



Recommendations from the Victorian Government response to the *Report of the Elder Abuse Prevention Project*

Overview

The Victorian Government responded in June 2006 to the *Elder Abuse Prevention Project Report* (December 2005) by funding the following recommendations which aim to strengthen the whole-of-government response to address abuse of senior Victorians. The recommendations promote and support the independence, safety and dignity of senior Victorians.

Recommendation 1

That the Victorian Government strengthens its response to elder abuse based on current legislative and service arrangements. This approach recognises the right of older people to determine their own course of action and where required, access practical assistance to support their needs to deal with situations of abuse and regain independence and control over their lives.

Recommendation 2

That the Department of Planning and Community Development (formerly the Department for Victorian Communities) be given lead agency responsibility for developing and maintaining a whole-of-government policy framework on prevention and responses to elder abuse, and for ongoing monitoring of implementation, evaluation and research.

Recommendation 3

That community education programs be developed to raise awareness of the risks of abuse. To be delivered on an ongoing basis and conducted sensitively in a way that does not unduly alarm senior Victorians or reinforce inappropriate negative stereotypes about ageing.

Recommendation 4

That a statewide information and education service is established to provide information; telephone assistance and referral support to older people experiencing or suspicious of abuse.

The service would provide community education and act as a central point for the dissemination of research and materials on good practice to older people, service providers and the general community.

Recommendation 5

That a broad alliance of government and community agencies be established to promote the prevention of abuse of older people and provide ongoing leadership and advice to the statewide service.

Recommendation 6

That DHS update its existing guide on the prevention of elder abuse for funded health services and community agencies and supports the development of local agency protocols. Resources should be provided to deliver training and support to agencies to complement prevention and community education strategies.

Recommendation 7

That assistance is provided to new and existing local interagency protocols to support and further develop collaboration and cooperation, to appropriately respond and support older people subject to abuse.

Recommendation 8

That Victoria's approach to the prevention of abuse towards older people be strengthened to improve cooperation and collaboration of prevention and response services, extending beyond the health and community services sector to include Office of Public Advocate, Victoria Police, financial services, legal and advocacy programs, community groups and spiritual leaders.

Recommendation 9

That Victorian communities are supported to be age friendly where older people can feel safe and confident. Communities should also be supported to promote the active participation of older people and to minimise the risk of social isolation.

Recommendation 10

That the Victorian Government works with the Commonwealth and other state and territory governments to research both the extent of elder abuse and best practice approaches to prevention, detection and service responses.

Recommendation 11

That consideration is given to the provision of specialised community legal services targeted to the specific needs of disadvantaged older people to improve access to justice.

For further information contact the OSV and refer to [7.2.2 The Victorian Department of Planning and Community Development \(Office of Senior Victorians\)](#).

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Definitions

10.1 Types of carers

An older person may be receiving support from all, one or none of these types of care or supports.

Primary carer

The main informal carer of an older person, often a formal partner, daughter or son, or extended family member. At times, a primary carer may be a close friend. The primary carer may be receiving a carer payment or allowance from the Commonwealth Government. The primary carer would be involved in care planning decisions and arrangements, should formal services be provided to an older person. The primary carer might also be receiving carer services in their own right, to support them in their caring role.

Carer

A person, often a neighbour or friend, who provides some type of support function on a consistent basis—maybe daily, weekly or monthly—that contributes to an older person’s capacity to live independently. They would not be receiving remuneration for their services from an older person or be contracted to provide government funded services for older people. They would not be receiving a carer pension to support their caring role. The carer might be aligned with a local church or service group, such as Rotary, Probus, Lions or Apex.

Care worker

A person employed as a personal carer or home help worker, by a community organisation or health service to provide services that assist with an older person’s daily living requirements. These employees are part of an assessed and contracted service arrangement which would be supervised and reviewed on a regular basis. Formal carers will have been trained and have an accredited tertiary care certificate of some type. They will be paid by the organisation they are contracted to. A formal carer might work for a private community care organisation as distinct from a government-subsidised one, in which case they should still have successfully completed an accredited training certificate appropriate to the work contracted to be undertaken with an older person.

10.2 Mental capacity testing

Mental capacity is generally determined by clinical assessment. Determinations of capacity may include assessment of cognitive skills (awareness, knowledge, judgment and reasoning) as well as one’s ability to execute necessary tasks (actual ability to carry out a decision or action).

In the case of ability to live independently, the person must be able to understand the decision at hand, to perform in the environment, and to appreciate their limitations or special care needs.

In order to make valid treatment decisions, a person must be able to (a) recognize there is a decision to be made, (b) understand the necessary information, (c) understand the options for treatment, (d) understand the possible consequences of each option (that is, risks, burdens, and benefits), and (e) rationally process the information to arrive at a decision consistent with his/her values.⁵⁰

⁵⁰ Department of Human Services Deputy Chief Psychiatrist, 2007, *Mental Health*.

10.3 Competency testing

Competence and capacity are terms often used interchangeably although they are not exactly the same. Competence is a legal term and is often presumed unless a court has determined that an individual does not demonstrate competence.

A testing of competence generally occurs within a legal environment, where evidence is presented by medical officers, family members and individuals, and on the basis of this information a decision is made about whether or not the person is 'competent' to make decisions regarding certain matters.

Neither incompetence nor mental incapacity is global or all-inclusive. A lack of competence or inability to make reasoned and informed decisions about major medical treatments does not mean the person cannot decide if they need pain medication or less invasive assistance. Furthermore, if the person demonstrates capacity in one domain (that is, independent living) this does not mean that the person is automatically capable of rational decisions across other domains including financial or medical matters.⁵¹

10.4 Protocol, policy and procedure

In the context of this document, the following terms have specific meanings:

Protocol

An agreement between a number of organisations on a mutually agreed course of action.

Policy

A course or line of action (what we do or do not do) in this service or agency.

Procedure

The mode of conducting the action (that is, how we do it) in this service or agency.

10.5 Duty of care

A duty of care encompasses a duty not to be careless or negligent, and arises from a relationship between parties that are regarded as sufficiently close as to infer that an obligation exists in some form.

This relationship involves the notion of 'proximity' or a degree of closeness.

Proximity is usually described in terms of time and (physical) space and 'circumstantial casual' relationship, such as the relationship between employer and employee, health worker and client.

Duty of care involves a legal obligation to avoid causing harm to another person. This only arises where it is reasonably foreseeable in a particular situation that the other person would be harmed by an action or omission, without the exercise of reasonable care.⁵²

Health and aged care workers have a duty of care to older people they are assisting. Under the *Wrongs Act 1958 (Vic)*, a worker is not negligent in failing to take precautions against a risk of harm unless:

- a) the risk was foreseeable (that is, it is a risk of which the person knew or ought to have known);
- b) the risk was not insignificant (not far-fetched or fanciful);⁵³ and

⁵¹ Ibid.

⁵² *The CCH Macquarie Concise Dictionary of Modern Law*.

⁵³ *Wrongs Act 1958 (Vic) Section 48(3)*.

c) in the circumstances, a reasonable person in the worker’s position would have taken those precautions.⁵⁴

If a worker breaches their duty of care, they have failed to meet the expected standards of care.

Duty of care refers not only to the actions of a worker, but also to advice the worker gives or fails to give. For points of application, refer to *Question 5: If abuse of an older person or their carer is suspected but not acknowledged, what should I do?* and *4.1.3 Relevant definitions and references* for information and context.

10.6 Enduring powers of attorney (financial)

An enduring power of attorney (financial) allows a donor to choose someone to make financial and legal decisions on their behalf. ‘Enduring’ means the power continues even when a donor is unable to make these types of decisions.

The test for capacity to make an enduring power of attorney (financial) is that a donor understands:

- the powers of the attorney
- when the attorney can exercise these powers
- that a donor can revoke these powers while they have capacity
- that the power will operate if a donor loses the ability to make legal and financial decisions
- that the donor may, in the power of attorney, specify conditions or limitations on, or instruction about, the exercise of the power to be given to the attorney⁵⁵
- once a donor loses capacity, they will not be able to supervise the use of the powers.

Formal requirements

An enduring power of attorney (financial) must be in the approved written form and comply with requirements outlined in Section 123 of the Instruments Act 1958. These include:

- the enduring power of attorney needs to be signed and dated by two adult witnesses in the presence of the donor and each other
- one witness must be authorised to witness the signing of a statutory declaration
- each witness must sign certificates containing information required by the legislation, including:
 - a statement that the donor signed the enduring power of attorney freely and voluntarily in the presence of the witness
 - the donor had the necessary capacity to understand and sign the enduring power of attorney
- the enduring power of attorney is only effective once the attorney has accepted the appointment
- a statement of acceptance in the appropriate form needs to be signed by the attorney.

The Office of the Public Advocate has published a two- page guide for people appointed with enduring power of attorney (financial), which includes some general information about what the law requires of attorneys. For example, the law requires that an attorney:

- act in a donor’s best interests
- wherever possible, make the same decision that the donor would have made
- keep accurate records of dealings and transactions made under the power
- avoid situations where there is a conflict of interest
- keep the donor’s property and money separate from their own.

⁵⁴ Wrongs Act 1958 (Vic) Section 48(1).

⁵⁵ Refer to Section 118(2) of the Instruments Act 1958.

For direct EPA application points refer to [2.1.1 Financial abuse](#), [7.1.2 The Victorian Civil and Administrative Tribunal–Guardianship List \(VCAT\)](#) and Case study [8.6 Financial exploitation](#).

10.7 Enduring powers of attorney (medical treatment)

An enduring power of attorney (medical treatment) gives an appointed agent authority to make decisions about medical treatment on a donor’s behalf if that person becomes incompetent through ageing, mental or physical illness or injury.

An agent may be a family member, friend or professional person, but a donor cannot appoint two people jointly. However, a person can appoint an alternative agent, should the original agent die, become incompetent or be uncontactable.

The agent can only refuse medical treatment on a donor’s behalf if it would cause unreasonable distress or if there were reasonable grounds for believing if the donor was competent, they would have considered the treatment unwarranted.⁵⁶

An enduring power of attorney (medical treatment) does not empower an agent to refuse palliative care.

An agent must:

- act in the donor’s best interests
- wherever possible, make the same decision that the donor would have made
- avoid situations where there is a conflict of interest.

To help the agent understand a donor’s views about possible medical procedures (for example, the use of a life support system), the Public Advocate suggests discussing this with the agent and for a donor to write down their wishes.

When the donor dies, the enduring power of attorney (medical treatment) ends.

If the agent is unsure what to do in a particular situation, they can contact the Office of the Public Advocate’s advice service or VCAT for assistance.

Alternatively, anyone who believes an agent is not acting in a person’s best interests can apply to the VCAT Guardianship List to challenge the decision to refuse medical treatment.

For direct EPA application points refer to [2.1.1 Financial abuse](#), [7.1.2 The Victorian Civil and Administrative Tribunal–Guardianship List \(VCAT\)](#) and the case study in [8.6 Financial exploitation](#).

10.8 Aboriginal

For the purposes of this document, ‘Aboriginal’ refers to people who identify as Aboriginal, Torres Strait Islander or as both Aboriginal and Torres Strait Islander.⁵⁷ Aboriginal organisations are those that receive funding to provide services to the Aboriginal community. Generic or mainstream organisations are those that are funded to provide services to a diverse population, including culturally and linguistically diverse (CALD) and Aboriginal people. Some generic organisations receive funding specifically targeted to provide services to Aboriginal people.

⁵⁶ Medical Treatment Act 1988 (Vic) Section 5B.

⁵⁷ Department of Human Services, 2006, *Building better partnerships: Working with Aboriginal communities and organisations: a communication guide for the Department of Human Services*.