

https://lh5.googleusercontent.com/ULDdhQEReUJlYn7odvxKAKZuhH0Rk3zOLldeCe_XOvpytdSPc_196aVrZ5JjDTuM8eil0YL3nnP11jL9AsiR7QSUhO4YgCANfkhbfU1sz6D6yc75wXWnfXkKIVBNAVPEKGfbf95s

## Introduction

The Australian Research Network on Law and Ageing (ARNLA) is an Australian wide network of legal scholars who are experts in the field.  Central to the work of ARNLA is the promotion of human rights and freedoms for older persons, drawn from the principal international instruments concerning older persons – the UDHR, ICCPR, ICESCR, CRPD and the UN Principles for Older Persons.

ARNLA is pleased to have this opportunity to make a submission in response to the ALRC Discussion Paper, *Elder Abuse(DP83).* ARNLA’s online submission addresses specific proposals contained in the discussion paper and our response is organized under the corresponding headings.

The following comments relate to aspects of the Discussion Paper beyond the formal proposals. This document should be read in conjunction with ARNLA’s online submission.

The following academics have contributed to the ARNLA submission:

Professor Wendy Lacey: University of South Australia Law School.

Professor Eileen Webb: Curtin Law School

Professor Robyn Carroll: University of Western Australia

Associate Professor Meredith Blake: University of Western Australia

Dr Susannah Sage-Jacobson: Flinders Law School

Dr Suzanne Jarrad: University of South Australia

Ms Teresa Somes: Macquarie Law School

Ms Lise Barry: Macquarie Law School



unisa-logo.png

**1.110 The tension between respecting the older person’s choices and also safeguarding the older person; protective responses may lead to overreach.**

ARNLA suggests that ageism is a strong normative influence generally in society, and is also prevalent in health care settings, where older persons constitute the majority of the patient population. Unconscious attitudes about the worth of older persons, and judgments on lifestyle, are evident particularly when frailty is present.

One example given in the discussion paper was a failure in hospitals to give effect to advance plans, which may be due to miscommunication but also to attitudes that dismiss the rights of older persons to self-determination. Research suggests that substitute decision makers may project their own beliefs or judgements about ‘best interests’ into the decision, rather than prioritizing the rights of the older person.[[1]](#footnote-1)

In addition to the influence of societal norms on ageing, health care settings are also subject to the medical paradigm of expert knowledge and certainty, which can further lead to the suppression of the older person’s voice. Doctoral research by one ARNLA member has found that assumptions about decision-making capacity of the older person led to practices that were disempowering, such as excluding the person from participating in decisions about their own life (Jarrad, 2016). In some instances, medical authority is extended beyond medical decisions, to decisions such as lifestyle and personal choices of patients. Observations suggest that health professionals can project their own values, personal and professional, onto an older person, and due to the power differential, are not challenged. ARNLA suggests that older people in the hospital environment are particularly vulnerable to having their preferences not respected and outcomes imposed. At times this may lead to unwanted outcomes such as entry into residential care.

Risk is often a reason for not supporting a person’s preferences, or challenging the older person’s decision making ability. ARNLA also suggests that ‘risk of harm’ is not always well evaluated, or the benefits of certain choices recognized. Consequently, risk aversion in medical settings can over reach and lead to constraints on choices.

ARNLA suggests that particular safeguards are needed in hospitals through a clear focus on respect for decision-making. There is also the need to consider independent assessors where ‘risk ‘is a major reason for constraints on choice, and particularly where outcomes are being imposed. Independent audits of capacity assessment processes where an outcome is imposed on the person is another alternative mentioned earlier. It is also proposed that more attention be given to utilizing home trials or transition services following hospital admission, to provide time for decision-making processes without hospital time constraints that may lead to rushed outcomes.

These issues will also need to be carefully considered in the context of supported decision-making models. Any models that are developed will need to be accompanied by the resources to provide information and training to those tasked with representing the will and preference of older people.

**1.16 A lexicon for the new supported-decision making paradigm**

ARNLA supports that a standard national lexicon be adopted to promote support for the decision making of older persons. While in SA, changes to the Advance Care Directives Act such as Substitute Decision Makers (SDMs) to ‘representatives’ could create confusion in the short-term for the community, the values that accompany the role of ‘representative’ would be educative about respect for the older person’s self-determination and encourage participation in decision-making.

**1.119 ‘Will, preferences and rights’ standard**

ARNLA supports the Commonwealth Decision-Making Model as embodied in the ‘Will, preferences and rights’ guidelines. Such a national standard will assist to facilitate much needed changes in the attitudes towards older persons and respect for their choices.

However, ARNLA is aware of the dearth of support and resources for ‘supporters and representatives’ required to bridge the gap between law and practice. ARNLA recommends that attention be given to sustainable resources to educate and support this population with their challenging role, especially at times of family or professional conflict; where community resources are unavailable to give effect to preferences; and for end of life decision-making.

**1.125 Tests of legal capacity**

Legal capacity is defined in the discussion paper as ‘the threshold for individuals to take certain actions that have legal consequences’. This aspect is very clear in relation to legal documents such as wills and contracts, based on an assessment of understanding specific to the transaction. A test of capacity may also occur in health care if there is a question as to whether the patient has sufficient understanding to consent to the proposed treatment.

However, there has been a strong trend in medical settings, especially hospitals, to use a capacity assessment approach for broader decisions, such as accommodation and care. This might be, for instance, when the patient is refusing to accept the proposed care arrangements following discharge.

ARNLA expresses strong concern about these processes in that they are without scrutiny or independent audit. While taking a functional approach, those undertaking such assessments may not have an adequate understanding of the common law principles, and there may often be a tendency to be concerned with the outcome rather than a neutral approach to assessing understanding. A ‘ muddling through’[[2]](#footnote-2) and subjectivity of the assessor is noted in literature, and practices have been observed in recent hospital based case studies that do not conform fully to common law requirements.[[3]](#footnote-3) Resource constraints can also shape the decision to be made,[[4]](#footnote-4) creating vested interests for health professionals. Further, attitudes of health professionals can assume inability of the older person for decision-making, and exclude the person from participation. Family values can also be given greater account than the older person’s preferences when resolving discharge plans.[[5]](#footnote-5) These practices are indicative of strongly entrenched attitudes and practices operating in medical settings.

While ARNLA supports the approach on supported decision-making, considers that this new approach could have a slow or negligible uptake in the current medical environment. To support changes in practice, ARNLA proposes that health and welfare professionals be given clear accountability in any legislation to engage in supported decision-making practices prior to any capacity assessment. Practical resources in risk assessment and values clarification, could assist these new supported decision making practices in a practical way.

Consideration of independent capacity assessors or auditors would provide protection to the decision-making rights of the older person where safeguarding has over-reached, or assumptions about decision-making capacity due to the presence of cognitive changes, remains prevalent.

**4. CRIMINAL JUSTICE RESPONSES**

ARNLA is concerned that there are no specific proposals associated with criminal justice responses in the Report. The Commission appears to believe that a specific offence dealing with elder abuse would be an ‘over paternalistic’ approach (at 4.39), and would therefore infantilise the criminal law’s approach to older persons. It also rejects the creation of a specific new offence on the basis that this would result in duplication, given that there are existing criminal offences which address the causation of physical and psychological harm.

ARNLA notes that the Report does not distinguish between the criminal law in the common law and the main Code jurisdictions (WA and Queensland) (see p81, 4,35) in relation to offences arising from a breach of a duty owed to another. The criminal law has recognized that in circumstances where harm results in the context of a familial or other intimate relationship, this may be addressed through the recognition that a duty exists between the perpetrator and the victim, and that this has been breached. However, there are important distinctions between the common law and the Code approaches which are not recognized in the Report’s discussion. The common law requires proof of a duty of care as an element of the *particular offence* of gross negligence manslaughter. Research carried out by members of ARNLA on the history of the common law on this point indicate that the vast majority of prosecutions in relation to breach of duty have been confined to homicide offences (see, eg., *R v Taktak* (1988, NSW), *Burns v R* (2012, HCA)), and does therefore not extend to other forms of harm. In the Code jurisdictions proof of a breach of a specified duty of care owed to a person who has suffered physical injury *establishes a causal link* between the person who has breached the duty and the harm caused. It does not create an offence but rather facilitates proof of causation where the circumstances are in the nature of a failure to assist, rather than a positive act of harm. Breach of this duty (with the relevant fault, a minimum of gross negligence) holds the accused to have ‘caused any consequences which result to the life or health of any person’ (see sections 259-265 of the Criminal Code (WA)).

It is suggested that a duty owed to older persons which works in this way would improve the criminal law’s approach to elder abuse as it would address issues of detection and reporting (through knowledge that a duty exists to exercise care which would therefore promote preventative responses), and would address the nature of much familial harm which is often through failure to provide necessaries rather than a deliberate act of harm, which may be easier to prove. Although the duty to provide the necessaries of life imposed on those who have the ‘charge’ of another under the Codes (Qld and WA) could be utilized in connection with the abuse of older persons, this has been interpreted as applying to those who do not have the mental competency to direct their own care (*Brightwater Care Group v Rossiter* (2009, WASC). This would be over-limiting in the case of many older persons who retain such capacity.

ARNLA therefore suggests that while there may not be sufficient justification for a new criminal offence, there is an argument to support the creation of a specific duty owed to older persons which could facilitate *proof* of an existing offence, given the circumstances associated with familial abuse. This may help to redress the deficiencies of the common law approach recognized by Glanville Williams.[[6]](#footnote-6) He comments that ‘there is no statutory or common law guidance as to who owes to whom and in what circumstances a duty can exist.’[[7]](#footnote-7) He specifically refers to the ‘dilemma’ in proving the necessary causative link between the event and the consequence.[[8]](#footnote-8)

ARNLA therefore recommends that the Commission give serious consideration to the introduction of a specific duty owed to older persons which would help to facilitate proof of a range of existing offences.

**Disadvantaged and Marginalised Older People**

Further consideration should be given to the needs of disadvantaged and marginalised older people who must navigate unique personal circumstances and are extremely vulnerable to abuse. For example:

**LGBTI Seniors:** The rights of LGBTI+ people in Australia have been part of significant public debate in recent times, especially in regards to marriage equality. However, little attention has been paid to the experiences of older LGBTI+ people; particularly those entering or already in aged-care facilities. LGBTI+ seniors are far more vulnerable to interactions with care-givers than their heterosexual and cisgender counterparts. Lack of education and understanding of how the law operates has resulted in many LGBTI+ seniors being unaware of how the legal system can be used to protect themselves against elder abuse and discrimination. Furthermore, historical discrimination has also made many LGBTI+ seniors unwilling to engage with the legal system.[[9]](#footnote-9) Issues of concern regarding elder abuse include legal protection for older LGBTI+ people and their families of choice especially in times of crisis,[[10]](#footnote-10) rights of same-sex partners, wills, superannuation, supported and substitute decision making, and end of life issues.

**CALD Seniors:** Due to the diversity of this group, the lack of specifically tailored services presents a challenge. Generally, older people from a CaLD background are less likely to be covered by superannuation schemes, are more likely to have retired earlier and are more likely to be dependent on a government pension.[[11]](#footnote-11)

There is evidence of persistent under-representation of older people from CaLD backgrounds accessing disability and aged-care services.[[12]](#footnote-12) Factors which may restrict CaLD older people accessing these services include; limited language skills, lack of understanding of services and insufficient accessible information.[[13]](#footnote-13) Communication skills which are already problematic may worsen due to natural ageing or more serious health issues such as dementia.[[14]](#footnote-14) Some studies suggest that English skills may be lost altogether as older people revert to their first learned language,[[15]](#footnote-15) or lose their most recently acquired language.[[16]](#footnote-16) CaLD seniors may also suffer due to a lack of (or declining) community networks, computer illiteracy and transport related difficulties.[[17]](#footnote-17) The ‘digital divide’ in particular may enhance difficulties accessing services.[[18]](#footnote-18)

Older people from a CaLD background are more likely to be living with their children (30% to 17%) and less likely to be living alone (21% to 29%) than those from non-CaLD backgrounds.[[19]](#footnote-19) As they tend to remain at home longer, when they must leave their home, they often require high-needs care, which is difficult to access when they are not already part of the system.[[20]](#footnote-20)

There is also often reluctance on the part of family members to self-identify as ‘carer’, as their services are seen ‘as a continuation of normal family roles.'[[21]](#footnote-21) This includes providing services such as maintenance, home care, meals and transport.[[22]](#footnote-22) A report by the AIHW seems to illustrate this tendency, which indicated that a higher proportion of Community Aged Care Packages clients were from CaLD backgrounds.[[23]](#footnote-23)

ARNLA has made further proposals in relation to the need for free National Interpreter Services for this group of older Australians as part of our online submission.

Please direct any inquiries about this submission to:

Ms Lise Barry

[Lise.barry@mq.edu.au](mailto:Lise.barry@mq.edu.au)

1. JT Berger, EG DeRenzo, J Schwatrtz, ‘Surrogate Decision-Making: Reconciling Ethical Theory and Clinical Practice’, Ann Intern Med. 2008:149-48-53; Joachim Krueger ‘On the Perception of Social Consensus’, in M Zanna (ed), *Advances in Experimental Social Psychology* (Vol 30, pp 163-240), (1998, New York: Academic Press); Angela Fagerlin, Peter Ditto, Joseph Danks, Renate Houts, William Smucker, ‘Projection in Surrogate Decisions About Life-Sustaining Treatments’, Health Psychology, 2001, Vol 20, No 3, 166-175 at 167; TG Guthell, Appelbaum ‘Substituted Judgment: Best Interests in Disguise’, Hastings Cent Rep; 13, 8-11; Shalowitz, Garrett-Mayer, Wendler – ‘The Accuracy of Surrogate Decision-makers: a Systematic Review’ Arch Intern Med 2006:166:493-7; Charlotte Emmett et al, 'Homeward Bound or Bound for Home? Assessing the Capacity of Dementia Patients to Make Decisions About Hospital Discharge: Comparing Practice with Legal Standards' (2013) 36(1) *International journal of Law and Psychiatry* 73. [↑](#footnote-ref-1)
2. M BKapp, 2002, Decisional capacity in theory and practice: Legal process versus ‘bumbling through’, *Aging and Mental Health*, vol, 6, no.4, pp.413-7. [↑](#footnote-ref-2)
3. Suzanne Jarrad, 2015, *Reclaiming personhood in later life: Towards a new model of decision-making*, Thesis submitted for the degree of Doctor of Philosophy, Flinders University, South Australia. [↑](#footnote-ref-3)
4. Christine Bigby, Mary Whiteside, &Jacinta Douglas 2015, *Supporting People with Cognitive Disabilities in Decision-Making: Processes and Dilemmas*, Living with Disability Research Centre, La Trobe University, Melbourne. [↑](#footnote-ref-4)
5. Linley Denson, L, Winefield, H & Beilby, Justin 2013, *Discharge planning for long-term needs: the values and priorities of older people, their younger relatives and health professionals’, Scandinavian Journal of Caring Sciences, vol.27, no.1, pp 3-12.* [↑](#footnote-ref-5)
6. [2009] Crim LR 631. [↑](#footnote-ref-6)
7. At p631 [↑](#footnote-ref-7)
8. At 633. [↑](#footnote-ref-8)
9. Liam Elphick and Eileen Webb, *Yesterday once more: Discrimination and LGBTI+ Seniors,* Monash Law Review (forthcoming) [↑](#footnote-ref-9)
10. ## Noell L Rowan and Nancy Giunta, ‘Building Capacity in Gerontological Social Work for Lesbian, Gay, Bisexual and Transgender Older Adults and their Loved Ones’ (2014) 57 *Journal of Gerontological Social Work* 75, 77.

    [↑](#footnote-ref-10)
11. Diane Gibson, ‘Patterns of ageing and service use in a culturally diverse population’, *AIHW*, 2011, 18 <www.culturaldiversity.com.au/component/docman/doc\_download/35-diane-gibson> [↑](#footnote-ref-11)
12. Jeni Warburton et al., ‘Ageing and cultural diversity: policy and practice issues’ (2009) 62(2) *Australian Social Work* 168-85. [↑](#footnote-ref-12)
13. Colette Browning, ‘Community care and CALD seniors’ (2008) 20 *Australian Mosaic* 23-4. [↑](#footnote-ref-13)
14. DT Rowland, ‘The ethnic aged population and the likelihood of special needs’ 1999 3(supplement) *Australasian Journal on Ageing* 50-4; Angelica Orb, *Health care needs of elderly migrants from culturally and linguistically diverse (CALD) backgrounds: A review of the literature* (2002) The Centre of Research into Aged Care Services, Curtin University of Technology. [↑](#footnote-ref-14)
15. Trang Thomas. ‘Older migrants and their families in Australia’ 2003 66 *Family Matters.* [↑](#footnote-ref-15)
16. Access economics report for Alzheimers Australia, ‘Dementia prevalence and incidence amongst people who do not speak English at home’ (2006). [↑](#footnote-ref-16)
17. Emad Nimri, *Social, Care and Support Needs of Older People from Culturally and Linguistically Diverse Backgrounds in the Gold Coast Region: Needs Analysis* (2007) Multicultural Seniors Program (MSP) for the Multicultural Communities Council Gold Coast Inc., Queensland Government Department of Communities. <http://www.mccgc.com.au> [↑](#footnote-ref-17)
18. Federation of Ethnic Communities' Councils of Australia(FECCA)*,*A Submission to the Advisory Panel on the Economic Potential of Senior Australians, *Realising the Economic Potential of Senior Australians – A CALD Perspective*, October 2011, 4. [↑](#footnote-ref-18)
19. Gibson, above n7, 18. [↑](#footnote-ref-19)
20. ## [VoulaMessimeri-Kianidis, ‘**A Mosaic of Culturally Appropriate Responses for Australian Culturally and Linguistically Diverse Background Elderly People’**](http://www.culturaldiversity.com.au/component/docman/doc_download/49-voula-messimeri-kianidis) (Speech delivered at Cultural Diversity in Ageing 2007 National Conference, Sofitel Melborune 7-8th June, 2007).

    [↑](#footnote-ref-20)
21. Commonwealth of Australia, *Who Cares ...? Report on the Inquiry into Better Support for Carers* (2009) House of Representatives, Standing Committee on Family, Community, Housing and Youth. [↑](#footnote-ref-21)
22. FECCA*,*A Submission to the Advisory Panel on the Economic Potential of Senior Australians, 8. [↑](#footnote-ref-22)
23. Australian Institute of Health and Welfare, ‘Special Population Groups’ (2006). [↑](#footnote-ref-23)