needs to encompass risk identification; prevention; community, service and individual education; early detection; early intervention; support and legal/criminal responses when necessary. It is important that any legal response distinguish between deliberate acts of harm or neglect and unintentional acts.

It is also critical that national consistency is achieved in the relevant State and Territory legislation, in relation to both defining elder abuse and setting out appropriate penalties for criminal acts.

Finally, it is worth considering the potential for restorative actions and schemes, particularly in relation to older people who have been financially harmed or ‘asset stripped’.

## **Q3. The ALRC is interested in hearing examples of elder abuse to provide illustrative case studies, including those concerning Aboriginal and Torres Strait Islander people; people from culturally and linguistically diverse communities; lesbian, gay, bisexual, transgender and intersex people; people with a disability; or people from rural, regional and remote communities.**

Resthaven, like other aged care service providers, has experience in supporting individuals who are victims of elder abuse and for whom there are limited protections in place. The following case studies illustrate a number of these limitations.

***Mr A****, an Aboriginal man, lives at home in a multi-generational family environment. He is a recipient of an Aged Pension, however this money is accessed each pension day by the family leader who has Mr A’s PIN number and card. Mr A has no access to his own fund, and is dependent on the family leader for shelter and food. Mr A receives a Home Care Package, and while Resthaven as the service provider recognises the practices within this household as abuse, our staff work cooperatively to negotiate solutions with respect given to cultural practices. Centrepay mechanisms were negotiated to pay Mr A’s accounts at the local pharmacy and for necessary services. At Mr A’s request, a staff member takes him to the bank fortnightly and then shopping, so he can make purchases to meet his own needs.*

***Mrs B*** *is 75 year-old woman residing in a residential aged care home. She has right sided paralysis, and some subtle frontal and executive cognitive deficits. She appointed her son as her Enduring Power of Attorney, Medical Power of Attorney and Enduring Power of Guardianship prior to her condition deteriorating.*

*On admission to residential care Mrs B’s cognitive function was assessed and indicated she had minimal impairment but there was some short term memory loss. Her son had taken over management of all of her financial affairs and he viewed her as “dementing” despite her having been assessed by her doctor and a geriatrician as having minimal deficit and able to make her own decisions.  Her son gradually ceased to consult with her and made decisions on her behalf. He removed all of her jewellery for “safe keeping” and was slow to bring in her personal items from her home. He provided her with regular spending money but repeatedly questioned her about what she spent it on. She became very concerned at his overly controlling ways but she valued the relationship with her son as her only child and did not wish to challenge him as she was fearful the relationship may be placed in jeopardy.*

*In conversations with the residential manager, Mrs B disclosed the son’s denial of her simple requests; the reducing amounts of funds he gave her for her personal use; the interrogative measures he took with her and his repeated derogatory comments about her “dementing”. With the support of the residential manager Mrs B, agreed to involve Aged Rights Advocacy Service and gradually felt more empowered to challenge her son. Her son refused to participate in any mediation meetings and Mrs B eventually took action in revoking her son’s legal position in managing her affairs and appointed another person to this role. She has subsequently not had any interaction with her son.*

The complexity of elder abuse issues seen in the broader population are often further exacerbated in rural and remote communities.

***Mr and Mrs C*** *reside 30 km from the nearest town; Mrs C has a diagnosis of dementia. Mr C is sole family Carer for his wife, and denies there is any other family. He has Enduring Power of Attorney. Staff of the local health service and previous aged care providers have concerns in relation to care provided to Mrs C by her husband. This is not based on witnessed abuse but a sense that “all is not right.” Hospital staff insisted that a Home Care Package be in place prior to Mrs C’s discharge from hospital, due to concerns for her welfare.*

*Home care staff are present in the home for only one hour each day due to the need for two staff to effect transfers, and the distance to travel to the client each day. Over a period of months, a picture has been established of a complex situation of abuse. Mrs C has been isolated from her family; a son and daughter contacted the in-home provider seeking information about their mothers wellbeing, as they are not able to gain information from Mr C. Mr C does not administer prescribed medications, the Pharmacist is able to provide the data referencing prescriptions filled. Homecare staff become aware of restrictions made to Mrs C’s diet, by Mr C, which cause her adverse effects. In-home staff are aware Mr C leaves his wife alone over extended periods, however he has refused all offers of respite.*

*Staff have also witnessed rough treatment and reported this to their supervisor.*

*Home care staff sought advice from the Office of the Public Advocate, and convened a meeting with police, health service staff and the client’s GP. The GP sought advice from medical defence, and decided not be involved in submitting an application to the Guardianship Board. Once an opportunity for hospital admission arose an ambulance was called by homecare staff, enabling an application to be made to the Guardianship Board while Mrs C remained an inpatient. The Guardianship hearing resulted in appointment of a Guardian and a decision made to admit Mrs C to residential care.*

***Mrs D*** *Lives in a multi-generational home with her daughter and grandson, in a rural town. There is a strong history of mental illness evident in each family member in this home. Mrs D, who is 80, is the home owner, and Mortgage holder, Mrs D receives a full DVA Pension, and the family need this income to support the household. Mrs D’s daughter has been renovating the home, and her mother, who is bed bound, remains in the home, while renovations occur, subjecting her to noise, dust, and intrusion, which upsets her as she has dementia. In the course of the renovations Mrs D is moved to the back room of her house, which is not suitable for her needs, as the bathroom is not accessible, heating and cooling is non-existent in this room. Home-care staff work to negotiate solutions to these challenges. Extensive negotiation and commitment to case management is required to reach a positive outcome for this client.*

These case studies illustrate a range of circumstances in which aged care providers have witnessed, and responded to, incidences of elder abuse perpetrated by family members. The UnitingCare network does not have available any case studies of elder abuse perpetuated within its services by staff or other residents, but notes that allegations of such incidents have been portrayed in the media.

## **Q4: The ALRC is interested in identifying evidence about elder abuse in Australia. What further research is needed and where are the gaps in evidence?**

While there has been some research conducted into elder abuse in Australia, significant gaps remain in the evidence relating to the prevalence, causes and risks relating to elder abuse in Australia which the UnitingCare network believes are best addressed by undertaking a national prevalence study. A recent report by the Australian Institute of Family Studies (AIFS) [[6]](#footnote-6) refers to two population based studies that have yielded ‘some insights’ into the extent to which older women experience violence. The clear limitations of such studies are that they focus on one gender and on violent offences.

The AIFS report also references data from elder abuse helplines, including helplines located in Victoria and NSW and the EAPU Helpline.[[7]](#footnote-7)

UnitingCare Queensland Elder Abuse Helpline data which has been collated over a five-year period from 1 July 2010 to 30 June 2015 has identified a number of patterns and trends of elder abuse in Queensland. These include:

* Victims are most commonly 80 to 84 years of age;
* The majority of victims are female (70 per cent). However, this must be noted against a marked decline of males in older ages groups;
* Most commonly, perpetrators are adult children, 50 to 54 years of age, with daughters almost as likely as sons to abuse elderly parents for financial gain;
* Spousal abuse occurs in older age groups and is more likely to be psychological and/or physical abuse and/or neglect;
* Financial abuse (40 per cent), psychological abuse (35 per cent) were the most frequently cited forms of abuse followed by neglect and social isolation (10 per cent each), physical abuse (less than 5 per cent) and sexual abuse (1 per cent); and
* Victims with confirmed or suspected dementia experience less psychological abuse than other victims of elder abuse[[8]](#footnote-8).

The Victorian data showed that the most common concerns relating to elder abuse were about financial issues (61 per cent) and psychological abuse (59 per cent). Physical abuse was less frequently raised (16 per cent) as was social abuse (9 per cent), neglect (1 per cent) and sexual abuse (0.4 per cent). Elder abuse issues were most commonly reported in relation to females (73 per cent) and the majority of perpetrators were male (60 per cent). The majority of perpetrators were children of the victims (67 per cent) with sons responsible for 40 per cent of the incidents reported and daughters 27 per cent. Spouses were reported as perpetrators in a small number of cases – husbands at 5 per cent and wives 3 per cent.

The NSW data also had similarities, with women comprised 71 per cent of victims, the most common age of victims was 75-84 year olds (33 per cent). Family members were the perpetrators in 71 per cent of calls, with adult children again being the largest group of perpetrators (26 per cent sons and 21 per cent daughters). Spouses represented 12 per cent of perpetrators. The most common abuse types included psychological abuse (57 per cent), financial abuse (46 per cent), neglect (25 per cent), physical abuse (17 per cent) and sexual abuse (1 per cent).

This evidence shows a clear pattern, with woman most likely to be abused, financial and psychological abuse the most common forms of abuse and perpetrators most likely to be family members, predominantly adult children. Sexual abuse was infrequently reported. The data also shows some variations that require further exploration, including the variations in the levels of reported neglect, physical abuse and spousal abuse. It is also important to note that these studies reflect only reported abuse, and not the full pattern of elder abuse.

Thus while the patterns and trends of elder abuse identified from the helplines may be repeated across Australia it is not advisable to generalise the Queensland specific data, or that from other jurisdictions, to inform legislative and policy decision making. Accordingly, the EAPU is prepared to work with the Australian Government to use the Helpline data and analysis to inform the development of a national prevalence study and to make available the resources and work of the EAPU Reference Group which has investigated the requirements of an elder abuse prevalence study for Queensland[[9]](#footnote-9).

Finally, the UnitingCare network notes that the need for a better evidence base was acknowledged in the Coalition’s pre-election commitment to a national study into the prevalence of elder abuse to better understand the problem; and to develop a national awareness campaign to educate and to change attitudes and values[[10]](#footnote-10).

## **Q11: What evidence exists of elder abuse committed in aged care, including in residential, home and flexible care settings?**

The WHO indicates that:

*Abusive acts in institutions include physically restraining patients, depriving them of dignity (by for instance leaving them in soiled clothes) and choice over daily affairs, intentionally providing insufficient care (such as allowing them to develop pressure sores), over- and under-medicating and withholding medication from patients; and emotional neglect and abuse[[11]](#footnote-11).*

Comprehensive data on the prevalence of elder abuse within residential and home based care across Australia is lacking, but there have been anecdotal reports of neglect related to low levels of staffing, deliberate over-use of medication, abuse by staff and of incidents of cognitively impaired residents harming other residents [[12]](#footnote-12).

Approved residential aged care providers and their staff are bound by the *Aged Care Act 1997* (Commonwealth) which includes compulsory reporting requirements for ‘reportable assaults’ which are defined in the Act as ‘unlawful sexual contact with a resident of an aged care home’ or ‘unreasonable use of force on a resident of an aged care home’ (Section 63 – 1AA).

For 2014-15, the Department reported receiving 2,625 notifications of reportable assaults of which 2,199 were recorded as alleged or suspected use of force, 379 as alleged or suspected unlawful sexual contact, and 47 as both. With 231,555 people receiving permanent residential care in 2014-15, the incidence of reports of suspected or alleged assaults was 1.1 percent[[13]](#footnote-13).

 It should be noted that reports under this legislation do not give a full picture of elder abuse within the residential aged care setting, as they are limited to physical abuse and do not include the most commonly reported forms of elder abuse as cited in the helpline data. Thus reports would exclude elder abuse which may be perpetrated within a residential aged care facility by family members, such as financial and psychological abuse, or by others such as by carers in the examples cited above.

**EAPU Helpline data**

The EAPU Helpline data for the period 1 July 2015 to 30 June 2016 shows that 8.9 per cent of elder abuse victims and 0.12 per cent of perpetrators lived in an aged care facility.

***Accommodation type – elder abuse victims***

*Fig. 3 Type of accommodation elder abuse victims lived in for the period 1/7/15 – 30/6/16. n=1487*

***Accommodation type – elder abuse perpetrators***

*Fig. 4 Type of accommodation elder abuse perpetrators lived in for the period 1/7/15 – 30/6/16. n=1620*

The data from the Helpline indicates that elder abuse is much less frequently reported in aged care facilities than in the community. In considering why this is the case we can reasonably expect it is because:

1. There is less opportunity for certain types of abuse to occur in highly regulated residential aged care settings;
2. Aged care facilities have mandatory and individual processes for responding to incidences of elder abuse and this reduces the need for individuals to contact the Helpline;
3. Residents of aged care facilities may be not capable or empowered to report abuse or may not be consciously aware that abuse is occurring.

## **Q12: What further role should aged care assessment programs play in identifying and responding to people at risk of elder abuse?**

Currently, the role of aged care assessment programs is limited to assessing an individual’s eligibility for aged care under the relevant legislation. Further, the points of interaction are limited, reducing the opportunity to identify people at risk of elder abuse.

Aged care and personal support workers have regular contact with older people in the home setting and the scope for them to identify and respond to actual and potential elder abuse should be further explored. Any such exploration would need to include legal implications and the provision of appropriate training and support. UnitingCare Queensland, through the EAPU, delivers training to frontline staff to help them understand what elder abuse is, how to identify signs of actual and potential abuse and how to respond appropriately. The service is willing to work with other stakeholders to inform the development and delivery of a national pilot training program.

## **Q13: What changes should be made to aged care laws and legal frameworks to improve safeguards against elder abuse arising from decisions made on behalf of a care recipient?**

The decision making capacity and individual rights of a competent older adult to make their own choices is already protected under law. Familial conflict is also often a source of difficulty that impacts on the individual older person in their decision making and interactions with aged care providers.

There are already stringent safeguards for providers in regards to key personnel, police checks, accreditation review of systems, community visitors’ scheme, health professional registration etc.  A key issue is the role of the family as decision maker for a non-competent person who has no formally appointed guardian or when the appointed guardian is seen not to be acting in the best interests of the person.  In our view, the accountability of legally appointed guardians and the follow up of the relevant state authorities to evaluate the effectiveness of formally appointed guardians requires strengthening. At the moment the default position or assumption is that the appointed guardian is acting appropriately.

In the majority of situations formal and informal arrangements work very well in ensuring the older person’s wishes are upheld. The formal appointment of a guardian, however, does not in and of itself ensure the best interests of the person are represented. The current process, by which the appointment of guardianship is accepted, does not include any education as to the breadth and scope of the role of the appointee.

As indicated earlier, assault reporting processes already exist for circumstances where aged care providers see evidence of such action taken whether it be by the guardian, or by others with influence over the older person. In the broader context of elder abuse (including financial abuse), however, response and reporting processes are less well defined and require clarification.

UnitingCare Australia believes that people assuming legal guardianship roles should be fully educated as to the extent of the role and the obligations and responsibilities associated with the role. We believe the arrangements should be subject to regular review and that external verification of their appropriateness should be required. Further the processes for aged care service providers (both residential and home based) to report actual and potential misuse of the guardianship role should be clarified, including legal obligations and protections for people making reports.

## **Q14: What concerns arise in relation to the risk of elder abuse with consumer directed care models? How should safeguards against elder abuse be improved?**

The introduction of consumer directed care (CDC) gives the care recipient greater control of how funds are used, and by extension therefore potentially extends that control to a person appointed to act on behalf of the older person. An area of grey exists where a third party (not the care recipient or the aged car provider) designs and receives a benefit. This can be complicated when the care recipient lives with the third party.

The issues arising in the current funding environment are not so much due to the CDC model but more specifically to the income tested fee component of the funding model. Care recipients sometimes see the means tested client contribution as a disincentive to engaging with the appropriate level of care to meet their care needs. Of more concern, aged providers on occasion witness evidence of family members acting in the role of surrogate decision maker electing not to engage support at the appropriate level, unfortunately based not on the ability to afford the support but a desire to maintain their inheritance.

Although not linked to CDC, a related risk exists at the time the older person requires admission to residential care. If the appointed guardian or representative is also the beneficiary of the person’s will, there is a risk they may choose to preserve their inheritance rather than sell assets to secure residential care.

There have been discussions concerning the CDC fund holding role of the aged care provider leading to a conflict of interest. This aspect will, however, be addressed by changes to the regulatory framework which take effect as of February 2017.

## **Q15: What changes to the requirements concerning quality of care in aged care should be made to improve safeguards against elder abuse?**

Approved provider status, police checks, regular assessment against quality standards by the Australian Aged Care Quality Agency and mandatory reporting already exist, and costs for the ongoing maintenance of these systems are borne by the aged care provider.

The standards are already rigorous with regard to provider systems and evidence of these is assessed by independent reviewers who also talk extensively with care recipients in the course of the reviews.

## **Q16: In what ways should the use of restrictive practices in aged care be regulated to improve safeguards against elder abuse?**

As indicated in the ALRC *Issues Paper*, there are guidelines and checks and balances in place in residential and home care in relation to the use of physical and chemical restraint although the use of restrictive practices is not explicitly regulated. The development of a national framework as exists for the disability service sector may have particular merit outside the regulated residential aged care sector.

Resources have been developed by the Department of Health to assist providers to minimize restrictive practices, in the form of a Decision-making tool and guidance on supporting a restraint-free environment in community and residential care (Department of Health and Ageing 2012). Providers undertake staff education to ensure best practice principles are applied to understanding changed behaviours, and engaging the least restrictive practices.

The Australian Aged Care Quality Agency also undertakes regular review processes through Accreditation Standards 2, 3 and 4. The Agency has the ability to require improvement and sanction providers who fail to demonstrate good practice in this domain. In addition, complaints can be made to the Aged Care Complaints Commissioner.

In the community setting, family members who lock doors to prevent the older person from accessing the outside environment, or use of chemical restraint by family members is sometimes due to limited access to, and poor understanding of, the benefits of input from specialized mental health services. A broader community understanding of elder abuse, in all of its presentations is important in addressing these issues and the UnitingCare network would strongly support the development and implementation of broader community awareness programs.

## **Q17: What changes to the requirements for reporting assaults in aged care settings should be made to improve responses to elder abuse?**

As previously noted, approved residential aged care providers are bound by the compulsory reporting requirements of the *Aged Care Act 1997 (Cwth)* in relation to physical abuse. As indicated, the requirements do not extend to all forms of elder abuse, some of which are difficult to detect and would not be easily captured by compulsory reporting regimes.

Further, while reporting is of physical assault mandated, the process of making a report does not in itself trigger any actions. It is up to providers to implement processes to address risks and negotiate solutions. Responsible providers invest time and resources to ensure positive outcome are achieved for older people. While reports are investigated it is not uncommon that no evidence is found to support allegations. It is the experience of some aged care providers that the police response can be variable, particularly if the allegations of abuse relate to a victim or perpetrator with diminished capacity.

## **Q18 : What changes to aged care complaints mechanisms should be made to improve responses to elder abuse?**

The UnitingCare network notes that the aged care complaints system has been subject to various reviews and improvements over the years. It remains important that reports be made initially to the management to ensure investigation, review and a timely response. It should be noted that providers are required to have well developed internal complaints mechanisms, which ensure positive outcomes for older people and maximise opportunities for improvement. Internal mechanisms for complaint handling are reviewed by the Quality Agency, along with specific outcomes. Mechanisms already exists to ensure improved performance in areas where the Quality Agency has concerns in relation to a provider’s system for complaints handling, or specific outcomes.

## **Q19: What changes to the aged care sanctions regime should be made to improve responses to elder abuse?**

Sanctions and penalties should only be implemented in the event aged care providers are found to have systematic issues and breaches of regulatory compliance. An important consideration is the ongoing care of care recipients while sanctions are in place. It should be noted that the magnitude of the risk should result in a graded approach to the application of sanctions. Such a graduated response should be available to the authorities.

## **Q20: What changes to the role of aged care advocacy services and the community visitors scheme should be made to improve the identification of and responses to elder abuse?**

The UnitingCare network believes that any expansion of the role of the community visitors scheme similar to that adopted in Victoria in relation to the disability sector (as mentioned in the ALRC Issues Paper), would require further consideration as to the benefits and issues associated with applying it to residential aged care.

Advocacy services perform a valuable role in assisting older people to negotiate a positive outcome, often by mediation, and education. The Aged Rights Advocacy Service in South Australia has developed a Train the Trainer model for abuse prevention, and a useful model for community services staff; “The protocol for responding to abuse of older people at home in the community”.

Given the largest numbers of older people live independently at home, or with informal assistance from family, friends, or privately sourced services, knowledge of these resources in the broader community is an important step in improving access. Consideration should be given to ensuring the broader community understands the full scope of what we understand to be abuse. Opportunities for educating people working in banking, emergency services, healthcare, churches, and councils, to recognise and report abuse would contribute to better outcomes for individuals living in the community setting.

There has been reluctance by advocacy services to be the initiator that seeks review of Guardians before the Guardianship Board. This aspect of the service is important and should be clearly defined as within scope.

Clients in rural and remote areas often have limited opportunities for face-to-face support from aged care advocacy services. Resources such as the Elder Abuse Helpline provide a point of contact for supporting victims and for individuals who may suspect (or have witnessed) elder abuse is occurring to contact a confidential source of advice anonymously. The Helpline significantly increases the opportunities for elder abuse to be identified, including when advocacy and community services are either not present or when an individual wishes to remain anonymous.

## **Q21: What other changes should be made to aged care laws and legal frameworks to identify, provide safeguards against and respond to elder abuse?**

A legal framework in isolation does not deliver an effective mechanism for prevention of abuse. Community education, education of personnel at key transition points to further support older people to live life without abuse in its many forms. A program to ensure individuals who are appointed as surrogate decision makers understand scope and breadth of their responsibilities, and the core tenets of advocacy. Improved access to professional advocacy supports in country areas and for special needs groups.

A recent matter in a SA residential home was debated in the media as it related to surveillance of a resident in their room within an aged care home. We think the matter challenges Federal and State law as it applies to individuals’ rights within an aged care home versus their own home. Whether they are competent, the issues of privacy and dignity for a resident, and other individuals (staff, visitors), and the broader issues of individuals who are vulnerable having similar risks whether they be in their own home, aged care, disability service, educational or health service environment.

## **Q32: What evidence is there of elder abuse by guardians and administrators? How might this type of abuse be prevented and redressed?**

As discussed earlier, in some cases appointed guardians are unaware of the core tenants of guardianship; and make decisions based on a desire to protect their own lifestyle, and not on the rights and wishes of the older person. Better educating persons to whom powers are granted should be a fundamental step towards the prevention of abuse, as should the use of external regular review of guardianship arrangements.

## **Q35: How can the role that health professionals play in identifying and responding to elder abuse be improved?**

The types of considerations of risk within aged care should be assumed to be present within all health services, irrespective of setting. Obviously chemical and physical restraint, handling of older individuals and relative prioritising of care of older individuals are important areas for review. In addition, all health professionals would benefit from community and targeted education about what constitutes elder abuse, how to identify people at risk and how to identify signs of abuse.

## **Conclusion**

The UnitingCare network has broad experience in relation to elder abuse – as a significant provider of residential and home based aged care services, as the operator of a dedicated elder abuse Help Line and Elder Abuse Prevention Unit and as the operator of a wide range of counselling and support services, including Lifeline services and face to face counselling.

The UnitingCare network believes that more research and work is required to better understand the prevalence and causes of elder abuse, and to develop and implement better prevention and early detection measures. In addition, the network believes that community education is required to help raise awareness of elder abuse and its signs and to increase the rate of detection and support.

The UnitingCare network strongly supports the commitment by the Government, made during the election campaign, to increase funding for elder abuse awareness, research and prevention and is prepared to make available its data and resources to assist in making older members of our community safer, regardless of their location.

1. <http://www.who.int/ageing/publications/toronto_declaration/en/> accessed 19 August 2016 [↑](#footnote-ref-1)
2. Kaspiew, R., Carson, R., & Rhoades, H (2016). *Elder abuse: Understanding issues, frameworks and responses*. Melbourne. Australian Institute of Family Studies. Page 2 [↑](#footnote-ref-2)
3. Ibid. Page 3 [↑](#footnote-ref-3)
4. Ibid. [↑](#footnote-ref-4)
5. <http://www.who.int/ageing/publications/toronto_declaration/en/> accessed 19 August 2016 [↑](#footnote-ref-5)
6. Kaspiew, R., Carson, R., & Rhoades, H (2016). *Elder abuse: Understanding issues, frameworks and responses*. Page 6 [↑](#footnote-ref-6)
7. Ibid. Page 6-7. [↑](#footnote-ref-7)
8. <http://www.eapu.com.au/uploads/research_resources/EAPU%20Helpline_%20Results%20of%20an%20investigation%20of%20five%20years%20of%20call%20data_2015.pdf> accessed 19 August 2016 [↑](#footnote-ref-8)
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13. 2014-15 *Report on the Operation of the Aged Care Act 1997*. [↑](#footnote-ref-13)