Clinical review of area mental health services 1997-2004
Workshop 2 Manual: elder abuse prevention and response – tools for supervisors and managers
Acknowledgements

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The material is aligned to and draws upon the With respect to age – 2009, Victorian Government practice guidelines for health services and community agencies for the prevention of elder abuse.
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Workshop outline

Session 1  Responding to indications of elder abuse
(90 MINS)
This session will provide strategies for responding to indications of elder abuse. You will have the opportunity to explore specific responses and strategies for situations where potential elder abuse is suspected. It will focus on creating a working environment where the barriers to reporting indications of abuse are minimised and staff feel supported in approaching supervisors and managers with their concerns.

Break
(15 MINS)

Session 2  Capacity to respond to elder abuse
(90 MINS)
The aim of this session is to strengthen your capacity to respond appropriately to suspected cases of elder abuse. Participants will look closely at tools and strategies for ensuring compliance with policy and legislation. We will focus on the obligation to act compatibly with policy and the possible impact on your work practices. You will learn techniques for implementing a best practice approach. This will include strategies for accessing support and information.
Workshop manual

This Workshop manual has been prepared to provide guidance to the participants during the course of the Workshop. It should provide a useful resource for the future. Your facilitator will refer to the material during the training session where required.

Symbols

- Checklist
- Discussion
- Activity
- Reflect
Introduction

Victorian Government Elder Abuse Prevention and Response Initiative

The Victorian Government is acting to overcome elder abuse, working with families, service providers, professionals and the community. This workshop is one element of an education and training package for professionals to strengthen the capacity of the Victorian workforce to identify and respond to elder abuse. This training is aligned to the With respect to age – 2009, Victorian Government practice guidelines for health services and community agencies for the prevention of elder abuse.

Objectives of training

Workshop 2 targets the supervisors and managers to whom indications of potential elder abuse will be reported. It supports managers and supervisors in responding to those suspicions and implementing an assessment process to determine whether elder abuse is occurring. It provides strategies around building capacity to respond to elder abuse and accessing resources and information to support detection of elder abuse cases.

This training will assist you to:

**Respond** to suspected cases of elder abuse sensitively and consistent with
- Your own organisation’s policies and procedures.
- The Charter of Human Rights and Responsibilities and the Victorian government’s empowerment model.
- Government legislation and policies and organisational policies and interagency protocols.
- Your duty of care as a worker.
- Your role as a supervisor and/or manager supporting your team.

**Assess** reports of suspected cases of elder abuse and put into operation appropriate actions to confirm suspected cases of abuse and organise referrals more broadly to have those cases managed.

**Contribute** to building the capacity of your organisation to prevent elder abuse.
We want you to be able to answer the following questions with confidence

1. How can I respond and follow up on indications or allegations of elder abuse when reported by a staff member or another professional or agency?
2. How can I encourage reporting and support my workforce?
3. How can I promote empowering and collaborative work practices?
4. When should I consult with or refer a matter to a more appropriate or more specialised service or authority?
5. What should I do if an older person declines support or intervention?
6. What steps should I take if I believe that a client’s competence is in doubt?
7. How do powers of attorney operate?
8. How can I contribute to the development and implementation of policy and procedures to support prevention of elder abuse?
9. How can I promote integrated service delivery and interagency cooperation?

Why has the government provided this training?

Evidence suggests that elder abuse is much more common than our society has traditionally admitted. Much of the problem has been hidden, undefined and unreported. Whilst elder abuse is not a new problem our society is increasingly recognising and describing as ‘elder abuse’ a range of situations involving the maltreatment or neglect of older people. The problem of elder abuse is likely to grow in prominence in Victoria due to the increasing number of older people living in our community, increasing longevity and increasing numbers of people with dementia.

The Victorian Government’s Elder Abuse Prevention and Response Initiative contains priorities aimed at dealing with elder abuse and protecting the rights of older people who live in their home in the community. Of particular significance to the training you are undertaking is the Victorian Government Practice Guide With respect to age – 2009 and the provision of professional education to those whose work brings them into contact with older Victorians. The training you are currently undertaking draws heavily on the Victorian Government Practice Guide With respect to age – 2009.

Many workers involved with older people encounter potentially abusive situations. Circumstances surrounding abuse may raise difficult legal, ethical and practice challenges. Issues for workers arise not necessarily from inadequate legislation or from reluctance to act, but often from uncertainty about how and when to act and who else to include. Training workers to recognise the signs of abuse and to take appropriate action constitutes a vital step in preventing elder abuse. The development of clear local agency policies and procedures and interagency protocols specifically designed to provide clarity to workers is another significant step that may already be impacting on you as a manager/ supervisor in your organisation.
Session 1 – Responding to indications of elder abuse

On completion of this session you will be able to:

1. explain your responsibility to follow up on indications of elder abuse
2. understand the barriers that discourage reporting of suspicions of elder abuse
3. create a work environment that encourages reporting of suspicions of elder abuse
4. support staff to report indications of elder abuse
5. respond to suspicions of elder abuse appropriately
6. understand the role of Seniors Rights Victoria
What is my responsibility to follow up on suspicions of elder abuse?

Older people have the right to live safely in their homes free from violence, abuse, neglect and exploitation. The links between elder abuse, disempowerment and discrimination have been consistently demonstrated in research throughout the world.

All supervisors and managers in Victorian agencies and organisations have a responsibility to their clients arising out of duty of care and their obligation to act compatibly with the Victorian Charter of Human Rights and Responsibilities. Working consistently with the key empowerment principles enunciated in *With Respect to Age – 2009* will ensure you fulfil these obligations and assist to redress discrimination and disempowerment and the incidence of elder abuse in our community.

In any community service agency high quality service delivery is a prime objective. Workers are the means of providing quality service and are often the front line in recognising and responding to situations where elder abuse is indicated. If adequate training support and supervision is provided workers will be able to give optimal high quality care to their clients. You have a responsibility to your workers to comply with Occupational Health and Safety legislation, policies and procedures and this will have flow on effects for your service delivery.

How is my role a key element in an elder abuse prevention and response initiative?

Responding to suspicions of elder abuse is an easily identifiable role of supervisors and managers. What may be less well understood is the pivotal role that can be played by creating a working environment where the barriers to reporting suspicions of abuse are minimised and staff feel supported in approaching supervisors and managers with their concerns. The key message of *Workshop 1: Elder abuse prevention and response – an introduction to concepts and practices* is that workers should advise their supervisor if there are any indications of potential elder abuse or harm being suffered by older Victorians. Intervention can not only prevent further abuse and reduce the harm being suffered but the earlier the intervention the lower the level of permanent damage, hurt or harm inflicted.
Activity

Instructions: Read the following case study and discuss with your group the questions which follow. Your organisation may have generic or elder abuse specific policies and procedures which would guide you in dealing with the above. If so please share these with your group.

Jeff’s story

Jeff is relatively new to the role of community care worker and has been providing assistance to Maria and Antony on a weekly basis for the two months that he has been employed by the council. Jeff likes Maria who is always chatty and tends to want to assist him with his work around her home. On occasion he has laughingly reminded her that he is employed so that she doesn’t have to do so much around the house. Antony is altogether different. Jeff finds him surly and hostile and has often wondered if the dismissive and domineering way he speaks to Maria is a product of cultural factors or if perhaps Antony is just an unpleasant person.

One Friday morning Jeff arrives at Maria and Antony’s house as arranged and finds Maria far less talkative than is usual. She tells Jeff that she has a headache and needs to lie down so Jeff sets about cleaning the bathroom and then moves on to clean the lounge room. On this day he finds the lounge room altered and at first can’t quite put his finger on the change. The room seems cleaner than usual as if someone has done his work for him already but the furniture is different, things are out of place, a chair is broken and there is what looks like a table cloth over the cabinet in which Maria has always kept a large collection of precious keepsakes from her life and travels. Jeff lifts the cloth and finds the cabinet almost empty with the exception of a few broken pieces that give the impression to Jeff of being salvaged in the vain hope they might be repaired. Jeff’s first instinct is to consider that Antony is responsible for the loss and damage and he wonders where Antony is and what has occurred. He recalls that when he arrived Maria was shielding her face from him but he had put this down to the headache. He wonders now if she had been crying.

Jeff completes his cleaning then knocks quietly on Maria’s door telling her he is finished for the day and asking how her headache is. Maria tells him she just needs more sleep but Jeff is concerned so asks if he can contact someone to come and care for her, a doctor or perhaps her daughter. Jeff notes the sound of anxiety in Maria’s voice as she tells him “Please don’t fuss I’ll see you next week”. Considering that he needs to respect Maria’s wishes Jeff reluctantly leaves.
When he leaves Jeff can’t shake off his feeling of concern so he contacts his supervisor Cathy. Cathy requests that he come in to the office so they can discuss the situation more fully. As he drives to the office he remembers a conversation with Cathy’s predecessor about Antony and worker safety and how, given the diminutive stature of Antony, he had quickly put it out of his mind. He wonders now if perhaps Maria was shielding her face because she was covering an injury. Jeff then starts to worry that he has jumped to a whole lot of conclusions based on some broken or missing keepsakes and the fact that he has never really liked or trusted Antony.

By the time he arrives at the office to meet with Cathy he is anxious and confused and concerned that his assessment is based entirely on feelings rather than any really significant facts and wonders how his meddling might impact on his ongoing relationship with Maria.

Cathy’s story
Cathy has just received Jeff’s verbal report and is aware that family violence has featured in Maria and Antony’s past. Cathy reads over the case notes in which there are references to extended periods of domestic stability interspersed with periods of escalating abuse ranging from verbal abuse to property damage and culminating in physical violence. Cathy notes that a range of other service providers are, or have been, involved with Maria and Antony from gambling and alcohol services to ethno specific services, family violence services and on at least one occasion during the course of the council’s involvement, police intervention. Cathy notes also that Maria’s daughter Tina is listed as her next of kin and that Tina has in the past expressed a desire to see her mother separate from her father due to her concerns for her mother’s welfare.

How will you prepare to deal with the process of getting Jeff to document what was seen and heard and what was said and done?

What are some strategies you could potentially implement to deal with the emotions that Jeff might bring to his report and which might still be affecting him personally?

What information could you provide Jeff with that will reassure him that the matter will be dealt with sensitively and appropriately by your agency?
How can I encourage and support reporting?

Change, in particular attitudinal change is difficult to achieve. In addition there will be a range of unique challenges facing each organisation in developing their workforce to learn to respond to potential elder abuse proactively. A key motivation for people at work is that they want to perform well and achieve set objectives. For public sector and community workers there is generally a sense of making a difference to people’s lives and achieving a better outcome for the community. The key to promoting and implementing an elder abuse prevention policy is to clearly link recognising and responding to elder abuse with providing better outcomes for older Victorians, their friends, family and the community.

To follow are some practical strategies to encourage reporting:

- Develop an elder abuse prevention policy and procedures for your organisation.
- Develop a process of genuine consultation about implementing an elder abuse prevention strategy.
- Remove any uncertainty as to how and when to respond to suspicions of elder abuse.
- Foster a positive attitude.
- Consistency of approach.
- Develop effective support in high impact areas.
- Identify and respond to the barriers discouraging responding to suspicions of elder abuse.

In detail:

- **Develop an elder abuse prevention policy and procedures for your organisation**
  Specific policy and procedures formally raise awareness of the issue of elder abuse. They provide a framework for an organisation to express its commitment to prevention of elder abuse and set expectations for work practices. They make clear a worker’s responsibility to respond to elder abuse and generally provide guidance as to appropriate work practices and actions that need to be implemented. The next challenge is to implement the policy effectively and achieve positive compliance in the workplace.

- **Develop a process of genuine consultation about implementing an elder abuse prevention and response policy**
  The implementation of any change to policy or an introduction of a new policy can be categorised as authoritarian change, thus in order for the workforce to take “ownership” of a vision and contribute constructively and positively to its implementation they need to be included in the process. It is important to develop a real process of consultation and involvement by your staff. The implementation process needs to identify workforce involvement as a key element of success and then find ways for genuine consultation and provide welcoming avenues for input. The key emphasis
here is on welcoming and encouraging staff to look at the issues. It is important to ensure that when issues or potential situations are raised there is feedback and follow-up. Sharing of information and frequent communication and feedback will help ensure suspicions are reported.

- **Remove any uncertainty as to how and when to respond to suspicions of elder abuse**
  
  Uncertainty can have a negative impact on implementation of your prevention strategy. In addition to uncertainty, there may be anxiety if this changes work practices, requires additional work requirements and fear as to non-compliance or indeed reporting suspicions that after assessment and investigation do not reveal elder abuse. Concerns need to be acknowledged and addressed.
  
  The challenge is to create an environment of certainty about when to respond and that this will be supported. Strategies for communication and consultation are important, also identifying where your staff may go for support prior to contacting their supervisor or manager. A well written policy and clear procedures will remove most elements of uncertainty.

- **Foster a positive attitude**

  This requires communicating a common vision to prevent elder abuse and empower older Victorians. It rests on frequent and positive communication of all types of information. Creating a pro-active approach to the importance of prevention will maintain a positive climate. Implementing an approach that welcomes the identification of issues is a key strategy to developing constructive attitudes to the process of implementation and cooperation from your workforce. Ensuring positive leadership at all levels of management and supervision will be vital to developing a positive commitment to the importance and value of elder abuse prevention in the organisation.

- **Consistency of approach**

  Develop a consistent approach to responding to reports of elder abuse. This is important because it also allows employees to support, coach and assist each other. It reduces uncertainty and it minimises misinformation. Ensure the process translates to a simple set of steps for all to implement. Develop and use a common language such as “empowerment”, “change”, “harm”, “potential” and “indications” so staff are comfortable in contributing to a dialogue around elder abuse.

- **Develop effective support in high impact areas**

  Identify the work roles or areas of work where contact with clients is more likely to require staff to be alert to potential elder abuse. This may be due to characteristics of clients or a high dependence on family and friends, the presence of risk factors or previous history of relevant issues.
• Identify and respond to the barriers discouraging responding to suspicions of elder abuse

Identify and understand the barriers or issues for your staff. Put yourself in the “shoes” of your staff and reflect on their perspective to reporting potential elder abuse to you. A genuine consultation approach will reveal their issues and challenges and the professional development needed to support workforce action.

Key barriers to reporting elder abuse for staff

• Being uncertain about whether something is elder abuse (A direct care worker does not need to be certain about whether a particular situation constitutes elder abuse. Direct care workers need to report any concerns they have to their supervisor or manager for further assessment. Early identification of existing or potential elder abuse can prevent situations from becoming worse)

• Experiencing conflicting emotions (Identifying elder abuse situations can be confronting, especially when workers have conflicting loyalties. However, elder abuse situations need to be addressed for the safety of all involved – or they have the potential to become more damaging. Direct care workers need to report any concerns they have to their supervisor at the earliest opportunity before irreparable harm is done).

• Having a close relationship with both the victim and the abuser (Identifying elder abuse situations can be confronting, especially when a worker has conflicting loyalties. However, elder abuse situations need to be addressed for the safety of all involved. Direct care workers need to report any concerns they have to their supervisor or manager for further assessment.)

• Fear of disrupting the victim's life if a report of elder abuse is made (It is challenging to report potential abuse, but if a situation is not addressed, the abuse may continue or even escalate. Managers or team leaders are expected to arrange for an assessment. Under the empowerment principles that underpin the approach to dealing with elder abuse, the best interests and the rights of the older person to make their own decisions will always be respected.)

• Not confident about organisation’s elder abuse policy (All relevant organisations that provide services to older people are encouraged to develop an elder abuse prevention policy. Managers need to clearly communicate their elder abuse prevention policies and make them available to staff.)
Activity

How do I help to create a working environment where the barriers to reporting suspicions of abuse are minimised and staff feel supported in approaching supervisors and managers with their concerns? In groups discuss the barriers that staff might face in reporting concerns about potential abuse. Share in your group actions your agency has taken in order to minimise these barriers and support staff who report suspicions of abuse.

Examine the 5 key barriers to reporting listed above for the staff you supervise or manage and then rank them in order with 1 being the greatest barrier and 5 being the least. Identify the messages you need to deliver to breach the barrier. Be prepared to report back.
Checklist for encouraging and supporting reporting of elder abuse

- Develop an elder abuse prevention policy and procedures for your organisation
- Develop a process of genuine consultation about implementing an elder abuse prevention strategy
- Remove any uncertainty as to how and when to respond to suspicions of elder abuse
- Foster a positive attitude
- Consistency of approach
- Develop effective support in high impact areas
- Identify and respond to the barriers discouraging staff from responding to suspicions of elder abuse
Checklist for responding to potential elder abuse

Follow organisational policy and procedures which will generally include the following steps.

- Receive and document the briefing from the worker
- Provide support to the worker as required
- Assess the urgency of a response
- Investigate and work with the older person to assess if elder abuse is occurring or other services are required in a supportive manner
- Undertake a risk assessment
- Document as required
- Plan intervention or refer to appropriate agency
How do I respond when I receive a report of potential elder abuse?

Firstly it is important to ensure the person is calm and believes that you are prepared to listen and will take their concerns seriously. Often a person will blurt out their information, their thoughts or what they think needs to happen in such a way that it is difficult for you to assess the situation with any certainty. Reassure them that because you want to be able to respond to this situation you need them to go through it again and will need them to answer some questions. Let them know that you will need to ask questions for the purpose of making sure you understand the situation. This helps remove the possibility of the person reporting becoming defensive because they think you doubt them. You do need to be careful they do not feel that they are on “trial” even if you are having trouble understanding the situation they are describing.

If possible give them some brief instructions on how you would like to receive the information from them.

- Encourage the person reporting to you to give you the information in chronological order.
- Ask them to describe what they saw or heard exactly. Let them know that you will be interested in hearing their opinion as to what they think the situation may indicate after you get down the “facts”.
- Tell them that you will ask questions to clarify.

Receive the information and make notes. Try not to interrupt unless there is a good reason such as their information is becoming subjective or the timeline is getting confused. Always identify that you are interrupting. “Sorry to interrupt but I need you to ….. so that I can understand this situation.”

Ask questions without using words such as “are you sure”, “could you have been mistaken” or any other phrases that may indicate you doubt them. Direct the focus of the need for questions on yourself. For example, “Have I got these dates right?”

You may want to paraphrase the information to confirm your notes. “I want to check that I have understood you correctly, is this right?” and repeat back the points you have made from their information.

Ask them their opinion. Why do you think ……? It is very important to separate the “facts” from what they feel or think but this does not mean you do not seek out this information. They need to know their insight is valued. They need to understand you welcome them raising their concerns.

Ensure they are safe and do not need any support. Explain the course of action you will take and any tasks or actions they need to take. They may need to make a written report or they may need to do nothing until you have considered the matter. Ensure that any timelines are clear. If they do not need to take any more action it would be appropriate to promise to report back to them about any resolution or actions taken. Ask them if they have any questions about the way forward.
Reflect

What debriefing processes exist in your agency?
Does your agency provide structured supervision?
What other supports are provided to workers at
times of stress or critical incidents?
What steps do I take to determine the level of urgency of any interim response?

The first step is to undertake a risk assessment based on the information you have been given. The following factors need to be considered in assessing the level of urgency and risk in cases involving suspected elder abuse:

- the vulnerability of the older person
- the danger to the older person or any other person
- the need for medical attention
- the nature and extent of the abuse
- the impact on the older person
- the risk of repeated or increasing abuse
- the risk of financial assets being lost irretrievably
- the relationship between the older person who has been abused and the abuser

Discussion

Refer back to Jeff’s report to Cathy. How might you categorise the level of urgency in responding to Maria’s circumstances? What information might you need to determine the risk to yourself and/or other workers who may conduct a home visit? What other agencies might you speak to in order to determine the risk to both Maria and staff? Would you consider contacting Maria’s daughter Tina?
Consider again the situation involving Maria and Antony that Jeff reported. What factors might impede Cathy from gaining a thorough picture from other relevant organisations regarding the current situation? What might obstruct her capacity to gain an insight into past factors which might inform the current situation? How do you make a thorough initial assessment in keeping with your duty of care whilst acting compatibly with privacy and confidentiality requirements?

If my agency does not have the capacity to make an initial response what arrangements are in place with other organisations to take on this role?

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Do your agency’s policies reflect a commitment to collaborative service delivery? How might they be improved whilst respecting privacy and confidentiality imperatives? Have you experienced situations where other organisations have refused to pass on pertinent information on the grounds of privacy and confidentiality?
How do I support the older person and clarify boundaries and issues of confidentiality?

The assessor must establish a rapport with the older person by fully explaining their role and responsibility within the organisation and by introducing the assessment process in a sensitive way. It may take more than one meeting for rapport to be established. It is also important to understand that the older person may be more willing to disclose some things to professionals not associated with the law (police and court staff) because of fears of a criminal justice response if illegal activity is disclosed.

If the older person is from a culturally and linguistically diverse community, strongly consider using a bilingual worker to assess the situation where available and appropriate, with the support of a professional interpreter accredited by the National Accreditation Authority for Translators and Interpreters (NAATI) where required.

The older person must be made aware of the responsibility of the professional making the assessment including: the limits of confidentiality (that is, when the assessor may need to breach confidentiality) and the requirement to contact police should immediate and significant safety issues exist.

The health or community care worker should be direct and non-judgmental. Asking an older person to describe, in a general way, how things are at home and how they spend their day, may be an effective way to open discussion, for example:

- ‘How are things going at home?’
- ‘How do you spend your days?’
- ‘How do you feel about the amount of help you get at home?’
- ‘How do you feel your (husband/wife/daughter/son/other carer) is managing?’
- ‘How are you managing financially?’

Meetings may be face to face and in a private environment. An older person may specifically request the presence of a friend or non-abusive family member for support. Ideally, an older person and their carers should be interviewed separately from each other, without friends, relatives or children present.

If abuse is disclosed, continued privacy should be respected.

Direct verbal questions may be appropriate as the discussion progresses, once trust and rapport has been established, and when there is a high degree of suspicion by workers that abuse exists. Listen to the older person’s story, acknowledging what they have said.

All older persons experiencing elder abuse need to have their relationship with the abuser acknowledged and understood. Seeking to understand the person in isolation from the context of their relationship to the abuser places the older person in a situation where they may feel misunderstood and ashamed of their continuing attachment and relationship with a person who is, usually, very significant in their life. Gaining a true understanding of the elements that the older person is struggling to integrate and make sense of, will help worker effectiveness.
Be empathetic, non-judgmental and non-blaming, for example:

- ‘That must be terrifying. You are a strong person to have survived that.’

Validate, for example:

- ‘You are not alone. Others experience abuse in their home/residential aged care/hospital.’
- ‘You are not to blame for the abuse.’
- ‘You did nothing to deserve or provoke the abuse. Abuse of a person is never justified.’
- ‘Your reactions are a normal response to a traumatic situation.’

Provide information, for example:

- ‘I can seek assistance for you and your family/carer.’
- ‘You have the right to live safely and with dignity, free of fear and abuse.’
- ‘What they are doing is a crime. It is not just a family or private matter.’

The practice approach to working with victims of elder abuse needs to be informed by a sophisticated understanding of the victim’s experience of the abuse, their relationship to the perpetrator and other significant family/support relationships and the impact of the abuse on daily functioning and quality of life.

The full extent of the abuse a person may be experiencing is more likely to be disclosed if the older person feels they have support. They may also need to be able to articulate their own assessment of their personal circumstances, which may include issues about their lifestyle and financial position, their relationship with the abuser and their emotional reactions to the abuse.
What about different values and cultural difference?

As with all individuals, an older person will have distinctive family values and differences which should be respected, including cultural nuances in communication.

It is important to understand the meaning or intention of a verbal or non-verbal behaviour in the context of a person’s culture, experience and intention. For example, some cultures value avoidance of physical, eye or verbal contact, whereas other cultures value maintaining eye contact in certain circumstances.

With the older person’s permission, contact other workers and organisations to assist with understanding of ethnicity and cultural behaviours and values, to know what methods and approaches might be acceptable regarding intervention and support. Engaging bilingual workers can help build trust with the client.

How do I work with the older person to manage risk?

The presence of one or more risk factors as indicators does not necessarily mean abuse has occurred or is occurring. Every case is unique.

Managing risk involves the systematic application of management policies, procedures and practices to the tasks of communicating, establishing the context, identifying, analysing, evaluating, treating, monitoring and reviewing risk.

Managing risk can involve:

- the identification of both threats and opportunities
- rigorous thinking and a logical and systematic process
- forward thinking, identifying and preparing for what might happen
- accountability in decision making
- communication with internal and external stakeholders
- balanced thinking in order to weigh up the cost of avoiding threats or enabling opportunities and the benefits to be gained.

Decide whether an interpreter is needed. Friends or family members should not be used as interpreters.
What does assessing risk involve?

Assessing risk involves:

- **risk identification**: the process of determining what, where, when, why and how something could happen
- **risk analysis**: a systematic process undertaken to understand the nature, and deduce the level of the risk
- **risk evaluation**: the process of comparing the level of risk against criteria that determine the significance of the risk.

Effective risk assessment must be based on:

- an older person’s view of their level of risk (collaborative and respectful)
- the presence of evidence-based risk indicators
- professional judgment that takes into account all other circumstances for an older person, the carer and perpetrator—inclusive of diversity and focusing on strengths.

Additional support, information and tools on risk assessment and management have been developed by a range of sectors, including:

- Service Coordination Tool Templates (SCTT) have been developed by Primary Care Partnerships (PCPs) to facilitate and support service coordination. The SCTT includes a section on risks and risk management in the ‘Summary and referral information template’. More information can be found at [http://www.health.vic.gov.au/pcps/sctt.htm](http://www.health.vic.gov.au/pcps/sctt.htm)
- The *Family Violence Risk Assessment and Risk Management Framework* provides scope and tools to assist with risk assessment. (see attachment 4 and 5)
Assessment of an older person’s response to abuse influences the type and pace of possible interventions. It may be important to:

- assess an older person’s strengths, including skills, will and attitudes, which can be built on to offset concerns and problems
- consider if cultural values are having an impact on the older person’s experience of, and response to, a potentially abusive situation and factor this into an appropriate service response
- encourage and assist an older person suspected of being abused to make their own decisions
- provide them with information about all relevant options, including the option to refuse services if they can make such a decision
- ensure intervention is focused on the safety of the older person, and ongoing protection from abuse
- notice if an older person appears to have capacity, but has low self-esteem, is self-blaming, isolated and/or denies suspected or actual abusive circumstances—if so, suggestions for intervention by a worker may be refused.

An intervention may need to focus on maintaining support for an older person over a period of time in whatever way is appropriate and possible.

If an older person recognises abuse and is prepared to accept intervention, strategies can be developed to:

- support them to rebuild their life in the best way possible, ideally without abuse
- address the underlying causes of abuse and work to minimise them.
How do I plan the most appropriate intervention?

Most cases of abuse are not clear cut. With the older person’s consent, service providers may need to explore several responses to assist an older person, including the possible response of the older person to the abuse and proposed intervention.

Possible service responses include:

- accessing services to relieve carer stress and further support the care of an older person
- cultural sensitivity and understanding
- informing an older person of their rights and options for change, and of formal services and support available (for example, SRV, other legal services, police)
- approaching carers and family members to inform and educate them about alternative ways to support an older person
- monitoring and continuing to observe the situation until more evidence becomes available or the situation resolves
- strategies to reduce isolation.

What should an intervention plan identify?

An intervention plan should seek to identify:

- safety issues and a safety plan where required
- the least restrictive care alternative
- minimum disruption of lifestyle
- freedom
- identification of the type of intervention
- the actions to be undertaken in order of priority
- who is responsible for each action
- when the action will take place
- how an older person and involved agencies are to be kept informed of the actions taken and their outcomes.

What if the older person does not want intervention or assistance?

If an older person is competent, but refuses help, a worker can only support and give advice about options. The worker can advise the person how to deal with emergencies and work out and agree on a safety plan with them. Strategies can be developed to help break through possible denial of abuse and feelings, such as fear, isolation, guilt and self-blame. Ongoing monitoring of the situation may be required.

Service providers concerned about an older client and possible abuse can call Seniors Rights Victoria on 1300 368 821 for information and advice on the situation, provided the client remains anonymous.
Activity

Case study continued.

Maria acknowledges the existence of violence in her relationship. Maria is able to clearly articulate her understanding of the level of risk she is exposed to. Maria wants no intervention. What more can Cathy do to ensure she satisfies her duty of care?

Jeff will continue to provide services to Maria and Antony. What obligation does Cathy have to Jeff in the circumstances and what supports should she provide?
What do I consider to assist the determination of an older person’s mental capacity?

While it is important to ensure that an older person is safe and not in danger of immediate or further abuse, it is vital to consider their level of mental capacity and whether they are capable of giving consent. In the case of suspected abuse this may relate to:

- whether an older person consented to the activity that may be abuse
- whether the older person can consent to further investigation or assessment
- certain decisions or actions being taken during the response process
- the recommendations of a care plan being actioned.

A person’s capacity to make a particular decision should only be doubted if there is a factual basis to doubt it. Do not assume that a person lacks capacity just because they are older or have a particular disability. Even if the person lacks capacity to make important life decisions, they still have the right to privacy.

Every adult is free to make their own decisions if they have the capacity. As a family member, friend, carer, or other individual involved with a person, you should always make this presumption unless it is established that they don’t have the capacity to make a particular decision.

Dementia is the most common form of assessed incapacity in older people. Dementia can also be a risk factor in abuse cases on the part of either the carer or the person with dementia or both.

Mental capacity is the ability to understand an act, a decision or transaction and its consequence. A person has capacity to make an informed decision if they understand the general nature and effect of a particular decision or action and can weigh up the consequences of different options and communicate their decision.

Capacity is decision specific and context dependent. It may fluctuate, and incapacity may be only temporary.
Culture, language, ethnicity, and religious impacts

Culture, language, ethnicity and religion are integral factors in how people make decisions, as well as the decisions they make. They shape how people think, behave and communicate.

For example, in some communities and in some families, individuals with capacity to make their own decisions freely allow others to make important decisions on their behalf. Sometimes a person may allow or prefer the head of a household to make all the important decisions.

Or there may be an established pattern where a parent within a family, or an elder of a community, makes certain decisions.

Sometimes the decision-making process is a collective one involving the whole community in meetings and discussions about the decision, such as in some Aboriginal communities.

Religious beliefs may impact on the decision made, or how it is made. For example, some Jehovah’s Witnesses and Christian Scientists hold particular beliefs that might affect their decisions about various medical treatments.

So, when you are determining capacity, make sure you take into account the person’s language, ethnicity, cultural values and religious beliefs.

You may need to do the following:

- Organise an interpreter if you can’t understand the person or have difficulty communicating with the person in English.
- Seek information about the cultural and ethnic background of the person as well as the religious beliefs of the person and consider it when you are assessing the person.
- Take into account the effect of a proposed decision on the person’s relationships within their cultural or religious community.

(Adapted from Capacity Toolkit, NSW Attorney General’s Department, 2009)
Reflect

“Everyone has the right to take risks or make risky decisions”

Reflect on the following scenario.

Spiros is 83 years old and migrated to Australia post WWII. Spiros has long standing alcohol abuse issues which were kept in check whilst his wife was alive. Since his wife’s death his alcohol consumption has become increasingly problematic resulting in his two children, Anna and Nicholas, deciding that it is best to enforce complete abstinence upon their father. They do this by taking control of his bank account and ensuring that he does not have the funds required to purchase alcohol. They provide him with all the food he requires, and pay his bills but deny him any additional funds. Spiros has few social contacts other than his neighbour, Tomas, and a group of men who he has been playing cards with for the last 15 years. Conflict arose between Spiros’s children and Tomas, who continued to give Spiros the occasional glass of wine. This conflict results in the breakdown of the relationship between Spiros and Tomas. As Spiros no longer has access to money, he finds that he no longer fits in at his weekly card playing sessions where heavy drinking and heavy betting are a major feature.

Being a resourceful man, Spiros takes to shoplifting alcohol from his local supermarket. He is caught once by supermarket staff, but as he has been a long standing customer they warn him that they will call police if this occurs again. Spiros is caught a second time, and police become involved. Spiros tells attending police that he only shoplifted because his children have stolen all his money.
What are the formal steps to determine testing for mental capacity?

If there is doubt about a person’s mental capacity to make decisions and understand the effect of decisions made, referral to a GP, psychiatrist, neurologist, psycho-geriatrician, geriatrician, neuro-psychologist or a cognitive dementia and memory service clinic (CDAMS) might be appropriate. An ACAS comprehensive assessment includes screening of a person’s cognitive state, which could result in a recommendation by ACAS for formal testing of capacity to one of the above sources.

If an older person is assessed as lacking the capacity to make their own choices and decisions, an application to VCAT for appointment of a guardian and/or administrator to make lifestyle or financial decisions on their behalf may be necessary. VCAT should be satisfied that the older person is unable to make reasonable decisions due to a disability, and that a problem exists which can only be solved by the appointment of an alternative legal decision maker.

If an older person refuses to be assessed, and there is concern for the person’s safety, an application to VCAT for the appointment of a guardian may be necessary to gain consent for an assessment. Before taking such a step, consider asking the older person’s family or friends to discuss the refusal with them, within the context of the suspect abuse.
When should I consult and when and how should I refer in cases involving elder abuse?

Referral is the process of directing a client to a service or third party that is better able to meet their needs, that is, needs that you or your organisation are unable to meet. Consultation is seeking advice from a third party to inform your organisation’s actions in providing a service to a client. Both actions require consideration as to whether any disclosure of information may breach the confidentiality of the client.

When considering referral, you will need to consider your organisation’s procedures for referring clients to other agencies or individual service providers. You also need to be aware of the other agency’s referral procedures and guidelines for maintaining confidentiality.

A key skill for any worker is identification of which services and treatments should be provided by other professionals or agencies and knowing who can provide those services. No agency or professional can provide every service needed by every client.

If recommending a service that will be provided by another professional or agency, the person making the referral needs to understand the implications of making the referral. He/she should understand enough about the services required to provide an appropriate referral or to provide guidance on how to find those services, and also help the client understand what to expect from the agency providing the service.
Involving clients in the referral process

Clients have a right to be involved in assessing the suitability of services to which they are referred, just as they have a right to be involved in identifying their needs, setting their goals and participating in decision-making on issues impacting on their lives.

Clients may like to know more about the service that you are referring them to so they can decide on the type and amount of information to be disclosed about them to this service. They may like to see information on the organisation’s role, responsibilities and expectations of service users, as well as the way this service will fit into their support network.

Active participation by clients in decision-making regarding referral to other services may influence how comfortable clients will feel about accessing services. They have built up trust with your agency and it may be that relationship of trust that persuades them to accept services or engage with another agency. So it is important that this referral where possible is followed up especially if you will continue to have some relationship with the client.

Engaging professional interpreters accredited by the National Accreditation Authority for Translators and Interpreters (NAATI) may be important in helping clients from culturally and linguistically diverse backgrounds be actively involved in the referral process.

What services can I refer to in the case of elder abuse?

Referral is integral to working with many people, particularly those with complex needs and/or chronic disease. The type of abuse, together with the individual factors of each case, will influence the type of referral made, for example, a GP, neurologist, psycho-geriatrician, geriatrician or neuro-psychologist for capacity testing, seeking advice from OPA or VCAT, liaising with other local service providers, such as ACAS, home care providers (formerly CACPs or EACH providers), HACC or subacute services to implement additional support.

If your agency does not provide an assessment service for older people, you will need to refer to an appropriate funded assessment service (for example, ACAS or HACC assessment or allied health assessment) for the older person concerned. An older person involved in a suspected abusive situation will need to agree to have the assessment.

Assessment workers can contact specialist services, for example, Seniors Rights Victoria for information on elder abuse matters, or a culturally specific service to gain greater understanding of cultural sensitivities, should the older person come from a culturally and linguistically diverse background.
What is the role of Seniors Rights Victoria?

Seniors Rights Victoria is a free state-wide service that has been established to help prevent elder abuse and safeguard the rights, dignity and independence of older Victorians.

Seniors Rights Victoria provides a range of services in relation to elder abuse, including a telephone helpline, referrals, legal advice and casework, advocacy, community education and workforce development information sessions.

The service operates from offices in Melbourne, Bendigo at the Loddon Campaspe Community Legal Centre, and four legal clinics through Seniors Law of Justice Connect. The only service of its kind in Victoria, Seniors Rights Victoria is the primary point of contact for people and services responding to elder abuse. Seniors Rights Victoria aims to lead research, advocacy, and policy and law reform on elder abuse, mistreatment and neglect.

Older people may self-refer to Seniors Rights Victoria, or be identified through existing services. Callers or clients may not necessarily identify their situation as abuse; it is often only through exploring the person’s concerns and issues that an underlying situation of abuse is uncovered. Consequently, the pathway into Seniors Rights Victoria is not always direct or through anticipated channels.

The service is funded by the Victorian Government through the Department of Health and Victoria Legal Aid and the Commonwealth Attorney General.

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Seniors Rights Victoria MISSION

Seniors Rights Victoria seeks to empower older Victorians so they can live in safety, with dignity and independence.

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Telephone information, support and referral

Seniors Rights Victoria has a helpline (telephone: 1300 368 821). Callers are provided with information about elder abuse, and about relevant available services. They may be referred to Seniors Rights Victoria’s own legal and advocacy practice or to other appropriate agencies.
Reflect

Read the following case studies provided by SRV. They demonstrate the range of possible actions that can be undertaken.

Case study 1: Financial abuse detected by a Community Health Centre worker

Facts: A Community Health centre worker contacted SRV to seek advice in relation to a client. The client suffered from memory loss and had limited capacity and multiple and complex health issues. Her daughter lived with her as her carer and also managed her finances. She had moved herself into the client's bedroom and re-located the client to the back bungalow.

A home visit to the client revealed that the daughter was in poor health. She was drunk and presented very poorly. The daughter claimed that she was under the supervision of a hospital and her signs of ill health were the result of alcohol abuse over many years. She also said that she suffered from depression.

The daughter was receiving a carer's payment, but provided limited care and support to her mother. She held a financial power of attorney for her mother and she had arranged for the home to be re-mortgaged. The daughter claimed that there were bills to pay and that the interest on the loan was quite high.

The client became agitated when the health worker tried to discuss these matters with her. She said her daughter was now in charge of everything and she didn’t want to know about it, as she couldn’t cope with it all. She didn’t want to speak to anyone about her situation.

Action taken and outcomes: SRV discussed with the health worker what the law requires an attorney to do, including the need to:

• act in the older person’s best interests
• not exercise powers beyond those set out in the form of appointment
• not have a conflict of interest with the interests of the older person
• keep an account of the transactions
• recognise the older person’s right to participate in decisions as much as possible and respect the older person’s worth, dignity and human rights
• ensure the decisions are appropriate to the older person’s characteristics, needs and wishes
• ensure confidentiality.
SRV explored with the health worker the client’s capacity to make decisions regarding her financial affairs. SRV explained that a person may have the capacity to make decisions even though they have memory loss or a diagnosis of dementia. SRV highlighted that a person’s capacity can fluctuate and is decision-specific. SRV also talked about the need to respect the right of an older person with capacity to make decisions, even decisions which appear not to be in their own best interests.

Further discussion took place about the client’s ability to make particular financial decisions. The health worker thought that her client could understand simple financial transactions like paying bills but not more complex ones like mortgaging her property. The worker did not think that her client could understand what it would mean to revoke a power of attorney. The worker informed SRV that her client had no idea what her daughter had done with her money.

After considering these issues SRV recommended that the service provider make an application to VCAT asking it to:

- investigate the use of the attorney by the daughter and seek an account of what had happened to the client’s money
- ascertain whether the client had the capacity to revoke the attorney and to make decisions about her financial and lifestyle affairs
- appoint an administrator (to manage her money) and a guardian (to make decisions about her lifestyle affairs) if required.

SRV informed the worker that if money had been misappropriated by the daughter, the administrator (if appointed) could then seek to recover any money lost, if practicable. Although the health care worker had already determined that this was probably the course of action required, she still needed advice and support with the matter to help her to decide whether she was making the right decision.
Case study 2: Intervention order used to stop the physical abuse of an older person and exclude the perpetrator from the older person’s home.

Facts: A caller to SRV was concerned about an older female neighbour. They had seen the older neighbour being assaulted by a person who resided with her. The caller claimed that the perpetrator was younger and stronger than the older neighbour.

SRV asked the caller to pass on information about the service to the neighbour and suggested that she ask her neighbour to contact the SRV Telephone Help Line. Initially the older woman was fearful of contacting SRV because of the potential consequences. However, after a further episode of violence, the older woman called SRV to discuss the issue and seek assistance.

Action taken and outcomes: After discussing the legal options with the older woman, a SRV solicitor made an application to the Magistrates’ Court for an Intervention Order under the Family Violence Protection Act 2008. The solicitor attended the Magistrates’ Court with the older person and an interim Intervention Order was granted by the Magistrate on the day. The order was served the same day by the police on the perpetrator and he was required to vacate the property.

A final Intervention Order was made two weeks later which prohibited the perpetrator from contacting the older person and engaging in violence towards her. It also excluded the perpetrator from the property.

The client had no family members or friends in the area and was socially isolated. There were no services assisting her at home. With the consent of the older person, SRV helped her to gain support from services in the community. The Aged Care Assessment Service assessed the older person for a Community Aged Care Package (CACP). The older person soon received assistance with shopping, transport to medical appointments, attendance at her local senior citizens’ centre and counselling services. The older person’s case manager also organised maintenance services to fix all window locks, damaged walls and light fittings and replaced the security doors.

The case manager also liaised with the neighbour to enlist ongoing support, which she was happy to provide. Home and Community Care (HACC) also provided 3 meals per week to the older person.
Case Study 3: Raising concerns regarding the abuse of another

Facts: Penny calls SRV about her father. She states her brother recently moved into her father’s house. Her brother has schizophrenia and was not taking his medication. He is also in receipt of the carer’s payment but is not looking after her father at all. Penny claims her father is scared of her brother and can’t stand up for himself.

She states her father has major health complications but does not have a cognitive impairment, and he has a Community Aged Care Package. Her brother won’t let Penny or any service provider under the CACP into the house. Penny states her brother has been socially isolating her father for some time now. Her father’s friends do not visit him anymore and her father never leaves the house. Every time Penny calls to speak to her father, her brother answers and hangs up. Penny is scared of her brother as he has a bad temper and can be violent at times. She is very concerned about her father. Penny wants advice.

Action taken and outcomes: SRV informs Penny that this is quite a common complaint but that unfortunately SRV cannot go to the house to investigate; there is no mandatory reporting of elder abuse in a community setting in Australia.

SRV clarifies whether Penny’s father has any issues around his capacity as this will inform the advice provided. Penny confirms that her father is still very lucid.

SRV recommends that Penny inform her father’s CACP caseworker about what is happening and highlight her concerns about her father’s health needs and safety. The CACP provider should take all reasonable steps to ensure that her father is safe and that his care needs are being met. SRV suggests that her father’s caseworker contact the local police station and ask the police to do a welfare check, making reference to their “You are not alone campaign”.

SRV also raises the possibility of her father’s caseworker applying to VCAT for a direction from the Tribunal to have the Office of the Public Advocate enter the property with the caseworker and the police, so that the caseworker can carry out the service.

SRV sends information out to Penny about its service and informs Penny that SRV is happy to meet with her father and to give him advice and possibly ongoing assistance for his situation. SRV also raises the issue of possible financial abuse which may need to be investigated down the track.
Determining who is best placed to take a lead role in a particular situation

Once referrals have been made, and where multiple agencies are involved, regular communication between services must occur. A case coordinator needs to be appointed through a collaborative process to ensure regular and ongoing risk assessment and care planning in consultation with the older person. Care coordination should be undertaken by a service that is providing significant ongoing support to the older person. Services should ideally develop memoranda of understanding to ensure appropriate care coordinators are identified and actively help the older person to manage their situation.

Allocating a care coordinator will usually depend on whether there is an existing trusted service relationship with an older person. Several primary care organisations may be prepared to coordinate a complex situation, for instance, local government HACC home help services, ACAS, HACC linkages, home care providers (formerly CACP or EACH providers). The local community health centre, local district nursing service, GP or family violence service may be the most appropriate, depending on the abuse type and situation.

The care coordinator has overall responsibility for ensuring the care plan is implemented and reviewed, including the response to elder abuse as part of the overall service response.

Sometimes, a range of providers may already be delivering services to an older person and/or their carer. In this circumstance, should an abusive situation become apparent, the service response would be incorporated into the existing care plan, coordinated by the care coordinator between existing providers. These issues will be considered more fully later in this session when we discuss policy development and interagency protocols.
Reflect

Instructions: Read the following case study adapted from *With respect to age – 2009* and consider what lessons might be learned and how you and your agency might improve upon the service delivery that Mrs T experienced.

Mrs T was 87 and was living at home with her youngest child – a son aged 58. Her daughter was living overseas and although supportive, had minimal input into her mother’s daily care. Mrs T immigrated to Australia 20 years ago and while her English had always been adequate for basic conversation, she felt more comfortable speaking in her native language – especially as she got older.

Mrs T received a range of services from a variety of agencies. These included an EACH package from a mainstream service, HACC social support (Planned Activity Group – PAG) and additional outreach one to one support from an ethno specific service. The family GP was also involved in her care along with specialist medical services, alternative medical services and the local pharmacy. In addition, she had on several occasions attended the hospital emergency department.

Mrs T told the PAG coordinator through an interpreter, who were both employed by an ethno specific service, that her son had been hitting her. When questioned further, she then made excuses for him saying “he is my son, he is always nervous”.

The PAG co-ordinator consulted with her management about the best way to proceed following this concern, and a plan to more closely monitor Mrs T’s situation was developed. The plan included a strategy to ensure workers safety – particularly for staff visiting Mrs T’s home when the PAG was closed over Xmas. However, just before Xmas, Mrs T came to the PAG with a red mark on her face.

Mrs T’s case manager at the other community aged care service informed Mrs T’s son that the ethno-specific service was concerned about the abuse by him towards Mrs T. The son then contacted the ethno-specific service. He was verbally aggressive to staff, and wanted to make a formal complaint about staff refusing to come into the home. The manager endeavoured to maintain the balance between duty of care and client confidentiality, but was stunned when the son then accused the service of making allegations around him molesting his mother.
While the PAG was closed, a one-on-one social support worker who was able to converse in Mrs T’s native language was brokered to work with Mrs T. This worker was deliberately not told of the suspected abuse by her employer to avoid influencing her assessment of the situation, but the service ensured that she was not put at risk during her visits. She developed a good relationship with Mrs T, and accompanied Mrs T and her son to medical appointments and assisted with shopping. Following her first visit to the house, the worker reported to her manager that Mrs T had told her that her son was hitting her. Following this report, the worker was then informed of the previous accounts, and was given a guarantee that she would never be isolated in the house with only Mrs T and her son.

The manager of the service that had contracted the ethno specific support worker then found that a number of other service providers had decided to withdraw their services to the home due to the aggressive manner of the son, who had also made threats to services and staff. This information had not been passed on to the other service providers involved, and it took some time for the full picture to emerge.

The PAG manager then contacted other agencies involved to discuss a management plan, but as this was occurring over the Christmas period, the meeting was delayed until 2 weeks after Christmas.

Because of the nature of this situation, when the meeting did occur, Mrs T’s son was not included in the discussion. This allowed the providers involved to detail a strategy that included observing and monitoring the situation, as well as case co-ordination and the specific responsibilities of each agency. The police were not involved.

Apart from the suspicion of physical abuse, further discussion and shared information revealed a disturbing picture.

- Mrs T’s son had recently moved back from Tasmania, and had taken Mrs T out of a nursing home where she had been residing, to return her to the family home.
- The son was taking his mother around to GP’s for prescriptions, but he controlled the allocation of her medication, and did not administer them as prescribed.
- Although the family GP had been caring for Mrs T for many years, since the son had moved in with his mother, the GP had never seen Mrs T without her son also being present.
- Mrs T frequently complained of the cold, but her son would not allow her to have the heating on in the house, nor would he allow her to sleep in the daytime – forcing her to stay awake.
- Mrs T’s son would not allow her to buy the support bandages needed for her legs, or any of the creams to treat her deteriorating skin condition.
Mrs T’s son tried to dissuade services from sending workers who were able to converse with his mother in her native language. He stated that it was better for his mother to continue speaking in English, although she struggled with English and would often become distressed when unable to find the right word.

Mrs T’s general health was deteriorating, and she was often in the nearby hospital emergency department, but would then return home. Following the interagency case meeting, a joint application was made to VCAT and OPA for the appointment of an independent guardian; however Mrs T’s health deteriorated to a point where she was admitted to hospital. She died in hospital.

The process to appoint an independent guardian came through after her death.
Session 2 – Developing capacity to respond to elder abuse

On completion of this session you will be able to:

1. make recommendations as to how to build the capacity of your organisation to prevent elder abuse
2. identify practice principles which will enhance your agency’s capacity to respond appropriately in situations where elder abuse is indicated
3. contribute to the development of an organisation elder abuse prevention policy
4. identify the benefits associated with interagency collaboration and the steps required for your organisation to play a role in the development of interagency protocols
5. describe how powers of attorney operate and the role of the Public Advocate and VCAT
What is the key to building capacity in my organisation to prevent elder abuse?

The key elements of capacity building are to:

- Develop an agency policy to respond to elder abuse
- Develop agency procedures to respond to elder abuse
- Educate the workforce to recognise and respond to elder abuse
- Promote collaboration across key agencies and services
- Develop interagency protocols for managing elder abuse
- Develop skills of workforce to assess and manage elder abuse
Why develop an agency policy?

Organisations are encouraged to review or develop elder abuse policies and procedures aligned to the Victorian Government Elder Abuse Prevention and Response Initiative, which embodies principles of empowerment and human rights of all adults.

An elder abuse policy should articulate an empowerment and supportive approach to address prevention, management and application of response strategies to suspicion or allegation of abuse.

A policy can provide a framework for responding to elder abuse. It provides agency workers with guidelines for identifying and responding to abuse. It can clarify the purpose and role of the service as well as the type and range of responses that can be provided to people in situations of abuse.

Developing an agency policy provides the agency with an opportunity to educate workers and to clarify its role in responding to clients and carers who have been abused. Agencies may also articulate their role in community awareness raising to minimise the risk or ongoing occurrence of abuse. By workers discussing this issue within their agency, and even with other service providers in their local area, a network of responses can be more fully developed.

Policies and procedures for responding to elder abuse should occur within existing service response frameworks.

*With respect to age–2009* contains a range of resources and recommended procedures to assist in developing an agency policy and procedures. An organisation may create a specific policy or embed in a general policy as a specific context.
What are the key elements to be included in an agency policy?

A number of elements are recommended as essential for an effective agency policy.

1. Introduction

An overview of the problem of elder abuse, the rationale for having a policy on elder abuse and an outline of the aims of the policy.

2. Principles

Agency policy should include clear principles that guide staff in working with older people and outline the framework or principles under which the agency operates in responding to situations of abuse.

The policy should state the fundamental principles or philosophy that is applied whenever the agency identifies or intervenes in a situation of actual or suspected abuse. (Refer to With respect to age - 2009)

3. Definitions

Clear definitions of elder abuse should be included and should be consistent with those outlined in With respect to age–2009. It is useful to include a list and/or definitions of types of abuse.

4. Detection

The ways that abuse and neglect could be detected by the agency should be mentioned. The detail might depend on the nature of the contact staff have with victims and abusers.

There may be specific and routine work tasks that could incorporate elder abuse prevention within procedures. For example, nursing staff may be required to specifically look for possible signs of physical and sexual assault when carrying out a physical examination of an older person. Reference to relevant procedures can form part of a detection policy.

In contrast, other staff or work roles will require much more general information on these elements. A general requirement to consider indicators and assess if there is a likelihood of elder abuse occurring may be one approach. A list of specific signs could be listed as part of that requirement. There is a detailed listing of potential indicators in With respect to age–2009.
5. Allocation of responsibility
The policy should clearly indicate the roles and responsibilities for identification and action in response to actual or suspected situations of abuse for all workers in the agency. This statement should recognise that different people in the organisation will have different boundaries to their roles.

6. Duty of care and confidentiality provisions
The balance between duty of care and confidentiality in situations of abuse needs to be clearly stated for all workers. The statement on confidentiality should make it clear that in situations of abuse confidentiality is between the client and the agency and not the client and service provider. The confidentiality provision should mention under which circumstances confidentiality can be overridden

7. Supporting the worker
The policy should include a statement about its commitment to support workers who identify and/or act upon situations of abuse. This should include training and information on the agency policy and procedures to be followed, training and information on elder abuse and support, supervision and debriefing provisions.

8. Administration of policy
The policy should attribute responsibility to a contact person or unit in the organisation. Ideally a date should be set for review of the policy to support continuous improvement
Checklist for key elements in an agency policy for elder abuse prevention

- Introduction
- Principles
- Definitions
- Detection
- Allocation of responsibility
- Duty of care and confidentiality provisions
- Supporting the worker
- Administration of policy
What are the key elements to be included in workplace procedures?

A procedure tells what the agency will actually do in response to a situation involving abuse. It helps if this is a clear step-by-step series of actions that must be followed by all workers.

This should include:

- the lines of communication within the agency between the person who identifies and the supervisor/coordinator, including how and what information is to be passed on
- the process for undertaking a response and follow up on suspicions
- documentation requirements including what forms or reports need to be completed and by whom. It should also indicate how documents will be stored
- decision making process for determining necessity for referral
- provision for process in cases where further access or intervention is denied by the client
- provision for the circumstances for continuation or cessation of services to the client or carer
- debriefing procedure for staff
- referral procedure that includes how client permission for referral is obtained, how the most appropriate referral agency is decided and how the referral is made, including the transfer of information
- liaison and co-ordination procedure including how and when the agency can and will seek advice and information from other agencies and people providing support services to the client or carer
- processes for responding appropriately to clients from culturally and linguistically diverse communities.
Checklist for key elements in agency procedures for elder abuse prevention

Procedures generally need to be developed concerning the following:

- Communication
- Reporting
- Assessment
- Documentation
- File management
- Staff debriefing
- Referral
- Consultation
- Liaison and co-ordination
Reflect

To assist agencies, the Primary Care Partnership community awareness grants program has produced, after a consultation process, an elder abuse prevention guide and a sample policy (Attachment 6).

Consider its applicability to the needs of your service. Do you think it could be incorporated into your current service, or improved or adapted to suit the needs of your clients?
What are inter-agency agreements?

Partnership or inter-agency agreements and inter-agency protocols are documents that record the agreed terms and conditions of collaboration between separate agencies and/or sectors. The terms ‘protocols’ and ‘agreements’ are sometimes used interchangeably with guidelines and Memoranda of Understanding (MOU).

• **Inter-agency or partnership agreement:**
  An inter-agency or partnership agreement is a document outlining the basis of a new relationship and the agreed objectives between partners. Agreements can be developed at a statewide, regional or local level. An agreement may be a broad, high-level agreement that documents the relationship between groups of agencies. An agreement may also be a simple agreement between two agencies about specific aspects of their work. Agreements can be contractually binding if there are consequences for partners for not complying with the agreed terms.

• **Protocols:**
  A protocol outlines broad working relationships and more detailed processes by which inter-agency partners will work together. Protocols document when and why partner agencies will interact, how they will interact, and what each partner can reasonably expect from the other. Protocols can provide legitimacy to relationships and processes already in place but which have not been formally documented. Protocols are practical, hands-on documents that outline specific processes and procedures between service delivery agencies. Protocols are not usually contractually binding but are used to set agreed good practice standards that parties should meet.

Agreements and protocols can occur together. A partnership agreement might contain the general aims and commitments of the partnership and the protocols outline how agencies work together.
How does my organisation become involved in the development of interagency protocols?

The scope of the Victorian Government’s response to abuse is broad, and incorporates a range of sectors. In local geographic areas, health and community service providers work cooperatively to achieve common local goals. The prevention, identification and management of elder abuse is one such goal.

Local service providers support older people to manage their health care needs and circumstances. In some instances, particularly where abuse may be involved, an older person and their primary carer may receive support from several community agencies and health services.

The development of local interagency protocols between existing health and community care networks, and funded services that may not currently be involved in a network, would strengthen and indicate how multiple service providers work together to address elder abuse in that local area.

Services relevant to elder abuse can be positioned locally, sub-regionally, regionally or centrally (that is, a statewide service).

Organisations network differently via their service outlets, according to sectors and service activity in a local area. Which networks the service outlet connects with will depend on commonalities that best support business outcomes.

There are some basic considerations to address when developing an interagency protocol:

An interagency protocol is a guide, across sectors, to best practice in responding to potential, suspected and actual abuse of older people.

This protocol could align well with existing interagency protocols between sectors, as long as the broader range of organisations that respond to elder abuse cases are scoped into the protocol agreement.

Refer to attachment three: Developing interagency protocols and service agreements. Author: Community Door Administrator Organisation: Queensland Council of Social Service
Checklist for an elder abuse inter-agency protocol

- promotes service provision consistency for older people and families
- builds familiarity and strengthens capacity for workers across sectors and disciplines to address elder abuse
- equips workers with practical, action-based pathways to deal with often complex inter-organisation relationships
- clarifies key points of contact and agreed roles between organisations to address cases of abuse
- defines when and how to refer an older person as a client
- describes how to communicate client/case information
- identifies safety procedures for workers during home visits
- decides what is deemed an emergency and how to deal with it
- provides better outcomes for older people regarding abuse.
Steps for developing protocols

There are some generic steps which can assist in developing inter-agency service agreements and protocols. These are shown below.

- Identify the need and purpose for establishing a protocol.
- Check if there are existing protocols that are relevant or could be adapted and used.
- Identify who should be involved (government, non-government, and community players).
- Contact potential inter-agency participants and gain preliminary support for the proposal.
- Organise an initial inter-agency meeting to discuss:
  - why a protocol is needed
  - issues the protocol is trying to address
  - purpose of the protocol
  - who is involved
  - issues or barriers to protocol development.
- Establish a shared commitment to working together to develop the protocol.
- Develop a process such as a working group with cross-agency representation to develop the protocol.
- Develop the draft protocol document for circulation and feedback.
- Finalise the protocol and distribute.
- Develop a working/steering group to oversee and support the process of implementation of the protocol including briefings and training to staff, staged implementation processes, mechanism for early detection of any problems, any additional resources/other supports required.
- Implement the protocol.
- Establish a mechanism for regular monitoring and review the protocol.
- Revise the protocol accordingly.
How can I plan my interagency protocol membership?

The first step is to identify and include relevant service providers and their networks to ensure the response to elder abuse is simple yet effective by sharing information and planning appropriate responses in a timely manner, but not duplicating effort.

What relevant services exist in my local area?

Service representation and mix in local areas are quite different from each other due to various reasons, including physical terrain and community history.

A broad range of organisations provide a variety of types of community-based services, with service outlets located in different geographic areas. Services to be included in a local interagency protocol will include local, sub-regional, regional and statewide organisations.

As participating members, a local interagency protocol will engage organisations that provide services into a local area.

Local service representation should include:

- local municipal council service outlets for aged care (HACC, CACPs, EACH, residential aged care, health promotion, disability, mental health)
- not-for-profit, charitable or private providers of community and residential aged care service (HACC, CACPs, EACH or EACHD packages, respite, residential aged care)
- community health services (allied health, health promotion)
- mental health services for older people, including aged persons mental health teams (APMH)
- health services, such as: services provided in the community (for example, hospital-in-the-home)
- Aboriginal Community Controlled Organisations (ACCOs)
- local CALD service networks and organisations
- hospital emergency and social work departments
- rehabilitation services
- local GPs and divisions of GPs
- allied health professionals
- pharmacists
- Victoria Police
- Ambulance Victoria (AV)
- Aged Care Assessment Service (ACAS)
- family violence intervention and support services
- Commonwealth Carelink centre
- Ethnic Communities Council of Victoria (peak body will then refer service providers to the appropriate ethnic or multicultural organisation)
• sub-branch of the Returned Services League of Australia (Victorian branch)
• supported residential aged care services
• residential aged care services
• community legal aid centres
• community district nursing services (for example, remote area nurses in bush nursing centres, Royal District Nursing Service).

Statewide services

Other services such as those with a statewide scope relevant to cases of elder abuse will not be as involved in developing each local interagency protocol. However, these broader services need to be referenced in each local interagency protocol, and referencing should be agreed to by those agencies prior to completion of the protocol. These agencies include:

• Seniors Rights Victoria (SRV)
• the Office of the Public Advocate (OPA)
• Mensline Australia
• the Commonwealth Aged Care Complaints Investigation Scheme
• Elder Rights Advocacy (ERA) Victoria
• Aboriginal services
• the Ethnic Communities Council Of Victoria
• State Trustees Ltd.
• No to Violence
• Women’s Domestic Violence Crisis Services

All agencies, both those with local service outlets and those with outlets scoping the state, need to receive a copy of the interagency protocol relevant to their role.

Ensuring copies are given to all agencies mentioned in the protocol will strengthen links between health, community and support services that will enable older people to receive the best support possible during a time of undue stress and concern in their lives.
What are the benefits of developing an interagency protocol?

An interagency protocol should assist workers across different sectors to be clear on:

- what is expected of them
- when it is appropriate to refer a matter to another organisation
- what sort of support they can expect to receive from each other
- which organisation has lead coordination responsibility and what might cause that to change.

What needs to be included in the interagency protocol?

To provide an effective, consistent and coordinated service response to abuse, interagency protocols should include:

**Principles of interagency practice**

The identification, assessment, protection and care of older people who have been abused is an interagency and multidisciplinary responsibility.

Interagency practice aims to bring about a coordinated, person-centred approach when responding to elder abuse, and requires:

- a shared understanding of the aims of a response or intervention
- a prompt response to the abuse of older people, as a priority for all agencies
- appreciation of and respect for the different roles and contributions of agencies
- commitment to partnership between agencies
- understanding of the context in which agencies work, and acknowledgement of their respective constraints
- Principles indicating how to work with older people. These include respect for the autonomy and dignity of older people and recognition of the right of a competent older person to refuse intervention based on the principles of empowerment
- Principles for reporting abuse to Victoria Police. Many forms of elder abuse— but not all—are crimes and require police intervention.

In situations requiring Victoria Police intervention, it is preferable that the older person be consulted and give consent for the report. However, when a significant risk to the safety of the older person or others is involved, confidentiality cannot be offered unconditionally.

Where a report to Victoria Police is required, an individual’s personal safety is at risk and Victoria Police intervention is requested, the consent of the person involved is not necessary.
• consistency with each participating agency’s elder abuse policy
• reference to member agency elder abuse policies, using an agreed framework or understanding for interagency assessment, intervention and care coordination roles, including referral
• the definition of abuse
• reference to types of abuse
• identified categories of older people who may be at greater risk
• processes to assess an older person’s competence and capacity to make decisions and choices
• steps for gathering and substantiating information about the alleged case of abuse while working within privacy principles and human rights frameworks
• clear procedures for documenting evidence in each agency’s existing service response framework
• roles and responsibilities of local, regional or statewide support services, as applied to a local case, and the identification of other referral agencies, including appropriate contact details
• criteria (which includes the choice by an older person) to determine the appointment of a service coordinator as well as the role of a service coordinator
• a local interagency response framework
• identification of emergency response criteria, for example, the immediate threat of physical harm; however, most cases of abuse are not emergencies
• capacity to collect data on elder abuse cases using agencies’ existing client data systems
• capacity to date and sign off by key staff in each local interagency protocol member organisation, who have the authority to commit capacity of the agency to an elder abuse service response
• a protocol review date and how the review is to be triggered (this should be included in the respective member agency’s quality systems)
• the ability to learn from each elder abuse case via debriefing information
• the ability to learn from implementation of the interagency protocol to inform fine-tuning of protocol components and practice
• the ability to identify interagency roles regarding community awareness raising
• processes for effectively engaging interpreters and bilingual workers
• on completion, the protocol distribution method
• ease of access to completed protocol for referral and use by staff, for example: electronic for information and staff training sessions; placement, where appropriate, on agency and respective participating network websites; as well as hard copy frameworks for immediate use near telephones.

See attachment three for an article on Developing interagency protocols and service agreements.
Checklist for key inclusion in a generic inter-agency protocol

- background/ introduction
- purpose of the protocol, including aims and objectives
- parties to the protocol
- the protocol’s perceived benefits
- principles that inform the protocol
- the legal background or other important contextual information about compliance requirements
- a conceptual framework or map which provides a whole of system diagram outlining the agencies involved in the protocol
- participating agencies’ roles and responsibilities
- any structures or existing networks that have a role and what that role is
- a set of procedures that provide practical guidance on how the protocol will be implemented
- arrangements for monitoring and reviewing the use of the protocol and responding to any breaches or grievances
- attachments, including forms, legislation, check lists, flow charts and a glossary of terms.
Service coordination role between agencies

Where multiple agencies are involved in supporting an older person and possibly that person’s carer, service providers should clarify service coordination and monitoring roles in the case of suspicion or alleged abuse.

This may involve:

- as part of the interagency protocol development, deciding which agency undertakes the service coordination role, on a case-by-case basis, and the expectations of that role
- how and when other service providers supporting that older person will inform the service coordinator of changes in their service provision role
- how agencies will inform the service coordinator of concerns regarding an older person’s situation, and requesting a review meeting if needed
- relevant local service providers participating in meetings convened by the service coordinator.

A service coordination meeting might also involve people who form an older person’s informal support network (such as family, friends or neighbours), so that both formal and informal service networks are coordinated.

Prior planning and agreement by agencies will strongly contribute to ‘ownership’ of the interagency protocol and contribute to stronger commitment to agreed processes.

A general principle to trigger the coordination role might be that the first agency to identify suspicion of abuse:

- notifies their supervisor
- assesses the situation (including involving the older person)
- proceeds according to agency policy and procedures
- activates the interagency protocol, depending on the circumstances of each case, as it unfolds.

In some situations, the case may be managed within the one agency using established internal elder abuse policies and procedures. The supervisor, in consultation with relevant others, may decide there is no need to activate the interagency protocol. However, it may be helpful to contact a member organisation in your interagency protocol for support and advice, particularly one that coordinates service response or provides assessment.
Victorian interagency response framework clarifies service response

An interagency protocol should clarify a process for response in this case to elder abuse, where multiple providers are involved.

The handout Victorian interagency response framework has been developed for health and community service providers for use by agencies to incorporate into their own elder abuse policy and procedures, and also for use in the development of local interagency protocol development.

The framework can be copied as it is, or modified to provide enhancements which will add value for use at a local level.

Agencies may like to add components from the samples (provided as handouts) Sample intervention and referral frameworks, or create their own modifications.

Reflect

Read Attachment one: The disappearing age: a strategy to address violence against older women. Consider the key points and the arguments for greater collaboration across agencies. What can your agency learn from this and how could this be reflected in your agencies policies, procedures and interagency arrangements?
What is a power of attorney?

A power of attorney is a legal document that a person executes to give another person the legal right to make decisions in the event that they do not have the capacity to make decisions. A power of attorney is a tool to empower older persons by allowing them to put in place their wishes regarding important decisions while they are competent. This permits their wishes to be respected when they cease to be competent. However they are open to abuse in their current form if the agent does not respect the wishes of the Donor or misuses the power to their own advantage. The Victorian Law Reform Commission completed a comprehensive inquiry into the Powers of Attorney which was tabled in parliament in August 2010. This paper recommends a range of changes to the law to prevent abuse while strengthening and encouraging the use of powers of attorney as a mechanism of empowerment.

In Victoria, there are four different powers of attorney.

- **A general power of attorney (non enduring power of attorney)** grants legal authority to a specified person to make clearly identified financial and legal decisions for another. The donor must have capacity to make those decisions and the general power of attorney automatically ceases if the donor loses capacity to make those decisions. Example: When a family member is travelling overseas they may give another family member a general power of attorney to make it easier to pay their bills, lodge their tax return etc. The relevant legislation is found in the *Instruments Act 1958* (VIC).

- **An enduring power of attorney (financial)** grants legal authority to a specified person to make financial and some legal decisions for another. It is usual to specify the date of the commencement of these powers, the nature of the powers and the conditions or terms under which the decisions can be made by the agent. If there is no date specified the powers commence when the document is executed. The agent’s powers will endure once the donor loses the capacity to make the decisions themselves. The relevant legislation is found in the *Instruments Act 1958* (VIC).

- **An enduring power (guardianship)** grants legal authority to a specified person to make lifestyle decisions for another and commences only when the donor is unable to make decisions for him or herself. It is usual to specify the conditions or terms under which the decisions can be made by the agent. A person lacks capacity to make decisions related to their lifestyle if they are unable to assess their own needs, and make decisions about what is required to have a reasonable quality of life in all the relevant circumstances. The relevant legislation is found in the *Guardianship and Administration Act 1986* (VIC).

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**Donor** = The person who gives away (donates) their legal right to make decisions.

**Agent** = The person to whom the legal right to make decisions is granted to by another (donor).

**Capacity** is defined as the ability to reason things out; to understand, retain, believe, evaluate relevant information for making a decision. A person may lose capacity to make decisions permanently or temporarily, due to accident or illness.
An enduring power (medical treatment) grants legal authority to a specified person to make medical decisions for another and commences only when the donor is unable to make decisions for him or herself. It includes in certain conditions a decision to refuse treatment. The relevant legislation is the Medical Treatment Act 1988 (Vic).

A person can only make a power of attorney if they have the capacity to do so. The witnesses to the execution of a power of attorney need to be satisfied that the donor has the capacity to make the grant of power to another. If witnesses have any doubt as to the donor’s capacity they are required to obtain an independent capacity assessment.

Capacity to grant a power of attorney is broadly defined as the donor at the time of making the grant understands the nature of the powers they are granting, that they can revoke these powers while they have capacity and that they will lose their power to make decisions and exercise those same powers of choice and decision making once they lose capacity. Capacity is defined as the ability to reason things out; to understand, retain, believe, evaluate relevant information for making a decision. A person may lose capacity to make decisions permanently or temporarily, due to accident or illness.

Agents have a high level duty of care to their donors. The most important condition is that they must act in the best interests of the donor at all times. Best interest is interpreted as what is reasonable given all the circumstances including where possible what decision the donor was most likely to have made if they had capacity.
What if I think that the agent is not exercising the power of attorney in the best interests of my client?

The Victorian Civil and Administrative Tribunal (VCAT) can revoke or suspend the enduring power of attorney. Anyone who has a genuine interest in the welfare of the donor can apply to VCAT to review the actions of an agent.

What if there are multiple powers of attorney?

As a general rule specific powers of attorney prevail over general powers.

**Scenario**

If a donor has granted to person A an enduring power of attorney (guardianship) that includes a power to make health care decisions including agreeing to medical treatment and choice of treatment and the donor has also appointed person B under an enduring power of attorney (medical treatment), person B's decisions will prevail over person A's.

**Scenario**

What if the donor granted to person A an enduring power of attorney in April 2002 and they granted an enduring power of attorney to person B in August 2005. The general rule is that the donor intended to revoke the earlier power of attorney they gave to A when they executed a power of attorney naming person B unless there is a clear intention that they were making B an additional power of attorney.

See: Useful links and resources (page 3) for further resources on Powers of Attorney
What is the role and powers of the Public Advocate?

The Office of the Public Advocate (OPA) is an independent statutory body established by the Victorian State Government, working to protect and promote the interests, rights and dignity of people with a disability. The vision and values of OPA are to work towards a just and inclusive society that values, respects, protects and promotes the dignity and human rights of all persons.

OPA provides a number of services to achieve this vision, and to meet legislative requirements outlined in the Guardianship and Administration Act 1986.

Important services include:

- **Advice Service**: an advice and information service for enquiries about matters including powers of attorney, guardianship, VCAT applications, and consent to medical/dental treatment
- **Advocate/Guardian Program**: statutory guardianship to Victorians who cannot make decisions for themselves, support to private guardians, and last resort advocacy for people with a disability
- **Community Guardian Program**: a program for volunteers who are appointed by the Public Advocate to act as independent guardians for Victorians with a disability.

In some cases, VCAT appoints the Public Advocate as guardian for adults with a cognitive disability (this includes intellectual disability, acquired brain injury, dementia, or chronic mental illness). The Public Advocate may then delegate that guardianship to an advocate/guardian from the guardianship program, or a Community Guardian from the Community Guardianship Program.
What is the role of VCAT?

The Victorian Civil and Administrative Tribunal is a collection of specialist tribunals that settle civil (not criminal) disputes in a wide range of matters. It has a number of “lists” or sections that deal with specific matters. The role of the Guardianship List is to protect persons aged 18 years or over who, as result of a disability, are unable to make reasonable decisions about their person or circumstances or their financial and legal affairs.

Under the Guardianship and Administration Act 1986 “disability” is widely defined and interpreted and includes:

- intellectual impairment
- mental disorder
- brain injury
- physical disability
- dementia.

Most matters in the Guardianship List relate to the appointment of guardians and administrators. However, the Guardianship List also has powers in relation to both enduring powers of attorney (financial) and enduring powers of attorney (guardianship). VCAT usually exercises these powers when an application is made by the Public Advocate, the principal, the representative or a person with a special interest in the principal’s affairs. Applications can be made on an urgent basis. In emergency situations, VCAT can make a temporary administration or guardian order for up to 21 days. The temporary order can be made at very short notice. If necessary it can be extended for a further 21 days.

Temporary orders allow VCAT to act swiftly to protect individuals who are at risk. VCAT can only make a temporary order when the person in question is at immediate risk and there are no less restrictive options for addressing the situation. Before the end of the temporary order VCAT must hold a hearing to decide whether an administration order is needed.

In relation to appointments of guardians and administrators, VCAT can:

- appoint guardians to make decisions for a person, including the person’s accommodation
- appoint administrators to manage a person’s financial and legal affairs
- revoke an attorney’s appointment, or vary, suspend or make another order in relation to a financial EPA (enduring power of attorney) under the Instruments Act 1958
- revoke or suspend an enduring power of attorney (medical treatment) under the Medical Treatment Act 1988
- consent to a “special procedure”, that is:
  - a procedure intended or likely to cause infertility
  - termination of pregnancy
  - removal of tissue for transplanting.
In relation to an enduring power of attorney (financial) document, VCAT can specifically:

- declare a document to be invalid if the principal had impaired decision-making capacity at the time the document was made, the document does not comply with formal requirements, or the document is invalid for another reason, for example, the principal was induced to make the document through dishonesty or undue influence
- revoke the appointment of a representative if satisfied that it is in the best interests of the principal to do so. VCAT can only exercise this power if satisfied that a principal has impaired decision-making capacity
- give permission to a representative to resign. If a principal has impaired decision-making capacity, a representative can only resign with the permission of VCAT or a court
- order a representative to lodge accounts and other documents with VCAT or that accounts be examined by a person appointed by VCAT
- give declarations, orders, directions or recommendations about the scope of a representative’s powers or the exercise of the representative’s powers
- give advisory opinions on any matter
- vary or suspend the document.
Attachments

Attachment one:
The disappearing age: a strategy to address violence against older women
Ludo McFerran, Consultant, Older Women’s Network NSW

Introduction
In the international debate on responses to family and domestic violence, one group, older women, has consistently disappeared. Older women fade away in the databases of homelessness, refuge residents, medical screening and any number of other critical indices. Do women move into a violence free period of their life as they age? Not according to the most recent evidence that indicates that one in four women who have experienced an incident of physical violence in the past 12 months is aged 45 years and older (Australian Bureau of Statistics 2006).

This Topic Paper examines a project by the Older Women’s Network NSW (OWN) to describe our current understanding of violence against older women and to develop a strategy to address the violence. The paper explores the challenge for the domestic and family violence sector of responding to the increased reporting of violence against older women. It highlights the urgent need to improve the capacity of the domestic violence, aged care and homelessness service systems to provide flexible, collaborative and sensitive support designed for the needs of older women, should they remain in the family home, leave or become chronically homeless.

1 The Project, Prevention of Violence Against Older Women (September – December 2008), conducted by the Older Women’s Network NSW (OWN), was funded by a NSW Domestic and Family Violence Grant (Office of Women’s Policy, NSW Department of Premier and Cabinet) and supported by the Australian Domestic and Family Violence Clearinghouse
The OWN NSW Draft Strategy to Prevent Violence Against Older Women

Aims:

- Promote better awareness and visibility of violence against older women.
- Create a safe and supportive environment in which older women can report.
- Improve the ability of support services to identify violence against older women.
- Provide appropriate and proportionate levels of support and assistance to older women.
- Ensure that targeted training skills enable key agencies and staff to respond appropriately to the needs of older women.
- Promote collaboration across key agencies and staff supporting older women.

The Federal Government’s homelessness white paper (2008), The Road Home, recognises the ageing of the homeless population and commits the country to an ambitious reform agenda. The white paper also recognises domestic violence as a key cause of homelessness. In this environment, a strategy concentrating specifically on reducing violence against older women is timely. Another timely factor is a new demand for a feminist analysis of ageing and the impact of gender-based violence on older women. Historically, feminism has not embraced ageing, preferring to focus feminist thought and practice on younger women (Calasanti, Slevin & King 2006; Hightower 2002). The ageing of many of the 1970s feminist activists is now helping to stimulate this discussion. It is in this context that OWN NSW seeks to foster a national debate on the issue of violence against older women, to develop a comprehensive national strategy to prevent the violence, and secure commitments from governments and service systems to implement the strategy.

Defining ‘older’

There is little consensus on the threshold of being an ‘older’ adult. The OWN Project chose 45 years and over as the benchmark age for becoming an ‘older woman’. This decision reflects the lower life expectancy of Indigenous women and that the Personal Safety Survey, Australia (Australian Bureau of Statistics 2006) uses 45 years of age as an ageing benchmark. In choosing the age of 45, the Project recognised that there is a great diversity of experience for women of different ages with vulnerability, poor health and dependency usually increasing as women grow older. The Project also focused on violence against older women in their own homes, as the vast majority of older women continue to live in the community, with only 5% of older Australians living in aged care facilities.

One in four

A number of factors have contributed to the abuse of older women being ‘lost in the cracks between the domestic violence and elder abuse services system’ (Brandl & Cook-Daniels 2002). These include focusing by the family
violence sector on younger women and their dependent children, defining the abuse of older people as age-related, rather than a lifelong continuum of violence for many women, framing older people as sexless and limited levels of collaboration between aged, health and family violence services.

Reporting rates for family violence in the past have suggested that older women are less at risk than younger women (VicHealth 2004). Only 3.3% of women aged 45 years and over reported experiencing violence from their current partner in the Women’s Safety, Australia survey (Australian Bureau of Statistics 1996). Of female clients accessing the Supported Accommodation Assistance Program (SAAP) services who were escaping domestic violence, less than 14% were aged 45 years and older (Marcolin 2005, p.15). Indigenous SAAP clients were the only cultural group in which older women outnumbered older men. Women seemingly appear to enter a violence-free zone between the ages of 45 and 65 years old, to reappear in studies of ‘elder abuse’ with recorded rates of abuse two and a half times the rate of men (Boldy et al. 2002).

But there is clear evidence that the levels of violence are being seriously underreported. Mears (1997) critiqued the methodology of the Women’s Safety, Australia survey (Australian Bureau of Statistics 1996) for failing to acknowledge a greater reluctance of older women to disclose personal matters and, thus, ensure accurate reporting of violence against older women. In a 1998 CASA House phone survey on sexual assault, over 25% of calls were from women over 50 years of age, who said they called because their anonymity was assured (Duncan 2002). In their national foundation study which sought to record the incidence and lived experiences of older people experiencing domestic violence, Morgan Disney (2000) found that over a third of the older women interviewed ‘had never known a life without violence’

‘Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse’, United Nations Principles for Older Persons No. 17, adopted by General Assembly resolution 46/91 of 16 December 1991.

As an understanding of the rights of older people and elder abuse improved nationally and internationally (for example, the declaration of 1999 as the United Nations Year of the Older Person and see the NSW Advisory Committee on Abuse of Older People in their Homes 1993), the issue of violence against older women became more publicly debated (Blue Mountains Community Legal Centre 2005; Caringbah Women’s Health and Information Centre 2005; Mears & Sargent 2000). This may have contributed to increased reporting by older women in the Personal Safety Survey, Australia (Australian Bureau of Statistics 2006, p. 20), which found that the proportion of older women aged 45 years and older reporting physical violence in the twelve months prior to the survey had increased to 25%. Further, the greatest increase in reporting between the two national safety surveys was by women aged 55 years and over: from 4.4% in 1996 to 10.1% in 2005.
Challenge for the domestic violence sector

That one in four older women report physical domestic violence (Australian Bureau of Statistics 2006) suggests that the domestic violence sector needs to ensure older women can access appropriate support. Morgan Disney (2000) in their study of older people and domestic violence found that the most common reason given by respondents for not speaking to anyone about their situation was shame and embarrassment. Older women thought that leaving the relationship, going to a refuge or calling the police were choices for younger women. Many of the women interviewed felt they had invested too much in their families and partners to leave, that they were too old to re-enter the workforce or were not prepared to be ostracised from their cultural community or the social networks they enjoyed as a couple. A common fear expressed by older women was that if they left their home they would be placed in an aged care facility.

‘Older women may need different systemic responses to younger women’ (Beaulaurier et al. 2007)

The nature of violence against older women has many features similar to that experienced by younger women but there are important differences in the nature of the violence and the choices available to them. Older women may be exposed to abuse by a broad range of family members and carers (Livermore, Bunt & Biscan 2001). Older women living alone are less likely to be physically or psychologically abused but may be more at risk of financial abuse by an adult child after the death of a partner (Brozowski & Hall 2004). Social isolation of both victim and abuser is a common feature of violence against older women.

There is a growing trend in Australia towards a more diverse domestic violence response system with greater capacity to provide outreach, allowing older women the option to stay safely in their homes. For example, Victoria has introduced an integrated, diverse family violence service system and a recent (2008) snapshot of services state-wide found that 18% of clients were aged 45 years and over (KPMG 2008). In one service, the Victorian Eastern Domestic Violence Outreach Service (2007-08), annual client data shows that 26.2% of outreach clients were 45 years and older, with a marked increase in number of clients aged 60 and older. Domestic and Family Violence Support Services Queensland report a slightly higher use by older clients (15.8% aged 45 years and older 1/1/2007-30/6/2008) with the main support provided being court support.

Building on ‘safe at home’ strategies, safety planning and better security measures in the home can assist older women staying home to be safer. Technology commonly used to monitor health emergencies in the home, for example, can be also used for security alerts in cases of family violence.

After a national survey of U.S. shelters in 1998 mapped services for older women, a policy of recruiting older women as staff, management and volunteers was introduced, with increased collaboration between domestic violence and aged services, and cross sector training workshops. New provisions
in the US Victim of Violence Prevention Act 2000 were directed to older and disabled victims. They included: grants for training and programs to improve the capacity of police and court staff to recognise, address, investigate and prosecute domestic violence and sexual assault against older people and people with disabilities (Hightower 2002).

Older women recounting their stories (Mears and Sargent 2000) of violence in their personal relationships described a range of survival strategies: blocking out the violence, channelling energy into work or study, leaving or waiting for the perpetrator to die. Of primary importance was being able to talk about and share their experience with other older women. Support groups for older women who have experienced family violence have been found to be ‘life-altering’ (Brandl et al. 2003).

Family Violence Services Recommendations

- Review supported accommodation and homeless models to ensure appropriate and proportionate access and responses for single older women.
- Develop policies and protocols for services responding to family violence that recognise the prevalence, specificity and complex nature of violence against older women.
- Develop safety plans for programs working with older women (including subsidised home security measures).
- Fund Community and Women’s Health Centres to develop support programs for older women.
- Incorporate strategies to address violence against older women into national and state and territory plans to reduce violence against women.
- Enhance the capacity of one specialist domestic violence service per region to act as conduit between the programs supporting older women and to ensure skilled responses to referrals of older women experiencing violence.

Hidden Homelessness

Older women do leave abusive relationships but leaving can be financially problematic.

All of the women had found it a very difficult experience and, almost without exception, none were financially better off, although several commented that their quality of life had improved. Many women reported that their families had not been supportive of their leaving (Morgan Disney 2000).

The financial barriers for older women to leave a violent relationship are great: far greater numbers of older women than men live on the single Age Pension and as many as 55% of women in their sixties have no superannuation (Association of Superannuation Funds of Australia 2008).

Leaving a violent relationship also results in a high risk of homelessness for older women as there is a scarcity of services that they can access that are appropriate for their needs. In their study of homeless, single women in Western Sydney, Robinson and Searby (2006) argue that the policy and service
emphasis on homeless women with children has led to a failure to address the complexities and diversity of women’s homelessness.

As an example of this complexity, most SAAP services for single people are for single men. The small number of single women’s services (there is no funded service specifically for homeless older women) receive only 3% of recurrent SAAP funding (AIHW 2009) and accommodate less than 7% of older (45 years and over Indigenous, 50 years and over non-Indigenous) SAAP female clients (Lai 2003, p. 14). Yet, the latest SAAP data collection reports that in 2007-2008, older women accessed SAAP services in greater numbers than men (AIHW 2009). According to a monograph on older SAAP clients (Lai 2003), older female clients (40%) were more likely than younger women to cite domestic violence as their predominant reason for seeking SAAP support (p.16). Where older women are able to access SAAP services, they are predominately supported in services for women escaping domestic violence (p. 14), many accompanying their adult daughter and grandchildren: three generations of displaced people.

A new monograph is required to map the reality of older women’s homelessness, capturing the impact of the significant number of unfunded places for homeless women being provided by the large charities, including an unfunded refuge for older women in Western Sydney that has operated for twenty years.

For according to Sharam (2008), who estimates that up to 30,000 older single women at housing risk are living on the Australian eastern coast, the levels of older women’s homelessness will continue to escalate:

Young women also tend to link their housing to partnership, more so than men, which means if the relationship breaks down in later life they are left more vulnerable to housing stress. Combine this with the lowest housing affordability since the early 1980s and we’re looking at an unprecedented number of pension-aged single women entering the primary homeless population in the next 20 years.

Older women need specific accommodation options, including specialised refuges and long term housing (Beaulaurier et al. 2007). Community housing is a major provider of housing for single people and older women: 62.5% of head tenants aged 45 years and older were women (AIHW 2008). Access is, to a large degree, dependent on available single person housing stock, which tends to be concentrated in the inner cities. The Australian Government has announced $6.4 billion for new public and community housing (the Hon. Tanya Plibersek MP, Minister for Housing and the Status of Women 2009). Advocates are concerned that as a result of the hidden nature of older women’s homelessness, this group may not benefit proportionately from the new housing provisions (S. Cripps, [Homelessness NSW 2009], pers. comm. 27 April).

Future long term housing options for older women must also address the issue of appropriate housing stock. This will require a ‘growth in higher density housing forms’ as the:

dramatic increase in lone person households into the future (the majority of which will be female lone person households) will likely account for much of the growth in higher density housing, particularly as older women demand smaller properties to minimise maintenance and costs (Tually, Beer & Faulkner 2007).

**Homeless and Social Housing Recommendations**

- Urgently provide funded proportionate levels of supported crisis accommodation services for older women.
- Recognise older people as a specific target group in homelessness programs.
- Conduct snapshot data collections to monitor usage of SAAP and housing services by older women.
- Review social and public housing programs to ensure appropriate and proportionate access and responses for single older women.
- Conduct research to map the hidden homelessness of many older women.
- Develop a strong advocacy base to ensure the rights of older homeless women are not neglected.

**Promote collaboration across key agencies and staff**

The bulk of support for older women at risk in their own homes is being provided by the aged care sector, where an estimated two thirds of clients are women. Yet many plans and strategies on abuse of older people have neglected the gendered nature of the violence and, despite advocating for collaboration across support services, they fall short of a comprehensive inclusion of all key agencies. The lack of collaboration between the aged care sector and the domestic violence sector has resulted in women falling through the cracks and not receiving adequate support and assistance.

The NSW Department of Ageing, Disability and Home Care (DADHC) Interagency Protocol for Responding to Abuse of Older People (2007) does incorporate an understanding of the effects of domestic and family violence on older people. The Protocol specifies that staff employed in NSW Government agencies ‘must report to the NSW Police regardless of the victim’s views’ where there is: serious injury, the perpetrator has access to a gun or other weapon and is threatening to cause harm, and there is immediate serious risk to individuals or workers are threatened. The Protocol stresses the need for collaboration with domestic violence services. It provides NSW with an imperative to improve collaboration across the key sectors and to include the aged care sector in an integrated response to family violence.

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2 The aged care sector comprises a range of Commonwealth and State programs, including Aged Care Assessment Teams (ACATs), Home and Community Care (HACC) Services, and Community Aged Care Packages. Australia wide, there were a total of 683,322 ACAT and HACC clients aged 65 years and over in 2004-2005; two thirds of clients were women (AIHW 2007). In contrast, there were 1279 female SAAP clients aged 45 years and older whose main reason for seeking assistance was domestic or family violence or relationship or family breakdown in the year 2006-2007, according to data provided to the OWN Project by the Supported Accommodation and Crisis Services Unit, AIHW.
Recommendations for Improved Collaboration

• Include Aged Care Services and Departments in State, Territory and National Plans and Strategies to Reduce Violence Against women.
• Include Family Violence and Homelessness Services and Departments in State, Territory and National Plans and Strategies to Reduce Abuse of Older People.
• Establish Interagency Protocols for Responding to Abuse of Older People in every State and Territory, which incorporate strategies to develop collaborative networks of domestic and family violence, aged, health and legal services to reduce violence against older women.
• Develop collaborative and accredited training on violence against older women for the domestic violence, aged and health sectors.
• Fund and train ACATs and HACCs to the levels necessary to respond to the reported levels of abuse of older people.

The role of the medical and health community

General Practitioners represent a critical group of service providers to improve older women’s awareness and reporting of violence and abuse. They were identified by Morgan Disney (2000) as the professional group most likely to be accessed by older women (46%, compared with 38% accessing police and 9.6% accessing refuges), although judged to be more unhelpful than helpful. The Australian Society for Geriatric Medicine (2004) states that ‘the medical profession should play a major role in recognition, assessment and management of cases of abuse’ and should be part of referral and decision making processes. The provision of a clinical referral pathway to domestic violence specialist support may assist GPs:

Beyond their initial response, most generalists have neither the expertise nor the capacity to meet the needs of women experiencing partner violence…

A key step is an offer of referral to specialist support, such as domestic violence advocacy (Hegarty, Taft, & Feder 2008).

Advances have been made in screening and training in the medical community. Routine health screening for domestic violence in NSW Health early childhood, alcohol and drug and mental health services was introduced in 2001, and is now routinely conducted in women’s health centres. Women are asked: ‘within the last year have you been hit, slapped or hurt in other ways by your partner or ex-partner?’ and ‘are you frightened of your partner or ex-partner?’

This program screens 10,000 women a month, with around 7.3% reporting physical abuse by their partner or ex-partner in the past 12 months (Spangaro 2007). The Practice Incentives Program (PIP) Domestic Violence Initiative pays general practices in rural and remote areas a subsidy to identify and appropriately refer patients experiencing domestic violence. There is no fee for practice nurses or Aboriginal health workers to undertake the primary training course (DiVeRT) delivered by Lifeline across Australia as part of the PIP Domestic Violence Initiative (Medicare Australia 2009).
Recommendations for the Medical and Health Community

- Extend routine screening of women for domestic violence by NSW Health to services accessed by older women such as breast screening (with questions adapted to be sensitive to older women).
- Provide training to services utilising Routine Screening to ensure that appropriate assistance and referrals are made.
- Encourage Divisions of General Practice to take a lead role in encouraging general practices to identify and respond to cases of violence against older women and, where possible, refer to a specialised family violence service.
- Deliver training to medical and allied health workers on violence against women and the abuse of older people as part of their core curriculum.
- Extend the Commonwealth funded Practice Initiatives Program (PIP) Domestic Violence Initiative scheme to ensure the training of all GP Nurses and Aboriginal Health Nurses.

Legal challenges

There has been much discussion in the Aged Care sector about the adequacy of existing legislation to protect older people from abuse, with calls for aged abuse specific legislation and mandatory reporting of all cases of aged abuse. New legislation in Victoria and Tasmania has specifically included economic abuse as a form of family violence and carers as people against whom orders can be made. Legal practitioners agree that older people should seek independent legal advice on their wills and early inheritance arrangements (Legal Aid NSW).

Any strategy or protocol to address these issues must be linked to training of the professionals involved. There is only one semester course on elder law given to law students (University of Western Sydney) and in NSW a small and recently established Older Person’s Legal and Education Program initiated by Legal Aid NSW to educate Community Legal Centres on abuse of older people.

Recommendations for the Justice and legal Sectors

- The National Council to Reduce Violence Against Women and Children to review Commonwealth, State and Territory legislation in order to recommend good practice legislation to reduce violence against women and specifically older women.
- Incorporate legal and justice sectors in collaborative protocols with domestic violence, aged and health sectors to ensure effective pathways for older women experiencing violence to appropriate legal services.
- Introduce core training and ongoing professional development across mainstream justice and legal services on elder abuse and violence against older women.
Promote Community Awareness

There is low community awareness of the abuse of older people (Arctraft Research 2004; Northern Rivers Social Development Council 2008). Community awareness campaigns have encouraged victims or third parties to report, stressed the dignity and respect due to older people, reinforced cultural values of ageing and promoted safety strategies for older people (Beaulaurier et al. 2007; Morgan Disney 2000; Zink et al. 2006). They have engaged the support of third party sources to alert services, including bank employees, postal workers, hairdressers, pharmacies and libraries. The support of religious leaders is critical for many older women, who tend to have stronger spiritual beliefs than younger women (Morgan Disney 2000). Campaigns that best reflect the concerns and sensitivities of specific communities of women are those designed in collaboration with those communities (Mears et al. 2003; Office of Public Advocate 2006).

Community Awareness Recommendations

- Fund local community awareness campaigns with older women as the target group using non-threatening and appropriate language.
- Encourage older women to report to confidential and expert services, with the message that ‘it is good for older women to talk with older women’ at their local older women’s group.
- Develop the campaigns as a collabortive initiative of the community, together with local aged, health and domestic violence services.
- Distribute the message through radio and other local media, and through local groups and services frequented by older women such as hairdressers, libraries, social and sporting clubs, and through religious leaders and general practitioners.
- Design specialised campaigns for specific communities (older women with disabilities, CALD women and Indigenous women) in collaboration with these communities.
- Fund a broader campaign to raise the status of older women; e.g. as mentors, survivors, backbones of their community.
Conclusion

Older women constitute a significant proportion of the Australian female population and ensuring they can enjoy a safe and healthy old age will be a challenge for Australia. The overarching message to emerge from the OWN NSW Project is that violence against women does not stop at the age of 45. Instead, the violence may become more complex, insidious and debilitating, compounded by factors such as the financial insecurity of single women in their fifties and early sixties, and a culture of silence and stoicism among older women.

The greatest immediate challenge is to provide older women experiencing violence and abuse with a safe and appropriate pathway to effective support and assistance. To do so requires an urgent response to the historically low funding of services for homeless older women, particularly appropriate permanent accommodation. A positive strategy is to include Aged Care Services in integrated family violence systems and maximise collaborative opportunities, such as joint training across all key sectors. Support to older women in the domestic violence response system should be appropriate and proportionate to the reporting rate indicated in the Personal Safety Survey, Australia (2006). Key professionals, such as General Practitioners, can help to increase the reporting of violence against older women by accessing specialist referral pathways. There is value in both a broad campaign to raise the status of older women as mentors, survivors, and backbones of their community, as well as localised campaigns to encourage older women to talk confidentially to a counsellor or join a local support group for older women.

Despite the challenging economic conditions, the Federal Government declares itself committed to the long term planning necessary to tackle homelessness and reduce violence against women. More than ever, it is time to ensure that being an ageing, single, older woman is not a barrier to being safe, well and housed.

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3 More than two thirds (39%) of the Australian female population is 45 years and older (Australian Bureau of Statistics 2008)
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The Victorian Law Reform Commission tabled its final report into powers of attorney in 2010. One of the terms of reference was to examine ways of minimising abuse in relation to the execution of and exercise of powers under powers of attorney documents. Below are some extracts from the final report where the question of abuse was discussed.

Protecting against abuse

Power of attorney documents can be extremely empowering for principals, however the Committee also heard that they are susceptible to abuse. While the extent of abuse is not known, the Committee was told that abuse, particularly of enduring powers of attorney (financial), is ‘not uncommon’. Abuse is often perpetrated by a close family member.

Abuse can occur both at the time a power of attorney document is created and when the power is being used by the representative, although abuse of validly executed documents appears to be more common. Overall, the Committee considers that the benefits that powers of attorney offer greatly outweigh the risk of abuse.

While participants in this Inquiry called for more safeguards against abuse, the Committee was cautioned against imposing requirements that are too onerous. In particular, there was concern that such requirements may deter principals from making powers of attorney or discourage people from agreeing to act as representatives. In this report the Committee has endeavoured to strike a balance between protecting principals and ensuring that the flexibility and useability of these arrangements is not unduly compromised.

The Committee heard that sometimes a principal may be pressured into signing a power of attorney and may not fully understand the implications of the document. To protect against abuse when a power of attorney document is created, the Committee recommends restricting the classes of persons who may witness these documents, making the witnesses’ role clearer and providing more education and support for witnesses.

At present the use of powers by a representative is almost entirely unregulated. To reduce abuse at this stage the Committee recommends that principals be empowered to appoint a friend or independent person or organisation as a ‘personal monitor’ who can oversee the use of powers by the representative. While it will generally be up to the principal to specify key decisions and actions which must be notified to the monitor, the Committee believes that representatives should be required to notify the monitor when an enduring power of attorney document is registered or upon activation of an enduring power of attorney document that is stated to commence when the principal...
has impaired decision-making capacity. The Committee also recommends clearer rules around when a representative is able to make a gift using the principal’s funds.

Sometimes misuse of a power of attorney may be unintentional: some representatives simply do not understand the limits of their authority or the obligations imposed on them by the role. The Committee recommends providing legislative clarity about the powers that a representative has under each type of power of attorney and the duties the role imposes. In addition, the Committee recommends the creation of four offences that relate specifically to abuse of powers of attorney and empowering the Victorian Civil and Administrative Tribunal (VCAT) to refer findings of abuse to the Director of Public Prosecutions and to award compensation where it finds abuse.

The Committee also makes a number of recommendations aimed at increasing the detection and reporting of abuse of powers of attorney, including educating parties who may be in a position to detect abuse, such as bank staff.
Attachment three:
Developing interagency protocols and service agreements. Author: Community Door Administrator
organisation: Queensland Council of Social Service

Introduction

Partnership or inter-agency agreements and inter-agency protocols are documents that record the agreed terms and conditions of collaboration between separate agencies and/or sectors. The terms ‘protocols’ and ‘agreements’ are sometimes used interchangeably with guidelines and Memoranda of Understanding (MOU).

Inter-agency agreements or protocols can serve a number of purposes such as:

- clarifying roles and responsibilities
- maintaining consistency of inter-agency relationships and practices
- explicitly stating what agencies and/or sectors have committed to
- providing a basis for negotiation of responses to a situation or resolution of differences between agency approaches, and/or
- providing an agreed process for resolving inter-agency differences.

Definitions

Inter-agency or partnership agreement:

An inter-agency or partnership agreement is a document outlining the basis of a new relationship and the agreed objectives between partners.

Agreements can be developed at a statewide, regional or local level. An agreement may be a broad, high-level agreement that documents the relationship between groups of agencies.

For example:

- state government and the non-government sector about their roles and responsibilities
- local government and the non-government sector about community development activities
- government and a consumer peak body about the interests of service users
- peak bodies representing different interest groups identifying the boundaries of their constituencies
- professional groups such as social workers, psychologists, welfare workers agreeing on inter-professional practices
- universities and the non-government sector agreeing to provide learning and development pathways for community services workers
- Aboriginal and Torres Strait Islander communities and the non-government sector or government about sustainable servicing practices to remote areas, or
- the non-government sector and business about pro bono contributions and volunteers.
An agreement may also be a simple agreement between two agencies about specific aspects of their work. For example:

- a homeless men’s shelter having an agreement with the local integrated mental health team for responding to crisis situations involving their residents with mental health issues
- a disability support service having an agreement with an accommodation service to access weekend respite care services for clients
- a network of after-school care programs having an agreement about delivery and access of workers to a training program operated by one of the agencies.

Agreements can be contractually binding if there are consequences for partners for not complying with the agreed terms.

Protocols:

A protocol outlines broad working relationships and more detailed processes by which inter-agency partners will work together. Protocols document when and why partner agencies will interact, how they will interact, and what each partner can reasonably expect from the other. Protocols can provide legitimacy to relationships and processes already in place but have not been formally documented.

Protocols are practical, hands-on documents that outline specific processes and procedures between service delivery agencies.

Protocols are not usually contractually binding but are used to set agreed good practice standards that parties should meet.

Agreements and protocols can occur together. A partnership agreement might contain the general aims and commitments of the partnership and the protocols outline how agencies work together.

Some examples of protocols include:

- a women’s refuge having a protocol with a specialist immigrant women’s support service on how referral and ongoing support procedures will include access to interpreters for women from culturally and linguistically diverse backgrounds
- an aged care provider offering community options having a protocol with local hospital social workers and community health social workers regarding the way eligibility criteria and referral processes will operate
- an out-of-home care network of agencies having a protocol outlining how each agency’s role will operate in the continuum of care and referral processes between agencies.
Reasons for developing service protocols and agreements

The reasons for developing service agreements and protocols are many and varied. Sometimes it is in response to issues that are having adverse effects on partners. Other times it will be to embark on a new initiative or take action on a common goal.

Agreements are most typically developed to:

• outline strategic priorities and planned commitments
• provide guidance around allocation of resources
• clarify roles and responsibilities
• signify a commitment to part of a process such as an integrated service system
• respond to new legislation or other compliance requirements
• establish the principles and agreements for co-location.

Protocols are most typically developed to:

• better coordinate local service delivery
• share information about service users across organisational and professional boundaries
• obtain priority access to services for clients in crisis or where high-risk circumstances exist
• outline specific management and service arrangements for co-location
• manage case management and coordination responsibilities for clients with multiple and complex needs where several agencies are involved.
  (Case management protocols cover the roles and responsibilities of the various agencies in client eligibility, access and referral processes, preliminary and ongoing assessment, delivery of care and support, ongoing care and support and exit planning.)
Benefits of interagency service agreements and protocols

Formal inter-agency agreements improve inter-agency practice and benefit clients, workers and agencies. The table¹ below can help agencies understand what they and their clients gain from participating in inter-agency protocols.

<table>
<thead>
<tr>
<th>For clients</th>
<th>For workers</th>
<th>For agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>A coordinated case plan can address a range of needs and provide more seamless service delivery.</td>
<td>Sharing information, assessment knowledge and intervention responsibility is less stressful and more rewarding than acting individually.</td>
<td>Reduces duplication of services and allows for greater efficiency in the use of public resources</td>
</tr>
<tr>
<td>Cooperative efforts by agencies improves access to services and can reduce duplication.</td>
<td>The quality of problem-solving and service planning is enhanced when all parties coordinate their efforts.</td>
<td>Can assist in easing workforce limitations and barriers created by agency mandates</td>
</tr>
<tr>
<td>More diverse expertise is available due to the united resources of agencies.</td>
<td>Increased contact and better relationships between service providers improves communication and role clarity, and eases the stress of individual work with clients in crisis or with complex needs.</td>
<td>Increased contact and better relationships between service providers improves communication and role clarity, and eases the stress of individual work with clients in crisis or with complex needs.</td>
</tr>
<tr>
<td>Models cooperation to clients, and exposes effective methods of problem-solving and relating to other professionals</td>
<td>Breaks down defensive ways of thinking, and reduces the undue responsibility or blame on any one worker or agency</td>
<td>Produces a wider picture of a community's needs, and can lead to shared planning across a range of agencies</td>
</tr>
</tbody>
</table>

¹ NSW Interagency Guidelines for Child Protection Intervention, NSW Government 2006
Formats for interagency agreements and protocols

If your agency is drafting an agreement or protocol, these documents usually cover a standard format. The following formats are provided as a guide to assist in the development process.

An agreement format covers:

• principles for the agreement
  The types of principles that might be found in an agreement include
  a commitment to:
  – equity
  – diversity
  – interconnectedness
  – democratic decision making processes
  – open communication
  – cooperation
  – consistency of process
  – efficiency of processes
  – focus on client outcomes and quality of life outcomes
  – transparency and accountability, and
  – keeping stakeholders informed.

• parties involved and their roles

• desired outcomes

• achievement of desired outcomes or how the partnership agreement will be enacted (such as activities to be undertaken or procedures to be followed)

• review processes and time frames

• life of partnership agreement

• status of the agreement (whether it is legally binding or not)

• any terms the parties agree to abide by and any consequences for breaching the agreement

• signatories and date.

An inter-agency protocol format covers:

• background/introduction

• purpose of the protocol, including aims and objectives

• parties to the protocol

• the protocol’s perceived benefits

• principles that inform the protocol, such as committing to working together and open communication

• the legal background or other important contextual information about compliance requirements

• a conceptual framework or map which provides a whole of system diagram outlining the agencies involved in the protocol

• participating agencies’ roles and responsibilities
• any structures or existing networks that have a role and what that role is
• a set of procedures that provide practical guidance on how the protocol will be implemented
• arrangements for monitoring and reviewing the use of the protocol and responding to any breaches or grievances
• complaints procedures
• attachments, including forms, legislation, check lists, flow charts and a glossary of terms.

Steps for developing protocols
There are some generic steps which can assist in developing inter-agency service agreements and protocols. These are shown below.

1. Identify the need for and purpose for establishing a protocol.
2. Check if there are existing protocols that are relevant or could be adapted and used.
3. Identify who should be involved (government, non-government, and community players).
4. Contact potential inter-agency participants and gain preliminary support for the proposal.
5. Organise an initial inter-agency meeting to discuss:
   • why a protocol is needed
   • issues the protocol is trying to address
   • purpose of the protocol
   • who is involved
   • issues or barriers to protocol development.
6. Establish a shared commitment to working together to develop the protocol.
7. Develop a process such as a working group with cross-agency representation to develop the protocol.
8. Develop the draft protocol document for circulation and feedback.
9. Finalise the protocol and distribute.
10. Develop a working/steering group to oversee and support the process of implementation of the protocol including briefings and training to staff, staged implementation processes, mechanism for early detection of any problems, any additional resources/other supports required.
11. Implement the protocol.
12. Establish a mechanism for regular monitoring and review the protocol.
13. Revise the protocol accordingly.
Resolving inter-agency differences

When implementing agreements and protocols it is inevitable that tensions will occasionally arise. This can be because of:

- a lack of clarity about roles
- professional and organisational philosophies
- different expectations about priorities and ways of working
- perceived power differences between partners
- communication failures
- varying degrees of commitment to the agreement or protocol.

The early recognition of problems and a shared commitment across agencies to deal with the problem are keys to resolving differences. Solving issues within the inter-agency group is the preferred approach. Only in extreme circumstances would the assistance of external mediators be sought.
Attachment four:
The Family Violence Risk Assessment and Risk Management Framework referral process (CRAF)

Why develop a Common Risk Assessment Framework (CRAF)?
Family Violence Reform has involved the development of a shared approach in the assessment and management of risk. This has involved:

• the development and ongoing growth of an integrated service system approach towards family violence that includes a shared understanding and practice
• building the capacity and consistency of risk assessment and risk management practice across the family violence sector
• cross-structural training that fosters a statewide, shared understanding of risk assessment and risk management that build on and develops regional networks.

Who should use this Framework? Multiple sectors and professions

• Identifying Family Violence training for mainstream professionals or groups who are a first point of contact for women experiencing family violence. Eg. Maternal and child health nurses, general practitioners, teacher, other health care providers
• Preliminary assessment training for service providers offering non-family violence specific support for services to people experiencing family violence. Eg. Police and court staff, member of community legal centres, member of community health centres, disability and housing services workers
• Comprehensive assessment training for specialist family violence professionals. Eg. Welfare, social work, psychology, counselling or family therapy

What information does this Framework provide?
The Framework comprises six components to effectively identify (risk assessment) and respond to (risk management) victims of family violence. The framework provides:

• a shared understanding of risk and family violence across all service providers
• a standardised approach to assessing risk
• appropriate referral pathways and information sharing
• risk management strategies that include ongoing assessment and case management
• consistent data collection and analysis to ensure the system is able to respond to changing priorities
• quality assurance strategies and measures that underpin a philosophy of continuous improvement.
Additional information

Attachment five: The Family Violence Reform

Family violence is complex. It can occur in a number of circumstances and in a range of ‘family’ settings and can take the form of abuse of the elderly, sibling abuse, violence between same-sex couples, adolescent children being violent towards parents, carers being violent towards people with a disability, or female to male partner violence.

In the overwhelming majority of cases, however, family violence is perpetrated by males against their female partners. The definition of ‘family’ also depends on the specific culture of the community to which the victim belongs. In Aboriginal communities, for example, ‘family’ encompasses extended family, kinship networks and communities.

Since 2005 Victoria has been committed to family violence reform to increase safety for women and their children experiencing family violence by making it easier for them to get the right help and by ensuring that perpetrators of family violence are held accountable for their behaviour. This includes integration of service, police and court responses so that those experiencing violence are supported by a single, coordinated and streamlined system.

**Family Violence Protection Act 2008 (Vic)**

For the purpose of this Act, family violence is –

(a) behaviour by a person towards a family member if that behaviour –

(i) is physically or sexually abusive; or

(ii) is emotionally or psychologically abusive; or

(iii) is economically abusive; or

(iv) is threatening; or

(v) is coercive; or

(vi) in any other way controls or dominates the family member and causes that family member to feel fear for the safety and wellbeing of that family member or another person; or

(b) behaviour by a person that causes a child to hear or witness, or otherwise be exposed to the effects of, behaviour referred to in paragraph (a).

The identification of family violence as a public issue rather than a private one has resulted in significant changes to the way services respond to the problem. Because it is now widely recognised that family violence is a significant socio-economic and health issue, important reforms to family violence service delivery have occurred.

Additional information:
www.dvrcv.org.au
Attachment six: Sample elder abuse policy

Purpose
The purpose of this policy/procedure is to:

• ensure that tools are in place to identify cases of elder abuse and that appropriate action is taken in cases of elder abuse or suspected elder abuse
• maintain the dignity and protect the safety and security of older people utilising the organisation’s service
• achieve an integrated and standardised approach to the management of elder abuse.

This policy should be read in conjunction with the following document:

• ‘With respect to age 2009: Victorian Government practice guidelines for health services and community agencies for the prevention of elder abuse.

The following Organisational Policies should also be taken into consideration:

• Occupational Health & Safety Policy
• Home Visiting Policy
• Client Confidentiality and Privacy Policy
• Storage of Client Records Policy
• Client Referral Policy
• Assessment of Client Capacity Policy
• Client Intake Policy
• Independent (Third) Person Policy
• Emergency procedure
• Public health risk policy
• Working with people from CALD backgrounds policy
• Using interpreters policy

*With respect to age 2009 can be viewed or downloaded online at: http://www.health.vic.gov.au/agedcare/publications/respect/index.htm#download

Policy Statement
This organisation will address suspected cases of elder abuse in accordance with ‘With respect to age – 2009: Victorian Government guidelines for health services and community agencies for the prevention of elder abuse’.

Elder Abuse Definition (See page 4 – With respect to age 2009).

Elder abuse is any act occurring within a relationship where there is an implication of trust, which results in harm to an older person.

This policy is not concerned with situations of abuse in consumer-based circumstances, professional misconduct, harassment and criminal acts by strangers, self-neglect or mistreatment, or Residential Aged Care Services (RACS) (See pages 5 & 6 – With respect to age 2009).
Abuse of older people is a complex problem and each situation will be unique. Personal beliefs and professional values, social, cultural and family experiences all influence perception of what constitutes abuse and neglect of older people.

**Key principles underpinning the implementation of the Victorian Government elder abuse prevention strategy (see page 3 – *With respect to age 2009*)**

- **Competence** – All adults are considered competent to make informed decisions unless demonstrated otherwise.
- **Self Determination** – With appropriate information and support, individuals should be encouraged to make their own decisions.
- **Appropriate protection** – where a person is not competent to make their own decisions, it may be necessary to appoint a guardian or administrator. If a person is represented, their wishes should still be taken into account as far as possible.
- **Best Interests** – The interests of an older person’s safety and wellbeing are paramount. Even when they are unable to make all decisions themselves, their views should be taken into account as far as possible.
- **Importance of relationships** – All responses to allegations of abuse should be respectful of the existing relationships that are considered important to the older person.
- **Collaborative responses** – Effective prevention and response requires a collaborative approach which recognises the complexity of the issue, and the skills and experience of appropriate services.
- **Community responsibility** – The most effective response is achieved when agencies work collaboratively and in partnership with the community.

**Duty of care** (See page 99 – *With respect to age 2009*).

A duty of care encompasses a duty not to be careless or negligent, and arises from a relationship between people from which it is inferred that an obligation to take care exists in some form.

Duty of care involves a legal obligation to avoid causing harm to another person. This only arises when it is reasonably foreseeable in a particular situation that the other person would be harmed by an action or omission, without the exercise of reasonable care. Health and aged care workers have a duty of care to older people they are assisting.

Under the *Wrongs Act 1958 (Vic)* a worker is not negligent in failing to take precautions against a risk of harm unless all the following apply:

a) the risk was foreseeable (that is, it is a risk of which the person knew or ought to have known)

b) the risk was not insignificant (not far-fetched or fanciful)

c) in the circumstances, a reasonable person in the worker’s position would have taken those precautions.
Procedure if you suspect potential abuse

Action taken will depend on the individual situation and will often involve a primary assessment team such as a Geriatrician, Doctor and Social Worker in conjunction with the person already involved with the situation of suspected abuse.

1. Staff should report any suspicion of abuse to their supervisor. (See attachments 1 & 2 for information on types and signs of abuse and risk factors and attachment 3 for questions to assist with identifying abuse).

2. If there is a concern that the older person does not have competence to make decisions, an appropriate referral to assess their capacity must be made. Assessment of an older person’s capacity to make decisions and informed choices is important. Their right to refuse support should be respected. An older person with mental capacity may be capable of managing their own affairs with minimal support from a health/community care worker. Mental capacity is the ability to understand an act, a decision or transaction and its consequence. A person has capacity to make an informed decision if they understand the general nature and effect of a particular decision or action and can weigh up the consequences of different options and communicate their decision. A person’s capacity to make a particular decision should only be doubted if there is a factual basis to doubt it (See pages 23 & 24 – With respect to age 2009).

3. Most situations of elder abuse are not emergencies. If it is an emergency situation, staff should activate the organisation’s emergency procedure. An emergency is defined as a situation that poses an immediate threat to human life or a serious risk of physical harm or serious damage to property. Depending on the type and context of abuse, it may be useful to talk through the idea of planning an emergency response with the older person, should it ever need to be activated. In an emergency response, an older person should be involved in making decisions about their life as much as possible. However, if a worker assesses that an older person is in imminent danger of harm or death, it may be necessary to arrange:
   • support (for example, ambulance services)
   • medical treatment for an older person or carer (for example, referral to local doctor or hospital emergency department)
   • emergency accommodation for an older person or carer (for example, referral to supported housing services in the region, a women’s refuge or other temporary housing)
   • police involvement, which may be required for the safety of the worker as well as an older person
   • an emergency application to VCAT (if the appointment of a temporary guardian is necessary, for instance, the Public Advocate) or a temporary administrator (for instance, State Trustees Limited) to protect an incompetent older person or their property and assets
   • other matters sensitive to cultural considerations, including religious beliefs, which ideally should be known prior to any emergency (See page 27 of With respect to age 2009).
4. Gather and document clear and relevant **evidence of abuse** (See page 36 – With respect to age 2009 for more detail about documentation).

5. Arrange for an **assessment of needs** of the older person, either in-house or refer to an appropriate funded assessment service (See page 23 – With respect to age 2009).

6. **Develop a care plan** to support an older person to prevent further abuse.
   - The care plan should include interventions to stop reoccurrence and may include a safety plan, developed in consultation with the older person.
   - Provide information about the older person’s rights and services available to assist, such as emergency services, local services, and state-wide services i.e. Seniors Rights Victoria (See page 31 – With respect to age 2009), local agency networks (LANs), and referral and interagency strategies.

**Reluctance to accept intervention**

If an incompetent older person is at risk and refusing help (despite efforts made to persuade) it may be necessary to contact the older person’s substituted decision maker. For example, Medical Attorney under power or Guardian under power or apply to the Victorian Civil and Administrative Tribunal to appoint a temporary guardian to consent to support services or some other intervention.

If an older person is competent but refuses help, a direct care worker can support and advise about options such as how to deal with emergencies. Strategies can then be developed to help the older person understand their rights, and feel confident and comfortable to take action.

In a case of self-neglect in which a competent older person chooses to live in squalor, the situation could be considered as a public health risk under the Health Act.

**People with dementia and their carers**

People with dementia (Alzheimer’s or related disorders) may be at risk of financial neglect and self-neglect/abuse that includes actions of self-injury by the individual upon themselves which are passive or active.

Carers of persons with dementia may require special attention where abuse or neglect is occurring, as they can be the recipients of verbal and physical abuse.
People from Culturally and Linguistically Diverse (CALD) backgrounds

Cultural factors influence how all forms of abuse are viewed, and specific strategies and responses to elder abuse should address such differences. Being culturally informed and providing sensitive support is an integral component of service provision. It is important that support is provided with an understanding of the cultural background.

People from different cultural backgrounds may require interpreter services. Family and friends should not be used as an interpreter (See pages 9 & 10 – With respect to age 2009).

Aboriginal and Torres Strait Islander People

Advice should be sought from people experienced with the particular cultural background of the family concerned, acknowledging that cultural difference may require special sensitivity in relation to neglect and abuse (See pages 7 to 9 – With respect to age 2009 for more detail about Aboriginal and Torres Strait Islander People).

Confidentiality and Privacy

Where possible, discuss with the person the concerns and gain permission to refer to other agencies. It is permissible to breach confidentiality in some very limited circumstances including where the older person has consented to the disclosure of information; where the law allows or requires the disclosure of confidential information; and, in extreme circumstances, where there is a clear and imminent threat to an identifiable person of serious bodily injury or death. (See pages 36 to 38 – With respect to age 2009 for more information about privacy and confidentiality)
### Elder abuse prevention guide

#### Definition of elder abuse

Any act occurring within a relationship where there is an implication of trust, which results in harm to an older person.

#### Key principles

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competence</td>
<td>All adults are considered competent to make informed decisions unless demonstrated otherwise.</td>
</tr>
<tr>
<td>Self-determination</td>
<td>With appropriate information and support, individuals should be encouraged to make their own decisions.</td>
</tr>
<tr>
<td>Appropriate protection</td>
<td>Where a person is not competent to make their own decisions, it may be necessary to appoint a guardian or administrator. If a person is represented, their wishes should be taken into account as far as possible.</td>
</tr>
<tr>
<td>Best interests</td>
<td>The interests of an older person’s safety and wellbeing are paramount. Even when they are unable to make all decisions themselves, their views should be taken into account.</td>
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<tr>
<td>Importance of relationships</td>
<td>All responses to allegations of abuse should be respectful of the existing relationships that are considered important to an older person.</td>
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<td>Effective prevention and response requires a collaborative approach which recognises the complexity of the issue and the skills and experience of appropriate services.</td>
</tr>
<tr>
<td>Community Responsibility</td>
<td>The most effective response is achieved when agencies work collaboratively and in partnership with the community.</td>
</tr>
</tbody>
</table>

#### Abuse types

- Financial
- Physical
- Sexual
- Psychological/emotional
- Social
- Neglect

#### Risk factors

- Family conflict
- Isolation
- Dependency
- Medical or psychological conditions
- Addictive Behaviour
- Language and cultural Barriers
- Carer situation

#### Relevant policies

This tool should be used in conjunction with the following documents:
- Elder Abuse Prevention Policy
- Occupational Health & Safety Policies
- Home Visiting Policy
- Client Confidentiality and Privacy Policy
- Storage of Client Records Policy
- Client Referral Policy
- Assessment of Client Capacity Policy
- Client Intake Policy
- Independent (Third) Person Policy
- Emergency procedure
- Language Services Policy

#### Key questions

1. How are things going at home?
2. How do you spend your days?
3. How do you feel about the amount of help you get at home?
4. How do you feel your (husband/wife/daughter/son/other carer) is managing?
5. How are you managing financially?
6. Is there anything worrying you?
7. What are the things worrying you?
8. What can I do to help?
9. Is there anything that you need?

#### Duty of care

A duty of care encompasses a duty not to be careless or negligent, and arises from a relationship between people from which it is inferred that an obligation to take care exists in some form.

A duty of care involves a legal obligation to avoid causing harm to another person. This only arises when it is reasonably foreseeable in a particular situation that the other person would be harmed by an action or omission, without the exercise of reasonable care.

If a worker breaches their duty of care, they have failed to meet the expected standards of care. If harm occurs to the older person as result of this breach of duty of care, the worker may be legally liable for damages arising from this harm.

Duty of care refers not only to the actions of a worker but also to the advice the worker gives or fails to give.
Assessing mental capacity
- General Practitioner
- Psychiatrist
- Neurologist
- Psycho-geriatrician
- Geriatrician
- Neuropsychologist
- Cognitive dementia and memory service clinic (CDAMS)

Suspect abuse
Report to supervisor

Does client have competency to make relevant decisions in this situation?

Competent
- Is interpreter or Cultural Advisor required
- Discuss situation and options with client
- Assess Risk, existing support etc.
- Document
- Request clients consent to provide further assistance

Consent
- Document client consent
- Consider what interventions are required e.g. HACC, Office of Public Advocate, Seniors Rights Victoria
- Does client consent to interventions?
- Make referrals
- Arrange Assistance
- Advocate as required throughout process

No consent
- Document client’s non consent
- Provide information
- Provide referral contacts
- Consider whether duty of care is met
- Continue to monitor & review

Consent
- Document consent
- Consider what interventions needed
- Does substituted decision maker consent to interventions?
- Make referrals
- Arrange Assistance
- Advocate as required throughout process

No consent
- Document non consent
- Provide information
- Provide referral contacts
- Consider whether duty of care is met
- Legal intervention may be required – e.g. if substituted decision maker is not acting in client’s best interests

Follow up according to agency policy

Elder Abuse Prevention Guide

Suspect abuse

Is it an Emergency?
- i.e. a situation that poses an immediate threat to human life, or a serious risk of physical harm or serious damage to property

Report to supervisor

Does client have competency to make relevant decisions in this situation?

Competent
- Is interpreter or Cultural Advisor required
- Discuss situation and options with client
- Assess Risk, existing support etc.
- Document
- Request clients consent to provide further assistance

Consent
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Follow up according to agency policy

Referral points and contact numbers

Emergency

POLICE, FIRE, AMBULANCE
000
Refer to your agency’s Emergency Policy

Statewide services
- Aged and Community Care Information Line – 1800 200 422
- Beyond Blue – 1300 22 4636
- Carers Victoria – 1800 242 636
- Commonwealth Carelink Centre – 1800 052 222/1800 059 059
- Elizabeth Hoffman House Aboriginal Women’s Service Inc. – 1800 796 112
- Ethnic Communities Council of Victoria – 9034 4122
- Immigrant Women’s Domestic Violence Service – 1800 755 988
- Lifeline (24hrs) – 131114
- Mensline – 1300 789 978
- Mental Health Advice Line – 1300 280 737
- National Dementia Helpline & Referral Services – 1800 100 500
- Office of the Public Advocate – 1300 309 337
- Relationships Australia – 1300 364 277
- Seniors Rights Victoria – 1300 368 821
- State Trustees Ltd – 03 9667 6466/1300 138 672
- State-wide Sexual Assault Service (24hrs) – 1800 806 292
- Suicide Helpline Victoria – 1300 651 251
- Victoria Legal Aid – 1300 792 387
- Victorian Aboriginal Legal Service – 1800 064 865
- Veterans Line (24hr) – 1800 011 046
- Victims of Crime Helpline – 1800 819 817
- VCAT – Guardians/Administrators List – 03 9628 9911/1300 079 413
- Women’s Domestic Violence Crisis Service of Victoria (24hrs) – 1800 015 188

Local services
- Aged Care Assessment Service
- Alzheimer’s Australia
- Centre Against Sexual Assault
- Community Health Services
- Department of Housing
- HACC services
- Local Community Legal Centre
- Local Domestic Violence Services
- Local Victoria Police Station
- Regional Indigenous Family Violence Support Workers
- Respite Hotline
Attachment seven: Guardianship & Administration flowchart of the Office of the Public Advocate

(www.publicadvocate.vic.gov.au)

Types of decisions
Guardian – living arrangements
– health care
– access to services
– access to persons
Administrator – financial and legal

Capacity
To have capacity means to know what you are doing, to understand the consequences of your actions, to understand choices exist and to make a decision based on your knowledge and understanding. Sometimes a qualified person may be required to make a capacity assessment (e.g. neuropsychological, psychiatric, gerontological). Capacity may be impaired by, for example mental illness, dementia, an acquired brain injury or an intellectual disability.

Substitute decision makers

Power of attorney – general
You give someone authority to make financial decisions for you only while you have capacity.

Enduring powers
You appoint someone to make decisions specified below for you in the event of your losing, at some time in the future, the capacity to make these decisions yourself.

Enduring power of attorney (medical treatment)
– Medical treatment decisions

Enduring power of attorney (financial)
– Financial and legal decisions

Enduring power of guardianship
– Lifestyle decisions (such as where you live)

A guardian is appointed by VCAT. The order will state the areas in which the guardian has authority to make decisions.

An administrator is appointed by VCAT and may be given legal authority to make financial and legal decisions.

Always ask to see the document appointing those above.

Person responsible
If a patient cannot consent to their own medical treatment the practitioner can obtain consent from the person responsible.


Best interests
Best interests involves discerning the decision this person would make having regard to who they are, their values, circumstances and the risks and benefits of various courses of action.

Where VCAT is satisfied that a decision-maker such as an enduring power of attorney is not acting in a person’s best interests, it can suspend or remove that authority and appoint a guardian or administrator.

Issues to consider
Some issues to consider include assessment of risk, level of conflict, safeguards and the person’s willingness to accept assistance.

Applying for a guardian or administrator
Some of the key determinants of when a guardian or administrator is appointed include:
– Irresolvable conflicts about what is in a person’s best interests
– the risk that the person may be subject to neglect, abuse or exploitation.

Is there a decision that needs to be made?

Yes

Does the person have capacity to make the particular decision?

Yes

Person makes decision

Unsure

No

Person has capacity and makes decision

Person lacks capacity and cannot make decision

Assessment

Does the person have an appropriate substitute decision-maker?

Yes

Are you satisfied the substitute decision-maker is authorised and will act in the best interests of the person?

Yes

Decision made by substitute decision-maker

No

Can the issues be resolved by informal decision-making through discussion with agencies, negotiation between conflicting parties or arranging for services? Is the person agreeable to the services?

Yes

Agreement reached

No

Apply to VCAT for a guardian and/or administrator

Types of decisions
Guardian – living arrangements
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– access to persons
Administrator – financial and legal

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References

## Acronyms

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<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>SRV</td>
<td>Seniors Rights Victoria</td>
</tr>
<tr>
<td>VCAACD</td>
<td>Victorian Committee for Aboriginal Aged Care and Disability</td>
</tr>
<tr>
<td>VACCHO</td>
<td>Victorian Aboriginal Community Controlled Health Organisation Inc</td>
</tr>
<tr>
<td>FVPLS</td>
<td>Aboriginal Family Violence Prevention &amp; Legal Service</td>
</tr>
<tr>
<td>CALD</td>
<td>culturally and linguistically diverse</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Partnership</td>
</tr>
<tr>
<td>NAATI</td>
<td>National Accreditation Authority for Translators and Interpreters</td>
</tr>
<tr>
<td>CRAF</td>
<td>Family Violence Common Risk Assessment Framework</td>
</tr>
<tr>
<td>ACAS</td>
<td>Aged Care Assessment Service</td>
</tr>
<tr>
<td>VCAT</td>
<td>Victorian Civil and Administrative Tribunal</td>
</tr>
<tr>
<td>CACPs</td>
<td>Community Aged Care Packages (now called Home Care Packages)</td>
</tr>
<tr>
<td>EACH</td>
<td>Extended Aged Care at Home Packages (now called Home Care Packages)</td>
</tr>
<tr>
<td>EACHD</td>
<td>Extended Aged Care at Home Dementia Packages (now called Home Care Packages)</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care program</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>PAG</td>
<td>Planned Activity Group</td>
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<tr>
<td>OPA</td>
<td>Office of the Public Advocate</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>APMH</td>
<td>Aged Person's Mental Health</td>
</tr>
<tr>
<td>CDAMS</td>
<td>Cognitive, Dementia and Memory Service</td>
</tr>
<tr>
<td>AV</td>
<td>Ambulance Victoria</td>
</tr>
<tr>
<td>SAAP</td>
<td>Supported Accommodation Assistance Program</td>
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