

# With Respect to Age

A Guide for  
Health Services  
and Community Agencies  
Dealing with Elder Abuse

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[Disclaimer: This document is intended to be only a general guide to the issue of abuse or neglect of older people. If legal advice is required, a legal practitioner should be consulted.]

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## FOREWORD

### The Purpose of this Guide

At some stage, most health and community service workers involved with older people will find themselves confronted with situations which can be described as ‘elder abuse’. Sometimes these situations are disturbing and complex, and may raise difficult legal, ethical or practice problems. Many of these problems stem from the lack of agreement among services on how situations of abuse should be defined and on how responsibility for intervention should be allocated.

This guide reflects the clear advice from service providers that, while elder abuse is a disturbing event, *dealing with these situations is part of the day-to-day work of providing health and community services to older people*. The problems for services arise not from inadequate legislation, or from reluctance to act, but from lack of clarity about the appropriate policies and procedures required at agency level, and uncertainty about the working relationships between agencies likely to be involved.

The guide has been written by the Aged Care Services Division of the Department of Health and Community Services (H&CS). It has been prepared after discussion with workers and health services that have confronted and dealt with problems of elder abuse. It draws on the views of various municipal councils and other agencies which have developed policies and procedures within their own jurisdictions. It affirms the view that Victoria’s existing services are appropriately placed to address problems of abuse or neglect of older people, and many are already doing so.

The guide is presented in three parts. Part 1 is a working introduction to elder abuse, describing its context and offering a checklist for action. It is written principally for workers in health and community service agencies.

Part 2 outlines the key policies and procedures, and gives a framework for procedures which can be adapted by agencies developing their own response to incidents of elder abuse or neglect.

Part 3 consists of a collection of case studies of the varied situations of abuse and neglect, and an outline of the roles of the more specialised services.

Elder abuse is not a new social problem, and there is no evidence that, overall, abusive situations are becoming more prevalent. Rather, our society is now beginning to recognise and describe as ‘elder abuse’ a range of situations involving the victimisation, maltreatment or neglect of older people. The increase in social concern is partly a reflection of the changing demographics of our society—a

society in which an unprecedented proportion of the population survives to old age. Ours is therefore a society in which larger numbers of people are potentially vulnerable to the risks of maltreatment or neglect.

Elder abuse is not exclusively a 'welfare' problem. Definitions of abuse also include situations such as theft and assault that are properly dealt with by the criminal justice system; in such cases, health and community service agencies must work with the police in dealing with them. Other situations are best regarded as forms of domestic violence, with interventions shaped accordingly.

The guide responds to that complexity, and builds on similar approaches from other States. As in those jurisdictions, the approach taken here focuses on the policies and procedures of local health and community services, and proposes strategies to optimise their ability to deal effectively with problems of elder abuse and neglect.

The Aged Care Division of H&CS is seeking responses to this guide in order to improve this material. A pro-forma for that purpose is enclosed.

## PART I

### 1. The Context: Why Elder Abuse has Become an Issue

This chapter describes some of the reasons why elder abuse and neglect have become prominent as public issues.

#### **Ageing of the Population**

The proportion of older people in Australia's population is rising. In 1991, the total population was 17.3 million. There were 2.0 million people aged 65 and over, and they comprised 11.4 per cent of the total. The proportion is expected to rise to 12.3 per cent in the year 2001 and to exceed 20 per cent in the thirty years after that.

Within this steady but comparatively modest rise in the 65-plus population, there will be a steeper rise in the proportion of the oldest groups—those aged 75-plus and those aged 85-plus. The underlying cause is the increasing longevity of the Australian population. Those aged 85 and over are now the fastest growing group in the Australian population, their numbers having grown from 55,000 in 1966 to 152,000 in 1990.

The growing *number* of older people is not in itself a social problem, and is not the cause of a problem of abuse of older people, any more than the size of the female population is a cause of domestic violence. Rather, the point is that the relative importance of the existing problem is likely to grow in prominence with the growth of the older population.

#### **Growing Old at Home**

The literature on maltreatment and neglect of older people has identified two groups of concern: elderly people who are living with family caregivers, and elderly people who are living alone.

Of all people aged 65 and over, 91 per cent live in private dwellings in the community; only about 9 per cent live in what the 1991 Census defined as 'non-private dwellings', a category which includes hostels, supported residential services and nursing homes. However, the proportion living in non-private dwellings rises considerably with age, such that while only 3.8 per cent of people aged 65-74 live in non-private dwellings, the proportion rises to 26 per cent at age 80 and over. Thus the quality of life in residential care is a matter that affects the oldest and frailest groups in the population, but even in these age groups the majority of people are living in the community.

#### **Older People Living with their Families**

It is difficult to estimate how many older people are living in private households with a family caregiver (for example, an adult daughter or son). The 1991 census recorded only a tiny number of people aged over 60 who were described as a 'grandparent' of the reference person in a private household (0.1 per cent of older people in private dwellings). The true figure will be larger than this. The reference person can be any member of the household, and some families filling in the Census would have assigned the grandparent to be the reference person. In these cases the grandparent would not be distinguishable from the category in which 65 per cent of older people are found—that is, as 'reference person or spouse'.

Whatever the number, it cannot be assumed that every older person living with their family is in need of care; many would be reasonably independent and contributing to the general welfare of the family, as caregivers for grandchildren and so on.

### **Older People Living Alone**

There is a definite trend towards older people living alone. This is a result of two factors in Australian society: the high rate of home ownership, and the increasing longevity of the population, especially among women.

Increasing longevity has meant that large numbers of older people end up living alone. This is particularly noticeable among married women who outlive their husbands.

The 1991 census showed that 39 per cent of all Victorians aged 75-plus in private dwellings lived alone (about 61,000 people, predominantly women). If persons in non-private dwellings are included in the count, the proportion living alone at age 75-plus falls slightly to 32 per cent. According to the National Housing Strategy, at age 65-69, one in four women are already living alone, compared to one in ten men (Anna Howe, 1992 p.25). At age 80, some 32 per cent of all Victorians are living alone.

It should not be assumed that people who live alone are necessarily lonely or isolated; most are actually in regular contact with family and friends. Nevertheless, it is among this group that there is the risk of elderly people suffering from self-neglect. Very often this is associated with the middle stages of dementia.

### **Dementia and Self-Neglect**

The rising proportion of older people living alone may lead directly to the problem of self-neglect. The group particularly at risk comprises those who are living alone, with few or no family connections (often because they have outlived most of their relatives), and who are in the early or middle stages of dementia. It is well recognised that dementia can be manifested by a lack of insight, and by suspiciousness about the motives of other people; the result may be a failure to seek help and a refusal to accept services such as home help or delivered meals. Given that some degree of dementia may affect a quarter of the population aged 80 and over, and that a third of people in this age group live alone, the at-risk group is not insignificant. Dementia is, however, not the only cause

of self neglect (see Cole 1992).

### **Dementia and Caregiver Stress**

Some dementia sufferers are living with their spouse or other family. Among this group there arises the potential problem of caregiver stress. The very considerable burden of looking after an ageing spouse or parent with dementia is well recognised in the literature. If the caregiver receives no help in coping (including help in recognising the cause of the person's demanding behaviour, and respite from it) then mistreatment of the sufferer may result. A recent Swedish survey found that caregivers (mostly spouses and children) reported a significantly higher rate of abusive behaviour on their own part against dementia sufferers than a control group of caregivers looking after normal elderly people of the same age (Grafstrom 1993).

Conversely, it must be recognised that many caregivers in this situation are themselves elderly and at risk of abuse at the hands of the dementia sufferer.

Some studies estimate that more than half of dementia sufferers manifest some form of aggressive behaviour—that is, verbal outbursts, physical threats or violence (Paveza 1992). On the other hand, a recent British study of dementia sufferers living in the community found that disturbed behaviour was relatively infrequent. Only 10 per cent of markedly demented, community-resident persons were described by their caregivers as noisy, 5 per cent as aggressive and 6 per cent as prone to wandering. When these problems arose, however, they were strongly associated with caregiver stress (O'Connor *et al.* 1990).

More than 100,000 Australians suffer from dementia. There will be a 20 per cent rise in the number of aged people with dementia between 1991 and 1996, mainly because of the rapid growth in the number of people aged 80 and over. The condition affects as many as a quarter of people in this age group.

To understand the needs of dementia sufferers, it is necessary to consider their living arrangements. The Australian Bureau of Statistics estimated that about half were living at home in the community; the other half were in residential care. Of those living in the community, nearly three-quarters were living with other people. This substantial group represents those living with a family caregiver.

In terms of neglect, the most at-risk group is those sufferers who are living alone. They comprise about a quarter of all those with dementia living in the community.

### **Financial Exploitation**

The high rate of home ownership among older people means that a majority of the older generation have significant financial assets. This can create the potential for financial exploitation if the older person becomes vulnerable because of mental decline. About 74 per cent of older Victorians living in private dwellings are home owners, and another 9 per cent are purchasers.

## **The Changing Map of Aged Care Services**

For almost a decade, both the Commonwealth and the State governments have been committed to a shift in the balance of aged care services. At the national level, the bulk of resources were previously devoted to residential services (nursing homes and hostels). There has been a conscious attempt to limit the growth of expenditure on nursing homes, and to expand the services funded under the Home and Community Care (HACC) program.

The expansion of home and community care services is seen as the most effective way of meeting the express desire of most elderly people to remain living independently in the community. Undoubtedly this is a valuable aim. However, two kinds of less desirable consequence have also been recognised:

- Community care can sometimes put an unreasonable burden on the older person's family as caregivers; and
- The fragmentary nature of service delivery in community care, compared to the unified management of a residential facility, can lead to a fragmentation of responsibility for monitoring the overall welfare of a vulnerable person.

Residential care, rather than community care, has hitherto been the focus of government concern about abuse of older people. There are some good reasons for this: people living in residential services are by definition likely to be frail and vulnerable.

As the balance shifts towards community care, there must be a sharper focus on finding appropriate mechanisms for protecting elderly people living in the community who may be at risk of maltreatment or neglect. The appropriate mechanisms will *not* be the same as those developed for residential services.

## **Older Parents with a Dependent Adult Child**

A consistent finding in the research literature on elder abuse is that one of the types of perpetrator is the dependent adult child of an elderly person. This may include a son or daughter with a mental illness, an intellectual disability, alcoholism or acquired brain damage. Naturally this is not true of all such people.

As the balance of care shifts towards an emphasis on community care, the use of institutional services is primarily focussed on people with marked dependency, whether transient or enduring. Many parents of disabled people will therefore remain the primary caregivers late into their middle age and beyond. The reasons are often complex, including parental commitment, a lack of other housing options, inadequate income or concern about unsatisfactory alternatives. The nature of the particular disability may be the key factor, inhibiting the person from setting up a stable household independent of their parents.

The result is that the parents, as they grow older, are faced with the prospect of providing permanent board or irregular refuge for an adult child. This in turn can expose the ageing parents to the emotional and physical stress of continuing caregiving, and the problem of coping with behaviour that may be disruptive and abusive.

Addressing these issues is now a major priority of services for people with disabilities in Victoria and the rest of Australia.

## 2. A Working Definition Of Elder Abuse and Neglect

At the most general level, abuse and neglect of older people can be regarded as an infringement of human rights. The United Nations has drawn up an International Plan of Action on Ageing, to which Australia became a signatory in 1981. This statement includes a set of Eighteen Principles for Older People, covering independence, participation, care, self-fulfilment and dignity. Principle 17 states:

Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.

Beyond their important symbolic value as an affirmation of human values, such principles provide little guidance for the practitioner until they are grounded in a society's particular complex of law and social policy. The first step is to attempt to define what is meant by 'abuse'. The second step is to specify the kinds of remedies that are available, or that should be made available, to deal with particular forms of abuse.

As many observers have noted, it is difficult to formulate a satisfactory definition of elder abuse and neglect that covers the several *different* types of misfortune that may befall an older person.

The solution adopted here is designed to help agencies *define the key problems* in a particular case in a way that focuses on possible *interventions*.

### **The Standard Definition**

The most common approach is to define elder abuse as neglect or harm to an older person resulting in physical, psychological, sexual or material (financial) injury, caused by the behaviour of a person with whom the older person has a relationship implying trust.

### **An Alternative Approach—Defining Abuse by its Context**

People generally recognise the fact of abuse or maltreatment, whatever they choose to call it, and whether or not they think the circumstances excuse it. The problem is that although people observe and are concerned about abusive behaviour, they are frequently unsure about the appropriate way to handle it or the appropriate agencies to call in.

We therefore need to pay attention to the different *contexts* in which incidents of abuse occur. This will be more useful than just defining the nature of the harm done in terms of physical abuse, psychological abuse or economic abuse, as other studies have done.

Critical to this approach is an appreciation that 'elder abuse' does not constitute a unique or

exclusive category of behaviour. Rather, it is a convenient way of talking about matters or situations that are usually categorised under other headings. The use of the term elder abuse should not be allowed to obscure the validity of these other categories, such as domestic violence, professional malpractice, fraud, or caregiver stress.

For example, the term ‘domestic violence’ is used to describe a range of socially unacceptable behaviour between the members of a family. The unacceptable behaviour may range from physical assault to psychological abuse. In most definitions, the term is not restricted to abusive behaviour by a husband against a wife (although this is its most common form), but extends to cover abuse by any member of a family against any other member, whether spouse, child, parent or grandparent.

This has two implications for a strategy on elder abuse. Firstly, we need to recognise that the popular (and narrow) understanding of domestic violence as being abuse between spouses *can also apply when the spouses are elderly*. Indeed, it is likely that an abusive marital relationship will remain abusive as the parties age. In these cases, it will not be helpful to redefine the problem as ‘elder abuse’ if by this we mean that it is no longer to be regarded as domestic violence.

It is more logical to regard such cases as an illustration of the way the terms ‘domestic violence’ and ‘elder abuse’ overlap. Some cases of elder abuse *are* domestic violence.

The second implication is that domestic violence should not be restricted to ‘wife abuse’ but should encompass other abusive family relations such as a young adult harassing a grandparent. As noted in chapter 10, Victorian law provides an important remedy in such cases under the *Crimes (Family Violence) Act*. Already, figures show that 3 per cent of complaints under this Act are laid by people aged 61-plus. The defendant in these cases is more likely to be a child or grandchild (56 percent) than a spouse (38 percent).

In other cases, the aged-care professional may decide that domestic violence is not the most appropriate interpretation of the abusive situation, even if it is a valid interpretation. Perhaps the abusive party is suffering from dementia and is prone to irrational outbursts of aggression. Conversely, perhaps the caregiver is prone to unacceptably rough treatment of a dependent elderly person, but the professional believes that the caregiver is acting under stress and could be given effective help to cope without recourse to intervention by a law-enforcement agency.

As can be seen from this discussion, everything depends on the *context* in which the abuse is occurring. It is therefore important to construct a list of typical situations in which cases of abuse, maltreatment or neglect are known to occur.

### **Eight Typical Situations of Maltreatment or Neglect**

***Type 1—Maltreatment or neglect by a family caregiver (or other type of unpaid caregiver such as a friend or neighbour).***

***Type 2—Domestic violence, or a destructive family relationship (usually between spouses,***

but also between parent or grandparent and adult child).

**Type 3—Maltreatment or neglect by a dependent adult (such as an adult child with a behavioural disorder associated with mental illness, alcoholism or acquired brain damage, or a spouse with dementia).**

**Type 4—Conflict in a shared household (for example, where an older person has moved into their adult child’s household, or vice versa, causing a conflict over autonomy).**

**Type 5—Financial exploitation in ‘non-commercial’ relationships (for example, where an adult child tries to gain control of an elderly parent’s assets).**

**Type 6—Maltreatment or neglect by staff in residential care.**

**Type 7—Professional malpractice, or maltreatment of an older person by a paid caregiver.**

**Type 8—Self-neglect - typically an elderly person living alone in squalor and failing to maintain basic self care.**

These eight situations do not exhaust the possibilities. Nor are these situations intended to be mutually exclusive. Each situation can be thought of as a one-line summary of the cast and setting for a particular type of domestic drama. Observers may differ in their interpretation of the most appropriate way to categorise a given situation, and a particular case of maltreatment may be judged to fit into more than one situation.

The situations are illustrated more fully in Chapter 9.

### **Common Characteristics of the Typical Situations**

Except in the case of self-neglect, these situations have two things in common:

- The victim and the perpetrator are in some sort of relationship involving *proximity, dependence, or trust*. The perpetrator of the maltreatment or neglect is a relative, friend or neighbour, or a worker in one of the human services. Thus we *exclude* cases where the perpetrator is a ‘stranger’ (a burglar or con man).
- The older person is *vulnerable* to continuing maltreatment or neglect. (Not *all* elderly people are vulnerable, but it is the vulnerability that creates grounds for intervention by outside agencies.)

Sometimes the older person’s vulnerability is due to mental *incompetence* (for example, in cases of dementia). In other cases it is due to physical *frailty* or economic circumstances which may, for example, force an older person to depend on another for housing. These two circumstances are usually quite different from each other and require quite different sorts of intervention.

Self-neglect is a special case where the public concern is due to the vulnerability of the older person but there is no ‘perpetrator’ in any meaningful sense.

Sometimes the older person is *dependent* on the perpetrator—for example, where the victim is frail or incompetent and the perpetrator is the principal caregiver. However, this dependence is not a defining characteristic of maltreatment and neglect, because in many other cases the victim is *not* particularly dependent, and may in fact be supporting the perpetrator.

This guide is not concerned with situations in which the perpetrator is a ‘stranger’—that is, someone with no personal relationship with the victim, such as a situation of street crime. Situations in which the perpetrator is a worker in the aged care field are covered in this guide. Situations in which the abuse occurs in residential care settings rather than at home are also covered.

**To summarise this approach to definition:—*Elder abuse or maltreatment of an older person is a term that can cover a variety of situations involving the victimization of an older person. The situations include domestic violence, professional malpractice, fraud, and abusive behaviour caused by caregiver stress. Elder abuse is best considered as a particular manifestation of these situations, and not as a separate category of behaviour. Situations of neglect and self-neglect involving elderly people are likely to raise similar practice issues for health and welfare agencies, though not necessarily involving abuse and victimization.***

### 3. Asking the Right Questions: A Checklist for Action

The checklist below is intended as a guide to the key issues and questions which health and community service workers will face when confronted with elder abuse. More detail will be found in Part 2 (chapters 5-8).

#### **Question 1. What is really going on here?**

The first major problem confronting services is working out what is happening. This checklist will help workers to categorise a given situation in a way which guides appropriate action, and which acknowledges complexity.

##### *Type 1—Maltreatment or Neglect by a Caregiver (family, friend or neighbour)*

Common elements—

- Older person is substantially dependent on perpetrator.
- The demands of caregiving may be unremitting.
- Caregiver cannot cope with the demands of caregiving.
- Impact can be physical or psychological harm or neglect.
- Caregiver is often remorseful and shocked by his/her behaviour.
- Perpetrator often has no previous history of maltreatment.
- Harm may be intentional or non-intentional.

##### *Type 2—Family Violence*

Common elements—

- Victim and perpetrator are usually spouses or parent/child.
- Dysfunctional family relationship is often longstanding.
- Domestic violence has been a feature of the family's life.
- Impact is usually physical or psychological harm.
- Victim is not necessarily dependent.

##### *Type 3—Abuse by a Dependent Adult*

Common elements—

- Perpetrator may be older person's child, spouse or other dependent relative.

- Perpetrator has disability or behavioural problem which explains continuing dependence on older person.
- Impact of abuse may be physical, psychological or financial harm or neglect.
- Older person feels responsible for perpetrator's welfare.
- Older person is not necessarily frail.

#### ***Type 4—Conflict in a Shared Household***

Common elements—

- Older person has been sharing the household with adult relative (e.g. married children).
- Situation has become intolerable for one or both parties.
- Impact is psychological or financial harm.
- Older person is not necessarily dependent.
- Older person or other party requires help to find alternative accommodation.

#### ***Type 5—Financial Exploitation***

Common elements—

- The misuse of an older person's possessions or money.
- Threats or undue pressure on the older person to sell the house, hand over assets, etc.
- Perpetrator may be a relative, friend, service provider, or paid carer.
- Victim may or may not be mentally competent.
- Victim may or may not be aware of the exploitation.

#### ***Type 6—Maltreatment by Staff in Residential Care***

Common elements—

- Failure to meet residential care standards set by Commonwealth or State legislation, legal duty of care, or contractual conditions.
- Lack of clear guidelines and service standards available to staff.
- Lack of adequate and/or skilled staffing for the care demands of the service.

#### ***Type 7—Professional Malpractice***

Common elements—

- Failure of a paid support service worker or professional to meet standards of care required by legislation, funding agreements, professional codes or the legal duty of care.
- Breach of contractual agreement.
- Exploitation of the trust relationship.

**Type 8—Self-neglect**

Common elements—

- Older person is found to be living in conditions of squalor and/or ignoring personal health and hygiene.
- Older person may refuse to acknowledge the neglect.
- Older person may be mentally incompetent.

See Chapter 9 for more details.

**Question 2. Is This an Emergency?**

Most situations of elder abuse are not emergencies. A situation which involves imminent danger or harm to the older person or someone else will need an immediate response in terms of:

- protection for the victim by police, appropriate agency or family;
- medical treatment by appropriate health service;
- accommodation through appropriate agency.

If the victim is incompetent, an application can be made to the Guardianship Board to appoint the Public Advocate as temporary guardian (see Chapter 10).

**Question 3. Is Access Being Refused?**

If abuse is suspected, but the worker cannot easily gain access to the older person, consider the alternatives.

What are the best options for assessing the person?

- at home or elsewhere?
- alone or with a trusted other?
- with an accredited interpreter?

Is police protection required for the victim or the worker?

- Section 459(A) *Crimes Act* gives police the right to enter private property for the purposes of arresting someone who is believed on reasonable grounds to have committed a serious indictable offence, or who is found committing such an offence. A ‘serious indictable offence’ means an offence punishable on first conviction with life or at least five years jail.
- Section 27 *Guardianship and Administration Board Act 1986* empowers the Guardianship Board to make an order allowing a specified person (such as an aged-care

worker) to visit the person with a disability in the company of the police for the purposes of preparing a report for the Board.

- Section 10 *Mental Health Act* 1986 gives police powers of apprehension of a person requiring psychiatric treatment, in limited circumstances. The person must have recently attempted suicide, or attempted to cause serious bodily harm to himself or to some other person, or be likely to do so.

#### **Question 4. Who Should be Consulted to Assess the Situation More Thoroughly?**

Others may need to be consulted to help build up an accurate picture of the older person's needs, the dimensions of the maltreatment, the alleged perpetrator's perspective and the degree of risk involved. For example:

- Informal supports—family, friends, neighbours
- Other involved health and welfare agencies
- The alleged perpetrator.

#### **Question 5. Does the Older Person Appear Mentally Incompetent?**

Assessment of competence is important because the autonomy of a competent adult and his or her right to refuse support must be respected.

Dementia is the most common form of incompetence in older people. Dementia can also be a cause of physical or verbal abuse on the part of either the caregiver or the demented person or both. If the older person's competence is questionable, a referral could be made to the Aged Care Assessment Team for a formal assessment.

If the older person refuses to be assessed, it may be appropriate to apply to the Guardianship Board for the appointment of a guardian to consent to the assessment. Before taking such a step, it may be appropriate to ask the person's family or friends to discuss the refusal with the person.

#### **Question 6. Is the Older Person Refusing Help?**

If an older person is competent but refuses help, a worker can only support and advise about options. The worker may need to develop strategies to try to break through the victim's reluctance or denial, which may be due to feelings of fear, isolation or self blame.

If a competent older person insists on living in unhygienic squalor, the situation could be tackled as a public health risk under the *Health Act* 1958.

If an incompetent older person is at risk and refusing help (despite creative efforts at persuasion), it may be necessary to apply to the Guardianship Board for the appointment of a guardian or an

administrator to consent to support services or some other intervention (for example, in a case of self neglect).

### **Question 7. Is Case Management Necessary?**

If a case is complex and involves various services, it may be appropriate to convene a case meeting of workers in relevant agencies (with the permission of the older person). The meeting would:

- develop a service plan
- appoint a case manager.

The choice of a case manager will usually depend on who has a major involvement and a trusted relationship with the older person.

### **Question 8. What are the Appropriate Intervention Options?**

#### *Option 1—Counselling and treatment programs*

- to help the older person recognise the problem and accept support;
- to help the perpetrator change violent patterns of behaviour;
- to provide drug and alcohol treatment programs for the perpetrator.

#### *Option 2—Education and support for caregivers*

- advice on techniques of care giving
- use of community services
- immediate respite and support

#### *Option 3—Increased support services*

- home care
- nursing
- day care
- incontinence programs

#### *Option 4—Alternative accommodation, either short term or long term*

#### *Option 5—Legal interventions*

- Guardianship proceedings (re incompetence—refer to GAB);
- Enduring power of attorney (refer to a lawyer);
- Intervention Order under the *Crimes (Family Violence) Act* (refer to police or magistrates court);
- Police prosecution for a criminal wrong (for example, assault or theft);

- Complaint regarding professional malpractice (refer to the Medical Board, the Nurses Board, the Health Services Commissioner, etc.);
- Referral to a specialist complaint agency (for example, Health Services Commissioner, H&CS Residential Care Regulation and Compliance Unit, Commonwealth Department of Human Services & Health, Residential Care Rights Service;
- Civil action (for example, negligence—consult a legal service).

## 4. Who Does What—A Quick Guide to the Agencies

This section gives a quick guide to the specialist or state-wide agencies which have distinct roles and powers relevant to elder abuse.

### Police

*When to refer:* A matter involving the maltreatment or neglect of an older person should be referred to the Police in these circumstances:—

—If it appears that a crime has been committed and the Police should investigate and prosecute. Offences may include assault, theft, extortion, fraud and sexual offences.

—If protection is required for the victim, the worker investigating the case or any other party.

—If the Police are being requested to apply to the Magistrates Court for an intervention order under Section 7 of the *Crimes (Family Violence) Act 1987*. Section 7 authorises the victim, the Police or any other person with the written permission of the aggrieved family member to apply for an intervention order.

—If Police assistance is required to enable a worker to assess an older person for a report to the Guardianship and Administration Board. See section 27(1) *Guardianship and Administration Board Act 1986*. Section 27(3) of the Act authorises Police to use reasonable force to enter premises.

—If a person requiring psychiatric treatment needs to be detained under Section 10 of the *Mental Health Act 1986*. For example, this might apply if the perpetrator was suffering from a chronic psychosis. (For further explanation, see question 3 in Ch 3 above.)

### The Health Services Commissioner

*When to refer:* A matter involving the maltreatment and neglect of an older person can be referred to the Health Services Commissioner if it is a complaint about a ‘health service’. A health service provider is defined in Victorian *Health Services (Conciliation and Review) Act 1987* as including a nursing home, hostel, supported residential service, hospital, doctor, nurse, etc. The complaint must come from the aggrieved consumer or someone acting on their behalf.

*Outcome:* Once a complaint has been lodged, the Health Services Commissioner will conciliate between the complainant and the health service or otherwise refer the matter to another agency. For instance, matters involving residential care services are routinely discussed with the relevant departments of H&CS or DHS&H who have the power to impose sanctions.

*Contact:* Level 30, 570 Bourke Street, Melbourne, 3000 Phone: 8601 5200 or 1800 136 066

### **Office of the Public Advocate**

*When to refer:* A matter involving the maltreatment and neglect of an older person can be referred to the Office of the Public Advocate for investigation or advocacy if it involves a person who appears to be incapable of making reasonable decisions (perhaps because of senility); the person may or may not need a guardian or administrator.

*Outcome:* The Public Advocate will investigate the situation and if necessary apply to the Guardianship and Administration Board to appoint a member of the family or a friend or the Public Advocate as the person's guardian, or to appoint a member of the family, a friend, solicitor, accountant or trust company (such as the State Trustee) as the person's administrator. The guardian then becomes the person's substitute decision maker for 'lifestyle' decisions and the administrator becomes their financial representative.

*Contact:* Level 4, 436 Lonsdale Street, Melbourne, 3000 Phone: 9603 9500 or 1300 309 337

### **Guardianship and Administration Board**

*When to refer:* A matter should be referred to the Guardianship and Administration Board (GAB) if it is necessary to protect the interests of an older person who is incapable of making reasonable decisions and needs a guardian or administrator. A guardian makes decisions about 'lifestyle' matters, and an administrator makes decisions about money matters. Much of the work of the Board is concerned with the financial affairs of clients. The Board can be seen as a mechanism for protecting people, particularly older people, from financial exploitation.

*Outcome:* Any person concerned about the wellbeing of an incompetent older person can lodge a GAB application. Interested parties will be notified about the hearing. The Board may make orders for guardianship (whether plenary or limited) or financial administration.

*Contact:* 55 King Street, Melbourne, 3000 Phone: 9628 9911 or 1800 133 055

### **H&CS Residential Services Registration and Compliance Service**

*When to refer:* A matter involving the maltreatment or neglect of an older person should be referred to the H&CS Residential Services Registration and Compliance Service if it involves questions about the standards of care in a 'supported residential service' or SRS (formerly known as a 'special accommodation house').

*Outcome:* Once a complaint has been lodged, you can expect H&CS to carry out whatever kind of investigation is necessary to detect and act upon abuses against the rights of residents. If there are breaches of the regulations or concerns relating to the standards of care, the available sanctions

range from fines to deregistration.

*Contact:* The nearest Regional Office of H&CS (listed in the White Pages)

## **The Commonwealth Department of Human Services and Health**

*When to refer:* A matter involving the maltreatment or neglect of an older person can be referred to the DHS&H Complaints Unit if it involves a question about the standards of care in a nursing home, hostel or SRS which is subsidised by the Commonwealth (most SRSs are not subsidised).

*Outcome:* Once a complaint has been lodged, DHS&H can be expected to carry out whatever kind of investigation is necessary to detect and act upon abuses against the rights of residents. The complaints and their outcomes are registered against the outcome standards. Measures that can be taken against the home where there is significant non-compliance include financial sanctions, revocation of approval or imposition of extra conditions.

*Contact:* Standards and User Rights section, Human Services & Health, ph 285 8888

## **The Residential Care Rights Service**

*When to refer:* An abuse of a resident's rights in a nursing home or hostel can be referred to the Residential Care Rights Service. The service is a non-government agency funded by the Commonwealth. Its purpose is to provide people with support and advice on the rights of residents in nursing homes and hostels.

*Outcome:* The service will assess the complaint, and if necessary support the complainant in taking up the matter with management and/or the Department. The service also helps set up residents' committees in nursing homes and hostels.

*Contact:* Suite 4B/C, 4th floor, 343 Little Collins St, Melbourne. Tel 602 3066.

## **Agencies Relevant to Domestic Violence**

*When to refer:* If the maltreatment of an older person seems to be best understood as a case of domestic violence, you can contact the local Community Policing Squad, the Registrar (Clerk of Courts) at a Magistrates Court or the Domestic Violence and Incest Resource Centre (DVIRC). Advice can also be obtained from Community Legal Centres, the Women's Health Services and the Women's Information and Referral Exchange (WIRE).

*Outcome:* The registrar at a Magistrates Court will advise on the procedure for obtaining an intervention order under the *Crimes (Family Violence) Act*. The Domestic Violence Resource Centre can provide advice about available procedures and support services, the police and legal interventions.

- Contact:*
- Magistrates Courts (listed in White Pages under Justice Department)
  - DVIRC, 139 Sydney Rd Brunswick Tel 387 9155
  - Community Legal Centres Tel 419 2752
  - WIRE Tel 654 6844

### **Aged Care Assessment Teams (ACATs)**

*When to refer:* The role of ACATs is to assess the physical, medical, social and psychological needs of the frail aged, and to help them gain access to appropriate services. Referral would be appropriate when maltreatment or neglect of a frail aged person at home is suspected, particularly when the situation appears to be due to caregiver stress, or to self-neglect by an elderly person living alone.

*Outcome:* ACATs have good connections with community care and residential care providers. The multidisciplinary teams are often well placed to identify situations of abuse or neglect, and to take appropriate action, such as making referrals to home-care services or to the Guardianship Board, or convening a case conference.

*Contact:* ACATs operate regionally and are listed in the 'Age Page' at the front of the White Pages.

### **Psychogeriatric Assessment and Treatment Services (PGATs)**

*When to refer:* PGATs will do an initial assessment of any elderly person who may need psychiatric services, including services for the management of dementia. Hence referral to a PGAT may be appropriate when a situation of abuse or neglect appears to be caused by the mental illness or dementia of an elderly person, whether that person is the 'victim' or the 'perpetrator' of the abuse.

*Outcome:* PGATs will assess the person and will provide treatment and case management if necessary. The multi-disciplinary teams should also be able to provide education for family caregivers and consultation and advice to other agencies.

*Contact:* Contact via the Psychiatric Services Manager in each H&CS regional office.

### **Local Home-care Services (HACC)**

*When to refer:* Referral is appropriate when it is believed that a frail aged person or a family caregiver would benefit from support by local home-care services (e.g. when lack of support is believed to be a cause of neglect or mistreatment).

*Outcome:* Most municipalities can carry out a professional assessment of an elderly person's home situation to determine whether the person would benefit from available support services. If the person is already receiving services, home-care staff can be expected to monitor and report to their supervisor on the person's general well-being.

*Contact:* Councils are listed alphabetically in the White Pages.

## PART II

### Framework for Agency Procedures

Professional staff in health and community services will naturally build on their existing generic practice guidelines to develop specific procedures for responding to situations involving maltreatment and neglect of older people. As an aid, the next four chapters offer the following operational framework:

*Chapter 5—Establishing Protocols as the Basis for Co-operative Action.*

*Chapter 6—Recognising a Problem*

*Chapter 7—Assessing the Situation*

*Chapter 8—Planning the Intervention*

## 5. Establishing Protocols as the Basis for Co-operative Action

All agencies delivering services to older people should develop protocols, policies and procedures on the issue of maltreatment and neglect. This introduction can be used as a guide to the main issues involved in drawing up *inter-agency protocols*.

### **The Purpose of Protocols**

Workers equipped with practical, action-based protocols will find it simpler to deal with complex inter-agency relationships.

Because various agencies may be involved with an older person who is the victim of maltreatment or neglect, inter-agency protocols can clarify the key points of contact between agencies. A protocol helps workers in different fields to know what is expected of them, when it is appropriate to refer a matter to another agency, and what sort of help they can expect to receive. It is designed to avoid conflict and confusion when the responsibilities of two agencies overlap. A protocol can also minimise situations in which no agency is inclined to accept responsibility.

Protocols really should be drawn up by the key staff in the agencies concerned; this will ensure ‘ownership’ of the protocols and hence commitment to the process they spell out. Thus a protocol cannot successfully be drawn up by a third party with no direct involvement.

The following material is offered as a suggestion of the topics that should be covered.

### **1. Role Definition by Key Agencies**

Each key agency should define its role in relation to maltreatment and neglect of older people, including eligibility criteria such as geographical boundaries and client group.

## **2. Agreed Working Principles**

Agencies in the network should develop a set of agreed working principles. These might include:

- use of a common definition of maltreatment and neglect of older people (see Ch. 2);
- agreement that member agencies will develop their own internal policies, using an agreed framework for assessment, intervention and case management;
- recognition of the right of a competent older person to refuse intervention

## **3. Emergencies**

The protocol should clarify the process for responding to emergency cases. The general principle might be that the *first notified agency* assesses the need for an emergency response, using agreed criteria. An emergency could be defined as a case that seems to involve the immediate threat of physical harm. (Most cases of abuse will not be emergencies.)

In dealing with emergencies, three areas of action will warrant consideration:

- protection for the victim, for example, referral to police;
- medical treatment, for example, referral to local doctor or hospital casualty;
- emergency accommodation, for example, referral to supported housing services in the region, or overnight admission to a hospital.

## **4. Information Exchange and Confidentiality**

There should be an agreement on the matter of disclosing information to other agencies.

Agencies often fear that disclosing information will leave them open to an action for defamation or breach of confidentiality. Each agency should clarify how the laws of defamation and confidentiality actually affect the agency and fit in with good work practices in the agency's dealings with others. For example, it is unlikely that an action for defamation would succeed if a statement of opinion is made in good faith by a worker in the course of duty and is not disclosed to anyone not involved in the case.

Matters to be considered include:

- What are the legislative, legal and ethical restrictions on disclosure of information? (for example, s.141 *Health Services Act* 1988 and s.135A *National Health Act* appear to

prohibit health workers from sharing client information without permission unless an exception applies)

- Under what circumstances will an agency allow another agency access to its records? (for example, only certain people may be given a copy of a police record)
- On what conditions will an agency provide a written report to another network agency? What will be included in it?
- Will an agency release information needed in a legal tribunal of some sort or will disclosure only be made in response to a subpoena?

## **5. Reporting and Case Management**

A strong case management framework is often essential to ensure that services work effectively for older people who have been maltreated or neglected. The protocol will need to establish an effective case management mechanism which addresses the following issues:

- criteria for case management
- choice and appointment of a case manager
- older people 'at risk'
- agreed role of the case manager
- responsibilities of other service providers.

## 6. Procedures for Recognising a Problem

Workers need to be pro-active in confirming or disconfirming suspected situations of maltreatment and neglect, given the tendency of some victims to deny or minimise the problem as a result of embarrassment, an exaggerated sense of responsibility, fear of retaliation or isolation.

### Identifying Risk Factors

Further research on maltreatment and neglect of older people is needed to uncover actual causes. Nevertheless, some major risk factors have been identified; these can inform workers which older people are potentially at a high risk of mistreatment. Assessment of the following major risk factors can be a useful screening process.

- **Dependency:** Research does *not* support the belief that the dependence of a frail elderly person on family caregivers is itself a cause of abuse. On the other hand, research has shown that an abusing relative is more likely to be materially dependent on the elderly victim than non-abusing relatives in a control group (Pillemer and Finkelhor, 1989).
- **Stress in the Caregiving Relationship:** Caring for a frail and dependent older person can be extremely stressful. The carer may have adopted the role through a sense of duty or pressure from other relatives. Whatever their motives, most carers are likely to experience moods of resentment, frustration or anger. These negative moods are likely to be reciprocated by the dependent person; very few people enjoy being dependent on others for daily living. Research suggests that **caring for a dementia sufferer** is most likely to lead to the kind of stress that results in abuse, if adequate support is lacking (Grafstrom, 1993).
- **Family Violence:** Some families have a history of family violence and conflict. Spouse abuse or domestic violence may be ongoing as the couple grows older. Similarly, a child who was abused physically, sexually or psychologically may now be the primary carer and repeat the cycle of abuse to a dependent parent.
- **Psychopathology in the Abuser:** There are two typical situations here. In one, the abuser is dependent on the elderly person for material support, and has a background of mental health problems, including alcoholism. In the other situation, the abuser not only has these personal problems but has caregiving responsibilities.
- **Isolation:** If the older person and the carer are socially isolated, lacking supportive contacts and social networks, there may be an increased risk of abuse and neglect.
- **Difficulties Accepting Care:** In some situations the elderly dependent person may abuse

the caregiver. This may occur due to difficulty in accepting their reliance on another person; psychiatric illness or dementia may result in aggression or a loss of insight.

Any combination of these factors may indicate a need for extra support and services to reduce the risk.

### **Shared Definitions of Abuse**

Acceptance of a common definition of what constitutes maltreatment and neglect of an older person will assist agencies to recognise such situations, develop consistent responses and gather consistent data.

The following definition is proposed:

*Elder abuse or maltreatment of an older person is a term that can cover a variety of situations involving the victimization of an older person. The situations include domestic violence, professional malpractice, fraud, and abusive behaviour caused by caregiver stress. Elder abuse is best considered as a particular manifestation of these situations, and not as a separate category of behaviour. Situations of neglect and self-neglect involving elderly people are likely to raise similar practice issues for health and welfare agencies, though not necessarily involving abuse and victimization.*

### **Requirements for Notification**

*By whom?*—Agencies need to develop clear guidelines regarding the obligation on direct care workers to report maltreatment and neglect.

- Contractual obligations on workers need to be clearly stated. Such procedures may be based on legal issues relating to duty of care and confidentiality.
- Guidelines for responding to anonymous referrals may also be provided in agency procedures.

*To whom?*—Agency procedures need to clearly identify whose responsibility it is within an agency to receive reports, assess and intervene. Procedures for recording the notification of the complaint also need to be developed.

## 7. Assessing the Situation

Once the alleged maltreatment or neglect is notified, the appropriate agency worker needs to respond by carrying out an assessment within specified timelines. The worker will need to assess the following factors: access barriers, whether an emergency response is required, the older victim's needs and response, the dimensions of the maltreatment or neglect, the alleged perpetrator's perspective, and the degree of risk involved. These factors are treated in turn below.

### Managing Barriers to Assessment

The degree to which a thorough assessment can be made depends on the worker's access to the parties. The victim may deny the existence of abuse completely, or be intimidated by a perpetrator who screens all phone calls, visitors and mail. Hence the worker must assess the barriers to access and consider the best entry options to the older person. For example:

- at home or elsewhere?
- alone or with a trusted other?
- interpreter needed?
- police protection required?

The police have certain rights of entry, for example:

- Police can gain entry uninvited if they form an honest and reasonable belief that a serious crime has occurred or is occurring. Section 459(A) of the *Crimes Act* gives police a right to enter private property when a serious crime is believed to have been committed. However, it is doubtful whether police have power to remain on premises against the wishes of an elderly person merely to assess the situation, if it appears that the maltreatment falls short of an indictable offence or a breach of the peace.
- Section 27 of the *Guardianship & Administration Board Act* allows police to give assistance to enable a worker to assess a person for a GAB report. Police can use reasonable force to enter premises.
- Section 10 of the *Mental Health Act* gives the police power to apprehend a person requiring psychiatric treatment, under certain defined circumstances.

Workers should refer to the Victoria Police to clarify questions of right of entry.

If an elderly person is in **residential care** (including a private Supported Residential Service) the Community Visitors have certain rights of entry. So also do the Health Services Commissioner and State and Commonwealth officers monitoring residential standards. See Chapter 10.

## Procedures for Emergency Responses

If on receipt of notification the worker assesses that the victim is in imminent danger of harm or death, it may be necessary to arrange emergency police protection, medical treatment and/or alternative accommodation. Police involvement may be required for the safety of the worker as well as the victim.

The worker should consider whether an emergency application to the Guardianship and Administration Board is necessary for the appointment of the Public Advocate as temporary guardian or the State Trustee as temporary administrator to protect an incompetent older person or their property and assets.

## Defining Factors to be Assessed

The assessment of the elderly person should cover the following factors: health, social supports, mental competence, and the victim's attitude to the abuse.

- *Health*—The health and functional status of the victim should be carefully assessed because the degree of independent functioning and care needs will influence case planning. For example, what self-care tasks can be performed? What role and relationship activities can the older person maintain?
- *Supports*—Attitudes and availability of supportive relatives, friends and neighbours are important because they often determine the extent to which outside support is needed. Co-ordination of informal and formal service networks is important. Outside community support services include counselling, home care, supported accommodation, etc. Needs and eligibility for these services should be assessed. (See the list of agencies in Chapter 10.)

It is important to assess an older person's strengths (including skills, will, attitudes) which can be built on to offset problems.

- *Competence*—The competence of the older person to understand the consequences of remaining in an abusive situation and his or her capacity for self-protection must also be assessed. Referrals to the Aged Care Assessment Team for a formal assessment of competence can be made if necessary.

'Incompetence' here means that, due to some kind of mental impairment, the person is unable to make reasonable decisions. Dementia is the most common cause of incompetence among elderly people.

It is important to assess the older person's adaptive behaviour and perception of risks involved. It is best not to ask leading questions, but to ask the person to relate in their own words how they would respond to a particular situation involving risk.

- *Victim's response to maltreatment and to proposed intervention*—Assessment of a competent older person's response to maltreatment is important as it influences possible interventions.

If an older person is competent but has low self-esteem, is self-blaming, isolated and denies maltreatment, intervention may be refused. Intervention options are then limited to trying to keep in touch to support the victim to provide information about options.

Once an older victim recognises the problem and is prepared to accept intervention, a worker can help the person rebuild a life without maltreatment.

If an older person is incompetent, an application to the Guardianship and Administration Board for appointment of a guardian and/or administrator to make lifestyle or financial decisions on their behalf may be necessary. The Board needs to 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.

### **Assessing the Dimensions of Abuse and Neglect**

As part of the assessment, a worker should determine the different manifestations of maltreatment or neglect (physical, psychological, financial and neglect), and the frequency and severity. This may involve sensitively questioning the older person, family and friends (with the victim's permission) to ascertain what signs or symptoms of maltreatment have been observed, how often and how severe they have been.

### **Understanding the Manifestations of Abuse**

**Physical** harm can be due to hitting, punching, shaking, slapping, sexual assault, use of a weapon, not feeding properly, not attending to personal hygiene or not providing necessary medication or shelter.

*Possible indicators*—Unexplained bruises, fractures, burns, lacerations. Unattended injuries, sunken eyes, pallor, malnutrition, poor hygiene, hypothermia, appearance of being over-medicated, absence of aids, ulcers.

**Emotional** harm can be due to threatening remarks or insults, harsh commands, isolation from social contact or having one's concerns and demands ignored.

*Possible indicators*—Insomnia, change in appetite, unexplained weight change, unexplained paranoia, tearfulness, excessive fears, agitation, low self esteem.

**Financial** harm can be due to threatening an older person into handing over assets, abusing or neglecting a legal responsibility to manage finances, stealing possessions and cash.

*Possible indicators*—Unexplained inability to pay bills, unexplained withdrawals from bank accounts, disparity between poor living conditions and known assets, transfer of assets when competency is questionable.

**Neglect** is a failure to provide an adequate degree of care and can be self inflicted (self neglect).

*Possible indicators*—Inadequate nutrition, accommodation, clothing, medical care, dental care. Poor personal hygiene, exposure to unsafe, unhealthy, unsanitary conditions, alcohol/drug abuse.

### **Defining and understanding the Context**

Categorisation of a particular situation into one or other of the contextual ‘typical situations’ described in Chapter 3 will provide a useful guide to intervention options. The categories are not mutually exclusive.

### **Reviewing any Intervention history**

A worker should assess what interventions have been made in the past, and if they were unsuccessful, why? This may involve contacting agencies which have been involved in the past (with the victim’s permission).

### **Assessing the Perpetrator’s Perspective**

Assessing the needs and perspectives of the alleged perpetrator is important because addressing his or her problems will usually alleviate the older victim’s suffering as well. The following factors may be relevant to guide intervention plans:

- Motivation—e.g. caregiving stress, greed, sense of powerlessness, inability to tolerate frustration, drug or alcohol dependence, psychiatric illness.
- Behaviour—Indicators of a possible perpetrator can include refusal of access to the elderly person, aggression, blaming others, alcohol/drug abuse, stress or fatigue.
- Record of past intervention—What has helped and what has not helped? Is there a criminal record, or current support for problems?
- Perpetrator’s response—Does the alleged perpetrator acknowledge or deny the behaviour? Is the alleged perpetrator willing to accept help or not? What does the alleged perpetrator blame for the problem (eg. alcohol, loss of job, family stress)?
- Physical and mental status of the alleged perpetrator—observations of family and friends may be useful.

- Risk of helping the alleged perpetrator—is there a safety issue for workers?
- Availability of resources (money, friends, services) to assist the alleged perpetrator.

### **Involving Other Agencies**

Comprehensive assessment involves gaining the perspective of other support workers involved with the situation (with the permission of the older victim). Issues of confidentiality may arise if permission is refused.

### **Degree of Risk**

Assessment of risk often requires workers to carefully balance the autonomy of the older person and their perception of risk with the anxiety of relatives and professionals regarding risks in the environment and risks to others.

Assessment of risk is particularly complex in cases involving self neglect or neglect by a carer. Intervention may result in the loss of an (imperfect) support system, and result in an unwanted move into residential care. Workers will benefit from guidelines which provide a clear conceptualisation of the concept of risk and a framework for assessment.

Factors to be considered may include the following (adapted from Gliddon & Finch, 1991):

#### *Risks to physical health of the older person due to possible:*

- falls or injury
- unstable health problems, e.g hypertension
- poor adherence to treatment program
- poor memory (due to dementia) which causes wandering, risks related to using heating and electrical appliances or domestic chaos (e.g. piles of rubbish, newspapers, etc.)
- mistakes in administering medication
- sexual assault
- inadequate nutrition
- unsafe physical environment (unsafe housing, domestic chaos, etc.)

#### *Risks to psychological and social well being due to possible:*

- social isolation
- verbal abuse
- lack of stimulation or motivation
- lack of valued role
- loss of independence
- financial exploitation.

### *Care-giving risk factors*

Risks to the older person's well-being caused by the care-giver's situation, such as:

- excessive physical burden of care
- demanding mental state of older person
- incontinence which causes carer stress
- 24-hour care without respite
- poor health of carer
- low emotional tolerance of carer
- carer's other responsibilities.

### *Probability and Seriousness of the Outcome*

Assessment of the acceptability of any risk involves assessing both the probability of the risk and the consequence of the feared outcome in terms of the person's quality of life or suffering. For instance, a risk of high probability but low consequence may be regarded as tolerable. In other words, some outcomes may be considered worth the attendant risks. On the other hand, risks of high probability and high negative consequence and suffering may be considered unacceptable. (See Brearley, 1982.)

### *Older Person's Perception of Risk*

An individual's world view will affect his or her perception of risk and acceptable suffering. This view reflects values which the person has developed over a lifetime and it can be useful for a worker to gain insight into a person's past lifestyle and values. For example, in a case of self-neglect, it may be possible to identify a crisis which has dramatically affected the person's lifestyle and precipitated self neglect, or which has caused a loss of role that has never been resolved.

Difficult safety judgements often involve balancing competing options and interests.

It is important to acknowledge that an older person may not consider the 'safest option' to always be the best option. If 'being safe' means giving up self determination and the right to choose, then it may not be acceptable. On the other hand, an older person's decision to take risks should be made with some consideration of the wishes of significant others. A support worker may need to engage the older person and interested parties in difficult decisions about risk by encouraging interaction focused on developing and maintaining the skills and abilities of the older person. (See Neugeboren, 1991 for a discussion of the self-neglectful client.)

Solution of the problem of self neglect can rely on co-ordination of an older person's formal and informal support networks.

## 8. Planning the Intervention

Intervention strategies should aim to minimise maltreatment or neglect and help the victim rebuild a life without maltreatment.

Intervention can include counselling and treatment programs to change problem behaviours, education on care giving and rights, increased daily living support services, respite or alternative accommodation and legal action.

### *Counselling and treatment programs*

- To help older person develop safety and coping strategies
- To provide self help support group for older person
- To help older person recognise problem and seek lifestyle without maltreatment
- To help perpetrator change violent patterns of behaviour
- Drug and alcohol treatment program for perpetrator
- Caregiver support—individual or group therapy

### *Education*

- Education on caregiving
- Education on effects of maltreatment and neglect
- Education to teach alternative to violent behaviour
- Information about community resources for older person and alleged perpetrator

### *Increased support services*

- Respite care—occasional or regular
- Home care, nursing
- Meals on wheels
- Incontinence programs
- Day Centre

### *Respite or alternative accommodation*

- Alternative living arrangements to separate older person and perpetrator. Eg. supported accommodation, flat, etc.
- Respite care for older person

### *Legal intervention*

- Power of Attorney
- GAB proceedings
- Intervention Order—Crimes Family Violence Act 1987 to limit physical or verbal maltreatment
- Police prosecution for criminal wrong
- Court mandated treatment program
- Complaint re professional malpractice
- Civil action—negligence, breach of contract, etc.

### **Victim's reluctance to accept intervention**

If an older person is competent but refuses help, a worker can only support and advise about options. The worker can advise the person how to deal with emergencies. Strategies can then be developed to help break through the victim's denial of maltreatment and feelings such as fear, isolation, guilt and self-blame. Individual counselling or joint support groups can help victims realise they are not to blame and do not have to tolerate maltreatment. (See Breckman & Adelman, 1988.)

In a case of self-neglect in which a competent older person insists on living in unhygienic squalor, the situation could be tackled as a public health risk under the *Health Act 1958*.

If an incompetent older person is at risk and refusing help (despite creative efforts at persuasion), it may be necessary to apply to the Guardianship Board for the appointment of a guardian or an administrator to consent to support services or some other intervention (eg. in a case of self neglect).

When the older person is prepared to accept intervention, strategies need to be planned to try to address the underlying causes.

### **Criteria for Case Management**

Not every case of abuse will require case management; a competent older victim could be quite capable of being their own case manager.

The policy could be to provide case management if the situation involves:

- crisis intervention
- a highly dependent older person who requires two or more support services
- an older person whose health (physical or psychological) or social skills are unstable
- an older person with multiple problems which require additional support services.

### **Choice of a Case Manager**

The agreed process might be that the agency worker who receives a referral and assesses a situation of concern will call a case conference to plan and co-ordinate possible interventions and appoint a case manager if necessary.

Several agencies which are prepared to manage complex situation may be identified. The choice would then depend on which agency worker has a trusted relationship with the parties involved. For instance, in some areas case management is offered by the local government home-care service, the Aged Care Assessment Team, a Linkages Project, the community health centre or the district nursing service. In other localities, case management may always be provided by the one agency.

Key agencies may decide to establish a weekly or monthly case conference. The meeting would provide a regular forum for service providers to appoint a case manager to selected clients. The meeting may be attended by representatives from the identified case management agencies within the network; other service providers would be invited to raise concerns and contribute to case discussion when relevant.

### **Agreed role of the Case Manager**

A possible role for the case manager would be:

- to be responsible for informing and gaining agreement from the older person, the family or carer as to the role of the case manager;
- to be responsible for contacting the older person's doctor, etc. with permission;
- to ensure that the needs of the older person, family and caregivers are monitored and that appropriate services are provided;
- to ensure that the situation and its outcomes are monitored;
- to liaise with any appointed case monitor and act on any concerns raised;
- to negotiate with agencies regarding needed services or any other problems;
- to act on grievances;
- to report to a case conference meeting, where appropriate, and recommend discontinuing case management.

### **Responsibilities of Other Agencies**

Agencies providing services may need to clarify their role in relation to case management and monitoring. This may involve service providers:

- informing the case manager of changes in their service provision role;
- informing the case manager of concerns re the older person's situation, and requesting a case management meeting if needed; or
- participating in meetings convened by the case manager

### **Case Management Procedures**

Relevant inter-agency protocols need to be followed. The case meeting might also involve people who form the older person's informal support network (such as family, friend or neighbour) as it is important to co-ordinate both formal and informal service networks.

A service plan is a useful way to document the needs of the older person, planned intervention strategies, timelines and worker/agency responsibility. Documented service plans can increase accountability in terms of what is to be done and who is responsible. Case records need to be kept carefully in case they are required in subsequent legal actions.

The case manager has overall responsibility for ensuring the service plan is implemented and reviewed.

### **Support for Secondary Victims**

Sometimes helping the victim of abuse will require responding to the calls made by neighbours, friends or relatives (secondary victims) who are affected by the maltreatment and also need support. Guidelines for helping secondary victims could be:

- informing secondary victims of emergency procedures
- providing information about investigations and encouraging continued non-judgmental support of the older person, especially if intervention is refused
- providing information about supports for the secondary victim as well as the older person, eg. counselling.

### **Monitoring**

Monitoring through ongoing contact with the older person and service providers helps ensure that the intervention and support services arranged are in fact minimising the maltreatment or neglect. Review of the service plan at regular intervals (through case meetings if necessary) can be an important monitoring device.

Some agencies may wish to develop a register of older people considered to be 'at risk' of maltreatment and neglect so concerns about their well being can be monitored at regular intra-agency or inter-agency meetings (see Sadler, 1993 for a discussion about the limited success of one such attempt). If necessary, a case conference of relevant workers can be convened to discuss specific concerns about an older person. Confidentiality issues need to be addressed through well developed guidelines.

Closure or finalisation of a case will of course be planned with the older person when the problem of maltreatment or neglect appears resolved. The older person needs to be made aware of his or her right to recontact a case manager at a later date if necessary.

In other cases, the abusive incidents will be only an episode in a continuing case (for example, a case of dementia). Here the decision when to close the case will not be determined by the outcome of the abusive episode itself but by the overall course of the case.

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## 9. Case Studies—Situations of Abuse and Neglect

The case studies below were culled from both the American and the Australian literature. A list of references will be found at the end of the document. The case studies are arranged in eight categories to illustrate the ‘typical situations’ described in Chapter 2.

### *Type 1—Maltreatment or Neglect by a Caregiver*

This is commonly assumed to be the *most* typical situation of abuse. Actually, the research literature does not support this assumption. Nevertheless, such situations certainly occur and are important to resolve. One type of situation can be attributed to ‘caregiver stress’:

There is a small minority of caregivers who deliberately mistreat because they cannot cope with the demands of caregiving. The likelihood of their mistreating is not necessarily linked to the amount of care they provide .... They tend to be people without a previous history of maltreatment and they are usually remorseful and shocked by their own behaviour: the daughter responsible for the 24-hour care of her father with Alzheimer’s who threw a dish at him after his afternoon feeding took two hours, or the wife of a man with a recent leg amputation who screams at him mercilessly to move faster while helping him to the bathroom. (Breckman and Adelman p.60)

A 79 year old woman suffering from heart disease, Parkinsons Disease and dementia was abused by her 60 year old daughter who, despite support from a local day hospital, visiting nurse and respite care, became extremely agitated and frustrated by the demands of caring for her mother. The visiting nurse observed slapping and rough handling of the mother with resultant bruising. A Guardian was appointed until a nursing home placement could be made. (*No Innocent Bystanders* p.32)

A 76 year old man, frail and suffering slight confusion, was abused by his 70 year old wife and family. His wife and children wanted him to go to a psychiatric institution because they refused to care for him. His wife continually force-fed him and over-sedated him, frequently bruising him badly. She finally force-fed him with tranquillisers and had him admitted to a regional psycho-geriatric hospital as a demented person. (*No Innocent Bystanders* p.32)

There is also *neglect* by a caregiver, which may be due either to malevolence or to incompetence:

An 89 year old woman, frail, demented and with a severe prolapse, was cared for by her 40 year old son who had a mild intellectual disability. A Guardian was appointed and the woman was admitted to a nursing home owing to the inappropriate care provided at home and the inability of the son to recognise his own limitations. (*No Innocent Bystanders* p.34)

A 57 year old woman, very frail and suffering from manic depression, lived with her 60 year old husband, who was physically and mentally competent but avoided any responsibility for care, leaving her incontinent in bed, alone for many hours and generally refusing to acknowledge her increasingly debilitated condition. [After intervention] a community nurse arranged daily home help, Meals-on-Wheels, and personal care for bathing and dressing. While the situation improved for the woman, she still required more help with hygiene during the day and night. (*No Innocent Bystanders* p.34)

In the typical cases that fall into this category, the elderly person will be substantially dependent on the person responsible for the maltreatment or neglect. Therefore the typical interventions will involve either providing extra support for the caregiver, or finding alternative caregivers.

Note that two of the cases described above could equally have been considered as falling within the category of domestic violence/destructive family.

### ***Type 2—Domestic Violence/Destructive Family Relationship***

If the victim and perpetrator are spouses, and the victim is dependent, the difference between this situation and the category of abuse by a caregiver may be a matter of interpretation. However, the assessment is likely to be significant in terms of the appropriate type of intervention, and its efficacy. The typical 'spouse abuse' situation is likely to be of long standing, and difficult or impossible to resolve satisfactorily. The 'presenting problem' of maltreatment will be attributable to this dysfunctional relationship, rather than being simply a response to the stresses of caregiving:

Mr Washington, age 74, was hospitalized for an infected leg ulcer. ... Mrs Washington stated [to the doctor] that she frankly didn't want to talk about her husband and that she didn't want him to come home. ... She went on to say that she had thought about divorcing her husband for most of their married life, and that she had suffered a lot. ... 'After five years of getting him through two surgeries and nursing him at home and catering to his every wish and whim, I've got to start paying attention to my own health and peace of mind'. ... To the social worker, Mr Washington screamed, 'Doesn't she know I could lose my leg? Doesn't she care? ... She slapped me around before but now that I'm better, she's going to find out who's boss'. (Breckman and Adelman p.101)

### ***Type 3A—Abuse by a Dependent Adult***

Typically the abuser is the elderly person's son or daughter, and has some form of disability which explains their continuing dependence.

Mr and Mrs O'Reilly, 84, suffered violence and threats at the hands of their son Gerald, aged 50. Gerald had been schizophrenic since his teens. He had lived with his parents most of his life. Mrs O'Reilly described how there had been 'a series of attacks' by Gerald against his father over thirty years: 'In later years he'd break up furniture ... He loved breaking up glass. Picks up the nearest thing, you know, throws it.' The parents told of how 'cranky' Gerald was in the mornings, and how they could not go into the kitchen if he was in

a bad mood. Over recent years he had begun to be violent towards his mother as well. The family had been known to the regional aged care service for many years. Help with house cleaning was arranged through HACC services. Recent interventions included referral to the local police and the mental health emergency team. The father wanted Gerald removed from the house but the mother would not countenance this. Subsequently Gerald was arrested for assaulting his father and the police, and was prevented from returning to his parents' house by his bail conditions. However, his parents let him return a few months later, as well as paying his fine. (Sadler 1993)

The daughter of [an older woman] moved in with her, and has never contributed in any way to her mother's support. 'I support **her**. She has epilepsy and is on disability. She's supposed to give me \$50 a month but never does. She even stole a \$25 gift certificate I won. We haven't gotten along ever. It's only nice when she's not here.' (Pillemer p.154).

These cases, in which the perpetrator is dependent on the victim, comprised a two-thirds majority of all physical abuse cases in one American study (Pillemer 1985). The victim may or may not be frail, but is obviously vulnerable because of their close proximity to the perpetrator. One factor which may complicate any intervention is the elderly person's sense of having a continuing responsibility for the welfare of the abuser. Outside agencies, such as psychiatric services, may consciously or unconsciously share this assumption that a parent, even if growing old, is responsible for supporting a child with a disability. Appropriate intervention may need to concentrate on finding alternative supports, including accommodation, for the abuser. Protocols may need to ensure that specialist agencies accept more responsibility for the supervision of their abusive client.

### ***Type 3B—Abuse by a Dementia Sufferer***

Typically, one member of an elderly couple is suffering from dementia, and behaves abusively towards the caregiving spouse:

Violence is emerging as a significant clinical challenge in families living with a relative diagnosed with Alzheimer's disease or a related dementia. ... Estimates are that 57-67 per cent of dementia patients manifest some form of aggressive behaviour, that is, verbal outbursts, physical threats, and/or violence. (Paveza *et al.* p.493)

'Well, she'd bang on the door at 2 am and accuse us of things. She accused me of killing her brother and waged war with both her fists. First she slapped me ... and then she waded in with her fists.' The caregiver [daughter] expressed more concern about the disruption and inconvenience the aggression caused the family, rather than a concern about her own safety. (Cahill and Shapiro 1993 p.12)

Aggressive encounters in male/female relationships, where males were physically stronger, intimidated caregivers. Fourteen elderly spouses [in a sample of 24 spouses and 15 non-spouses of dementia sufferers] claimed that these aggressive incidents really frightened them: 'A couple of times he tried to hit me. Once he did get me. I think once he did get the kitchen knife but I sort of got it from him. ... Well, when he threatened to kill me that was very frightening because, you know, he wasn't a big man but he's got a terrible lot of strength.'

(Cahill and Shapiro 1993 p.13)

The aggressive behaviour may or may not be one-sided:

[Violence] has been conceptualized differently in patients and caregivers, with a focus on aggressive symptoms in dementia patients and abusive and neglectful behaviours in caregivers. ... Our findings suggest that severe violence expressed towards a family caregiver is not rare. Given this intensity of patient aggression, it is understandable that some violent caregivers describe a mutually violent relationship with the patient. ... Although abusive behaviour by the dependent aged person cannot justify the response of the caregiver, the development of primary prevention strategies requires a better understanding of both patient and caregiver behaviours. (Paveza *et al.* p.493)

#### ***Type 4—Conflict in a Shared Household***

In these situations, the elderly person has typically begun sharing a house with a married child and spouse. The situation has become intolerable for one or both parties, but the elderly person cannot easily get out. For example:

Dolores: 'I bought a house with my daughter and son-in-law. We were all going to live together ... I had put my daughter's name on the deed, which was the wrong thing to do. Once the name was on the deed they wanted me out.' Shortly after moving in, her son-in-law became psychologically and physically abusive. It did not take Dolores long to call the police. When they were not helpful, she turned to her son. Then she called a senior centre after seeing an advertisement on TV. Later, on the advice and help from a social service agency, she sought help from the courts, eventually forcing the sale of the house and losing half her investment. 'But at least I have my sanity.' (Breckman and Adelman p.129)

In this type of situation, the older person may *not* be particularly dependent on other members of the family. Hence the problem is not one of caregiver stress. Rather, the problem is that the older person feels trapped in a household that he or she is no longer the head of. The aim of the intervention in this type of situation will usually be to help the older person to re-establish an autonomous household, either by moving out or by persuading the other people to move out. If frailty precludes a move to complete independence, the compromise may be supported accommodation. Financial difficulties may be present.

#### ***Type 5—Financial Exploitation***

The following cases are drawn from the records of the Guardianship Board:

A 78 year old woman, suffering diabetes and legally blind, was under pressure from her brother to leave her unit to his son and daughter, rather than sell it to provide an ingoing fee to a hostel. The woman also said that her brother had earlier tried to deprive her of money and goods from their parents' will. The woman was referred to a solicitor who encouraged her to sell the unit.

An 81 year old woman, frail and schizophrenic, lived alone and allowed no-one into the house. She was 'befriended' by a young woman who arranged to do all her shopping and banking, with the result that each fortnight her entire pension was spent but no food was bought. Her daughter made an application to the Guardianship and Administration Board which resulted in the older woman being admitted to a psychiatric hospital in a very frail and undernourished state. The young woman disappeared after the police had been alerted.

Mrs D, aged 83, had been steadily declining with dementia. While still mentally competent, Mrs D had signed an Enduring Power of Attorney (EPA) appointing her daughter as attorney. The daughter arranged for Mrs D to move in with her. Later she sold Mrs D's home, arranged for Mrs D to move into a cheap supported residential service, bought an interstate property with the \$180,000 proceeds of the house sale, and left Victoria. The matter was brought to the Guardianship Board. The Board revoked the EPA as not being in Mrs D's interests and appointed the State Trustees instead. However, the Police Fraud Squad believed the money could only be retrieved by civil action as no crime had occurred; on this view, an EPA gives the attorney unfettered discretion to deal with the estate.

A 76 year old man, with limited mobility, incontinence and dementia, was placed in a Special Accommodation House. There he was visited and constantly pressured by his son into giving him significant amounts of money.

Some of these cases will involve the kinds of fraud or theft that are readily dealt with by the police and the courts, once notified. Other cases, however, are less clear cut, either because there are doubts about the real wishes of an older person who is facing conflicting family pressures, or because there are doubts about the person's competence. In the latter case, the Public Advocate and the Guardianship Board may need to intervene.

### ***Type 6—Maltreatment or Neglect by Staff in Residential Care***

This area has now received considerable attention from government and others. To quote *No Innocent Bystanders* on the kinds of problems that may be found in poor-quality residential services:

Examples ranged from actions that caused the older person distress but were not life-threatening, such as pooling of clothes, toothbrushes and razors, poor quality linen, sloppy unattractive food and inadequate cleaning of floors and so on, to actions that directly endangered the older person's life, such as inadequate attention to correct doses of medication, not following up signs of physical deterioration with appropriate medical help, neglecting to toilet the incontinent person ... neglecting to treat skin breaks ... and neglecting to provide food and liquid to residents. (*No Innocent Bystanders* p.34)

Appropriate intervention may now occur at several points: internal complaints to the residential care facility; complaints to the State or Commonwealth department responsible for regulating the facility; the Health Services Commissioner, the Office of the Public Advocate, the State Trustee, the Residential Care Rights Service, and/or the Community Visitors.

### ***Type 7—Professional Malpractice, or Abuse by a Paid Caregiver***

Professional malpractice in this sense does not necessarily imply malevolence; it may be a case of professional ignorance about best practices in care of the aged. For example:

An 82 year old woman with slight short-term memory impairment was referred to a local geriatric assessment team by the proprietor of the Special Accommodation House where she lived. The woman's GP had prescribed three types of neuroleptic drugs and two minor tranquillisers for the treatment of her confusion. The mixture of drugs had caused symptoms of Parkinsons Disease and more confusion. The geriatrician from the Aged Care Assessment Team advised on the correct management of drugs. (*No Innocent Bystanders* p.35)

When such cases involve health workers, there are usually several courses of possible intervention: choosing another doctor or seeking a second opinion; lodging a complaint with the Health Services Commissioner, the Medical Board, the Nurses Board of Victoria, etc. For example, the Nurses Board has power under the *Nurses Act* 1993 to investigate complaints about professional misconduct. If actual harm is suffered, the older person may also have remedies under common law such as an action for negligence or breach of contract.

At the systemic level, there is the ongoing task of evaluating and improving the practices of health workers—eg the diagnosis and treatment of dementia.

Cases involving a service providing residential care have been categorised separately above, because there is a distinctive set of regulatory agencies for these services.

### ***Type 8—Self-neglect***

Particularly where an older person is living alone, these cases may involve difficult decisions as to the person's mental competence, an adult's presumed right to decline help from available services, and the community's right to control public health hazards. For example:

The fate of a blind elderly Fitzroy resident found living in squalor last week hangs in the balance while authorities debate his future. ... Mr N, 83, had lived in a run-down, single-fronted terrace for more than 15 years ... He was found to be in good health [by the hospital] ... Although Mr N hopes to return to his own home, his rented house, owned by Mr K, is likely to be boarded up ... Mr K said Mr N was devastated at being uprooted and shunted off to St Vincents Hospital by the police. He said his tenant was 'a very private man' who would never let anyone inside the front door. He had no idea that Mr N lived in such disgusting conditions [and he] was angered that he was seen as responsible for the way Mr N lived... The mayor has slammed her staff for not reporting Mr N's living conditions. 'I have issued directions to council's community services staff to report anything suspicious', she said ... Meanwhile, community groups have defended Council workers who delivered Mr N's shopping every fortnight, but at his request did not enter the house. (*Melbourne*

*Leader* newspaper, February 1992)

This case illustrates very well the dilemmas and the need for agencies to develop their own protocols.

Another case, from the Office of the Public Advocate, demonstrates the kinds of intervention that can be tried in such situations:

Mr and Mrs P are an elderly couple with alcohol-related dementia, including short-term memory loss. They have no family, and were living in their own home in meagre circumstances with four cats, and with minimal support from neighbours, the Royal District Nursing Service (RDNS) and the State Trustees. Mr and Mrs P were haphazard with hygiene and meals, and they fluctuated in their acceptance of outside help. Their only regular outing was a weekly visit to the butcher to buy \$250 worth of meat. Most of this ended up in the rubbish bin or was fed to the cats. They had no memory or conception of the implications of their actions; and their savings were fast diminishing. They refused to move into alternative accommodation.

The neighbours, the RDNS and the State Trustee believed the only solution was to appoint a guardian to look into housing options. The investigation by OPA involved discussions with all parties, including the couple's doctor. The doctor did not feel that the couple were necessarily 'at risk' or in need of a guardian, if they accepted more support. The OPA investigator found that the couple would agree to extra services. The couple were referred for assessment by the Aged Care Assessment Team. The outcome was that increased services were supplied and accepted, the couple remained in their own home, and the application for guardianship was withdrawn. (Office of the Public Advocate *Annual Report* 1990 p.55)

For further reading on self neglect see Clark 1990, Cole 1992, Neugeboren 1991, Shah 1992, Vostanis 1992.

## 10. Functions of the Specialist Agencies

This chapter examines the role of the existing set of agencies involved in dealing with the maltreatment or neglect of older people. Each of these services was briefly outlined in Chapter 4. There follows a more detailed description of the way different agencies deal with the different aspects of the issue, according to the separate charters of these agencies. It does not attempt to evaluate their performance.

### The Guardianship and Administration Board

#### **Function**

The role of the Guardianship and Administration Board (GAB) is to protect the interests of adults who, because of a disability, are incapable of making reasonable decisions and who are in need of a guardian or an administrator. A guardian makes decisions about 'lifestyle' matters, and an administrator makes decisions about money matters. The powers of the Board are set out in the *Guardianship and Administration Board Act 1986*.

#### **Relevance to the issue of Maltreatment**

The Board has a very important role in protecting older people from maltreatment or neglect. A sample of 1000 cases showed that nearly 60 per cent of GAB clients are aged 65-plus, and in fact 42 per cent are aged 75-plus. About two-thirds of clients in the 75-plus age group are female, which is partly a function of the male/female imbalance at older ages. Dementia seems to be the major cause of disability among older clients: according to very incomplete data, dementia characterised 64 per cent of clients aged 75-plus (Carney and Tait, 1991, p.35).

Up to now, it appears that the Board's workload has been dominated by the institutional services. Only a minority of GAB clients are living 'at home in the community'—only 10 per cent, compared to 90 per cent of the general population. The group most likely to be living at home are the 'young-old'; some 29 per cent of those aged 65-74 are living in private dwellings.

#### **Procedures**

The focus of the Board's work is the hearing. Most hearings (70 per cent) result in an administration order being made; only 14 per cent of cases result in a guardianship order or some combination of the two. Thus most of the work of the Board is concerned with the financial affairs of clients. The Board can be seen as a mechanism for protecting people, particularly older people, from financial exploitation.

This does not mean that the Board is always judging disputes or hearing allegations of financial

abuse. On the contrary, most of the hearings occur because the (non-disabled) applicant wants to get legal authority to do something which the applicant already believes is in the disabled person's best interests. For example:

[Typically] the applicant needs legal authorisation to move money or sell property. Unless the bank or estate agent is convinced that the person signing the form has the legal authority to do so, the transaction may not proceed. One typical case involved Mr Nicholson, an 86 year old man living in a nursing home. His son applied to be appointed to become administrator to authorise him to pay his father's bills, and to sell his father's house if necessary. The Board duly appointed him administrator (Carney & Tait p.57).

In other cases, however, there may be a dispute between family members about the most appropriate way to handle the elderly person's financial affairs. Such disputes may or may not involve allegations that someone has acted or is likely to act dishonestly. An analysis of 1000 Board hearings revealed that about 10 per cent involved allegations of financial abuse or exploitation. For example:

One case involved an 81 year old woman, Mrs M, living in a Melbourne nursing home. Her grandson had visited her husband (living in the hostel section of the nursing home) and taken away some key documents, such as a will, as well as signed cheques made in the grandson's name, and a TV set. The grandson also lived rent-free in the grandparents' holiday house. Mrs M's daughter was appointed administrator, and the grandson stopped the questionable practices.

Once a case of possible financial abuse comes to the attention of the Board, the Board has the power to call witnesses and subpoena any relevant documents. Thus the Board can take evidence from a geriatrician as to whether the person had the mental capacity to sign a document, such as an Enduring Power of Attorney. The Board can also revoke an Enduring Power of Attorney if it is not being exercised in the best interests of the person who signed it.

### **Boundaries to the agency's role**

The value of the Guardianship Board is its role in protecting individuals who would otherwise be vulnerable to various kinds of abuse. In practice, a majority of these are elderly people. A Board hearing is a way of ensuring public scrutiny (and therefore accountability) in a large number of cases where an adult's ability to act independently is weak or threatened. The Board hearing assesses the situation and decides whether the appointment of a guardian (or an administrator) would be the best available way of protecting the interests of the person, and, if so, exactly what powers should be given to the guardian.

There are two kinds of limitation to the Board's effectiveness. One is the limitation inherent in the status of guardian: a guardian or administrator can protect or even advance the interests of the represented person in some important ways, but cannot solve all the person's problems. The second limitation is that the Board only has jurisdiction over a certain class of persons: those with a disability that weakens their competence to act on their own behalf. Thus the Board has no authority to appoint a guardian merely as an advocate for a vulnerable person who does not fall into this class.

## THE OFFICE OF THE PUBLIC ADVOCATE

### Function

The Office of the Public Advocate (OPA) acts as an advocate on behalf of people with a disability. Sometimes the action taken by OPA is to bring a case before the Guardianship Board. Conversely, the outcome of Board hearings is often that OPA is appointed to be the represented person's guardian. OPA is appointed only when no other suitable guardian is apparent. The powers of OPA are set out in the *Guardianship and Administration Board Act 1986*.

### Relevance to the Maltreatment and Neglect issue

Under the statute, OPA's clients include people with intellectual disability, mental illness, brain damage, senility or physical/sensory disability. In 1990, about 42 per cent of clients were aged 70-plus. Of the cases involving elderly people that come to the attention of OPA, a considerable number are about financial exploitation. A smaller number involve self neglect. The former have been described above in relation to the Guardianship Board. In cases of self neglect, it is nearly always found that the elderly person is suffering from dementia. Such cases tend to be referred to the Public Advocate by other health, welfare or protective service workers who are unsure about their own mandate to act.

### Procedures

The two main procedures relevant to this report are called by OPA 'individual advocacy' and 'systemic advocacy'. The need for systemic advocacy usually emerges from reflection by OPA on the causes underlying the individual cases its advocates are dealing with. Examples are: undertaking a research project; participating in a government review of residential care regulations; or conducting seminars for staff in other agencies on maltreatment of older people.

Cases needing individual advocacy come to the attention of OPA from a number of sources. The Guardianship Board refers many cases to OPA in order to get an investigation of matters material to Board hearings. Other referrals come from social workers, lawyers, neighbours, the State Trustee, and so on. For example:

Mary H. is a frail and confused woman who was currently a patient in a hospital. She had previously lived in a Special Accommodation House (SAH). A social worker contacted OPA. The OPA investigator had to establish whether there was a prima facie case for guardianship. Enquiries were made to banks, building societies, solicitors, hospitals, the electoral office, the SAH and Mrs H's son. It was established that the son was a signatory to Mrs H's bank account and that he was spending her pension on himself. The SAH fees were substantially in arrears. Ultimately the Guardianship Board appointed the State Trustee as administrator of Mrs H's affairs (OPA Annual Report 1990, p.53).

Apart from carrying out short-term investigations like this, OPA can have an ongoing role when appointed as guardian in an individual case. The guardianship role may itself be either short-term or ongoing, and it may be limited to a certain area of decision-making (eg. decisions about housing).

The role of OPA as guardian should not be confused with the role of case manager. OPA as guardian is the client's alternative decision-maker, but OPA generally relies on local services to carry out accurate assessments of the needs of an OPA client and of the availability of resources to meet those needs.

### **Boundaries to the agency's role**

As mentioned above, OPA is conscious of the difference between the role of guardian and of case manager. OPA is usually too removed from the person's local environment to be an effective case manager, even if the resources were available. Sometimes OPA undertakes this role by default, because no other agency can be found willing to accept the role. OPA does not regard this as satisfactory.

A separate point relates to the limited investigatory powers of the Public Advocate. Under section 27(1) of the *Guardianship and Administration Board Act*, the Board may make an order empowering the Public Advocate, or another specified person, to visit a person with a disability in order to prepare a report for the Board, if it has received information on oath that the person:

- ‘(a) is being unlawfully detained against his or her will; or
- ‘(b) is likely to suffer serious damage to his or her physical, emotional or mental health or well-being unless immediate action is taken.’

The Public Advocate has advised that the wording of section 27 places a heavy burden on OPA by requiring a statement on oath that the disabled person is likely to suffer *serious* damage unless *immediate* action is taken. On some occasions OPA receives information that gives rise to a sound and reasonable prima facie reason for believing that a person with a disability is at risk. Such evidence is not necessarily sufficient to initiate proceedings under section 27. *No Innocent Bystanders* recommended (Rec 24) that the Public Advocate's investigatory powers be strengthened, and suggested that the powers of the Health Services Commissioner might provide an appropriate model. The Health Services Commissioner may apply to a magistrate for a warrant to enter and inspect premises to interview specified people, or to inspect specified documents. The legislation contains a number of protections against the abuse of this power—for example, requiring the Commissioner to give the magistrate who issued the warrant a written report setting out the results of the execution of the warrant.

It is proposed therefore that the Attorney-General examine the adequacy of the investigatory powers of the Public Advocate, and in particular the proposition that the Public Advocate should be able to apply to a magistrate for a warrant to investigate when he has received information indicating that a person with a disability may be the victim of serious abuse.

## **THE HEALTH SERVICES COMMISSIONER**

### **Function**

The Office of the Health Services Commissioner was established by the Victorian Government in

1987. Its role is to investigate and resolve complaints against health services. Nursing homes, hostels and supported residential services are among the services covered. The Commissioner does not have a continuous role in monitoring health services. Instead, HSC relies on specific complaints. Its powers are set out in the *Health Services (Conciliation and Review) Act 1987*.

### **Relevance to the issue of Maltreatment and Neglect**

Older people comprise a significant group among the users of the HSC. In 1991, the figures showed that 250 of a total of 2063 complaints (12 per cent) were received from people aged sixty-five and over. These related to all categories of health service: hospitals, doctors, and so on. There were 65 complaints against residential care services: 36 were about nursing homes, 26 about supported residential services, and 3 about hostels. These complaints amounted to only 3.1 per cent of all complaints, but they represent a large number of people in residential care because a single complaint often represents all the residents in a facility, who may number 30-100 people (Health Services Commissioner, *Annual Report 1991*).

As noted, 12 per cent of complainants are older people, a proportion about equivalent to their numbers in the general population. On the other hand, older people comprise a much larger proportion of consumers of health services. For example, people aged 65-plus accounted for a quarter of admissions and 44 per cent of all hospital bed-days in Victoria in 1988, and had twice the rate of usage of Medicare services compared to the population as a whole (John Deeble, 1992, p.32). It is not immediately clear why older people should be under-represented among complainants to the Health Services Commissioner. It may be that fewer older people are dissatisfied with services received. On the other hand, a lack of awareness of the Health Service Commissioner's office, and/or a fear that a complaint may result in reprisals, despite the Commissioner's power to keep the identity of a complainant confidential, may be factors.

### **Procedures**

Complaints may be lodged by a consumer, a person chosen by the consumer, or anyone with sufficient interest acting on behalf of a consumer (including a health professional or the Public Advocate). Most complaints begin with a telephone call, followed by a written statement.

The Commissioner relies heavily on conciliation, whether formal or informal. Resolution of complaints includes the following steps:

- *Attempt at direct solution:* The first step is to put the two parties in touch with each other to see if the complaint can be resolved immediately. Most complaints are settled this way.
- *Assessment:* If a direct attempt fails, the complaint is assessed to see if it should be investigated and conciliated. Many more complaints are resolved during this assessment.
- *Conciliation:* All but a handful of the remaining complaints then go to confidential conciliation, which usually results in a settlement on mutually agreed terms.
- *Investigation:* A small number of serious complaints which are not suitable for conciliation, or which have resisted all informal attempts to resolve them, are then investigated. In

complaints against registered providers, it is usually the professional registration board which hears the complaint, but in all other cases the Commissioner has the power to investigate and to propose remedies.

From January to December 1991, some 37 per cent of the 1771 completed complaints were resolved directly by the provider, 48 per cent were settled informally by the HSC, 6 per cent were referred to other agencies, 6 per cent were settled in formal conciliation, 3 per cent were investigated by registration boards, and 0.5 per cent were formally investigated by the Commissioner.

### **Boundaries of the agency's role**

As a specialist in complaints, the Commissioner is in a strong position to identify consumer satisfaction or dissatisfaction with the health system. Central among the Commissioner's statutory duties is to evaluate and identify the *causes* of complaints, and to advise providers on how to follow the guiding principles of health care set out in the Act. These principles include quality care which is prompt, considerate and respectful, and which encourages decisions about treatment in an environment of informed choice.

Regarding complaints against residential care services, an overlap of responsibility exists between the Health Services Commissioner, the Victorian Department of Health & Community Services, and the Commonwealth Department of Human Services and Health.

Some complaints come to the HSC as the first port of call. Others come to the HSC only if the complainant has been dissatisfied with the explanation received from the relevant government department. This means that the HSC can act either directly or as an independent back-up for aggrieved consumers.

Paradoxically, the multiplicity of agencies with responsibility for monitoring or regulating residential care has caused confusion and uncertainty in the industry as to who should intervene when poor service is uncovered.

The Health Services Commissioner can investigate the performance of the Department of Health & Community Services in ensuring compliance with the guiding principles of the Act.

The Commissioner has extensive powers of investigation, but no power to enforce sanctions such as fines or deregistration. However, a provider must report to the Commissioner on how remedies proposed by the Commissioner have been implemented. If remedial action is not taken, the Commissioner may refer the issue to an appropriate agency with powers of enforcement, or name the provider in Parliament.

The Commissioner, and the Health Services Review Council, also have a role in policy development. For example, the former Commissioner chaired a Government review of the *Medical Practitioners Act*, which led to draft legislation that defines 'professional misconduct' more closely and strengthens the powers and accountability of the Medical Board. More recently, the Commissioner and the Australian Medical Association drew up a Code of Practice for medical practitioners with patients in nursing homes, hostels or supported residential services.

## THE COMMONWEALTH DEPARTMENT OF HUMAN SERVICES AND HEALTH

### Functions

The Commonwealth Department of Human Services & Health (DHS&H) has responsibility for the *National Health Act 1953* and the *Aged or Disabled Persons Care Act 1954*. Thus the department has a funding and regulatory function with regard to health services, including residential services.

### Relevance to the issue of Maltreatment

DHS&H is relevant principally as the regulatory authority responsible for nursing homes and hostels.

### Procedures

The Commonwealth department has a range of options for responding to issues of maltreatment or neglect of older people living in residential care:

- The nursing home and hostel standards
- The complaints unit
- The Residential Care Rights Service (an independent advocacy service funded by the Department)
- The Charter of Residents' Rights and Responsibilities
- The Resident/Proprietor Agreement

Each is discussed in turn below.

**Monitoring and enforcement of standards for nursing homes:** Standards for Commonwealth-funded nursing homes were gazetted in November 1987 under section 45D of the *National Health Act 1953* (NHA). Adherence to the standards is a condition of approval. The standards have seven major objectives relating to health care, social independence, freedom of choice, homelike environment, privacy/dignity, variety of experience and safety.

In Victoria, the standards are monitored by teams comprising a nursing officer and an administrative officer. Homes are visited at least once every two years, or more frequently in cases where problems persist. Statements on their compliance with the standards are published.

In cases of significant non-compliance, the Department may impose financial sanctions on a home by withholding Commonwealth benefit in respect of new residents (section 45E or 45FA) or suspending or revoking approval of the home (section 44). Where appropriate, additional conditions of approval may be imposed on a home (section 44AD).

**Monitoring of hostel standards:** Hostel standards were enshrined in legislation in 1990 under the *Aged or Disabled Persons Care Act 1954* (ADPCA). They are similar to nursing home standards and cover freedom of choice, care needs, dignity, privacy, social independence, variety of experience and homelike environment. Again, the hostels are monitored by teams comprising an

administrative officer and a nursing officer. Statements on hostels' compliance with the standards are published. Non-compliance with the General Condition, which includes the Outcome Standards, can result in the withdrawal of Commonwealth funding for all or part of the facility. More flexible sanctions are currently being drafted.

**The Complaints Unit:** A Complaints Unit was established in Victoria in late 1989 to handle complaints against Commonwealth-funded hostels and nursing homes. Two complaints officers investigate complaints from both anonymous and named sources. A complaint may lead to a full inspection by the standards monitoring team.

The complaints and their outcomes are registered against the outcome standards. Measures that can be taken against homes where there is significant non-compliance are the same as those listed in the previous paragraphs. However, more reliance is placed on mediation to ensure a satisfactory outcome to residents.

Because of the inter-relationship between this unit and the Department of Health & Community Services, the Health Services Commissioner, the Residential Care Rights Service and the Office of the Public Advocate, an information-sharing protocol has been developed to rationalise the complaints handling system.

**The Residential Care Rights Service:** As part of its reforms in aged care, the Commonwealth began funding independent advocacy services in 1989. The service funded in Victoria is auspiced by the Older Persons Action Centre and is known as the Residential Care Rights Service. Its purpose is to provide support and advice on residents' rights, to encourage action by individuals and groups including approaches to management, to assess complaints, and to help set up residents' committees in nursing homes or hostels.

**Charter of residents' rights and responsibilities:** The Commonwealth has drawn up a Charter of Residents' Rights and Responsibilities. The Charter is a schedule to both the NHA and the ADPCA, and it re-affirms the personal, civil, legal and consumer rights of residents in Commonwealth-funded nursing homes and hostels.

**The Resident/Proprietor Agreement:** The Resident/Proprietor Agreement, which has legal status under the NHA, enables the principles in the Charter to be enforced. Residents themselves can take legal action against proprietors if conditions are not met. However, proprietors of nursing homes are not obliged to offer the agreement. In these cases, a notice is issued rendering the proprietor responsible to the Commonwealth for the terms contained in the common form of agreement.

### **Boundaries of the Commonwealth's role**

The Commonwealth department is principally concerned with the regulation of the nursing homes and hostels which it funds. It is not responsible for the private-sector supported residential services in Victoria. Conversely, there has been less attention to the regulation of standards of care in home-care services. This imbalance is now being addressed. The Commonwealth and State governments have recently launched standards for HACC services. These require services to develop an appropriate complaints mechanism.

## THE VICTORIAN DEPARTMENT OF HEALTH & COMMUNITY SERVICES (H&CS)

### **Function**

H&CS has responsibility for the *Health Services Act* 1988 and the Health Services (Residential Care) Regulations 1991. Thus the department has a regulatory function with regard to health services, including supported residential services. The Act and Regulations specify a range of requirements which must be met by supported residential services, in order to be registered and licensed to operate in Victoria.

### **Relevance to the issue of maltreatment and neglect**

H&CS is relevant mainly as the regulatory authority responsible for supported residential services. These establishments used to be called special accommodation houses, and are essentially private-sector hostels for frail aged or disabled people. About 60 per cent of residents are aged 70-plus (Ministerial Review of Special Accommodation Houses, 1987, p.13).

### **Procedures**

Victoria has had specific legislation to protect residents in supported residential services since 1974. In the past, the legislation has been criticised for concentrating on physical aspects (buildings, linen, food) rather than quality of life. The 1988 legislation recognises the resident as the purchaser of a service. It prescribes the responsibilities of the provider and sets out penalties for failure to deliver any agreed services.

The principles in section 10 of the *Health Services Act* 1988 can be described as a bill of rights for residents. The principles are similar to the outcome standards set by the Commonwealth for nursing homes and hostels. Their aim is to protect vulnerable people in residential care from harm through exposure to exploitation, maltreatment or neglect.

The Residential Care Regulation & Compliance Unit is the agency within H&CS that has responsibility for these regulatory functions. The functions are:

- the registration and bi-annual re-registration of each facility and approval of the proprietor to operate;
- the routine inspection of registered facilities to ensure compliance with the Act and Regulations;
- the investigation of complaints from residents or others regarding care and accommodation;
- the provision of advice and educational support to proprietors and health care providers.

Under the *Health Services Act* 1988, Authorised Officers (Nursing Advisors) may enter a registered funded agency or health service establishment to ascertain whether the Act and the regulations are being complied with.

Complaints to the Residential Care Regulation & Compliance Unit come from residents, their relatives and friends, staff, community visitors associated with the Office of the Public Advocate, visiting health professionals (district nurses, aged care assessment teams), local government (health surveyors) and sometimes MPs representing their constituents. Complaints are often anonymous.

Complaints range from the minor and vexatious to the serious and urgent. Advisors are able to visit a facility at any point in time. For example, in order to investigate a complaint in relation to food and nutrition, the Adviser will visit at meal times, or if the complaint related to the practices of night staff, Advisors will visit during the night or early morning.

Advisors will discuss the allegations and the underlying issues with all those concerned (complainant, residents, manager, providers). Sometimes resolution is through conciliation; on other occasions further education and ongoing monitoring is required; or, in serious and substantiated cases, the application of sanctions.

Where there are breaches of the regulations or concerns about the standard of care, the Department has a range of options:

- Nursing Advisors may advise and educate in order to alter the attitudes of management and staff and thus improve the quality of care;
- Infringement notices may be issued, or the Department may give notice of an intention to revoke registration, or may issue a short-term registration whose renewal is contingent on demonstrated compliance with special conditions. The Department may also appoint an administrator, prosecute, censure in parliament, and/or revoke the registration and close the facility.

Referral to another government agency is sometimes appropriate. For example, a complaint involving a negligent treatment by a medical practitioner may be referred to the Medical Board and/or the Health Services Commissioner. Concerns relating to the inappropriate management of the finances of a resident may be referred to the Guardianship Board. Inappropriate care of a resident known to be a client of Psychiatric Services or Intellectual Disability Services may be referred back to those agencies. A highly dependant resident in a supported residential service will be referred to an Aged Care Assessment Team. An incontinent resident will be referred to a Continence Nurse Adviser. An elderly confused resident exhibiting severe behavioural problems which are currently being poorly managed will be referred to a Psychogeriatric Assessment and Treatment service or a community mental health clinic.

### **Boundaries of the Department's role**

H&CS has a critical role in regulating one major form of residential care—namely supported residential services. It not only monitors and enforces compliance with the prescribed standards of care, but also attempts to improve standards by educating the service providers.

Since 1992, the Department has overhauled the regulatory regime. Amendments to the *Health Services Act* in 1994 eliminated the overlap between Commonwealth and State regulation by removing nursing homes and hostels from coverage by the Victorian legislation. Responsibility for

regulating Victoria's supported residential services was given to the new Division of Aged Care Services. The Division has a strong commitment to enforcing compliance with the Health Services (Residential Care) Regulations 1991. Major results have been as follows:

- Since 1991, inspections have been concentrated on 300 SRSs rather than the 900 hostels, nursing homes and SRSs previously monitored. The Department has ended the wasteful duplication of effort with the Commonwealth.
- Definite time lines are now placed on proprietors to rectify breaches of the Regulations detected by Authorized Officers. Known breaches will no longer be allowed to persist indefinitely.
- Proprietors of SRSs in breach have been instructed to attend meetings with the Manager of the Unit, at which they have been advised of the consequences of continuing breaches of the Regulations.
- Proper procedures have been implemented for the preparation of briefs for legal action. The Nurse Advisors have been more thoroughly trained in legal procedure to improve the quality of the Department's briefs for counsel.

There are, however, limitations on the extent to which a high standard of care can be maintained in supported residential services by means of regulation alone. Since H&CS does not have a role in funding SRSs, the Department must use other policy instruments to improve the quality of life for current and potential SRS residents. Improving their access to outside services, such as Adult Day Activity Support Services, has been identified by the Department as one such strategy. Another is to overhaul the management of psychiatric services in order to improve the case management of clients. This includes the creation of Psychogeriatric Assessment and Treatment Services (PGATS) to work alongside the 19 ACATs. One of the aims is to ensure that clients are not referred to inappropriate SRS accommodation, and to ensure that clients living in SRSs are not isolated from the rest of the service system.

## THE VICTORIA POLICE

### **Function**

The Victoria Police operate under an organisational philosophy that stresses the maintenance of law and order. Its objectives are 'the preservation of peace, protection of life and property, and the prevention and detection of crime.'

### **Relevance to the issue of maltreatment**

Two roles of the police are relevant to the present project:

- responding to 'family incidents' involving an older person;
- investigating other matters reported by the public in which an older person may be at

risk (including self neglect).

The Police keep records of their attendance at family incidents. These are defined as incidents in the home involving some form of mistreatment committed by a member of the family or the household (including an incident caused by a visiting boyfriend or by a permanent boarder). In 1990-91, the police attended 11,087 family incidents throughout Victoria (Victoria Police, 1991, p.151). In the great majority of cases, the complainant was aged 21-45 years. Only about 360 or 3.3 per cent were incidents in which a person aged over 61 was the complainant or victim. Conversely, in about 2.2 per cent of incidents, the 'other principal party' (meaning the apparent perpetrator) was aged more than 61. These figures are consistent with the figures below on the age distribution of people seeking family violence intervention orders.

### **Procedures**

The guidelines for all police are defined in the following documents:

- Victoria Police Manual
- Victoria Police Standing Orders
- Victoria Police Manual—Administrative Procedures and Personnel Management
- Force Circular Memorandums.

There are no specific documents defining police intervention in cases of maltreatment or neglect of older people. On the other hand, there are guidelines that cover two related areas:

- Force Circular Memorandum—Family Violence
- Code of Practice for Sexual Assault Cases.

**The Community Policing Squads:** As well as the normal police force at District level, there are 26 Community Policing Squads. In the Melbourne metropolitan area, there are 10 squads, one in each District; in country areas there are 16 squads. Metro squads have a staff of up to 18, led by a senior sergeant; country squads have from one to five members.

All squads are supported by the Community Policing Co-ordination Office in East Melbourne. This office also incorporates the Family Violence Project Office and the Victim Liaison Office.

The work of the squads completely overlaps with the regular police force, in the sense that all police must respond to incidents of law-breaking. However, the CPS provide a specialist service that focuses on domestic violence, sexual assault and child abuse. Thus the squads are normally referred cases involving incidents of domestic violence.

### **Boundaries of the police role**

Insofar as incidents involving the maltreatment of older people may involve law-breaking, the police have an obvious role. One situation of maltreatment is best considered under the heading of domestic violence, and in this regard the police role will be the same as in other 'family incidents'. It should be noted that the category of 'family incidents' includes behaviour such as assaults that may often constitute breaches of the criminal law. Often, therefore, the police are the appropriate

investigatory body where offences such as assault, theft and fraud are suspected, whether in private homes or in institutional settings.

However, as *No Innocent Bystanders* remarked (p.125), criminal law will be a useful remedy in only a limited number of cases. Nevertheless, these drawbacks should not deter people and community agencies from reporting suspected offences against older people to the police.

The police also have a role in assisting other agencies fulfil their protective functions—for example, section 27 of the *Guardianship and Administration Board Act*, authorising the police to assist the Public Advocate, gives the police the power to use reasonable force to enter premises so that an assessment of a disabled person can be made. This would cover cases where a vulnerable elderly person was apparently being kept isolated from necessary services. Similarly, section 10 of the *Mental Health Act* gives the police the power to apprehend a person who requires psychiatric treatment, in certain defined circumstances, and section 9 authorises the police to take the person to an appropriate psychiatric inpatient service. This situation might arise, for example, where an older person was under threat from the behaviour of a psychiatrically disturbed son or daughter, and the latter was refusing to seek treatment.

More generally, the police have an important role as the all-purpose agency for responding to after-hours crises or cases where a member of the public has raised a concern but does not know exactly which agency is appropriate to deal with it. Thus the police should be a vital part of the referral networks among aged care services.

## DOMESTIC VIOLENCE—FORMS OF INTERVENTION

### Definitions

The terms ‘domestic violence’ or ‘family violence’ are used to describe a range of socially unacceptable behaviour between the members of a family. The unacceptable behaviour may range from physical assault to psychological abuse. Often the terms domestic violence and family violence are used narrowly as synonyms for ‘wife abuse.’ An example of a broader definition is as follows:

Family violence occurs between people who are known to each other by way of familial or other domestic relationships, past or present. It includes abuse of parents, siblings and other relatives, but predominantly involves violence against sexual partners and the abuse of children (Victorian Community Council Against Violence, *Family Violence—Everybody’s Business, Somebody’s Life*, p.60).

The *Crimes (Family Violence) Act 1987* is the major form of legal protection for victims of domestic violence in Victoria. Although the Act does not contain an explicit definition of family violence, the Act has a scope that goes beyond wife abuse. In effect, it offers protection against *any* member of a family or household who is assaulting, threatening to assault, molesting or harassing any other member. The victim may be a child or a grandparent as well as a wife; the perpetrator may be a mother as well as a husband.

Thus the Act's implicit definition of domestic violence overlaps very substantially with child abuse. It also overlaps with the field of elder abuse.

Alternatively, it can be said that the Act's definition of domestic violence *encompasses* much of child abuse and abuse of older people. But if elder abuse is regarded as a distinct (though not exclusive) field, it will be more natural to regard this field and the field of domestic violence as *overlapping*. Some incidents of abuse can then be regarded as *both* domestic violence and elder abuse; other incidents, such as professional malpractice or fraud against an older person, might be classified as elder abuse but do not fit the definition of domestic violence.

Intervention in the field of domestic violence has evolved under competing paradigms of criminal law and civil law.<sup>1</sup> Forms of legal intervention available to the victim may include recourse to the Family Courts under the *Family Law Act*, if the parties are or were married or have children. There are also a range of psychologists and family therapists who, though they lack the coercive powers of the police and the courts, are nevertheless capable of dealing with a range of behaviour falling under the broader definition of domestic violence (such as 'psychological or emotional or verbal abuse', which the Community Council Against Violence included in its definition of domestic violence).

Evidence mounted in the 1980s that existing forms of protection were in many cases either ineffective or inaccessible. As a result, the *Crimes (Family Violence) Act* was introduced in 1987. Its aim was to make the police and the courts more effective as forms of intervention. (For a good discussion of the legal issues, see *Report No.2*, Victorian Community Council Against Violence 1991).

The administration of the Act is within the portfolio of the Attorney-General, who receives reports on its implementation from the Family Violence Prevention Committee. The Committee has representatives of a range of government and non-government agencies.

### **Relevance to older people**

The main purpose of the Act was to protect women from violent husbands and de facto spouses. However, the Act can be used by any person in a household against another member of the household if the relevant criteria are met. In 1992-93, some 9039 complaints were laid under the Act in Magistrates Courts.

Comparatively few older people are using the procedures under the *Crimes (Family Violence) Act*. From 1 July 1992 to 30 June 1993, only 297 people aged 60 or older applied for intervention orders. This is only 3.3 per cent of the more than 9,000 complaints laid in that year; see the *Crimes*

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<sup>1</sup> Thus the Community Council Against Violence stated:

“Council believes that the criminal justice system should be applied to its full extent as the prime means of confronting and stopping domestic violence.”—*Report No. 2: the Legal System and Family Violence*, Feb.1991, p.8.

However, such attempts to persuade the community that family violence should be equated with criminal assault in the home have so far been only partially successful.

*(Family Violence) Act Monitoring Report 1992-93*, Table 2.1a. Nevertheless, it is clear that *some* older people are making use of intervention orders to prevent mistreatment by other members of the family. Further interpretation of these figures will be found below.

### **Procedures under the *Crimes (Family Violence) Act 1987***

The *Crimes (Family Violence) Act 1987* provides a legal remedy for a person who is the victim of ongoing assault or harassment committed by another member of the victim's family or household.

The types of harm covered by the Act are diverse. They include physical assault, threats, damage to property, harassment, molestation and offensive behaviour. The victim and the perpetrator must be currently or recently members of the same household, but they do not have to be married or related to each other. The great majority of those using the Act are partners in marital or de facto relationships and other relatives.

The Act enables the victim or 'aggrieved family member' to apply to a magistrates court for an intervention order prohibiting the offender from continuing the harmful conduct. The victim can apply personally to the court for an order, or an application can be made on behalf of the victim by a member of the police force. In certain circumstances the application can be made by another person on the victim's behalf.

The order can require the offender to leave the household and cease contacting the victim, if the magistrate believes such steps are necessary to protect the victim. An order can be made for up to 12 months. An offender who breaches an order made against him or her can be charged with committing a criminal offence.

### **Boundaries of the Family Violence procedures**

It was noted above that only 3 per cent of people seeking intervention orders are aged 60-plus. This could either be an accurate reflection of the (low) level of mistreatment of older people by family members, or it could be an indication that the available forms of intervention are not well adapted to the circumstances of older people.

There is some evidence that older people are using the procedures differently from non-aged people. In general, women comprise the great majority of 'aggrieved family members' (that is, people taking out an order). Women comprise 85 per cent of this total group, men only 15 per cent. But among older people as complainants, the proportion of men rises considerably. Thus, among people aged 65-plus taking out orders, women comprise 62 per cent of complainants, men 38 per cent.

The reason for this difference can be attributed to the characteristics of the person against whom the order is sought. Older people are more likely to be seeking orders against their children and grandchildren than against their spouse.

When older women seek intervention orders, the defendant is slightly more likely to be their child, step-child or grandchild (48 per cent) than their husband (45 per cent).

This pattern is more pronounced among men. Some 70 per cent of the intervention orders taken out by older men (men aged 61-plus) are against their children (or grandchildren, sons-in-law, etc.). Only 26 per cent of the orders are against wives.

Three different points should be noted. Firstly, it is evident that the ‘classic’ form of domestic violence—spouse abuse by a husband—is not confined to younger couples. There were 100 cases in which a person aged 61-plus laid a complaint against a spouse. In 74 of these cases the complainant was the wife, and in 24 of these cases the wife was aged 71-plus.

Secondly, just as many older women are likely to seek protection from abusive children as from abusive husbands. Thirdly, older men are much more likely to seek protection from abusive children than from wives.<sup>2</sup>

These facts about the available forms of intervention are probably not widely recognised, even among the agencies dealing with domestic violence and marriage breakdown. For example, the Domestic Violence and Incest Resource Centre is aware that a small proportion of older women seek its help, and that it is not currently geared to dealing with the special needs of this target group. The same is certainly true of the women’s refuges, which are focussed almost entirely on helping non-aged women with dependent children. No agencies have a specific focus on the short-term housing needs of older people who are victims of domestic violence, and there is no reliable information on the likely demand for such help. More generally, there has been little attention to the overall question of adapting the forms of intervention and support to the situation of older people who become victims of domestic violence.

## HOME AND COMMUNITY CARE SERVICES

### Function

Services funded under the Home and Community Care (HACC) program include home help, delivered meals and home nursing. Their purpose is to help people to maintain their independence while continuing to live in their own homes. Target groups for the program are elderly people, people with disabilities and their carers. Discussion in this paper will concentrate on frail aged people.

### Relevance

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<sup>2</sup> The relative importance of the Family Violence law for different groups in the family can be understood by comparing the size of the following four groups of “aggrieved family members”:

- wives seeking orders against their husbands (71% of all orders);
- older people (men and women aged 61-plus) seeking orders against their children or grandchildren (1.7% of orders);
- older people seeking orders against their spouse (1.1%);
- children under 17 seeking orders against a parent (1.7%).

Source: *Crimes (Family Violence) Act Monitoring Report 1992-93*, Caseflow Analysis Section, Department of Justice, Melbourne 1993. In the list above, there is an overlap between the first and third items.

The HACC target group, since it includes frail aged people and family caregivers, overlaps very largely with the group who may be at risk of mistreatment or neglect. The infrastructure for the local aged care system comes largely from HACC. HACC services therefore have a good capacity to monitor the wellbeing of the at-risk groups. How far this potential is realised will vary from one municipality to another, depending on the way in which the services are organised.

Home nursing services are also a major part of the HACC program. Across the metropolitan area, they are largely delivered by the Royal District Nursing Service.

### **Procedures**

Procedures for assessing client needs and monitoring the effect of services on client welfare vary between municipalities. In some areas, the services are delivered on a fairly instrumental basis; in other areas, there are more sophisticated procedures for assessment, monitoring and case management. The general direction of the HACC program is towards encouraging such improvements in the quality of services. As a matter of good management, most municipalities will already have developed internal procedures for monitoring users. Home care workers and visiting nurses would normally be expected to report to management any significant change in their client's wellbeing. In most cases, naturally, such changes in the status of the older person are a result of improvements or declines in health, availability of family support, and so on—that is, factors other than abuse. Until recently, most home care services have therefore not necessarily felt the need to develop formal procedures to deal with issues of abuse or maltreatment.

For the same reason, the National Guidelines for the HACC program have put much more emphasis on delivering a good service to eligible clients than on assessing the risk that clients may be at risk of maltreatment in the home (*Getting it Right*, 1992). The Guidelines are at pains to respect the autonomy of older people, their right to privacy and their right to refuse a service. The Guidelines make no direct reference to procedures for dealing with maltreatment, except in cases where the fault lies with the service itself.

On the other hand, all or most HACC services would have had to confront these issues on occasion. As a general rule, staff would be expected to report suspected maltreatment or self-neglect to their supervisor. It would be up to the supervisor to decide in what way the matter should be further investigated.

### **Boundaries of HACC**

HACC services have clearly not been designed as 'adult protective services', and there is no question of extending them very far in this direction. Nevertheless they already form the basis of the aged care system for elderly people living in the community, and they must be considered an essential part of any strategy for alleviating some of the situations in which elderly people suffer maltreatment and neglect. Often it is the HACC service that is the first to become aware of situations of maltreatment or neglect, because the HACC service is the only formal service to have close and ongoing contact with the older person. Two situations in particular are relevant here: caregiver stress, and self neglect.

When the burden on a family caregiver is the cause of maltreatment, there will often be scope for HACC services to alleviate the situation by offering more support, or a more appropriate kind of support, or referral to alternative services such as respite care or residential care. The possibility of such intervention will depend on the capacity of the HACC services to monitor and assess the client's overall situation, and it will also depend on the quality of the service's links with other relevant agencies.

Home nursing services, because their front-line staff are professionally-trained health workers, are in a good position to detect certain kinds of maltreatment and neglect.

Self neglect raises some distinctive issues. In particular, it demands a subtle approach to the potential clash between the principle of respecting the autonomy of older people and the principle of ensuring that society does not abandon a mentally incompetent person. Local HACC services are well placed to detect and decide on how to respond appropriately to such situations. Again, links to other agencies including the Guardianship Board will be important.

## AGED CARE ASSESSMENT TEAMS

### **Function**

The Aged Care Assessment Teams (ACATs) (previously known as Geriatric Assessment Teams) were set up to make assessments of the needs of frail aged people. At first their main focus was to assess whether a person was in need of nursing-home care. They are now undertaking a broader role in assessing people's eligibility for hostel care, for rehabilitation and for home care. At this stage, the nineteen ACATs in Victoria have no monopoly on assessing eligibility for home care; most such assessments are done by the local service providers or the home-nursing services.

### **Relevance**

The work of the ACATs is almost entirely focussed on frail aged people. Hence it can be assumed that the ACAT target group will include part of the sub-set of elderly people at risk of maltreatment or neglect. The relevance of the ACATs is increased by the fact that the teams are designed to undertake all-round assessments of the social and medical circumstances of the older person, and are well connected to the regional system of aged care services.

### **Procedures**

The teams rely on other agencies and individuals in health and welfare services to refer elderly people to them for assessment. Such referrals may come from GPs, nursing homes, hospitals and home care services. Members of the team include geriatricians, social workers and nurses.

Assessments should cover the older person's family and social environment as well as their medical condition. Ideally the assessment should involve a home visit, but actual practice varies between teams. The outcome of the assessment should be a recommendation about the most appropriate mix of available services to meet that individual's needs.

**Boundaries of ACATs**

The great value of ACATs for the present purpose is that they are strategically placed to assess the health status and social circumstances of large numbers of frail aged people (over 30,000 assessments annually, 80 per cent being people aged 70-plus, and 80 per cent living in the community—see Otis, 1992.) The ACATs are multi-disciplinary teams, and usually have strong credibility with both the region's health services and its local welfare services. The teams are already routinely seeing elderly people who would be part of the at-risk group. It would be comparatively easy to modify the assessment tools so that they were more sensitive to these risk factors. On the other hand, the ACATs are not designed for ongoing case-management of individuals with complex needs. All that a team normally does is to make a referral to another service-delivery agency. Nevertheless, 40 per cent of ACAT assessments are re-assessments, so the ACATs do have a role in ongoing monitoring of client welfare.

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