CPSA COMBINED PENSIONERS & SUPERANNUANTS ASSOCIATION

Submission to the Australian Law Reform Commission's Inquiry into Elder Abuse

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Combined Pensioners & Superannuants Association of NSW Inc (CPSA)

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CPSA is a non-profit, non-party-political membership association founded in 1931 which serves pensioners of all ages, superannuants and low-income retirees. CPSA has 108 branches and affiliated organisations with a combined membership of over 22,000 people living throughout NSW. CPSA's aim is to improve the standard of living and well-being of its members and constituents.

CPSA welcomes the opportunity to comment on the Australian Law Refrom Commission's Inquiry into Elder Abuse. As an organisation representing the views of pensioners of all ages and other low income retirees, CPSA has a keen interest in the issue of elder abuse.

Summary of recommendations:

Recommendation 1: *That the Australian Government negotiates a national framework for the reporting of elder abuse by emergency services, health professionals and others who may be expected to witness or find evidence of elder abuse during the course of their work.*

Recommendation 2: *That income Management should not be introduced as a preventive measure against elder abuse.*

Recommendation 3: *That the Australian Government extends mandatory reporting of significant physical and sexual assault in residential aged care to resident-on-resident assaults for the purpose of informing a policy response to this problem.*

Recommendation 4: *That the Australian Government introduces an objectively measurable system of aged care quality standards for residential care and home care.*

Recommendation 5: *That the Australian Government prescribes mandatory-staff-to-resident ratios for residential care which relate to individual care needs defined with reference to an objectively measurable system of aged care standards for residential care.*

Recommendation 6: *That the Australian Government ensures that an objectively measurable system of aged care quality standards for residential care and home care includes a complaints scheme which ties in closely with outcomes and deliverables under that system.*

Introduction

CPSA's submission responds to questions posed in the Australian Law Reform Commission's Issues Paper prepared to facilitate responses to the Commission's Inquiry into Elder Abuse.

CPSA has successfully campaigned for an Elder Abuse Helpline in New South Wales, now in its fourth year of operation. Given that the most relevant court jurisdictions and laws dealing with elder abuse in the community are state and territory jurisdictions and laws, the Australian Government's role in responding to elder abuse should support state and territory initiatives.

The Australian Government should certainly support research into elder abuse, but most of all it should ensure that in the one area where it has direct regulatory power to address elder abuse, aged care, it does all it can to prevent it and apply sanctions where it is not successful in preventing it.

CPSA's expertise is not in the area of law. Its comments in this submission are therefore confined to research into elder abuse, Income Management and aged care.

Elder abuse - research

Community awareness of elder abuse is low even though as a category elder abuse overlaps with domestic violence.. The lack of data collection and collation is a major impediment to understanding the incidence of the various forms of elder abuse.

The data collection experience since the commencement of operation of the NSW Elder Abuse Helpline illustrates how difficult it is to obtain comprehensive and accurate data on which to base policy development in this area.

During 2013/2014, the majority of callers to the NSW Elder Abuse Helpline consisted of family members (38%) followed by service providers (32%). Older people made up 17% of the callers and ‘concerned others’ comprised 13%.

Of the types of abuse reported in the calls, the majority was psychological (34%) followed by financial (31%) and neglect (15%).

However, the available data about calls to the Helpline only detail the number of calls and the type of abuse reported in the call. There is:

- no information on whether the abuse has been substantiated or not;
- no information on what occurred after the call was made.
- no information on the incidence of elder abuse in NSW.

This is no criticism of the NSW Elder Abuse Helpline, which is designed to assist those experiencing elder abuse or being at risk from elder abuse. However, it does highlight that research and policy development in the area of elder abuse is hampered by the virtual non-existence of vehicles for accurate and comprehensive data collection.

To address this lack of data collection capability, it is important to tabulate all formally identified cases of elder abuse. This inevitably means enlisting the assistance of agencies (police, courts, health jurisdictions) and professionals (lawyers, formal carers) in reporting instances of elder abuse in a uniform way. To do so, a strict definition of elder abuse, which necessarily primarily serves the purpose of a legal response to elder abuse, is necessary, to enable the thrust of policy development to be focused on prevention.

However, various states have protocols in place for agencies and professionals to adhere to when they encounter elder abuse. A major problem is that these protocols tend to be paper tigers only and, in the case of NSW Interagency Policy for Preventing and Responding to Abuse of Older People, specifically nominates the NSW Police, NSW Health, Aged Care Assessment Teams, sexual assault services, mental health services and the Guardianship Tribunal as respondents to apparent elder abuse but does not mandate the collection of information on incidences of elder abuse for collation across the jurisdiction.

Recommendation 1: *That the Australian Government negotiates a national framework for the reporting of elder abuse by emergency services, health professionals and others who may be expected to witness or find evidence of elder abuse during the course of their work.*

Social security – income management

It is difficult to see how restricting the range of goods and services which the income recipient can buy with their Basics Card will deter people around them from using the card for themselves if they are intent on doing so. Financial abusers could use the Basics Card to make purchases for themselves of approved goods and services. Even if the Basics Card was effective in this regard, the income support recipient, who – for example - may not have an alcohol or gambling addiction or problem, would be banned from buying alcohol or going to the club among other things. It would place restrictions on someone who is being financially abused.

Financial exploitation of older people and of people with disability is a very complex issue. More often than not, the victim does not seek out assistance, because they fear reprisal, they are ashamed, or they do not know where to get help.

Even where an older person seeks assistance, income management does nothing to address the problem of the abuse. It might make it a bit more complicated for the abuser, but obviously the solution would be an intervention aimed at the abuser, rather than at the older person.

Also, income management typically only applies to half of an individual's base rate of income support. As cited by the Elder Abuse Prevention Association, financial exploitation of older people often involves the individual's assets and can include forced property transfers, embezzlement, and improper use of legal guardianship arrangements or powers of attorney. These types of financial exploitation would not be resolved or alleviated by income management.

Recommendation 2: *That income Management should not be introduced as a preventive measure against elder abuse.*

Aged care – evidence of elder abuse

Year	Nursing home places	Contacts with Complaints Scheme	Contacts in scope	Contacts in scope - complaints	Reportable assaults	Relative year-on-year increase in assaults[1]
2008/2009	228,038	12,573	7,962	not tallied	1,411	
2009/2010	237,164	13,166	8,055	not tallied	1,488	1.4%
2010/2011	247,379	13,606	8,468	4,013	1,815	16.9%
2011/2012	252,890	11,517	6,995	4.031	1,971	6.2%
2012/2013	254,848	12,605	8,074	3,811	2,256	13.6%
2013/2014	263,788	11,803	8,228	3,903	2,353	0.8%
2014/2015	273,503	10,924	7,537	3,725	2,625	7.6%

The Aged Care Act 1995 provides for mandatory reporting of significant sexual and physical assaults by staff of residents in residential aged care facilities, also known as 'reportable assaults'. The following statistics of the incidence of reportable assaults are culled from the Government's annual Reports on the Operation of the Aged Care Act 1995. They cover permanent and flexible care, but not home care.

Over the seven years that mandatory reporting has been in place, the total number of nursing home places has increased by 20 per cent. However, the number of reportable assaults has risen 86 per cent over the same period. At the same time, the number of contacts with the complaints scheme has actually fallen (by 13 per cent), as have the contacts-in-scope (by 5 per cent) and the contacts identified as complaints (by 7 per cent).

It should be noted that reportable assaults within the meaning of the Aged Care Act, exclude resident-on-resident assaults or resident-on-staff assaults. There are no statistics available, although anecdotal evidence suggests that these types of assaults are prevalent within nursing homes.

Apart from this statistical evidence, there is strong anecdotal evidence of abuse of residents and of neglect in nursing homes sourced from relatives of residents and carers working in nursing homes.

[1] Calculated as follows: (Reportable assaults for year/Nursing home places for year)/
(Reportable assaults for previous year/Nursing home places for previous year)*100%

Recommendation 3: *That the Australian Government extends mandatory reporting of significant physical and sexual assault in residential aged care to resident-on-resident assaults for the purpose of informing a policy response to this problem.*

Aged care – quality requirements

The operating budgets of aged care providers are largely shaped by the Australian Government through the funding and accreditation process. These accreditation standards are process- rather than outcomes-based, meaning they assume that procedures and processes at an organisational level can be used as a proxy to gauge the quality of care being provided to recipients.

In order to maintain accreditation and receive funding, aged care organisations must keep extensive records detailing interactions between care staff and recipients. In practice, this means that aged care workers spend less time actually providing care and more time filling out paper work. It also means that aged care providers tend to use standardised procedures and processes wherever possible. Such a working environment undermines employee autonomy by mandating the order, manner and time at which particular tasks must be done. It also undermines the capacity of workers to deliver care according to the recipient's wishes.

The accreditation standards, which are input-based, cannot possibly support the delivery of high quality care unless they consider the outcomes experienced by aged care recipients. If the accreditation standards do not consider the outcomes of care, that is the experiences of care recipients, then there is no accountability for quality of care because quality is not actually being measured at all. The current aged care standards also lack clinical rigour to the point where clinical care performance cannot be measured objectively against them.

The way aged care quality compliance is run in Australia passively encourages neglect of residents. To introduce realistic safeguards against the abuse and neglect of nursing home residents, the aged care quality compliance system needs to be made the subject of a

comprehensive, independent review. The aged care quality compliance system must be significantly more outcomes-focussed and needs to ensure staffing levels in nursing homes are adequate. CPSA believes that nursing homes, like child care centres and hospitals, need mandatory staff-to resident-ratios to ensure adequate care quality.

Recommendation 4: *That the Australian Government introduces an objectively measurable system of aged care quality standards for residential care and home care.*

Recommendation 5: *That the Australian Government prescribes mandatory-staff-to-resident ratios for residential care which relate to individual care needs defined with reference to an objectively measurable system of aged care standards for residential care.*

Aged care – restrictive practices

In the absence of an adequate aged care quality compliance, restrictive practices in aged care can develop to the point where they are no longer used solely for the benefit of residents, but also for convenience and cost-effectiveness of care delivery.

While this issue should be addressed as part of a comprehensive, independent review of the aged care quality compliance system, the greater part of the answer will almost certainly not be a change in regulation, but a recognition that in many nursing homes staffing levels are inadequate for the care needs that residents present. Restrictive practices are an issue which highlights that aged care quality regulation and resourcing are inseparable considerations.

Aged care – reportable assaults

As the statistics from the Government's Reports into the Operation of the Aged Care Act 1995 (see response to Question 11), reportable assaults have increased dramatically and disproportionally with the growth in nursing home places. While there is no reporting of staffing levels in residential aged care, it is not possible to link the dramatic increase in reportable assaults to a decline in staffing levels. However, anecdotally, this link is very plausible indeed.

The majority of reportable assaults in nursing homes are likely to have been committed by staff, who are the sole category of persons in constant contact with residents and who are under increasing pressure to do more with less and may snap and handle residents roughly.

While the mandatory reporting regime appears to be adequate, the policy response to the evidence it produces has been ineffective, or rather, there has not been a policy response. As with restrictive practices, what the evidence suggests is that understaffing is linked to reportable assaults on residents. However, the way information about reportable assaults is presented gives little insight to what extent assaults could be linked to poor staffing or are malicious.

In addition, resident-on-resident assaults are not reportable. It was and continues to be resisted by the industry on the grounds that no effective action against residents who commit assaults can be taken. This is a breathtaking admission by the industry of its own inadequacy in two respects. First, the industry implicitly concedes it cannot separate violent residents from non-violent or other violent residents. Second, it wants to ignore the problem by not collecting information about resident-on-resident assaults across the industry.

Clearly, the mandatory reporting system should be extended to include resident-on-resident assaults, to define the scope of the problem rather than to mete out punishment to violent residents, who in most cases of assault can be assumed to be non-compos mentis. Defining the scope of resident-on-resident assaults is a prerequisite for an adequate policy response.

Aged care – complaints mechanisms

The current aged care complaints scheme distinguishes between complaints that are in-scope and complaints that it cannot process. Essentially, both the volume of all contacts and the volume of in-scope contacts processed by the complaints scheme shows a slight, absolute decline, while the number of nursing home places have increased by 20 per cent since the scheme started in 2008. This means that in the more pertinent relative sense contacts with the scheme have declined substantially.

There are two possible interpretations of this substantial decline, one being that the complaints scheme is driving significant quality improvement in residential aged care. The other interpretation is that consumers are giving up on the complaints scheme. The latter interpretation is the more likely one, given that reportable assaults, arguably the most serious of complaints which must be included in the complaints scheme tally, have gone up dramatically both in absolute as well as in relative terms in a steady and quite steep trend.

Obviously, if the more serious category of complaints experience rises in this fashion, it is unlikely that less serious complaints are dropping. They would be increasing, except that they are not made to the scheme. Anecdotally, CPSA can report that callers to its information service are scathing about the complaints scheme.

The overall number of complaints to the scheme (i.e reportable assaults and other complaints) decreased by 7 per cent since the distinction made in 2010. At that time, the rate of reportable assaults to overall complaints was 45 per cent. In 2015, that rate had risen to 71 per cent.

All this really very strongly suggests that the complaints scheme, in its various iterations over the years – it having been reviewed and changed so often another indication that policy makers, too, are concerned about the scheme's performance -, is that the scheme is not working. Reporting is down where it is not mandatory and up where it is mandatory. What is more, mandatory complaints continue to rise steeply. The scheme does not appear to resolve much and quite clearly does not inform effective policy development.

Recommendation 6: *That the Australian Government ensures that an objectively measurable system of aged care quality standards for residential care and home care includes a complaints scheme which ties in closely with outcomes and deliverables under that system.*

Aged care - sanctions

The aged care sanctions available to the regulator are adequate. The problem is that they are the deterrent component of an aged care quality compliance system based on extremely soft, ill-defined aged care standards, as discussed earlier.