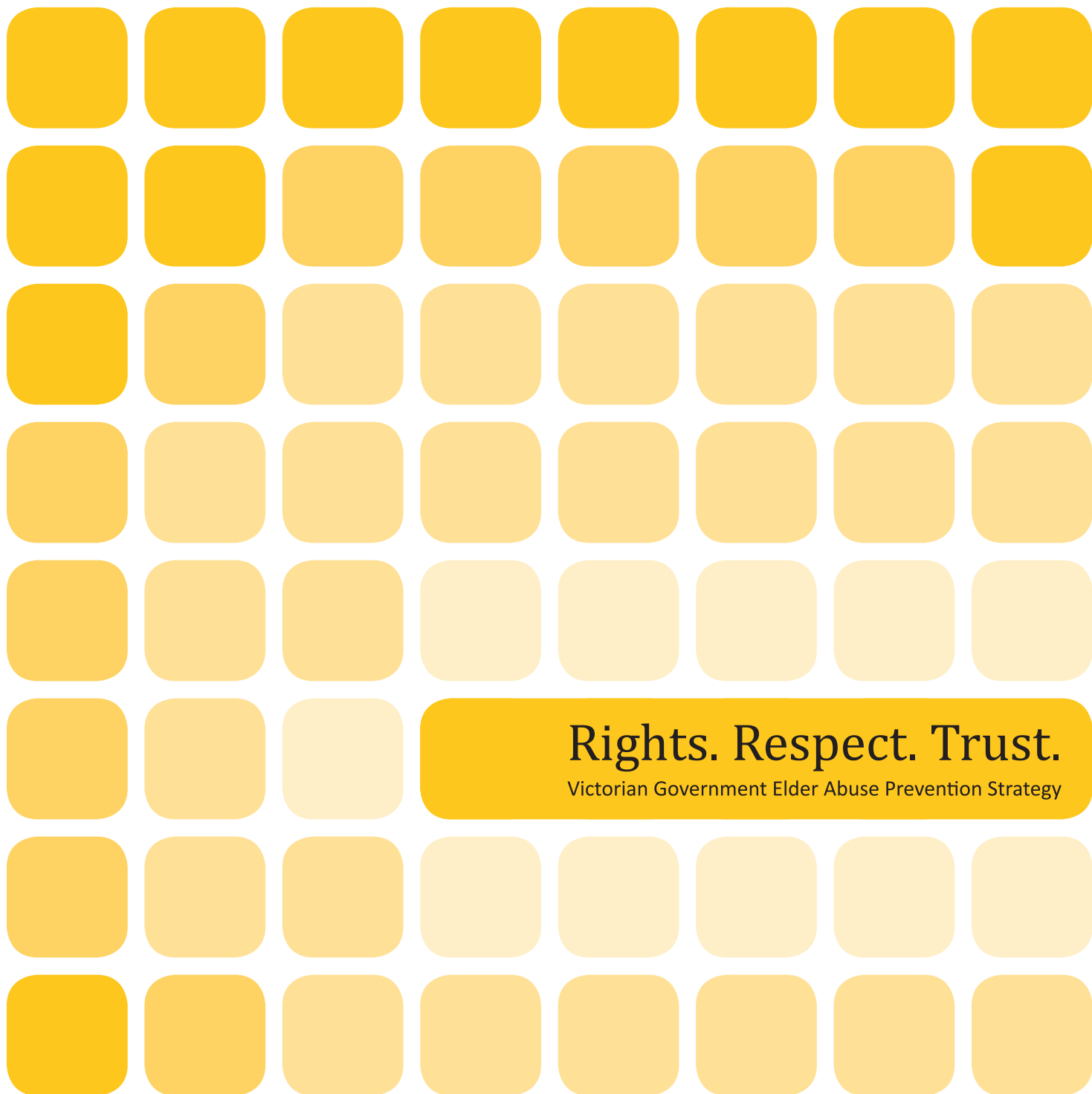


# With respect to age – 2009

Victorian Government practice guidelines for health services and community agencies  
for the prevention of elder abuse



**Rights. Respect. Trust.**

Victorian Government Elder Abuse Prevention Strategy

# With respect to age – 2009

Victorian Government practice guidelines for health services and community agencies  
for the prevention of elder abuse

June 2009

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## Minister's foreword

Most senior Victorians lead healthy, active and passionate lives, are independent and supported by caring family, friendships and service support networks of varying types.

Older people have the right—as do people of all ages—to live safely in their own homes, free from violence, abuse, neglect and exploitation. However, sometimes older people experience abuse, and these situations should be addressed.

Abuse involving older people is a complex social problem which requires careful and considered responses.

The Victorian Government responded to the *Report of the Elder Abuse Prevention Project, December 2005*, and provided funding of \$5.9 million to implement 11 recommendations.

The Victorian Government Elder Abuse Prevention Strategy, Rights. Respect. Trust. is made up of the following key initiatives:

- Seniors Rights Victoria, which includes a telephone helpline, advocacy and support, an older person's legal service and community education.
- the Victorian Government Practice Guide *With respect to age – 2009*, for health services and community agencies dealing with elder abuse.
- professional education material and a financial literacy awareness raising package for older people.
- a broad communications strategy targeting the general population and older Victorians.

Links between the abuse of older people, disempowerment and discrimination have been consistently demonstrated in research throughout the world.

The Victorian Government response to elder abuse is firmly based on principles that empower older people. Our aim must be to enable and empower older people to act for themselves and on their own behalf, to exercise their rights and be confident of the services and resources available to assist them. This approach underpins all the initiatives of the Victorian Government Elder Abuse Prevention Strategy.

The purpose of *With respect to age – 2009* the Victorian Government practice guide, is to support providers of health and community services who work with older people to develop their own agency policies and procedures, as well as local interagency protocols to address incidents or suspicion of abuse.

I congratulate and thank all who have contributed to the development of this guide.



**HON LISA NEVILLE MP**  
Minister for Senior Victorians



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## Preface

Preventing abuse of older people in our society is increasingly acknowledged as a social concern.

In 1995 an earlier version of this guide, *With Respect to Age*, was written and distributed by the then Department of Health and Community Services to Victorian health services and community agencies.

Since then, many Victorian health and community service providers have developed specialist expertise and practical wisdom for navigating complex scenarios where older people are subject to abuse – especially where family members are involved. In addition, many providers have developed formal and effective protocols and resources, which have been shared within local networks.

No evidence exists to indicate an increase in abuse of older people, but detection is increasing. The existence and reporting of abuse towards older people is likely to grow in prominence due to three main factors:

- increasing numbers of older people, particularly the significant increase in the number of people aged 75 years and above expected over the next 15 years
- increasing longevity
- increasing numbers of people with dementia.

Many health and community care workers involved with older people encounter abusive situations. Circumstances surrounding abuse may raise difficult legal, ethical and practice challenges.

At a broader level, other jurisdictions have developed abuse prevention models and responses, including supporting service provider peer networks, advocacy and community awareness raising campaigns.

Significant international research on elder abuse prevention continues, including the development of principles and community-based service model approaches by the World Health Organization (WHO).

This guide is principally for workers in health agencies and community services that support older people. Its preparation drew on:

- advice from older people who live in Victoria
- consultation with workers in health and community sectors
- the views and experience of a range of stakeholders.

Many organisations are well advanced and eager to develop their skill and capacity further to respond to elder abuse, as well as share approaches and knowledge with other service providers.

These guidelines reflect clear advice from service providers that, while abuse is disturbing, dealing with these situations is part of the day-to-day business of providing health and community services to older people and their primary carers. Issues for service providers arise not necessarily from inadequate legislation or from reluctance to act, but often from uncertainty about how and when to act and who else to include.

The Victorian Government's strategic response to elder abuse affirms that Victoria's existing services, and the networks that bind them at a local level, are appropriately placed to manage suspected and actual incidents of abuse.

## Acknowledgements

The contributions to the development of this guide by many staff in the Department of Human Services, the Department of Planning and Community Development (Office of Senior Victorians), the Department of Justice, Victoria Police, statutory bodies such as the Office of Public Advocate and Victoria funded agency staff are gratefully acknowledged. In addition international contributions as well as those from other Australian states and territories are also acknowledged, with thanks.

***Elder abuse is a violation of human rights  
and a significant cause of injury, illness,  
lost productivity, isolation and despair.***

***Confronting and reducing elder abuse requires  
a multisectoral and multidisciplinary approach.***

Active Ageing, A Policy Framework, World Health Organization, 2002

## Feedback

We welcome your comments with regard to this publication. Please send your ideas or information to email: [aged.care@dhs.vic.gov.au](mailto:aged.care@dhs.vic.gov.au).



# Background and context

## Overview

The purpose of this guide is to:

- outline the Victorian Government response to the abuse of older people who live in their home, in the community
- provide practical guidance for health and community service workers to develop agency policies and procedures to respond and act on suspicion or allegation of elder abuse
- support the development and review of interagency protocols that enable cooperation in responding to elder abuse
- provide a range of resources that assist and reinforce the development of policies, procedures and protocols
- strengthen the capacity of health services and community service organisations to respond with confidence to prevent, and to address, elder abuse as required.

This guide targets workers supporting older people in:

- health services, such as:
  - hospitals, including emergency departments
  - rehabilitation services
  - subacute services
  - nursing and allied health services provided in the home and other settings
  - community health services
- community agencies, such as:
  - local government
  - not-for-profit organisations and private organisations involved in providing home and community care (HACC)
- providers of:
  - Community Aged Care Packages (CACPs)
  - Extended Aged Care at Home (EACH) packages
  - Extended Aged Care at Home Dementia (EACHD) packages
  - respite services
  - mental health services for older people
  - community legal aid services
  - family violence support services
  - Aboriginal services
  - services supporting people from culturally and linguistically diverse backgrounds.

## 1.1 The policy approach—empowering older people

A Fairer Victoria<sup>1</sup> is the Victorian Government's social policy action plan presenting key principles and initiatives that support social sustainability. A Fairer Victoria focuses on the needs of disadvantaged community members, including families, children, older Victorians, Aboriginal Victorians, people with a disability and people with mental health issues.

In that policy context, the Victorian Government response to the prevention of abuse of older people report, *Supporting the Safety and Dignity of Senior Victorians* (June 2006), addresses prevention, awareness-raising and service response at the individual, organisation and community levels. The approach is a combination of service responses and legal interventions which protect the independence, dignity and safety of senior Victorians. These include support from health services and community agencies, criminal and civil justice remedies, and complaint and compliance mechanisms.

The Victorian Government's approach is based on empowering older people, consistent with the universal human right to live life free from violence and abuse. It also reflects a commitment to support the safety, security and dignity of all older people in our community.<sup>2</sup> The *Charter of Human Rights and Responsibilities Act 2006* came into effect on January 2008, making it the first charter of human rights enacted by an Australian state.<sup>3</sup>

The empowerment model is underpinned by values reflected in policies and practice that support self-determination, informed choice and the ability of adults to make their own decisions. This approach also extends to the protections under the *Guardianship and Administration Act 1986* for older people who lack capacity.

An adult protective and mandatory reporting approach is not supported by the Victorian Government, senior Victorians and industry stakeholders. Other Australian states and territories have developed empowerment approaches, as has the World Health Organization (WHO).

Whole-of-government family violence reform has also been a key strategy of A Fairer Victoria, with key objectives of increasing safety and accountability. Intimate partner violence is the leading contributor to the health burden of women. Family violence reform resources have also been targeted to increasing mainstream system capacity to respond to diverse communities, including Indigenous communities, women with disabilities and women from CALD backgrounds.

<sup>1</sup> *A Fairer Victoria, Creating Opportunity and Addressing Disadvantage 2005–06 and 2007*. For further information refer to: [www.dvc.vic.gov.au/web14/dvc/dvcmain.nsf/allDocs/RWPBA66A032F874AC59CA2572D00026A891?OpenDocument](http://www.dvc.vic.gov.au/web14/dvc/dvcmain.nsf/allDocs/RWPBA66A032F874AC59CA2572D00026A891?OpenDocument)

<sup>2</sup> United Nations Organization, 1948, *Declaration of Human Rights*, Geneva.

<sup>3</sup> Victorian Charter of Human Rights and Responsibilities Act 2006. For further information refer to: [www.justice.victoria.gov.au/humanrights/](http://www.justice.victoria.gov.au/humanrights/)

### 1.1.1 Key principles underpinning the implementation of the Victorian Government Elder Abuse Prevention Strategy

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

The Victorian Government approach is driven by informed examination of the shortcomings and strengths of our current systems, rather than from a crisis approach. The philosophy of empowerment involves listening to older people—it is an active process. Older people should be provided with the best available information to assist them to make decisions about their lives, including information about the services they can access, should they require them.

## 1.2 The nature and definition of abuse

Elder abuse was recognised in the 1980s as an under-reported form of societal violence, similar to child abuse in terms of having unrefined methods to detect and modify the abuse. Currently, there is no systematic collection of statistics or prevalence studies (that is, the total number of ongoing cases in the population at a point in time). However, some Australian studies estimate that prevalence ranges from below 1 per cent to 5 per cent.<sup>4</sup> Results of different studies vary, depending on the methodology and definitions used, but evidence suggests that abuse of older people is much more common than societies admit. Much of the problem is hidden, and data is not collected in a consistent manner.

While the population is growing older and living longer, this does not mean that people are exposed to abusive circumstances that they would not have encountered when younger. The difference is that with advancing age may

<sup>4</sup> Boldy D, Horner B, Crouchley K, Davey M, Boylen S, 2005, *Addressing elder abuse: West Australian case study*, *Australasian Journal on Ageing* 24(1): 3–8.

come new vulnerabilities—not always associated with frailty. Some correlates of ageing may create a life pattern not as robust and as capable of managing life issues and new experiences, whether chosen or imposed, including:

- shrinking social and friendship networks
- reduced access to information
- capacity to keep up to date with changes
- loss of economic power.

When choosing an age to define ‘older’ for the purposes of this issue, 65 years is commonly used, but most people do not experience vulnerabilities at that stage in their life.

The Commonwealth Government uses population estimates for the general population aged 70 years or over, plus Aboriginal Australians<sup>5</sup> aged 50 years and over, when planning services for older people. The *Commonwealth Government Aged Care Act 1997* recognises the implications of differences in health status and life expectancies between the Aboriginal population and general population.

Other countries, and some international bodies, use 60 years. The age chosen is influenced by cultural context and life course.

For the purposes of identifying and defining abuse of older people, the focus should be on the effects on the older person, rather than the intention of the perpetrator.

### 1.2.1 Victorian Government definition of elder abuse

The report of the Elder Abuse Prevention project, *Strengthening Victoria’s Response to Elder Abuse* (December 2005), defines abuse as:

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

This definition is consistent with Australian and international agreement about what constitutes abuse of older people and defines a relationship where trust is the sole connection. It excludes relationships that, for example, are based on the exchange of money for services.

For information on types of abuse (financial, physical, sexual, psychological or emotional, social and neglect) and suggested identifying behaviours and signs, refer to [Section 2: Types of abuse and risk factors](#).

Abuse is typically carried out by someone close to an older person with whom they have a relationship implying trust, including family members or friends. Often an older person is dependent on the perpetrator, for example, where an older person is frail or incompetent and the perpetrator is the principal carer. Mental incompetence (for example, dementia), physical frailty or economic circumstances may force an older person to depend on another for housing. However, dependence is not a defining characteristic of abuse—the older person might not be dependent, and may actually be supporting the perpetrator.

Sometimes abuse is the continuation of long-standing patterns of physical or emotional abuse within a family. It could also be the result of stressful situations, such as changes in living arrangements and personal relationships which occur when the care needs of an older person change due to increasing frailty. Abuse can also be the result of the personal characteristics and life course of the perpetrator, such as substance abuse or financial dependency.

Abuse may occur as a result of ignorance or negligence—or it may be deliberate. Some forms of abuse are criminal acts, for example, physical and sexual abuse. Other types, such as financial misappropriation, may not

<sup>5</sup>Department of Health and Aged Care (DHAC), 2001, *Aged Care in Australia*, Canberra

reach the level of criminality, but may require redress through guardianship or civil proceedings ([Section 8: Case studies](#) contains some examples).

The range of acts or omissions that constitute abuse occur along a continuum: at one end, harm results from a poor understanding of an older person's needs; at the other, harm results from aggression and serious physical assault. In different circumstances, different sorts of interventions are required.

The underlying principle of empowerment on which the Victorian Government response to abuse for people living in the community is based focuses on 'strengthening the arm' or capacity of an older person to say and act on what they want to happen and when.

## 1.3 Abusive relationships other than those based on trust

People generally recognise abuse, but often choose to excuse it due to surrounding circumstances. Paying attention to the different contexts in which incidents of abuse occurs can be more useful than merely defining the nature of the abuse, such as physical, psychological, sexual, neglect or financial.

### 1.3.1 Consumer-based circumstances

These occur when money is exchanged for a service, and are based on commercial relationships, for example: financial planners, accountants, tradespeople, hairdressers.

Consumer Affairs Victoria (CAV, refer to [7.2.3 The Victorian Department of Justice](#)) provides consumer protection for Victorians regarding products and services. CAV advises on consumers' rights and responsibilities and who to contact when dealing with businesses and buying products in Victoria, for example:

- buying and selling cars and property
- renting a house, flat or building
- managing credit and debt
- shopping over the Internet
- fundraising
- current consumer scams and how to avoid them.

### 1.3.2 Professional misconduct

Where concern exists about how health or community care professionals conduct themselves in general, including suspicion of or alleged abuse, courses of intervention include lodging a complaint with:

- the organisation employing the worker
- the Health Services Commissioner
- the Medical Board
- the Nurses Board of Victoria
- other appropriate regulatory authorities.

For example, the Nurses Board of Victoria has power, under the *Health Professions Registration Act 2005*, to investigate complaints about professional misconduct.

Professional misconduct includes:

- unprofessional conduct of a health practitioner, where the conduct involves a substantial or consistent failure to reach or maintain a reasonable standard of competence and diligence

- conduct that violates or falls short of, to a substantial degree, the standard of professional conduct observed by members of the profession of good repute or competency
- conduct of a health practitioner, whether occurring in connection with the practice of the health practitioner's health profession or occurring otherwise than in connection with the practice of a health profession, that would, if established, justify a finding that the practitioner is not of good character or is otherwise not a fit and proper person to engage in the practice of that health profession.

'Professional performance' means the knowledge, skill or care possessed and applied by a registered health practitioner in the provision of regulated health services. A 'professional standards panel' is one established by a responsible board under Schedule 2 of the Act. 'Proprietary interest' means a legal or beneficial interest, and includes a proprietary interest as a sole proprietor, partner, director, member or shareholder of a company or as the trustee or beneficiary of a trust.

Such misconduct can be reported to appropriate professional regulatory bodies, the Health Services Commissioner or, in some cases, the relevant government department.

The Nurses Board of Victoria also has the power to investigate complaints of 'unprofessional conduct' within the meaning of Section 3(1) of the Health Professions Registration Act.

Alleged criminal activity should be reported directly to the police.

If harm is suffered, an older person may have remedies under common law, such as an action for negligence or breach of contract.

### 1.3.3 Harassment and criminal acts

Such acts by strangers are excluded from the definition of elder abuse due to the absence of a trusting relationship, and are more appropriately classified as criminal activity.

### 1.3.4 Self-neglect or self-mistreatment

Behaviours identified as self-neglect or self-mistreatment would not align with the definition of elder abuse, nor the context, as defined in this guide.

Such behaviours might be better managed through the broader health system, the police or local municipal council, depending on the circumstances. For example, if self-neglect occurs in which a competent person insists on living in unhygienic conditions, the situation could be addressed as a nuisance under the *Health Act 1958*.<sup>6</sup> However, the nuisance provisions in the Health Act only enable action to be taken with respect to a person who has a nuisance emanating from their property that poses a risk to the health of their neighbours. In this instance, the local municipal council may be the first point of contact.

Self-neglect or self-mistreatment of an individual may co-exist with abuse associated with a relationship between that individual and a trusted person.

### 1.3.5 Residential aged care services (RACS)

Older people may also be susceptible to abuse in residential aged care or similar settings, which could be evidenced in physical, financial, sexual, psychological, emotional or neglectful behaviours similar to community settings.

Policy and practice regarding preventing abuse of older people in community and residential aged care settings are quite similar. However, abuse that occurs in a residential aged care setting might better be characterised as a 'failure of care' on the part of the provider, who has the responsibility to ensure that residents are protected from abuse.

<sup>6</sup> Refer to Part 3 of the Health Act. The Health Act will be replaced by the *Public Health and Wellbeing Act* on 1 January 2010.



The Commonwealth Government, as the funder and regulator of residential and community aged care services under the Aged Care Act 1997, introduced major safeguards against abuse. Refer to [7.2.4 The Commonwealth Department of Health and Ageing](#) for further information.

## 1.4 Additional considerations

### 1.4.1 Abuse of older Aboriginal people

#### Abuse in context

Those who work in the field and work in Aboriginal communities will be familiar with the increasing incidence of abuse. Many Aboriginal people have either personally experienced abuse or violence, or know someone who has.

Statistics on abuse or violence in Aboriginal communities points to an increase in incidence. However, becoming more familiar with the factors contributing to this increase should strengthen understanding of how better to improve the situation.

One factor alone cannot be singled out as causing abuse in Aboriginal families; rather, a multitude of interrelated factors are attributable. A useful way of understanding these factors is by categorising them into two groups:

#### Group 1 factors include:

Colonisation; policies and practices; dispossession of land and traditional cultural dislocation; inherited grief and trauma; dislocation of families through child removal policies; the impact of institutionalism; the breakdown of community kinship systems and Aboriginal lore, including the adaptation and change of gender roles.

#### Group 2 factors include:

Marginalisation as a minority; society attitudes in general and stereotyping; direct and indirect racism; economic exclusion; unemployment; welfare dependency; past history of abuse; entrenched poverty; destructive coping behaviours; addictions; alcohol and drug abuse; health and mental health issues; low self-esteem and a sense of powerlessness.<sup>7</sup>

Group 2 factors can be caused or compounded by Group 1 factors. The interplay of these factors in individual families' experiences of abuse can be exceedingly complex.

#### Addressing abuse of older Aboriginal people

The combination of the above factors impacts on older Aboriginal people considerably, particularly the responsibility for a variety of roles to meet the expectations of their community. For example, many older Aboriginal people provide multiple caring roles, including kinship care. This may involve caring for children removed from parents due to abuse and neglect and then cared for by family, rather than by a foster carer unrelated or unknown to them. These multiple roles may expose older Aboriginal people to broader potential abuse from within their community.

<sup>7</sup> Cripps, K, 2006, *Indigenous Family Violence: From Emergency Measures to Committed Long-Term Action*. An early draft of this paper was presented 29 November 2006 as part of the Robert Riley Memorial Lecture Series, Curtin University. For further information refer to: [dbs.ilectures.curtin.edu.au/ilectures/ilectures.lasso?ut=856](http://dbs.ilectures.curtin.edu.au/ilectures/ilectures.lasso?ut=856). Dr Kylie Cripps is an Aboriginal academic, currently a CIPHER post-doctoral research fellow at the Onemda VicHealth Koori Health Unit, University of Melbourne.

Heightened interventions have led to increased scrutiny of Aboriginal people, perhaps contributing to instability within families. Many feel disempowered in their roles, because traditionally, family structures were safe and secure. Western law and the struggle to live in two societies continue to affect Aboriginal people.<sup>8</sup>

In the context of Aboriginal culture, the term ‘older’ and ‘elder’ are often used interchangeably. In the context of abuse of older Aboriginal people, the term ‘recognised elders and respected community representatives’ could be used, because age alone does not necessarily bring with it recognition as an elder. Some Aboriginal communities will have few recognised elders; in other instances Aboriginal people above a certain age will refer to themselves as elders.

When discussing or negotiating with Aboriginal communities it is important to recognise and involve elders and respected community members as well as communicate with Aboriginal community organisations. This will vary between communities, and might involve, for example, making contact with the Aboriginal Housing Board of Victoria to assist with disseminating written information. Workers should select an Aboriginal organisation whose purpose aligns with the assistance sought. Relevant Aboriginal organisations include local Aboriginal community-controlled organisations or Aboriginal peak bodies, such as the Victorian Aboriginal Community Controlled Health Organisation (VACCHO). For further information refer to [7.1.16 Victorian Aboriginal services](#).

Aboriginal people may also receive service support from generic or Koori-specific organisations. Much will depend on the choice of an older person and the circumstances they experience.

### Current government strategies addressing Victorian Aboriginal communities, older people and abuse

In 2002 the Victorian Government released a framework made up of three stages to develop and implement an Indigenous Family Violence Strategy (IFVS)<sup>9</sup> for Victoria:

- Stage 1 established an Indigenous-led taskforce to advise government how to address family violence within Indigenous communities effectively (the final report was released in 2003).
- Stage 2 was the government’s response to the recommendations of the taskforce (2004), which established an Indigenous Family Violence Partnership Forum in April 2005.
- Stage 3 involved the development and implementation of a ten-year plan to address family violence in Indigenous communities, which was launched in June 2008.

The Indigenous community and the Victorian Government recently agreed on a ten-year plan (Stage 3, above), called Strong Culture, Strong Peoples, Strong Families—Towards a Safer Future for Indigenous Families and Communities, to address Indigenous family violence. The plan is the culmination of a community-led process, supported by government and overseen by the Indigenous Family Violence Partnership Forum. The plan outlines agreed strategies and actions for both government and community to prevent and eliminate family violence in Indigenous communities.

Indigenous community members provided extensive input into the development of the plan under the leadership and guidance of Indigenous Family Violence Regional Action Groups (refer to [7.1.16 Victorian Aboriginal services](#)). These groups have a lead role in strengthening community leadership and driving local action to educate, prevent, reduce and respond to family violence in the Indigenous community.

These groups are an inclusive mechanism for the Victorian Indigenous community to develop local responses to family violence matters, ensuring they are responsive and culturally relevant to indigenous individuals, families and communities.<sup>10</sup>

<sup>8</sup> Report on the findings of the *Department of Human Services The Koori Alcohol and Drug Plan 2003–2004*.

<sup>9</sup> Refer to: [www.office-for-children.victoria.gov.au/family-violence-sexual-assault/indigenous](http://www.office-for-children.victoria.gov.au/family-violence-sexual-assault/indigenous)

<sup>10</sup> For further information refer to: [www1.dvc.vic.gov.au/aav/](http://www1.dvc.vic.gov.au/aav/)

The Department of Human Services report *Improving the way we work with Aboriginal organisations*<sup>11</sup> aims to strengthen outcomes for Aboriginal Victorians by supporting the capacity of Aboriginal community-controlled organisations (ACCO).

The Home and Community Care (HACC) Victorian Indigenous Committee for Aged Care and Disability (VICACD) vision is to improve the wellbeing and quality of life of Aboriginal elders, carers and people with a disability living in Victoria. VICACD represents the needs of Aboriginal people and agencies in Victoria on aged care and disability issues.

The Department of Human Services, Aged Care Branch, has developed a Strengthening Home and Community Care (HACC) in Aboriginal Communities strategy (January 2008), which responds to several projects and reports commissioned by the department from 2002 to 2006. The project aims to enhance the capacity of HACC-funded Aboriginal organisations to provide services to Aboriginal aged and disabled people and their carers.

This strategy takes into consideration the principles of the Cultural Respect Framework (Australian Health Ministers Advisory Council, 2004, *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–09*, Department of Health, South Australia).

The document *Improving the Lives of Indigenous Victorians: Victorian Indigenous Affairs Framework* aims to ensure Aboriginal people receive the best possible services into the future (refer to the *Project Report*, April 2007<sup>12</sup>). The report highlights the scope, depth and breadth of issues facing this sector on a range of fronts. This project reflects a partnership between key Aboriginal peak and statewide bodies and Commonwealth and Victorian State Government departments.

In May 2008 the Department of Human Services released an updated and more targeted Aboriginal Services Plan (January 2008 to December 2010), replacing the 2004 version.<sup>13</sup> This new plan is more specific, and highlights areas to improve outcomes and help bridge the life expectancy gap between Aboriginal and non-Aboriginal people and improve the quality of life for Aboriginal people in Victoria.

Addressing the abuse of older Aboriginal people lies in the context of existing strategies, networks and structures which engage older Aboriginal people and Aboriginal communities in Victoria.

## 1.4.2 Abuse of older people with culturally and linguistically diverse backgrounds

Cultural factors influence how all forms of abuse are viewed, and specific strategies and responses to elder abuse should address such differences.

Being culturally informed and providing sensitive support is an integral component of service provision. It is important that workers provide support with an understanding of culture beyond their country of origin. For example, the perpetrator's refusal to allow workers who speak the older person's language from communicating with them in their preferred (or only) language may be a factor contributing to ongoing abuse. Such isolation can prevent an older person from making disclosures to outside supports, and their only opportunity to communicate without being overheard by the perpetrator may be during personal care activities.

Not having access to workers who can identify with an older person's background (particularly language) can result in minimal understanding of the cultural context of some language or actions that may consequently be deemed insignificant. For example, if a worker commented, 'That person is nervous' in an Anglo-Australian context, there would generally be no cause for immediate concern. However, such a statement made about an elderly Polish person may be cause for concern, because many in the Polish community use the term

<sup>11</sup> For further information refer to: [www.health.vic.gov.au/koori/improveorg.htm](http://www.health.vic.gov.au/koori/improveorg.htm)

<sup>12</sup> For further information refer to: [www.health.vic.gov.au/koori/posfuturereport.pdf](http://www.health.vic.gov.au/koori/posfuturereport.pdf)

<sup>13</sup> For further information refer to: [www.dhs.vic.gov.au/pdpcd/koori/index.htm](http://www.dhs.vic.gov.au/pdpcd/koori/index.htm)

‘nervous’ or ‘nervousness’ to refer to aspects of mental health issues—from mild depression through to someone experiencing a major psychotic episode.

Knowledge of particular cultural barriers faced by older people is important, particularly in the context of safety planning. Prior experience with authorities, such as police, the court system or any type of regime may impact on an older person’s likelihood of accessing these options to enhance their safety.

Victorian Government policy states that, when working with people from a CALD background who do not speak English well, workers should use a professionally qualified interpreter. Friends or family members should not be used as interpreters.

Department of Human Services-funded agencies and services have access to language services (refer to [www.dhs.victoria.gov.au/multicultural/](http://www.dhs.victoria.gov.au/multicultural/) for additional policy information). Staff in all agencies should be familiar with their agency practice regarding accessing language services.

Preventing an older person with a CALD background from having contact with members of their language and/or cultural group can be a form of abuse resulting in physical, mental and social isolation, and can increase the level of dependence on the carer.

What Anglo-Australians consider inappropriate or abusive may not be considered so in other cultural groups, particularly when it comes to financial management.

Ethno-specific service providers can be consulted by mainstream providers to provide cultural advice on a range of factors and assist with contextual understanding of different communities. This approach contributes to informed and effective response and support.

### 1.4.3 Gender and diversity considerations

A Fairer Victoria (2007)<sup>14</sup> outlines and builds on the Victorian Government’s commitment to ensuring fair and accessible services for all Victorians with a focus on disadvantage and inequality.

Victoria’s Integrated Health Promotion Framework<sup>15</sup> recognises differences in gender and culture beliefs, and that gender relations and cultural values and practices are central to how health beliefs and behaviours are developed and carried out.

A shift has occurred away from treating women and men as respective homogeneous groups. We now look at how sex and gender interact with other social determinants, such as socio-economic status, Aboriginal origin, age, disability, cultural and linguistic diversity, geographic location, sexual orientation and gender identity.

The Victorian Women’s Health and Wellbeing Strategy Stage 2, 2006–2010 (VWHWS) developed a gender and diversity lens aimed at Department of Human Services policy makers and workers in funded agencies. This was designed to assist with considering the gender implications of their work, which will have beneficial outcomes for both women and men.

The principles underpinning the Victorian Government’s Family Violence Reform include recognition that:

Responses to family violence must recognise and address the power imbalance and gender inequality between those using violence (predominantly men) and those experiencing violence (predominantly women and children).

<sup>14</sup> A Fairer Victoria, 2008, For further information refer to: [www.dvc.vic.gov.au/web14/dvc/dvcmain.nsf/allDocs/RWPBA66A032F874AC59CA2572D00026A891?OpenDocument](http://www.dvc.vic.gov.au/web14/dvc/dvcmain.nsf/allDocs/RWPBA66A032F874AC59CA2572D00026A891?OpenDocument)

<sup>15</sup> Department of Human Services, 2003, *Integrated health promotion: A practice guide for health providers*: [www.health.victoria.gov.au/healthpromotion/what\\_is/index.htm](http://www.health.victoria.gov.au/healthpromotion/what_is/index.htm)

Family violence affects the entire community and occurs right across society, regardless of location, socio-economic and health status, age, culture, gender, sexual identity, ability, ethnicity or religion; therefore, responses must take into account the needs and experiences of people from diverse backgrounds and communities.

Sex and gender are not mutually exclusive concepts. Gender should sometimes be considered outside the traditional concepts of masculinity and femininity. For example, some people born intersex may not have a clear biological sex distinction, and transgendered people may experience an inner sense of gender that is different from their sex.

Responses to the impacts of gender and health require different strategies for women and men, and these will be influenced by a range of cultural, social and economic factors. For example, gender can influence:

- decision making
- access to resources
- the organisation of family life and care responsibilities
- division of paid and unpaid labour
- economic status
- educational background
- experiences of abuse or violence.<sup>16</sup>

<sup>16</sup> Women's Health Victoria: *Why Women's Health?* [www.whv.org.au/health\\_policy/gender.htm#why](http://www.whv.org.au/health_policy/gender.htm#why)

# 2

## Types of abuse and risk factors

### Overview

Elder abuse is a complex phenomenon which is not easily classified.

Abuse of an older person occurs within a broad range of different relationships and environments. The perpetrator may be a relative, friend or service provider (staff or volunteer).

For guidance regarding abuse by a paid carer, a dependent adult, a family violence situation or conflict in a shared household refer to [Section 7: Resources](#).

This section intends to inform workers about the types of abuse and some associated behaviours and signs that might align with an abusive situation. These descriptions aim to raise the capacity of direct care workers, health professions, service coordinators, case workers and managers to identify suspicion of abuse and then to act with increased confidence, utilising agency policy and procedures and interagency protocol as indicated in this guide.

Incidents can fall into more than one category and involve more than one person, for example, a spouse, de facto spouse, friend or person of trust.

Despite complexities surrounding the issue, research shows that financial abuse is one of the most common types of abuse, and is often accompanied by other forms of abuse.

Research also shows that women are two or three times more likely to experience elder abuse than men, and sons and daughters are most likely to be responsible for the abuse.<sup>17</sup>

### 2.1 Types of abuse

#### 2.1.1 Financial abuse

This covers the illegal use, improper use or mismanagement of a person's money, property or financial resources by a person with whom they have a relationship implying trust.

**Behaviours that are financially abusive include:**

- threatening, coercing or forcing an older person into handing over an asset, for example, signing paperwork concerning property, wills or powers of attorney
- abusing or neglecting powers of attorney to manage an older person's finances
- stealing goods from an older person, whether expensive jewellery, credit cards, cash, electronic equipment or basic necessities such as blankets and food
- using an older person's banking and financial documents without authorisation, for example, credit cards
- managing the finances of a competent older person without permission
- misuse of an older person's possessions or money
- taking an older person to a general practitioner other than their own, for an assessment of decision-making capacity, in order to access an enduring power of attorney (refer to [10.6 Enduring powers of attorney](#))

<sup>17</sup> Advocare Inc., 2003, Western Australia.

(*financial*) and *10.7 Enduring powers of attorney (medical treatment)* in *Definitions*), particularly if the doctor speaks a language different from the older person

- appropriating the proceeds of the sale of an older person's home with the promise of providing future accommodation or care, and then not providing it
- pressuring an older person to relinquish an anticipated inheritance, or for a gift or a loan
- incurring bills for which an older person is responsible
- threats or undue pressure on an older person, for example, to sell the house or hand over assets.

**Signs of financial abuse include:**

- missing belongings of an older person, for example, jewellery or art
- the inability of an older person to access adequate food, clothing, shelter or utilities
- promises of 'good care' in exchange for transferring property or money from bank accounts to the carer
- unfamiliar or new signatures on cheques and documents
- the inability of an older person to access bank accounts or statements
- the inability to pay normal accounts, and the presence of unpaid bills
- significant withdrawals
- a decline in an older person's spending habits
- fear, stress and anxiety expressed by an older person
- transfer of assets in circumstances where the person may no longer be sufficiently competent to manage their own financial affairs
- accounts suddenly switched to another financial institution or branch
- drastic changes in the types of banking activities, or to a will
- an increase in the number of unpaid bills handled by a family member
- an absence or lack of amenities when the older person seemingly can afford them, for example, television, clothes, clean linen
- an out-of-character increase in the interest shown by the carer to the older person, or the carer showing unusual concern with the money spent on the beneficiary.

## 2.1.2 Physical abuse

This covers non-accidental acts that result in physical pain or injury or physical coercion.

**Behaviours that are physically abusive include:**

- pushing and shoving
- kicking, punching, slapping, biting, burning
- rough handling
- restraining with rope, belts, ties
- locking the person in a room, building or yard
- using chemical restraints, including: alcohol, prescribed and unprescribed drugs, household chemicals, poisons (a blood test would be required)
- holding a pillow over a person's head.

**Signs of physical abuse include:**

- internal injuries, unexplained bruises, pain on touching
- evidence of hitting, punching, shaking, slapping or use of a weapon, for example, bruises, lacerations, choke marks, abrasions or welts
- burns, for example, by ropes, cigarettes, matches, iron, hot water
- broken and healing bones
- observed unexplained injuries or conditions, such as paralysis, scalp injuries, scratches, sprains, punctures, unattended injuries, hypothermia, dehydration, pressure sores due to physical restraint
- over-sedation or under-sedation (drug induced)
- unexplained pain or restricted movements
- cringing or acting fearfully
- unexplained hair loss (perhaps from pulling), eye injuries, missing teeth
- unexplained accidents
- stories about injuries that conflict between the older person and others.

**2.1.3 Sexual abuse**

This broad term covers a range of unwanted sexual acts, including sexual contact, rape, language or exploitative behaviour, where the older person's consent was not obtained or where consent was obtained through coercion.

**Behaviours that are sexually abusive include:**

- non-consensual sexual contact, language or exploitative behaviour
- touching an older person inappropriately or molestation
- sexual assault
- cleaning or treating the older person's genital area roughly or inappropriately
- viewing obscene videos or making obscene phone calls in the presence of an older person without their consent.

**Signs of sexual abuse include:**

- unexplained sexually transmitted diseases
- recent incontinence (bladder or bowel)
- internal injuries
- human bite marks
- scratches, bruises, pain on touching, choke marks on throat, burn marks
- injury to face, neck, chest, abdomen, thighs or buttocks
- trauma, including bleeding around the genitals, chest, rectum or mouth
- torn or bloody underclothing or bedding
- anxiety when near, or contact suggested with, the alleged perpetrator
- changes in sleep patterns, sleep disturbance or nightmares.



## 2.1.4 Psychological or emotional abuse

This involves inflicting mental stress via actions and threats that cause fear of violence, isolation, deprivation and feelings of shame and powerlessness.<sup>18</sup> For example, it could include treating an older person as if they were a child, engaging in emotional blackmail or preventing access to services.

These behaviours—both verbal and non-verbal—are designed to intimidate, are characterised by repeated patterns of behaviour over time, and are intended to maintain a hold of fear over a person.

### Behaviours that are psychologically or emotionally abusive include:

- pressuring, intimidating or bullying
- name-calling, degrading, humiliating or treating the person like a child, in private or public
- threatening to harm the person, other people or pets
- verbally or physically abusing an older person
- preventing an older person from speaking
- talking about not being able to cope as a carer
- repeatedly telling an older person that they have dementia
- threatening to withdraw affection or access to grandchildren or other loved ones
- threatening to put an older person into a nursing home
- emotional harm (blackmail) via threatening remarks, insults or harsh commands
- preventing access to services.

### Signs of psychological or emotional abuse include:

- resignation, shame
- depression, tearfulness
- confusion and social isolation
- feelings of helplessness
- unexplained paranoia
- excessive fear
- insomnia
- marked passivity or anger.

## 2.1.5 Social abuse

This includes the forced isolation of older people, and sometimes has the additional effect of hiding abuse from outside scrutiny and restricting or stopping social contact with others, including attendance at social activities.

### Behaviours that are socially abusive include:

- preventing contact with family and friends
- withholding mail
- not allowing the older person to use the phone or monitoring their phone calls or disconnecting the phone without consent
- living in, and taking control over an older person's home without their consent
- preventing an older person from engaging in religious or cultural practices, including preventing those from CALD backgrounds from meeting their cultural needs

<sup>18</sup> Australian Society of Geriatric Medicine, 2003, revised *Position Statement No. 1: Elder Abuse*.

- moving an older person far away from the immediate family
- preventing an older person from engaging in Aboriginal cultural practices if they identify as Indigenous.

**Signs of social abuse include:**

- sadness or grief at the loss of interaction with others
- withdrawal or listlessness due to people not visiting
- changes in levels of self-esteem
- worry or anxiety after a particular visit by specific persons
- appearing ashamed.

### 2.1.6 Neglect

This involves the failure of a carer or responsible person to provide life necessities, such as adequate food, shelter, clothing, medical or dental care, as well as the refusal to permit others to provide appropriate care (also known as abandonment). This definition excludes self-neglect by an older person of their own needs.

**Behaviours that are actively or passively neglectful include:**

- failure to provide the necessities of life, such as food, warmth and shelter, or blocking others from providing basic needs
- receiving the carer's allowance and not providing care to an older person for whom one has a responsibility.

**Signs of neglect include:**

- inadequate nutrition, accommodation, clothing, medical or dental care
- poor personal hygiene
- poor skin integrity
- exposure to unsafe, unhealthy, unsanitary conditions
- malnourishment and unexplained weight loss
- hypothermia or overheating
- inappropriate clothing for the season
- the person left alone, abandoned or unattended for long periods
- lack of social, cultural, intellectual or physical stimulation
- lack of safety precautions or inappropriate supervision
- injuries that have not been properly cared for
- carer displaying overly attentive behaviour in the company of others
- under-medication or over-medication.

## 2.2 Possible risk factors

The complex dynamics in which abuse occurs makes it difficult to determine or identify all factors associated with an increased risk of abuse.

Identifying risk often requires workers to balance carefully the autonomy of an older person and that person's perception of risk, with the anxiety of relatives and professionals about risks in the environment and to others.

Risk identification is particularly complex in cases involving neglect by a carer. Untimely intervention may result in the loss of a support system for an older person, or an unwanted move into residential care.

The following circumstances may identify older people at higher risk of abuse, which could contribute to a useful assessment process.

Combinations of these factors may indicate a need for additional support and services to reduce the risk of abuse or address suspicion.

### 2.2.1 Stress in the care 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.

Sometimes carers experience resentment, frustration or anger. These feelings—however expressed—may be reciprocated by the dependent person. Few people enjoy being dependent on others for basic daily living needs.

### 2.2.2 Difficulties accepting care due to health status

In some situations, an older, dependent person may abuse a carer. This may occur due to difficulty in accepting reliance on another person. Psychiatric illness or dementia may result in aggression or a loss of insight and perspective.

The Australian Bureau of Statistics estimates that approximately half of all people with dementia live at home in the community, while the other half are in residential care. Of those living in the community, nearly three-quarters live with other people. This substantial group represents those living with a carer who is often older, which may place the carer at risk of abuse by a person with dementia.

Caring for a person with dementia can lead to the kind of stress that results in abuse if inadequate support is available for the carer.

### 2.2.3 Family violence

#### Where dementia is a factor

The following preventative strategies, though not definitive, may be useful for service providers:<sup>19</sup>

- recognise the stressors related to dementia and caring for a person with dementia
- problematic when the carer of a person with dementia starts dementing
- recognise the role of carers and reflect this in the organisation and delivery of services
- provide more flexibility in service provision and easier access to information.

Refer to *Figure 5: Useful interventions and considerations when developing strategies to prevent or intervene when abuse is suspected and dementia is a concern*.

Family violence can occur in a number of circumstances and in a range of family settings. It can take the form of abuse of the elderly, sibling abuse, violence between same-sex couples, adolescent children being violent towards parents, carers being violent towards a person with a disability, or female-to-male partner violence. However, in the overwhelming majority of cases, family violence is perpetrated by males against their female partners.

The definition of ‘family’ also depends on the specific culture of the community to which the victim belongs. For more information about responding to families when family violence is identified or suspected (refer to *Example 10: Assessing risk* in *3.1.2 Assessment*).

<sup>19</sup> Department of Human Services, Alzheimer’s Association Victoria and La Trobe University, 2000, *Draft protocol: In response to the discussion paper Overcoming Abuse of Older People with Dementia and their Carers*.

## 2.2.4 Isolation

If an older person and the carer are socially isolated, lacking supportive contacts and social networks, there may be an increased risk of abuse and neglect.

## 2.2.5 Dependency

Dependence of a frail older person on a family carer is not a cause of abuse. An abusing relative is more likely to be materially dependent on an older person than non-abusing relatives (refer to Pillemer and Finkelhor, 1989).

## 2.2.6 Psychopathology in an abuser

The abuser may be dependent on an older person for material support, and have a mental health condition as well as dependencies, such as alcoholism or drug abuse. An abuser may also have carer responsibilities.

## 2.2.7 Older parents caring for a mature-aged child with a disability

Sometimes, situations of abuse occur where older parents are caring for a relative with a disability. Many parents of children with disabilities remain primary carers into late middle age and beyond. They are usually co-resident, primary carers of their children who predominantly have an intellectual disability or, less frequently, an acquired brain injury (ABI) or physical disability, for example, multiple sclerosis, cerebral palsy or multiple chronic illnesses.

Primary carers may be up to eighty years old. These living/caring arrangements are usually based on a strong commitment by the carer to continuing care, and are most likely to be of mutual satisfaction to both parties. The living arrangement often involves the co-resident person with a disability taking an active role in running the household.

For the carer, these arrangements may also result in social isolation, depression and poor health. The factors that lead to abuse of the carer are complex, and can involve isolation, the challenging behaviour of the person with the disability, increasing frailty of the carer, and belief by both parties that there are no alternatives to their present situation.

Should the son or daughter being cared for by the older parent have other types of disability, such as alcohol or drug addictive behaviours or mental health issues, then appropriate responses to the abuse of an older person will need to take these additional complexities into account.

## 2.2.8 Other circumstances

These may include:

- lack of information about their rights as an older person, and the fact that those rights are being eroded or abused
- insufficient planning for a purposeful and secure old age
- existing frailty or physical dependency, or the expectation or fear of approaching frailty
- psychological dependency
- inadequate social networks and poor housing conditions
- cultural factors, which can include misuse of customary law for Aboriginal and Torres Strait Islander people, or the expectation in some cultural groups that frail and unwell people will stay home and care for children while their parents work.

## 3

## Service response frameworks

### Overview

Funded health services and community care organisations (for example, community health, HACC providers, family violence and community legal aid services) already use established service response frameworks to manage the day-to-day and emergency care requirements of clients.

Many primary health service providers are familiar with Victorian Primary Care Partnerships (PCPs)<sup>20</sup> which provide a common range of practical tools and approaches to support service delivery. Different sectors (for example, family violence and community legal aid) will have similar tools and approaches to those of PCPs, though the frameworks may vary.

Within the context of PCPs, common service coordination elements provide a framework to develop local systems and processes to facilitate functional integration across PCP agencies. The purpose of functional integration is to make the PCP range of services more visible to people seeking to use those services and consequently easier to access. Achieving functional integration enables service providers to remain independent of one another as entities, but still work in a cohesive and coordinated way so that consumers experience a seamless and integrated response.

Integrating a response to abuse within existing service coordination frameworks, such as the PCP framework, ensures that suspicion or allegations of abuse are treated as core business when providing services to older people and their carers.

Various organisations have developed frameworks to map their service response to elder abuse (refer to [Section 6: Sample intervention and referral frameworks](#)) to assist your thinking.

### 3.1 Primary health provider service coordination stages

#### 3.1.1 Initial contact and initial needs identification (INI)

##### Definition

The first point of contact with the service system commonly includes the provision of accurate service information, the provision of other information, such as health promotion literature, and/or direct access to services via initial needs identification (INI).

As an initial screening process, INI is not a diagnostic process, but identifies the underlying issues and presenting issues to determine risk to the consumer, eligibility and priority for services, and balances service capacity with client needs. The practitioner undertaking INI looks beyond the presenting issues to what underlying issues may exist.

<sup>20</sup> Refer to the Primary Care Partnership (PCP) *Service Coordination Practice Manual 2007, the PCP Good Practice Guide for Practitioners 2007* and [www.health.victoria.gov.au/pcps/publications/sc\\_pracmanual.htm](http://www.health.victoria.gov.au/pcps/publications/sc_pracmanual.htm)

### Policy

When initial contact and identification of service need is undertaken by the relevant worker in your organisation, pay attention to the suspicion or identification of abuse.

If there is suspicion of abuse—either of an older person or the primary carer—the relevant worker should first consult their supervisor before discussing suspected abuse with an older person.

Confidentiality of information must be respected, and the wishes of an older person who may experience abuse should take precedence.

Workers involved in a service response involving elder abuse should be supported by their employer to develop appropriate self-care strategies. Agencies need to ensure the provision of adequate supervision, monitoring and training for workers involved in cases of suspect or alleged abuse.

### Procedures

#### EXAMPLE 1: ACTING ON SUSPICION

##### Question 1: How do I know when someone has been abused?

Commonly, several types of abuse may occur at one time, with indications of different types of abuse being present. However, the presence of one or more indicators does not necessarily mean that abuse has occurred. In these circumstances, workers should remain vigilant to indicators of abuse (refer to [Section 2: Types of abuse and risk factors](#)).

Many forms of elder abuse also constitute family violence. ‘Family violence’ includes violent behaviour that is repeated, controlling, threatening and coercive, and occurs between people who have had or are having an intimate relationship (refer to [Example 10: Assessing risk](#) in [3.1.2 Assessment](#)).

Family violence can occur between family members (parents, spouses, children, partners) and between people who are living or have lived in the same household or residential facility, without the need for the relationship to be intimate, in relationships involving paid or unpaid care and dependency.

Family violence occurs across all cultural and socio-economic groups.

#### EXAMPLE 2: IDENTIFY THE INSTANCE OF ABUSE

A worker should determine the different possible types of abuse through sensitive questioning of an older person and the older person’s family and friends. This should be done with the permission of the older person, to ascertain what signs or symptoms of abuse have been observed or suspected, their severity and frequency.

##### Question 2: When abuse is suspected what should I do?

- Discuss your concerns with your supervisor.
- Vital considerations when addressing abuse include how suspicion is managed, who is spoken to and when.
- Ensure that actions do not cause more harm, and do not undermine the rights of an older person or their carer.
- Considering some basic questions and issues relating to abuse can assist with needs identification. Open-ended, non-judgmental questions about caring and family relationships and dependencies are recommended.

- Any safety concerns for staff should be addressed and managed.
- Be aware that abusive situations make it more difficult for an older person to stand up for their own rights. Identifying the alleged perpetrator or perpetrators of abuse is integral to this stage.
- An older person may or may not be cognitively impaired or mentally competent, nor be aware of the abusive situation. They may not even refer to it as abuse.
- Gathering and substantiating information about individual cases of abuse might need to be done over time, proceeding slowly and carefully.
- Involve other organisations, drawing on their perceptions, judgment and experience to assist in identifying suspected instances. This process helps validate concerns and supports health and community care workers to act on triggers of suspicion.

### Question 3: What about different values and cultural difference?

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

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

With the older person's permission, contact other workers and organisations to assist with understanding of ethnicity and cultural behaviours and values, to know what methods and approaches might be acceptable regarding intervention and support.

Decide whether an interpreter is needed. Friends or family members should not be used as interpreters.

### Question 4: How do I ask an older person about possible abuse?

The health or community care worker should be direct and non-judgmental.

Asking an older person to describe, in a general way, how things are at home and how they spend their day, may be an effective way to open discussion, for example:

*'How are things going at home?'*

*'How do you spend your days?'*

*'How do you feel about the amount of help you get at home?'*

*'How do you feel your (husband/wife/daughter/son/other carer) is managing?'*

*'How are you managing financially?'*

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

If abuse is disclosed, continued privacy should be respected.

Direct verbal questions may be appropriate as the discussion progresses, when trust and rapport has been established, and when there is a high degree of suspicion by workers that abuse exists.

Listen to the older person's story, acknowledging what they have said. Be empathetic, non-judgmental and non-blaming, for example:

*'That must be terrifying. You are a strong person to have survived that.'*

Validate, for example:

*'You are not alone. Others experience abuse in their home/residential aged care/hospital.'*

*'You are not to blame for the abuse.'*

*'You did nothing to deserve or provoke the abuse. Abuse of a person is never justified.'*

*'Your reactions are a normal response to a traumatic situation.'*

Provide information, for example:

*'I can seek assistance for you and your family/carer.'*

*'You have the right to live safely and with dignity, free of fear and abuse.'*

*'What they are doing is a crime. It is not just a family or private matter.'*

### **Question 5: If abuse of an older person or their carer is suspected but not acknowledged, what should I do?**

Direct care workers should not keep information regarding suspicion of or actual abuse to themselves, even if requested to do so by an older person or carer.

Direct care workers should be supported by their employing organisation, receiving regular supervision as well as other opportunities to provide feedback about their work, including capacity to discuss concerns about home visits or general support needs.

A worker should not be placed in a position of compromise, which might occur if a worker feels caught between discussion with an older person and expectations of their role as a direct carer worker.

Direct care workers have a duty of care, which is a legal obligation to avoid causing harm to another person (refer to [10.5 Duty of care](#) in [Definitions](#)). This only arises where it is reasonably foreseeable in a particular situation that the other person would be harmed by an action without the exercise of reasonable care.<sup>21</sup> Duty of care refers not only to the actions of a worker, but also to advice the worker gives or fails to give.

Workers should take care not to give advice beyond their level of competence or beyond the expectations of a person in their position.

Possible actions for the worker to consider include:

- leaving an open opportunity for further contact with the older person
- stating that if abuse becomes a concern, you are available to discuss it with them if they wish
- providing the older person with the means of contacting appropriate support organisations
- looking for further indicators of suspicion of abuse at the next meeting, and if there are any, documenting them clearly in the client file
- consulting your supervisor if concerned about the risk of homicide or suicide, or where there is evidence of neglect
- using open-ended, non-judgmental questions about care giving, family relationships and dependencies
- assessing an older person's adaptive behaviour and perception of risks involved
- asking the person to relate in their own words how they would respond to a particular situation.

Should tensions between duty of care and confidentiality arise, the worker should discuss the situation with their supervisor.

<sup>21</sup> *The CCH Macquarie Concise Dictionary of Modern Law.*



## 3.1.2 Assessment

### Definition

The assessment process collects, weighs and interprets relevant information about the client situation and service needs, including suspected or actual abuse. Assessment is an investigative process using professional and interpersonal skills to uncover relevant issues and develop a care plan.

Assessment is not an end in itself, but part of a process of delivering care and treatment. Several assessments may be required, because specific disciplines collect and interpret particular information to inform the recommended care plan. Each agency should have assessment tools in place that meet consumer, service, agency, reporting and program requirements.

### Policy

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

An assessment worker should first consult their supervisor or line manager before discussing suspect abuse with an older person or an older person's carer or family members.

Assessment workers should contact specialist services, for example, Seniors Rights Victoria (refer to [7.1.1 Seniors Rights Victoria \(SRV\)](#)) for information on elder abuse matters, or a culturally specific service to gain greater understanding of cultural sensitivities, should the older person come from a culturally and linguistically diverse background.

### Procedures

Comprehensive assessments that involve more in-depth or service-specific information include other health and community care workers involved with the situation. Permission should be obtained from an older person to involve other workers before undertaking additional assessments. Issues of confidentiality may arise if permission is refused.

A range of considerations should be explored when identifying the next appropriate action, taking into account all the information, context and timing of the situation.

#### EXAMPLE 3: SERVICE-SPECIFIC ASSESSMENTS

In the case of suspected or alleged abuse, a service-specific assessment may be needed, depending on the type and scale of abuse.

While workers from different disciplines (for example, nurses, social workers, occupational therapists, direct care workers) have distinct expertise, it may be appropriate to draw on broader knowledge such as drug treatment, sexual assault, legal services or family violence services.

Where the abusive situation requires it, expertise beyond the scope of a discrete discipline should be sought and included in the care plan and assessment process (refer to [7.1 Services](#)).

#### EXAMPLE 4: MENTAL CAPACITY TO MAKE DECISIONS AND GIVE CONSENT

Assessment of an older person's capacity to make decisions and informed choices is important. Their right to refuse support should be respected. An older person with mental capacity may be capable of managing their own affairs with minimal support from a health or community care worker.

It is important to consider issues of mental capacity and consent when responding to abuse where an older person has a disability that affects their capacity to make informed decisions (for example, neuro-degenerative conditions, such as dementia). Capacity to make informed decisions is critical, particularly in the context of suspicion or allegations of abuse be it financial, physical, sexual, neglect, mistreatment or medical assessment and treatment. In all circumstances, an older person's consent should be documented appropriately in client records.

#### Question 6: What do I consider to assist the determination of an older person's mental capacity?

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

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

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

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

Dementia is the most common form of assessed incapacity in older people. Dementia can also be a cause for physical or verbal abuse on the part of either the carer or the person with dementia or both (refer to *Figure 4: Strategies for preventing abuse or intervening where abuse is a concern and dementia is a consideration*).

#### Question 7: What are the formal steps to determine testing for mental capacity?

If there is doubt about a person's mental capacity to make decisions, referral to a cognitive dementia and memory service clinic (CDAMS), GP, psychiatrist, neurologist, psycho-geriatrician, geriatrician or a neuro-psychologist might be appropriate (refer to *10.2 Mental capacity testing* in *Definitions*). An ACAS comprehensive assessment includes screening of a person's cognitive state, which could result in a recommendation by ACAS for formal testing of capacity to one of the above sources.

If an older person refuses to be assessed, and there is concern for the person's safety, an application to VCAT for the appointment of a guardian may be necessary to gain consent for an assessment (refer to *7.1.2 The Victorian Civil and Administrative Tribunal—Guardianship List (VCAT)*). Before taking such a step, consider asking the older person's family or friends to discuss the refusal with them, within the context of the suspect abuse. Contact with the person's appointed advocate, guardian or attorney may also be appropriate.

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

### Question 8: What is undue influence and consent?

Abuse due to undue influence may occur even where an older person is capable of understanding what is being done to them or on their behalf. Undue influence is a risk when a person is vulnerable or dependent on another, and may involve the other person (maybe the primary carer) threatening to withdraw essential support or threatening to harm the older person, if their wishes are not met.

Many instances of financial abuse contain elements of undue influence reflected by a fear of the disapproval or anger of the person on whom they have become dependent.

### EXAMPLE 5: RECOGNISE BARRIERS TO ASSESSMENT

The degree to which a thorough assessment can be made depends on the worker's access to the situation. An older person may deny the existence of abuse completely, or be intimidated by a perpetrator.

### Question 9: Is support required for others aware of the abuse?

Sometimes assisting an older person who is being abused requires responding to the needs of neighbours, friends or relatives who are affected in some way by the abuse and also need support, such as:

- informing them of plans for emergency procedures
- providing information about investigations and encouraging continued non-judgmental support of an older person, especially if intervention is refused
- providing information about supports for them as well as an older person in the suspected or actual abusive situation, for example, counselling, if appropriate.

### Question 10: What does the carer think about the situation?

A carer may be under stress and frightened about what will happen. Placing them at ease while fact-finding is not easy, but could be the most productive way of identifying the seriousness of abuse.

Asking a carer to describe the day-to-day care of an older person will often open up discussion, and enable health and community care workers to check for stress, financial difficulties, health and other problems, as well as consider the carer's ability to manage their caring role.

Consider the following approaches:

- broach the topic sensitively
- assist a carer to feel supported and comfortable to share concerns they have with you
- indicate that you want to support them in their care role
- where options exist, support a carer to make decisions
- involve extended family and other people who are important to a carer
- be sensitive to and discuss a carer's fears about approaching other health and community organisations and services, such as Victoria Police, OPA or VCAT
- be clear that your role is to keep an older person safe.

Use open-ended, non-judgmental questions about being a carer, level of dependency, family and home environment, concerns, stress indicators and support networks, for example:

*'How is the person you are caring for?'*

*'How has life changed since you became a carer?'*

*'Have you been able to talk with someone about these changes?'*

*'What's it like having an older person dependent on you?'*

*‘Has it affected your relationship?’*

*‘Do you know what practical assistance is available to you?’*

*‘What kinds of things are you doing now, as part of your care role?’*

*‘Can you take a break–have some time for yourself?’*

*‘Do you ever worry that the person being cared for is not safe?’*

*‘Are you ever worried that you might hurt the person you are caring for?’*

It may be preferable to avoid discussing concerns or actions with an older person’s primary carer under the following conditions:

- if it will place either an older person or you as a worker in danger, at risk or a in compromised situation
- where the family ‘closes ranks’, further isolating an older person and reducing the possibility of being able to help an older person.

#### **Question 11: Does the older person want the intervention or assistance?**

If an older person is competent, but refuses help, a worker can only support and give advice about options. The worker can advise the person how to deal with emergencies. Strategies can be developed to help break through possible denial of abuse and feelings, such as fear, isolation, guilt and self-blame.

If an older person is at risk and refuses assistance, despite a range of efforts over time, it may be necessary to apply to VCAT for the appointment of a guardian or administrator to consent to support services or some other intervention. For further information refer to [7.1.2 The Victorian Civil and Administrative Tribunal–Guardianship List \(VCAT\)](#).

If an older person who has capacity is living in unhygienic conditions, the situation could be referred as a nuisance under the Health Act 1958 to the local municipal council (refer to [1.3.4 Self-neglect or self-mistreatment](#)).

The worker needs to assess the barriers to access and consider the best options to speak with an older person, for example:

- at home or elsewhere
- alone or with a trusted other
- with police protection if required.

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

If an older person lives in a private supported residential service (SRS), Community Visitors have certain rights of entry, as do authorised officers in Department of Human Services regional and central offices appointed by the Secretary of the Department of Human Services (refer to [7.2.1 The Victorian Department of Human Services \(DHS\)](#)).

#### **Question 12: Are there cultural considerations to take into account?**

Should an assessment occur within the realm of an older person’s own culture and language in order to increase the worker’s access to and understanding of the situation?

Is an interpreter needed?

It is important to consider both bicultural and bilingual issues.

#### **EXAMPLE 6: PLAN FOR SAFETY INTERVENTION**

Determine the need for a safety plan.

If there are safety concerns, consult the older person and then, with their permission, inform other relevant

service providers who support that person, an older person's GP or other members of an older person's household.

The safety intervention needs to show appropriate planning if the suspected perpetrator lives in the same household or nearby.

If concerns are ongoing, discuss and develop a safety plan with an older person, their family (where relevant), their advocate or guardian and in consultation with relevant providers.

### Question 13: What elements should a safety plan cover for an older person?

The safety plan could include strategies to be implemented should the abusive situation progress or deteriorate.

Ensure that you:

- document safety concerns clearly by date and source of information
- write objective notes in plain English, detailing known current or past injuries, circumstances or concerns relevant to the suspect or abusive situation
- refer or assist an older person to:
  - attend a specialist assessment by a geriatrician or GP if required
  - involve local police if abuse is of a criminal nature
  - involve local legal services, depending on the type of abuse
- are aware of cultural considerations when planning options
- are aware of concerns of an older person that may inhibit their capacity to act on any component of the plan
- review the plan regularly, because circumstances may change for the older person.

### EXAMPLE 7: EMERGENCY RESPONSE

Urgent action is required in an emergency. This is defined as a situation that poses an immediate threat to human life or a serious risk of physical harm or serious damage to property.

The appropriate emergency service (ambulance, police or fire) must be called without delay.

Depending on the type and context of abuse, it may be useful to talk through the idea of planning an emergency response with the older person, should it ever need to be activated.

The agreement to act in the case of an emergency could be included in a safety plan. However, responses to emergencies, by their very nature, cannot always be planned.

When the dangerous situation is resolved, the workers involved should report to their supervisor. The incident and actions taken should be carefully documented according to agency policy and procedures.

### Question 14: What happens to an older person when there is an emergency response?

In an emergency response, an older person should be involved in making decisions about their life as much as possible.

However, if a worker assesses that an older person is in imminent danger of harm or death, it may be necessary to arrange:

- support (for example, ambulance services)
- medical treatment for an older person or carer (for example, referral to local doctor or hospital emergency department)

- emergency accommodation for an older person or carer (for example, referral to supported housing services in the region, a women’s refuge or other temporary housing)
- police involvement, which may be required for the safety of the worker as well as an older person
- an emergency application to VCAT (if the appointment of a temporary guardian is necessary, for instance, the Public Advocate) or a temporary administrator (for instance, State Trustees Limited) to protect an incompetent older person or their property and assets
- other matters sensitive to cultural considerations, including religious beliefs, which ideally should be known prior to any emergency.

#### EXAMPLE 8: SAFETY OF STAFF

Older people and primary carers whom workers support are unique and individual, but so too are workers. Occupational health and safety procedures are integral to agency human resource policies, and should be clearly stated and implemented, and form part of an organisation’s induction and in-service system for all staff.

Ensuring assessment workers and direct care staff are safe and confident to work with an older person within the broader context of service delivery, particularly when undertaking home visits, is an important procedure to implement generally, and even more so in the context of suspicion of or confirmed abuse.

#### **Question 15: How do I continue providing support services to an older person when suspected or confirmed abuse is occurring?**

Services such as food services, personal care, allied health, community nursing or day programs are often provided to an older person, who may also be experiencing abuse.

All workers involved in providing those services (including those from other organisations) should be made aware of broader abuse concerns and supported in managing themselves and the situation while they continue to deliver support services.

Some abuse cases may continue for a long period of time, depending on the circumstances. Staff, whether direct care or assessment workers, should be supported. Self-care strategies for workers include:

- engaging in reflective practice
- avoiding overwork (avoiding overtime or carrying caseloads that exceed recommended levels)
- knowing and accepting personal limitations
- rewarding themselves for reaching goals
- planning fun and relaxing activities
- taking care of physical needs: maintaining a balanced sleep schedule and healthy diet
- attending to emotional needs, particularly talking about fears and doubts and seeking counselling when appropriate
- remembering and acting on one’s own social needs—valuing friends and family, and friendships outside work circles
- making time for themselves.

Sometimes, debriefing or support services such as trauma counselling should be offered to staff via the employee assistance scheme or similar service.

Staff need support to maintain their service focus and confidence to work in an abusive environment.

**EXAMPLE 9: WORKING WITH THE PERPETRATOR**

When speaking to an alleged perpetrator, remember that they may be an offender—or completely innocent of any blame. Always keep an open mind about which category the person fits into.

**Question 16: How do I continue to provide services to an older person if the alleged perpetrator is integral to the older person's life?**

Assessing the needs and perspectives of the alleged perpetrator is important, because their response to intervention may assist or worsen the situation.

If police involvement is imminent, minimise speaking to the alleged perpetrator prior to police arrival. If a criminal investigation is required and a worker has spoken to the alleged perpetrator, they will most likely have to supply the police with a statement about what they said to the person, and what the alleged perpetrator said to the worker.

Behaviour indications of a possible perpetrator can include:

- refusing access to an older person
- aggression
- blaming others
- alcohol or drug abuse
- stress or fatigue.

Questions to consider when working with the alleged perpetrator include:

- What is the alleged perpetrator's response?
- Do they acknowledge or deny the behaviour or situation?
- Are they willing to accept help?
- Does the alleged perpetrator refer blame for the problem (for example: alcohol, loss of job, family stress, health issues)?
- What other information is available?
- What is the alleged perpetrator's physical and mental status? (It may be useful to draw on observations of family and friends).
- Is there a record of past intervention, including what approaches and methods helped or hindered?
- Does the alleged perpetrator have a known criminal record, or current support for particular problems?
- Is there known risk related to offering assistance to the alleged perpetrator?
- Is there a safety issue for workers or an older person?
- Are there resources available (money, friends, services) to assist the alleged perpetrator?
- Is motivation known (for example, carer stress, greed, sense of powerlessness, inability to tolerate frustration, drug or alcohol dependence, psychiatric illness)?
- Are there pre-existing patterns of abuse, including family violence?
- Are there other circumstances that may have a negative impact on the home environment and/or family dynamics?

A direct care worker should not alert or confront the alleged abuser. When and how this is done requires professional decision making between agencies on a case-by-case basis.

**EXAMPLE 10: ASSESSING RISK**

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

**Question 17: What does managing risk involve?**

Managing risk can involve:

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

**Question 18: What does assessing risk involve?**

Assessing risk involves:

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

Effective risk assessment must be based on:

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

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

- The PCP summary and referral information, core referral template, which includes a component called 'Alerts'. This table contains a section on risk and associated risk code sets. If more than one type or category of risk applies, the code and description of the primary or most significant risk is asked for first, with secondary risks following. This PCP template simply alerts about risk and the types—it does not assess the risk or situation.
- The Family Violence Risk Management Framework provides scope and tools to assist with risk assessment.<sup>22</sup>

For family violence service contact details refer to [7.1.6 Family violence services](#) and [www.dvirc.org.au](http://www.dvirc.org.au).

<sup>22</sup> Refer to the Family violence risk assessment and risk management framework at: [www.women.vic.gov.au/web12/rwpgslib.nsf/Graphic+Files/FinalRiskAssessmentandRiskManagementFramework/\\$file/FinalRiskAssessmentandRiskManagementFramework.pdf](http://www.women.vic.gov.au/web12/rwpgslib.nsf/Graphic+Files/FinalRiskAssessmentandRiskManagementFramework/$file/FinalRiskAssessmentandRiskManagementFramework.pdf) and [www.familyviolence.vic.gov.au](http://www.familyviolence.vic.gov.au)



### 3.1.3 Care planning

#### Definition

A care plan documents the agreed service needs of an older person, planned intervention strategies, timelines and worker/organisation responsibility. Documented service plans clarify accountability in terms of what is to be done and who is responsible. Care records must be kept secure and be carefully written in case they are required in legal actions.

Care planning incorporates a range of existing activities, such as care coordination, case management, referral, feedback, review, re-assessment and monitoring. Care planning involves the judgment/determination of relative need, as well as competing needs, and assists older people and/or primary carers to make decisions appropriate to their needs, wishes, values and circumstances.

#### Policy

Planned intervention in the case of abuse should determine whether the aim of the intervention is:

- prevention of further abuse
- early intervention to prevent the escalation of abuse
- intervention to support an older person if the abusive situation continues
- intervention to stop abuse re-occurring
- resolution of the underlying causes of abuse
- intervention to stop abuse.

Policy documentation should include direction for workers to follow should they believe that a criminal offence may have been committed.

The policy should detail procedures about reporting suspected criminal conduct to Victoria police.

Policy should also detail procedures about how to make contact with Victoria Police, ambulance, fire or emergency health services if the matter is assessed as urgent.

Policy must reflect the rights of an older person, including where immediate actions are to be taken. These actions must be explained to an older person prior to and while they are occurring.

#### Procedures

##### EXAMPLE 11: DEVELOPMENT OF A CARE PLAN

A care plan to address abuse should be consistent and integral with agencies' existing care plan systems.

#### Question 19: What should be considered and included in a care plan when addressing suspicion of or confirmed abuse?

The following points should be considered:

- the type of service response required
- known facts
- further information or facts required
- other key people who should be consulted and their roles (relevant family members, friends, service providers)

- whether an older person is at risk of significant harm, and if so:
  - the type and degree of risk
  - staff security and safety issues
  - an intervention plan
- identified resources, services and personnel appropriate to assist the client
- the older person's wishes
- a description of an older person's competency to make informed decisions
- whether a guardianship order is being considered (refer to [7.1.2 The Victorian Civil and Administrative Tribunal–Guardianship List \(VCAT\)](#))
- coordination of internal service provision
- a review date.

#### **EXAMPLE 12: PLANNING APPROPRIATE INTERVENTION**

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

Possible service responses include:

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

#### **Question 20: What should the intervention plan achieve?**

The intervention plan should seek to achieve:

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

### Question 21: How do I assess an older person's response to suspected abuse?

Assessment of an older person's response to abuse influences the type and pace of possible interventions. It may be important to:

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

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

#### EXAMPLE 13: WHEN AN OLDER PERSON IS PREPARED TO ACCEPT INTERVENTION

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

- support them to rebuild their life in the best way possible, ideally without abuse
- address the underlying causes of abuse and work to minimise them
- work with them to rebuild their life without abuse.

Preconceived ideas by workers to create behavioural change with an older person may not be successful because other types of support are preferred.

### Question 22: What kind of structured supports might assist an older person?

Individual counselling or joint support groups may assist an older person to realise they are not to blame and need not tolerate abuse. Counselling and treatment programs may involve individual counselling or family therapy to:

- assist them to recognise the abuse and seek a lifestyle without abuse
- assist them to develop safety and coping strategies
- find a way to be safe from the perpetrator
- assist the perpetrator to change their patterns of behaviour
- provide a drug and alcohol treatment program for the perpetrator
- facilitate attendance at self-help or carer support groups to assist the older person or their carer recognise the abuse and accept support.

In cases where abuser psychopathology is a major causative factor, acute or ambulatory care to address psychiatric illness or drug or alcohol problems may be required.

### Question 23: What other forms of support might be suitable?

Some older people are averse to the idea of formal or informal counselling, and may not want to change their situation or behaviour. This should be respected. The service response may be to continue supporting them in their current circumstances for a long period of time. The types of support offered could include:

- information and education on:
  - being a carer, including carer rights
  - the effects of abuse
  - alternatives to abusive behaviour
  - community resources for the older person and alleged perpetrator
- provision of community support services, such as:
  - home care or personal care
  - meals on wheels
  - community nursing
  - day care/planned activity groups
  - incontinence programs
  - allied health services
  - social support
- provision of occasional or regular respite care, such as:
  - in-home respite, planned activity groups or institutional respite to relieve carer stress
  - advice on caring techniques
  - immediate respite and support
  - crisis care, including options such as:
    - › admission to an acute hospital bed
    - › emergency residential respite care
    - › women's refuge
    - › other emergency housing option
- short- or long-term alternative accommodation or living arrangements, which can include:
  - the separation of the older person and the perpetrator
  - an alternative residence for an older person experiencing abuse, or for the perpetrator
  - supported accommodation or a flat, as alternatives.

#### Question 24: What types of legal intervention might support an older person?

Reflecting the principles of this approach, older people who have experienced abuse should be provided with as much support and information as possible to assist their decision on how to proceed after or during an incident of abuse.

Legal interventions include:

- power of attorney
- VCAT guardianship proceedings
- intervention order
- police prosecution for criminal offence
- court-mandated treatment program
- civil actions—negligence, breach of contract.

If an older person is cognitively impaired or otherwise incompetent, an application can be made to the Guardianship Board to appoint the Public Advocate as a temporary guardian.

Other reasons for legal intervention include criminal offences in cases of theft and fraud or physical or sexual assault (refer to [7.1 Services](#) for further information).

#### EXAMPLE 14: PERPETRATOR RESPONSE

An integral part of planning a response to elder abuse is managing the likely response to the intervention by the alleged perpetrator. Utilise knowledge gathered in the assessment stage, particularly [EXAMPLE 9: Working with the perpetrator](#) in [3.1.2 Assessment](#).

#### Question 25: When is an agreed coordinated service plan between multiple agencies necessary?

Where multiple agencies are involved in providing existing services, or planned additional services to address the abusive situation either for an older person or alleged perpetrator, an agreed coordinated plan is essential to ensure adequate support for the older person, an effective and clear maintenance strategy and a consistent approach from all agencies involved.

Multiple services may be broad-reaching, depending on the case at hand, for example: GP, specialist health services, Victoria Police, family violence services, legal services and several funded community care providers.

## 3.2 Common service coordination tasks

Delivering coordinated services to clients encompasses common tasks which can be applied at any stage. Abusive situations require additional considerations, for example:

### 3.2.1 Care coordinator

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

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

Sometimes, a range of providers may already be delivering services to an older person and/or their carer. In this circumstance, should an abusive situation become apparent, the service response would be incorporated into the existing care plan, coordinated by the care coordinator between existing providers (refer to [5.2.4 Service coordination role between agencies](#)).

### 3.2.2 Referral

Referral is the transmission of personal and/or health information relating to an individual from one agency to another—with the individual's consent—for the purpose of further assessment, care or treatment. Referral is integral to working with many people, particularly those with complex needs and/or chronic disease.

When considering referral pathways regarding abuse, the specific needs of an older person in relation to their culture and health needs must be considered, after obtaining their consent for referral action.

The type of abuse, together with the individual factors of each case, will influence the type of referral made, for example, a GP, neurologist, psycho-geriatrician, geriatrician or neuro-psychologist for capacity testing, seeking advice from OPA or VCAT, liaising with other local service providers, such as ACAS, CACPs, EACH, HACC or subacute services to implement additional support. Refer to [7.1 Services](#) for further information.

Service providers can also contact Seniors Rights Victoria for information and direction regarding elder abuse and legal services for older people (refer to [7.1.1 Seniors Rights Victoria \(SRV\)](#)). As an older person's situation evolves, referral reviews should occur.

### 3.2.3 Documentation, confidentiality and information exchange

#### The importance of clear and accurate documentation

Existing service coordination tools should be used to document clear and relevant details of suspected and substantiated cases of abuse.

Without good documentation, it is difficult to assess the prevalence of alleged abuse and provider responses.

Identified cases of suspected and actual abuse require good documentation of evidence, especially for those that might formally proceed to the Office of the Public Advocate (OPA) and the Victorian Civil and Administrative Tribunal (VCAT). Refer to [7.1 Services](#) for information on these organisations.

Agency policies and procedures provide formal processes for documenting cases of abuse, as well as utilising agreed protocols, including privacy and information sharing between providers.

#### Privacy and confidentiality

Privacy and confidentiality are related but distinct concepts. The Office of the Information Privacy Commissioner explains:

- Confidentiality is a concept that is related to, but different from, privacy.
- An obligation of confidence is generally owed by the recipient of information to the provider of the information.
- Privacy is the right of the subject of the information, no matter who provided and who received the information.
- Confidentiality often deals with information other than personal information. Confidentiality is about controlling the disclosure of information, while privacy obligations go wider to encompass collection, quality and disposal.<sup>23</sup>

Privacy and confidentiality are key issues to be considered in all elements of service coordination and referral, including, in the case of elder abuse, interagency protocol development and practice.

#### Information privacy

Information privacy law is concerned with setting minimum standards in relation to the collection and handling of personal information. It incorporates safeguards for a range of personal information handling activities, such as collection, storage, access, transmission, disclosure, use and disposal.

In general, obligations imposed by privacy law and laws relating to confidentiality, information gathered or collected about an older person who has capacity should only be shared with anyone else, including another agency, with the consent of the older person.

For assessment procedures regarding testing for capacity refer to [Example 4: Mental capacity to make decisions and give consent](#) in [3.1.2 Assessment](#).

Many organisations have developed consumer consent to share information forms,<sup>24</sup> which ideally should be

<sup>23</sup> Office of the Victorian Information Privacy Commissioner, 2006, *Guidelines to the Information Privacy Principles*, September 2006, p. 4.

<sup>24</sup> To view a sample consent to share information form refer to [www.health.vic.gov.au/pcps/downloads/coordination/consumerconsent.pdf](http://www.health.vic.gov.au/pcps/downloads/coordination/consumerconsent.pdf)

completed prior to the provision of services by an organisation.

Privacy requirements indicate that all information collected on any person, including an older person or their carer, should be handled in the strictest confidence, including the recording of information on client files.

File confidentiality must be preserved, particularly if notes for other members of the family are stored in the same file. Ideally, notes for each individual should be stored in separate files.

Consent is one of a number of conditions to be met, for personal information to be transferred interstate or overseas.

### Which privacy laws do I comply with?

Different privacy laws apply to different types of organisations and programs.

All services or agencies and their respective workers need to ensure that they handle all information about clients in accordance with the requirements imposed by applicable privacy legislation.

Depending on the nature of the agency and the services it provides, these requirements may be imposed by the *Information Privacy Act 2000*, the *Health Records Act 2001* or the *Privacy Act 1988* (Cwth).

Providers are also encouraged to become familiar with their organisation's privacy and confidentiality policy and procedures.

You can obtain further information about privacy law from the following websites:

- The Privacy Act 1988 (Cwth) applies to the Commonwealth public sector and some parts of the private sector (refer to the Commonwealth Office of the Privacy Commissioner's website at: [www.privacy.gov.au](http://www.privacy.gov.au))
- The Information Privacy Act 2000 (Vic) covers state government agencies and local municipal councils (refer to: [www.dhs.vic.gov.au/privacy/public/index.htm](http://www.dhs.vic.gov.au/privacy/public/index.htm))
- The Health Records Act 2001 (Vic) covers the handling of health information by state government agencies, local municipal councils and the private sector (refer to the website of the Office of the Victorian Health Services Commissioner at: [www.health.vic.gov.au](http://www.health.vic.gov.au)).

### Privacy principles interact and co-exist with other legislations

Existing provisions in other statutes governing confidentiality, use and disclosure of personal information and those that regulate access to certain kinds of personal information continue to apply.

Specific statutory provisions override the general standards in both the Health Records Act and the Information Privacy Act to the extent of any inconsistency.

### Limits on the rights to privacy and confidentiality

Older people and their carers should be informed of their right to privacy and confidentiality as well as the limitations on these rights.

It is permissible to breach confidentiality in some very limited circumstances.

Exceptions to the obligation to maintain confidentiality include where the older person has consented to the disclosure of information; where the law allows or requires the disclosure of confidential information; and, in extreme circumstances, where there is a clear and imminent threat to an identifiable person of serious bodily injury or death.

Information may also be used or disclosed for a secondary purpose, without consent, for these additional reasons: serious threat to public health, safety or welfare; law enforcement and security; research or statistical analysis; investigation of unlawful activity; or information required or authorised by another law. For example:

- the law of privacy permits organisations to disclose information about a person without that person's consent in specified circumstances.
- the Information Privacy Act and the Health Records Act, permit an organisation to disclose personal information about an individual if it reasonably believes that the disclosure is necessary to lessen or prevent a serious and imminent threat to an individual's life, health, safety or welfare.<sup>25</sup>

### Department of Human Services Privacy Policy

The Department of Human Services is committed to protecting the privacy of personal information which the department and its funded service partners handle. Personal information is information which directly or indirectly identifies a person.

In accordance with the Department of Human Services' responsibilities, the services and functions which the department and its partners provide relate primarily to the areas of health, community support and the protection of public health and safety. Due to the nature of the services provided it is recognised that much of the information collected is particularly sensitive.

The Department of Human Services is bound by the Victorian privacy laws, the Information Privacy Act and the Health Records Act, as well as other laws which impose specific obligations in regard to handling information.<sup>26</sup>

Where organisations also receive funding for services from the Commonwealth Government, the Commonwealth requirement must be adhered to in the first instance. Where the Victorian requirement is greater than the Commonwealth requirement, the higher standard is applied.

Common agreement should be reached between organisations regarding the disclosure of information in line with privacy principles and practice.

Organisations often fear that disclosing information will leave them open to an action for defamation or breach of confidentiality. Each organisation needs to clarify how the laws of defamation and confidentiality affect the organisation and fit in with good work practices in the organisation'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 their duty and is disclosed only to those involved in the service response.

A helpful general guide to the privacy laws that affect Victorians is *Privacy Lives*<sup>27</sup> produced by the Victoria Law Foundation. The booklet is not intended to be a substitute for legal advice.

Further considerations may include:

- What are the legislative, legal and ethical restrictions on disclosure of information? (For example, Section 141 of the *Health Services Act 1988* and Section 135A of the *National Health Act 1953* may prohibit health workers from sharing client information without permission unless an exception applies.)
- Under what circumstances will an organisation allow another organisation access to its records?
- On what conditions will an organisation provide a written report to another organisation? What will be included in it?
- Will an organisation release information needed in a legal tribunal, or will disclosure only be made in response to a subpoena?
- Do you really need all the personal information you collect?
- Are customers who provide information over the telephone/Internet/in person given clear notice about how the information will be used and disclosed?

<sup>25</sup> Refer to Information Privacy Principle 2.1(d).

<sup>26</sup> Department of Human Services, Corporate Integrity Information and Resolutions Unit. For further information refer to: [www.dhs.vic.gov.au/pdpdciiru](http://www.dhs.vic.gov.au/pdpdciiru)

<sup>27</sup> The Victoria Law Foundation, 2008, *Privacy Lives, Your Guide to Privacy Law in Victoria* (second edition). A printed booklet is available from Privacy Victoria, Health Services Commissioner, your local council, and Information Victoria, 505 Little Collins Street, Melbourne, 1300 366 356. For further information refer to: [www.victorialaw.org.au](http://www.victorialaw.org.au)



# 4

## Developing agency policies and procedures

### Overview

Victorian Government-funded organisations providing services to older people are encouraged to review or develop elder abuse policies and procedures aligned to the Victorian Government Elder Abuse Prevention Strategy, which embodies principles of empowerment and human rights of all adults (refer to [1.1.1 Key principles underpinning the implementation of the Victorian Government Elder Abuse Prevention Strategy](#)).

Policy and procedures responding to elder abuse should occur within existing service response frameworks (refer to [10.4 Protocol, policy and procedure](#) in [Section 10: Definitions](#)).

### 4.1 Agency elder abuse policy framework

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

Agencies may also articulate their role in community awareness raising to minimise the risk or ongoing occurrence of abuse.

#### 4.1.1 Aim

An agency elder abuse policy should aim to:

- increase awareness of elder abuse in the community
- improve the ability of health and community workers to detect and act on signs and symptoms of abuse when first detected
- educate staff in effective intervention
- provide clear role expectations of staff and management to address abuse.

#### 4.1.2 Principles

Agency policy should include clear principles that guide staff in working with older people (refer to [1.1.1 Key principles underpinning the implementation of the Victorian Government Elder Abuse Prevention Strategy](#)).

#### 4.1.3 Relevant definitions and references

##### Definition and nature of elder abuse

The definition should be ‘Any act occurring within a relationship where there is an implication of trust, which results in harm to an older person’ (refer to [1.2 The nature and definition of abuse for further information](#)).

##### Types of abuse

For details of types of abuse refer to [Section 2: Types of abuse and risk factors](#).

## Duty of care

This involves the obligation to take reasonable care to avoid injury to a person whom it can be reasonably foreseen might be injured by an act or omission (refer to [Question 5: If abuse of an older person or their carer is suspected but not acknowledged, what should I do?](#) and [10.5 Duty of care](#) in [Section 10: Definitions](#)).

## Enduring powers of attorney

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.

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.

Refer to definitions [10.6 Enduring powers of attorney \(financial\)](#) and [10.7 Enduring powers of attorney \(medical treatment\)](#).

## Family violence

This includes violent behaviour that is repeated, controlling, threatening and coercive and that occurs between people who have had or are having an intimate relationship. Violent behaviour includes physical assaults and a range of coercive tactics, including intimidation, direct or indirect threats, sexual assault, emotional and psychological torment, economic control, property damage, social isolation and any other behaviour that causes a person to live in fear (refer to [7.1.6 Family violence services](#).)

### 4.1.4 Expectations of workers and service coordinators

In many instances a direct care worker will be the first to recognise or suspect the abuse of an older person.

Direct care workers may suspect that something is wrong by witnessing the abuse first hand, or noticing several risk factors affecting an older person.

#### What is expected of workers and service coordinators, should they be suspicious of abuse

1. Health and community care staff should, in the first instance, report suspicion of abuse to their supervisor.
2. Gather, substantiate and document clear and relevance evidence using existing service coordination tools (refer to [3.2.3 Documentation, confidentiality and information exchange](#)).
3. The service coordination framework includes:
  - initial contact and initial needs identification
  - assessment
  - care planning
  - service coordination
  - referral
  - regular review.

4. Describe other relevant agency procedures and processes, for example, occupational health and safety considerations.
5. Include clear statements and expectations about staff roles and responsibilities:

*The worker is expected to:*

- follow their agency's policies and procedures
- contact Victoria Police or an ambulance if the matter is urgent
- refer suspected, disclosed, witnessed or alleged abuse to their supervisor
- discuss possible options with an older person
- keep a detailed, confidential record of what happened.

*The worker is not expected to:*

- solve the problem
- medically assess an older person and their living situation in any way
- decide whether the incident meets the threshold for laying criminal charges.

*The supervisor is expected to:*

- follow their agency's policies and procedures
- contact Victoria Police or an ambulance if the matter is urgent
- consult specialist services if they are unsure what action is required
- refer the abuse of an older person to the appropriate authority, agency or service where further action or intervention is required, to ensure the safety and wellbeing of an older person (refer to [7.1 Services](#))—where possible, the supervisor should seek the consent of an older person to a referral
- discuss possible options with an older person and the primary carer, if appropriate, and provide or organise support as required
- keep a detailed and secure confidential record of what happened, in accordance with agency record keeping policies and procedures
- inform their manager of concerns or issues regarding the alleged abuse.



## Local interagency protocols

### Overview

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

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

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

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

### 5.1 Getting started

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

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

#### 5.1.1 Definition of a local interagency protocol

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

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

An agreed elder abuse interagency protocol:

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

### 5.1.2 Plan your interagency protocol membership

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

The geographic catchments of PCPs<sup>28</sup> offer a strong basis on which to form local interagency protocols.

PCPs are ideally situated to initiate the establishment of effective protocols on a range of service issues in the community.

Some PCPs may plan to engage other PCPs as well as other existing sector networks, such as family violence, community legal aid or mental health, to develop an elder abuse local interagency protocol.

### 5.1.3 Identify the services in your local area

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

A broad range of organisations provide a variety of types of community-based services, with service outlets located in different geographic areas. Services to be included in a local interagency protocol will include local, sub-regional, regional and statewide organisations (refer to [7.1 Services](#)).

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

Local service representation should include:

- local municipal council service outlets for aged care (HACC, CACPs, EACH, residential aged care, health promotion, disability, mental health)
- not-for-profit, charitable or private providers of community and residential aged care service (HACC, CACPs, EACH or EACHD packages, respite, residential aged care)
- community health services (allied health, health promotion)
- mental health services for older people, including aged persons mental health teams (APMH)
- health services, such as:
  - services provided in the community (for example, hospital-in-the-home)
  - hospital emergency and social work departments
  - rehabilitation services
- local GPs and divisions of GPs
- allied health professionals
- pharmacists
- Victoria Police
- Ambulance Victoria (AV)
- Aged Care Assessment Service (ACAS)
- family violence intervention and support services (refer to [7.1.6 Family violence services](#) and [www.dvirc.org.au](http://www.dvirc.org.au))
- Commonwealth Carelink centre
- migrant resource centre

<sup>28</sup> Refer to [www.health.victoria.gov.au/pcps/](http://www.health.victoria.gov.au/pcps/) for further information.

- sub-branch of the Returned Services League of Australia (Victorian branch)
- supported residential aged care services
- residential aged care services
- community legal aid centres
- community district nursing services (for example, remote area nurses in bush nursing centres, Royal District Nursing Service).

### Statewide services

Other services such as those with a statewide scope relevant to cases of elder abuse will not be as involved in developing each local interagency protocol.

However, these broader services need to be referenced in each local interagency protocol, and referencing should be agreed to by those agencies prior to completion of the protocol. These agencies include:

- Seniors Rights Victoria (SRV)
- the Office of the Public Advocate (OPA)
- Mensline Australia
- the Commonwealth Aged Care Complaints Investigation Scheme
- Elder Rights Advocacy (ERA) Victoria
- Aboriginal services
- the Ethnic Communities Council Of Victoria
- State Trustees Ltd.

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

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

## 5.2 Developing your local interagency protocol

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

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

### 5.2.1 Organise an initial planning meeting

This initial planning meeting of key service providers should:

- review any current protocols and their implications for the local area
- brainstorm about who else might be consulted and involved
- list the tasks to be completed before agreement about an interagency protocol can be reached
- timeline the tasks and allocate responsibility for them amongst the planning group.

## 5.2.2 Expand the initial planning group

This expanded planning group will form a short-term protocol development group, recruiting more locally recognised providers (including relevant regional and statewide specialist services), to:

- develop a draft interagency protocol
- distribute the draft to all relevant local service providers for comment and consultation
- negotiate an agreed interagency protocol and intervention model based on feedback, consistent with Victorian Government elder abuse policy
- achieve sign-off by a person of authority in each organisation party to the interagency protocol
- publicise and distribute the interagency protocol (including on agency websites) to all relevant agencies and others who might be interested
- over time, share with other providers what has been learned from the development and implementation of the interagency protocol to address elder abuse, including what worked in each local area, what did not and what could be improved.

## 5.2.3 What to include in the interagency protocol

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

### Principles of interagency practice<sup>29</sup>

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

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

- a shared understanding of the aims of a response or intervention
- a prompt response to the abuse of older people, as a priority for all agencies
- appreciation of and respect for the different roles and contributions of agencies
- commitment to partnership between agencies
- understanding of the context in which agencies work, and acknowledgement of their respective constraints.

### Principles indicating how to work with older people

These include:

- respect for the autonomy and dignity of older people (refer to [1.1 The policy approach—empowering older people](#))
- recognition of the right of a competent older person to refuse intervention based on the principles of empowerment (refer to [1.1.1 Key principles underpinning the implementation of the Victorian Government Elder Abuse Prevention Strategy](#)).

### Principles for reporting abuse to Victoria Police

Many forms of elder abuse—but not all—are crimes and require police intervention.

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

<sup>29</sup> Extract from the *Interagency Protocol for Responding to Abuse of Older People*, 2007, NSW Government.

Where a report to Victoria Police is required, an individual's personal safety is at risk and Victoria Police intervention is requested, the consent of the person involved is not necessary (refer to [7.1.4 Victoria Police](#)).

### Other interagency protocol components

These should include:

- consistency with each participating agency's elder abuse policy (refer to 4 Developing agency policies and procedures)
- reference to member agency elder abuse policies, using an agreed framework or understanding for interagency assessment, intervention and care coordination roles, including referral
- the definition of abuse (refer to [1.2 The nature and definition of abuse](#))
- reference to types of abuse (refer to [Section 2: Types of abuse and risk factors](#))
- identified categories of older people who may be at greater risk
- processes to assess an older person's competence and capacity to make decisions and choices (refer to [10.2 Mental capacity testing](#) in [Section 10: Definitions](#))
- steps for gathering and substantiating information about the alleged case of abuse while working within privacy principles and human rights frameworks
- clear procedures for documenting evidence in each agency's existing service response framework (refer to [3.2.3 Documentation, confidentiality and information exchange](#))
- roles and responsibilities of local, regional or statewide support services (refer to [7.1 Services](#)), as applied to a local case, and the identification of other referral agencies, including appropriate contact details
- criteria (which includes the choice by an older person) to determine the appointment of a service coordinator as well as the role of a service coordinator (refer to [5.2.4 Service coordination role between agencies](#))
- a local interagency response framework (refer to [6.1 Flowcharts and diagrams](#) and [5.2.5 Victorian interagency response framework clarifies service response](#))
- identification of emergency response criteria, for example, the immediate threat of physical harm; however, most cases of abuse are not emergencies (refer to [Example 7: Emergency response](#) in [3.1.2 Assessment](#))
- capacity to collect data on elder abuse cases using agencies' existing client data systems (for example, SCTT; refer to [www.health.vic.gov.au/pcps/coordination/sctt2009/projects.htm](http://www.health.vic.gov.au/pcps/coordination/sctt2009/projects.htm))
- capacity to date and sign off by key staff in each local interagency protocol member organisation, who have the authority to commit capacity of the agency to an elder abuse service response
- a protocol review date and how the review is to be triggered (this should be included in the respective member agency's quality systems)
- the ability to learn from each elder abuse case via debriefing information
- the ability to learn from implementation of the interagency protocol to inform fine-tuning of protocol components and practice
- the ability to identify interagency roles regarding community awareness raising
- on completion, the protocol distribution method
- ease of access to completed protocol for referral and use by staff, for example: electronic for information and staff training sessions; placement, where appropriate, on agency and respective participating network websites; as well as hard copy frameworks for immediate use near telephones.



## 5.2.4 Service coordination role between agencies

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

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

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

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

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

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

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

## 5.2.5 Victorian interagency response framework clarifies service response

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

The following framework (*Figure 1: Victorian interagency response framework*) has been developed for health and community service providers for use by agencies to incorporate into their own elder abuse policy and procedures, and also for use in the development of local interagency protocol development.

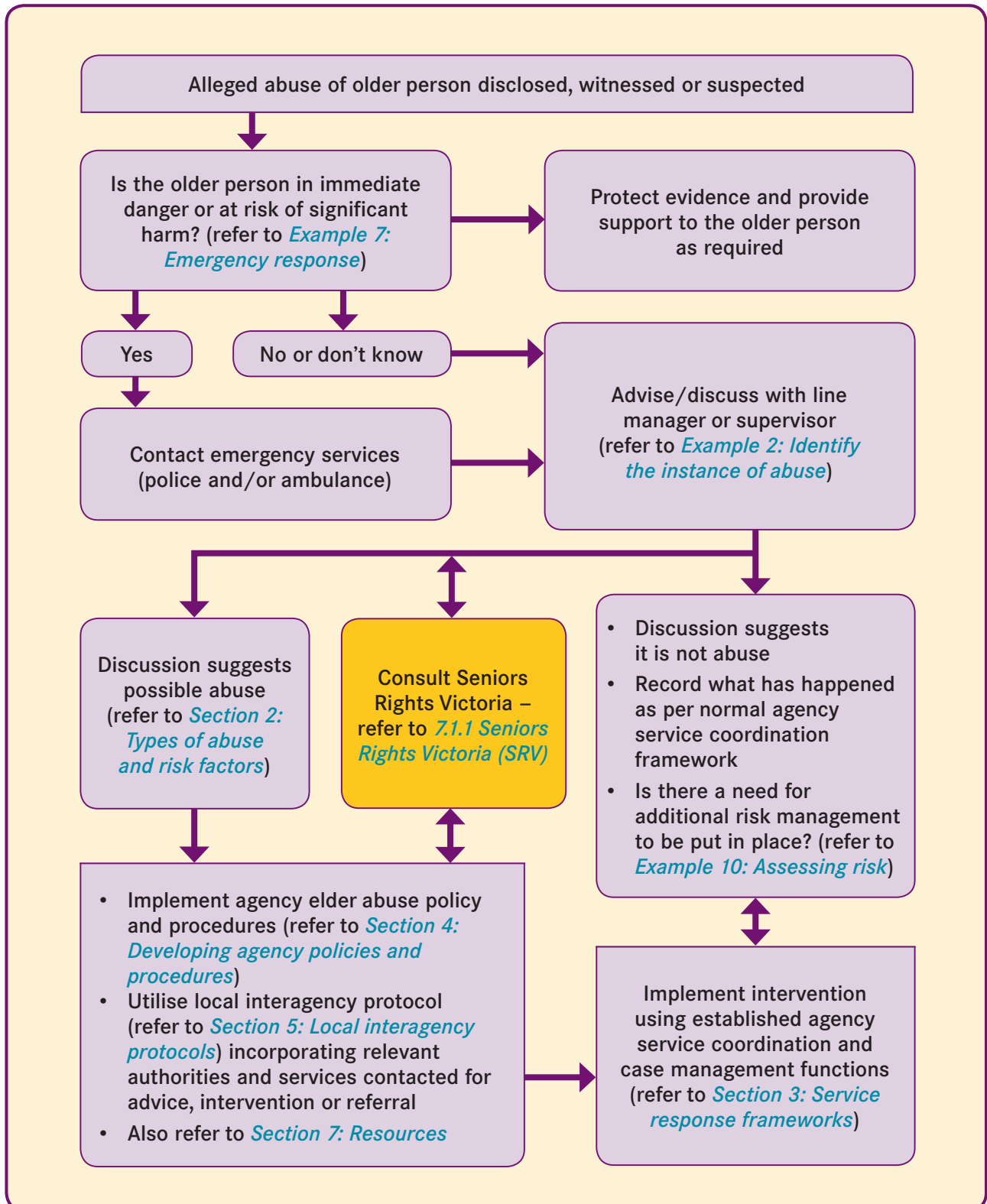
The framework can be copied as it is, or modified to provide enhancements which will add value for use at a local level. Agencies may like to add components from the samples provided in *Section 6: Sample intervention and referral frameworks*, or create their own modifications.

The core elements of the Victorian interagency framework should remain as they are presented in *Figure 1: Victorian interagency response framework*.

For further information or support to address elder abuse and interagency protocol development refer to *7.1.1 Seniors Rights Victoria (SRV)*.

**Figure 1: Victorian interagency response framework**

Adapted from the NSW Department of Ageing, Disability and Home Care, 2007, *Interagency protocol for responding to abuse of older people*.





## Sample intervention and referral frameworks

### Overview

Several Victorian health services and networks of community-based organisations have already developed local policies and procedures to address elder abuse. Included in those efforts were frameworks indicating intervention pathways addressing elder abuse at the local level. Some samples are provided on the following pages for health and community care organisations to include in the development of their own policies and procedures.

### 6.1 Flowcharts and diagrams

The following sample flowcharts and diagrams are provided as examples for agency decision making and referral as well as local interagency protocol pathways. These samples include:

- an agency intervention and management flowchart–Hornsby Ku-ring-gai Hospital Rehabilitation and Aged Care, New South Wales, Australia
- an agency intervention flowchart–Elder abuse referral pathway, Queensland Government, Department of Communities
- strategies for preventing abuse or intervening where abuse is a concern and dementia is a consideration–Department of Human Services, Alzheimer’s Association Victoria and La Trobe University
- a prevention of elder abuse information kit for HACC workers–Bendigo Health Services
- an interagency response framework: NSW Department of Ageing, Disability and Home Care.

Figure 2: A sample agency intervention and management flowchart

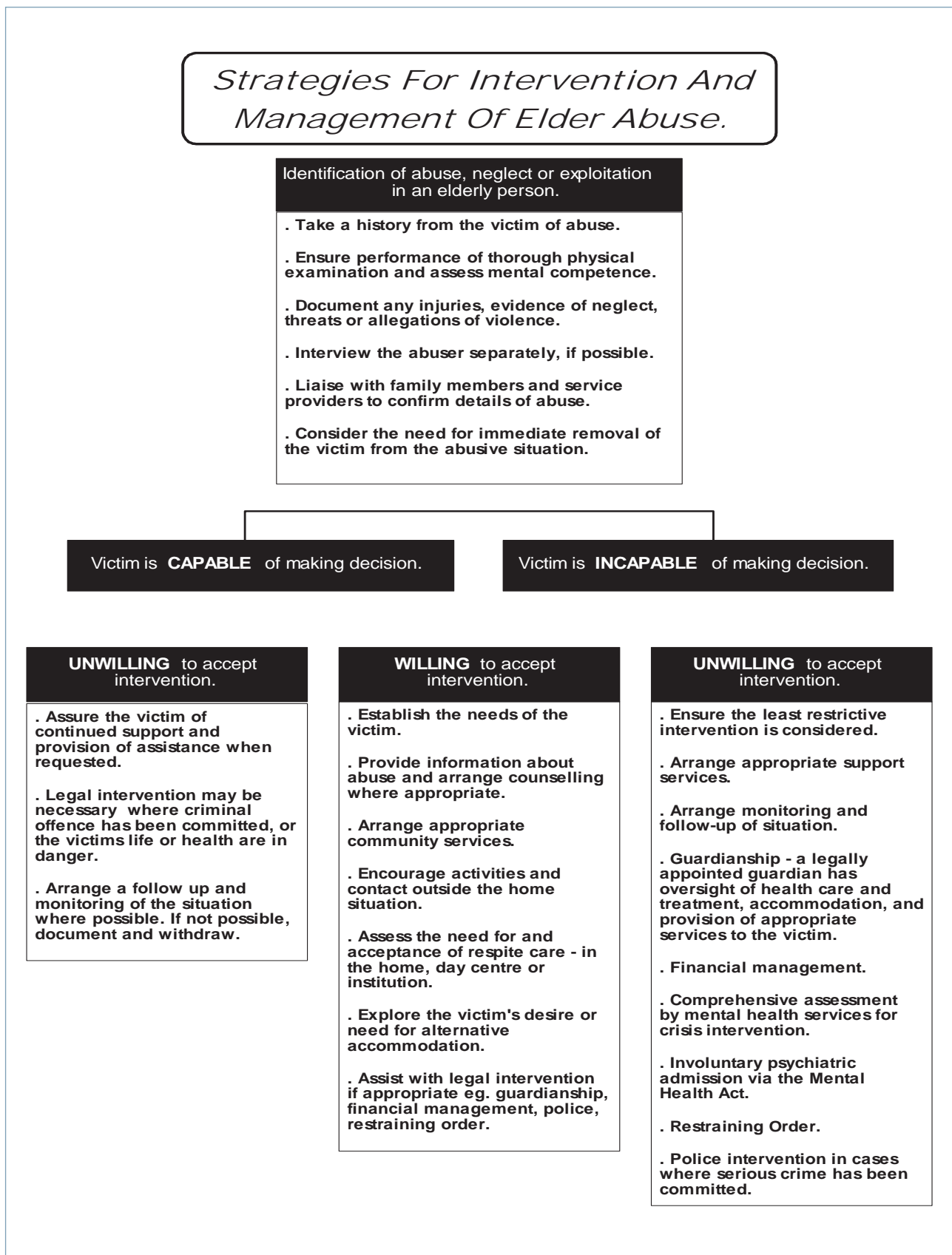
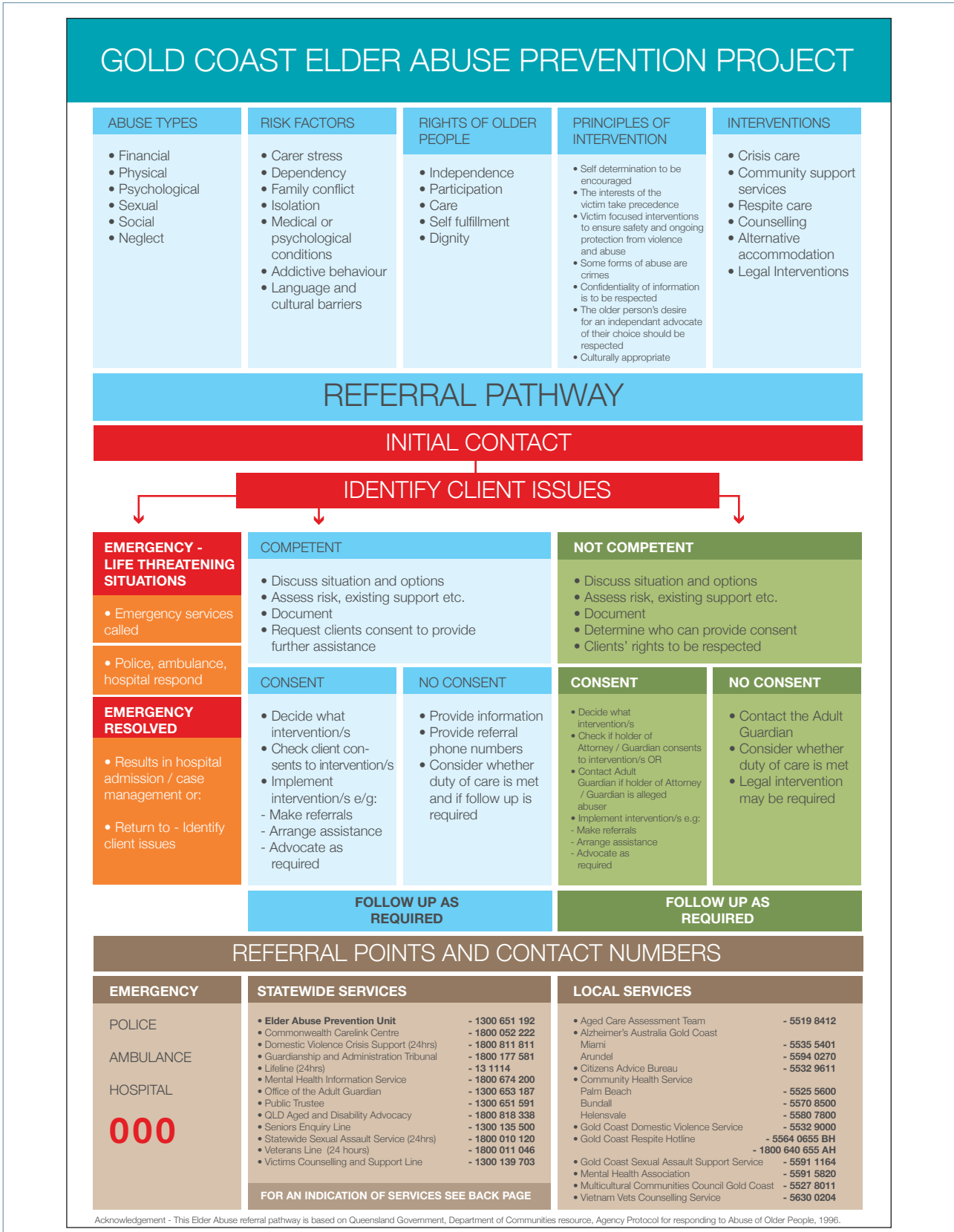
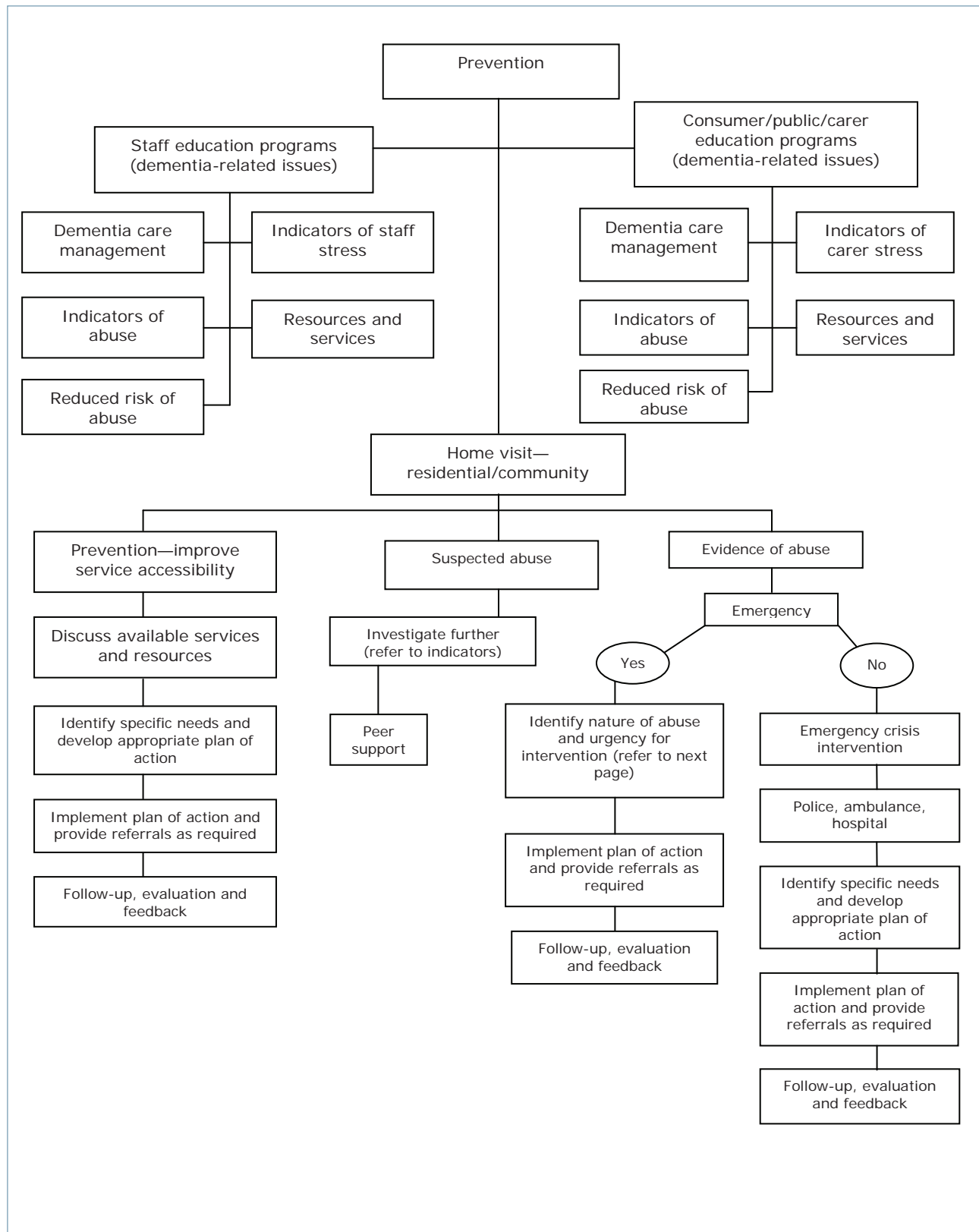


Figure 3: A sample agency intervention flowchart–Elder abuse referral pathway example



Source: Queensland Government, Department of Communities, 1996, Agency Protocol for Responding to Abuse of Older People

Figure 4: Strategies for preventing abuse or intervening where abuse is a concern and dementia is a consideration



**Figure 5: Useful interventions and considerations when developing strategies to prevent or intervene when abuse is suspected and dementia is a concern**

Primary factors contributing to abuse	Specialist	Emergency responses	Community services	Respite care	Counselling	Education	Alternative accommodation	Legislation
Lack of knowledge	Yes	Maybe	Maybe	Maybe	Maybe	Yes	Maybe	Maybe
Carer stress	Maybe	Maybe	Yes	Yes	Yes	Yes	Yes	Maybe
Psychopathology of the person with dementia	Yes	Maybe	Yes	Yes	Maybe	Yes	Maybe	Maybe
Level of dependency of the person with dementia	Yes	Yes	Yes	Yes	Maybe	Yes	Yes	Maybe
History of family violence: carer retaliation	Yes	Maybe	Maybe	Maybe	Yes	Maybe	Maybe	Maybe

*Legend*

Specialists—psychiatrists, geriatricians, psychologists, neurologists, psychogeriatricians, neuropsychologists and cognitive, dementia and memory services (CDAMS).	Alternative accommodation—supported residential services, residential aged care services (high and low care).
Emergency responses—police, community policing programs, Aged Care Assessment Services (ACAS), Aged Psychiatric Assessment and Treatment Teams (APATTs).	Education—World Wide Web, libraries, carers associations, Alzheimer’s Association Victoria, Gerontic Nursing Professional Unit at La Trobe University.
Community services—home nursing services, community nursing (HACC), home support programs, carers associations, Alzheimer’s Association Victoria and carer resource centres.	Legislation—accessing mainstream legal services, including applications to the Victorian Civil and Administrative Tribunal (VCAT) Guardianship List for the revocation of enduring powers of attorney, the court for restraining orders and the criminal justice system.
Respite—respite services (refer to Carelink counselling—psychologists, carers association, Alzheimer’s Association Victoria).	

Source: Department of Human Services, Alzheimer’s Association Victoria, and La Trobe University, *Draft Protocol: in Response to the Discussion Paper: Overcoming Abuse of Older People with Dementia and Their Carers*, Melbourne, 2000, p. 5.

### Figure 6: Flowchart–Responding to abuse of older people: Bendigo Health Services

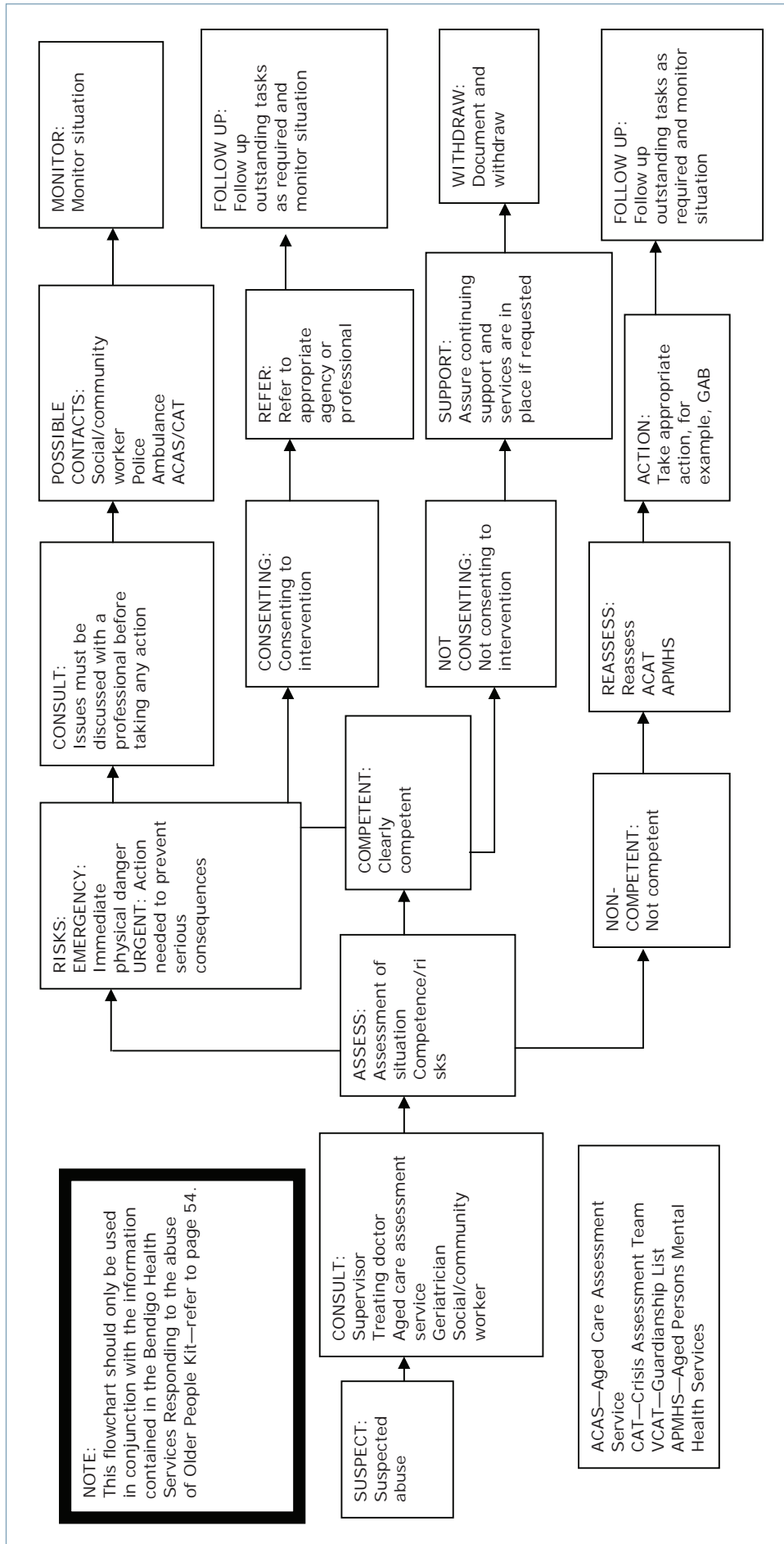
In 2005 the Department of Human Services (Loddon-Mallee Region) provided funding to the Bendigo Health Care Group to update its resource for HACC and aged care workers, which includes:

- discussion of the rights of older people
- risk factor characteristics and indicators of abuse
- discussion of the role of professionals and community workers
- a local area contact list and support services referrals.

Contact	Phone/Fax/Email
<b>Social Work Department, Bendigo Health</b>	Phone: 5454 7123

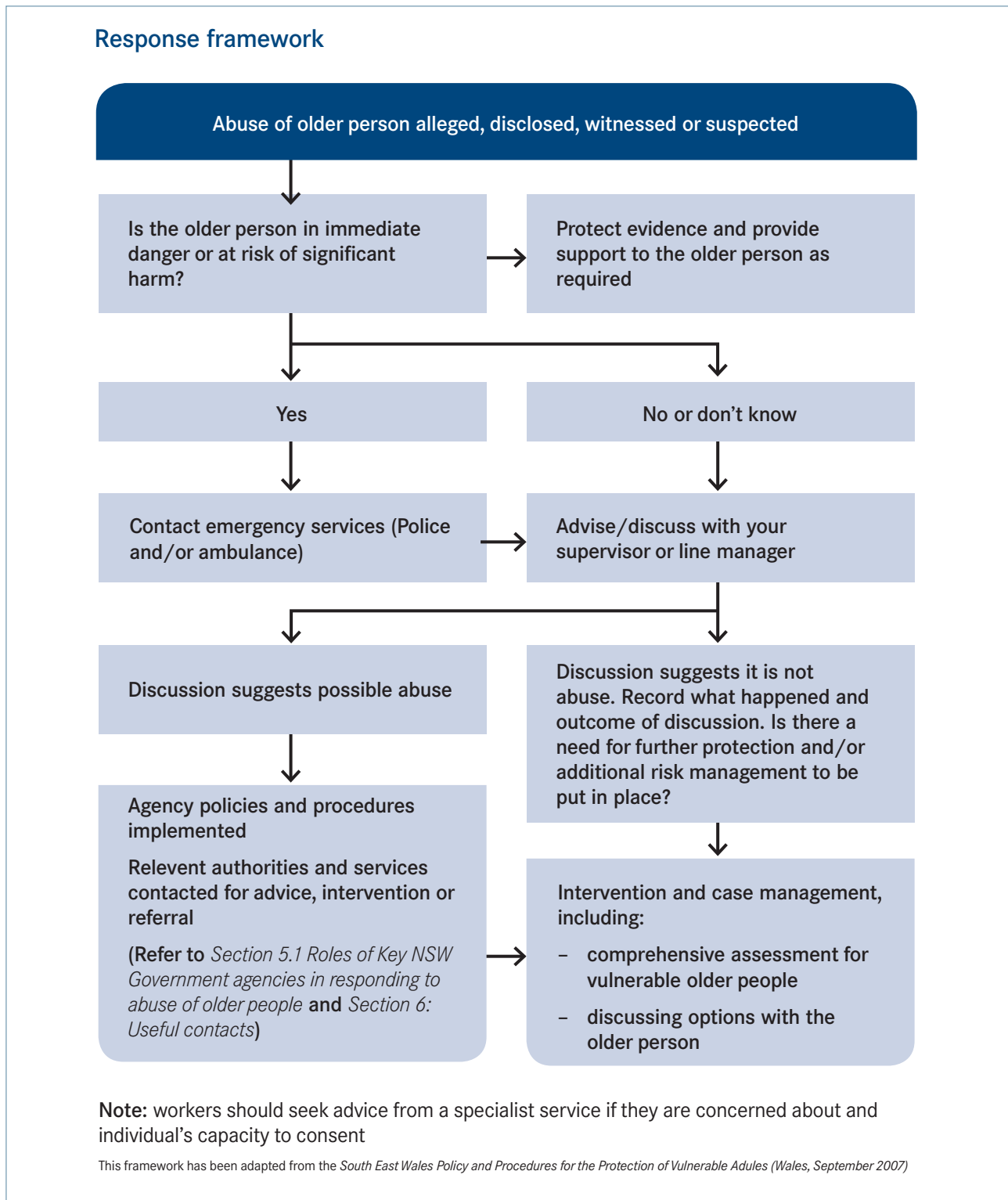


Figure 6: Flowchart—Responding to abuse of older people: Bendigo Health Services



This sample is an extract from the Bendigo Health Services Prevention of Elder Abuse Kit presenting the roles of professionals and community workers.

Figure 7: A sample interagency response framework – NSW Department of Ageing, Disability and Home Care, 2007



# 7 Resources

## Overview

The following resources have been provided for reference and use by community agencies and health services to enhance their capacity to act on suspicion and allegations of elder abuse.

## 7.1 Services

### 7.1.1 Seniors Rights Victoria (SRV)

Seniors Rights Victoria (SRV) is a Victorian government-funded specialist elder abuse service, established to assist with elder abuse concerns and to safeguard the rights, dignity and independence of older Victorians.

SRV commenced in April 2008, and is managed by a partnership between the Council on the Ageing (COTA) Victoria, the Public Interest Law Clearing House (PILCH), Eastern Community Legal Centre (ECLC) and Loddon Campaspe Community Legal Centre (LCCLC). COTA maintains a coordination role on behalf of the partnership.

SRV operates from offices in central Melbourne, outer east metropolitan Melbourne and in regional Bendigo. Protocols and pro bono legal affiliations are being developed to enhance statewide coverage.

SRV is a key point of contact for older people, their family members and friends, professionals working with older people, as well as members of the general community who may have concerns about suspicion of elder abuse.

#### Role in relation to elder abuse

SRV provides the following services:

##### Telephone information, support and referral

SRV operates a telephone helpline that provides information on elder abuse, including services available to assist. The helpline refers cases of concern to appropriate funded agencies that service the area where the older person lives, as well as SRV's own legal practice.

The telephone helpline is run by staff and trained volunteers, who treat all calls as confidential.

##### Legal service

SRV operates a legal practice at its central and regional sites, pro bono legal clinics at outreach locations and a secondary consultation service. SRV is committed to assisting older people in their local communities encouraging and actively support community legal centres to respond to an older person's needs.

SRV legal service expertise includes assistance on issues related to ageing with elder abuse as being a priority, for example:

- elder abuse
- accommodation
- health
- financial and consumer issues

- discrimination
- substitute decision making and end-of-life issues
- grandparenting.

The SRV legal service provide the following types of assistance:

- legal information and advice
- casework
- secondary consultations to service providers
- systemic advocacy and law reform (including strategic litigation)
- referrals to other legal and/or support services
- short-term advocacy
- engagement in test cases
- community and professional legal education.

#### **Short-term individual advocacy and support**

SRV provides short-term assistance to clients who are vulnerable due to the unavailability of a relevant local service. The purpose is to provide older people who experience or are at risk of elder abuse with support in order to enhance their safety, security and wellbeing. Assistance may include information, referral, liaison and short-term counselling, as well as face-to-face meetings if necessary.

#### **Advocacy**

SRV is developing specialist knowledge on the subject of elder abuse which will be used to undertake a range of advocacy activities on behalf of older people including:

- collecting SRV data and identifying trends relating to the nature of abuse
- forming strategic relationships with tertiary institutions
- developing links with interstate and overseas abuse prevention organisations and research institutions relevant to the Victorian experience
- distributing relevant information to SRV stakeholders.

#### **Referrals to funded providers in local areas**

SRV links to funded health and community services to:

- ensure effective and timely response to SRV referrals at a local level
- facilitate sharing of information and resources on elder abuse
- refine referral pathways.

#### **Community education**

SRV provides broad community awareness-raising activities, information and education sessions for community groups and older people.

Community education sessions may include information about abuse in its various forms, the rights of older people, options for action and legal issues. SRV will use a peer-to-peer education model where older people deliver the sessions to other older people, their families and carers.

Community education sessions are also available to meet the needs of older people with culturally and linguistic diverse (CALD) and Indigenous backgrounds.

Printed materials, the SRV website and the content of education session and awareness raising activities are consistent with the Victorian Government Elder Abuse Prevention Strategy.

### Professional education

SRV may also provide professional education sessions using products developed via the Victorian Government Elder Abuse Prevention Strategy (refer to [1.1.1 Key principles underpinning the implementation of the Victorian Government Elder Abuse Prevention Strategy](#) and [Section 9: Recommendations from the Victorian Government response to the Report of the Elder Abuse Prevention Project](#)).

Contact	Phone/Fax/Email
<b>Seniors Rights Victoria (SRV)</b> Monday to Friday 10.00 am to 5.00 pm. C/o COTA, Level 4, 98 Elizabeth Street, Melbourne, 3000 Website: <a href="http://www.seniorsrights.org.au">www.seniorsrights.org.au</a>	Helpline phone: 1300 368 821 Email: <a href="mailto:info@seniorsrights.org.au">info@seniorsrights.org.au</a>

## 7.1.2 The Victorian Civil and Administrative Tribunal–Guardianship List (VCAT)

The key role of the VCAT Guardianship List is to make decisions about applications made under the Guardianship and Administration Act 1986.

Any person may apply to VCAT for an order appointing a guardian and/or an administrator, in respect of a person with a disability who has attained the age of 18 years, or to take effect when the person turns 18.<sup>30</sup>

VCAT does not have general jurisdiction over people with a disability.

All applications should be made on the form provided by VCAT. The applicant must send a copy to the person about whom they are applying (the proposed represented person), as well as to the person's primary carer, their nearest relative and the existing (or proposed) guardian or administrator.

VCAT also requires the applicant to attend the hearing, and to make the necessary arrangements for the proposed represented person to attend.

The VCAT Guardianship List has a duty to ensure that its decisions are in the best interests of the proposed represented person. Its processes are inquisitorial, rather than adversarial.

There are two considerations to be aware of regarding VCAT's scope:

1. 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
2. VCAT has jurisdiction over people with a disability that weakens their competence to act on their own behalf, but VCAT has no authority to appoint a guardian as an advocate for a vulnerable person who does not fall into this category.

Upon receiving an application for guardianship or administration, VCAT can refer the matter to a statutory body for an investigation. This is usually to the Office of the Public Advocate (OPA). A report of this investigation is provided to VCAT and is confidential to VCAT. It can only be obtained from VCAT, which will usually release the report to parties unless there are serious issues of confidentiality or the risk of harm to others involved.

OPA provides a duty officer and State Trustees has an officer present each day at VCAT in Melbourne who can assist parties.

<sup>30</sup> Some of the paragraphs in this section are based on *The Law Handbook 2008*, Fitzroy Legal Service, Melbourne, Victoria, Australia.

The powers of the tribunal are set out in the Guardianship and Administration Act 1986, but also the *Instruments Act 1958* (enduring powers of attorney (refer to definitions [10.6 Enduring powers of attorney \(financial\)](#) and [10.7 Enduring powers of attorney \(medical treatment\)](#)) and the *Medical Treatment Act 1988*.

### Role of the tribunal in relation to elder abuse

In the case of suspected or alleged elder abuse there could be a range of causes for a person to make application to the Guardianship List.

The person making application could be the older person themselves, their spouse or partner, a family member or concerned friend. For examples of VCAT cases considered to be elder abuse refer to [8.10 VCAT cases](#).

Once VCAT has received an application under the Guardianship and Administration Act, it has the power to call witnesses and subpoena relevant documents. VCAT can take evidence from a geriatrician about whether the person had the mental capacity to sign a document, such as an enduring power of attorney. VCAT can also revoke an enduring power of attorney if it is in the best interests of the donor to do so.

VCAT can appoint guardians or administrators and can make orders about enduring powers (refer to definitions [10.6 Enduring powers of attorney \(financial\)](#) and [10.7 Enduring powers of attorney \(medical treatment\)](#)). An enduring power of attorney is a document by which a competent person (the ‘donor’) appoints another person (the ‘attorney’) to manage the donor’s financial affairs.

For further information about how to make application to VCAT and what processes to expect, refer to:

- The Law Handbook, published annually by the Fitzroy Legal Service<sup>31</sup>
- [7.1.3 The Office of the Public Advocate \(OPA\) Victoria](#), particularly the various publications on their website about making applications to VCAT under the Guardianship and Administration Act.

Contact	Phone/Fax/Email
<b>Victorian Civil and Administrative Tribunal (VCAT) Guardianship List</b> 55 King Street, Melbourne 3000 Website: <a href="http://www.vcat.vic.gov.au">www.vcat.vic.gov.au</a>	Phone: 9628 9911 or 1800 133 055

### 7.1.3 The Office of the Public Advocate (OPA) Victoria

OPA acts as an advocate on behalf of people with a disability (including intellectual disability, mental health issues, brain damage, dementia or physical/sensory disability), sometimes bringing a case before VCAT.

The outcome of a VCAT hearing is often that OPA is appointed the represented person’s guardian, when no other suitable guardian is apparent. OPA is then the client’s alternative decision maker. The powers of OPA are set out in the Guardianship and Administration Act 1986.

OPA generally relies on local services to carry out needs assessments of an OPA client, including allocation of resources to meet those needs. OPA is usually too removed from the person’s local environment to take on the role of case manager or service coordinator, though this may occur by default if no other agency can accept the role, which may not be the best outcome for the person concerned.

A separate point relates to the limited investigatory powers of the Public Advocate. Under Section 27(1) of the Guardianship and Administration Act, VCAT 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 VCAT if it has received information on oath that the person is:

<sup>31</sup> Fitzroy Legal Service, 2009, *The Law Handbook*, Section 16.6: Guardianship and administration. For further information refer to: [www.fitzroy-legal.org.au/](http://www.fitzroy-legal.org.au/) or subscribe via [www.lawhandbook.org.au/](http://www.lawhandbook.org.au/) or contact Fitzroy Legal Aid on (03) 9411 1307.

- a) being unlawfully detained against their will; or
- b) likely to suffer serious damage to their physical, emotional or mental health or wellbeing unless immediate action is taken.

The two main relevant procedures are:

- individual advocacy cases come to the attention of OPA from several sources, for example, VCAT, social workers, lawyers, neighbours and State Trustees
- ‘systemic advocacy’ emerges on the causes underlying the individual cases advocates deal with.

### Role in relation to elder abuse

A matter involving abuse can be referred to OPA for investigation or advocacy if it involves a person who appears to be incapable of making reasonable decisions (perhaps because of dementia), and the person may or may not need a guardian or administrator.

Apart from short-term investigations, OPA may have an ongoing guardianship role in an individual case either for the short term or ongoing, and limited to a certain area of decision making (for example, housing).

In 2006–07, 46 per cent of enquiries related to people aged 70 and over, with the largest cohort aged 81 and over (31 per cent). Of the cases involving elderly people, a considerable number were about financial exploitation.

Contact	Phone/Fax/Email
<b>Office of the Public Advocate (OPA)</b> Level 5, 436 Lonsdale Street, Melbourne 3000 Website: <a href="http://www.publicadvocate.vic.gov.au">www.publicadvocate.vic.gov.au</a>	Phone: 9603 9500 or 1300 309 337

## 7.1.4 Victoria Police

Victoria Police provides localised and specialist services to the community, including investigation of criminal offences, community safety education and crime prevention programs. Victoria Police contributes to a high quality of life for individuals within the Victorian community by ensuring a safe and secure society.

### Safety and security issues

Where safety and security issues of older Victorians are identified locally, Victoria Police may develop relevant responses—often in partnership with other local service providers. It may be appropriate for the police multicultural liaison officer or the local crime prevention officer to become involved.

### Where abuse sits in a family violence context

Victoria Police acknowledges that older people can be victims of family violence, which is often insidious and well hidden. Where abuse sits in a family violence context, the *Family Violence Protection Act 2008* would apply.

The Police Code of Practice for the Investigation of Family Violence was introduced in 2004, and emphasises that police will treat all such reports seriously. When attending family violence incidents, the Police Code of Practice requires police, at a minimum, to make an informal or formal referral to support services. Police are required to make an assessment of risks and threats using a risk assessment tool developed for this purpose.

When responding to elder abuse in the context of family violence, specialised advice is provided by Victoria Police family violence advisors (FVAs), family violence liaison officers (FVLOs) and family violence management officers (FVMOs), located throughout Victoria. These police have dedicated roles in identifying local issues around family violence within the community. They act as a focal point between other police and external local

providers. Their role is associated with family violence only, and responds to prevention as well as alleged incidents of family violence by supporting operational police.

#### **Where abuse is deemed a criminal offence**

Specially trained Victoria Police sexual offence and child abuse units (SOCAUs) provide a 24x7 response to any victim of sexual assault. Work is often undertaken jointly between the local criminal investigation unit and externally with Centres Against Sexual Assault (CASA). Where abuse is deemed a criminal offence, mainly operational police and members of SOCAUs and criminal investigation units will be involved.

#### **Developing protocols with local service providers on specific issues**

Many local police stations have formed partnerships with local service providers, which take the form of working groups to address specific local issues, develop protocols and formal or informal agreements. At times, local service providers are part of local safety committees which identify and address safety issues within a local government area. Service providers are encouraged to develop and strengthen relationships with local police in the prevention and intervention of elder abuse.

If a local community safety response is required, workers should contact crime prevention officers (CPOs), who work in close collaboration with local communities to reduce crime and the fear of crime. Consulting closely with local communities and analysing crime trends and statistics, CPOs can develop and help implement local crime prevention programs.

#### **Response to older Aboriginal people**

Victoria Police responds to the needs of older Aboriginal people, initially by offering the same service response as for the general population. When police become aware of the person's Aboriginal status, the station police Aboriginal liaison officer (PALO), where one is appointed, will be made aware of the issue and will offer assistance. Where no PALO is appointed, an Aboriginal community liaison officer (ACLO) can fulfil this role. Police also refer to the Victorian Aboriginal Legal Service (VALS) to assist with legal advice for the victim and to clarify legal processes. Where the alleged perpetrator is an Aboriginal person and in custody, police will contact VALS as a matter of course.

#### **Role in relation to elder abuse**

Individual complaints concerning abuse will be responded to by operational police in local police stations. The response may vary according to the health status and competency of an older person and their connection with local community service networks.

In the context of elder abuse, Victoria Police can be contacted when there is:

- suspected criminal offence involving an older person
- potential risk to the safety of an older person, worker, carer or family members
- an identified need to address personal and community safety involving older persons.

Contact	Phone/Fax/Email
For advice and local community education and prevention, contact the officer in charge of the local police station. Refer to 'police' in the <i>Business and Government</i> volume of the <i>White Pages</i> . Website: <a href="http://www.police.vic.gov.au/content.asp?Document_ID=7">www.police.vic.gov.au/content.asp?Document_ID=7</a>	In an emergency, phone: 000



### 7.1.5 Aged Care Assessment Services (ACAS)

ACAS are a part of the National Joint Commonwealth and State Aged Care Assessment Program (ACAP) and operates under the Commonwealth Guidelines and Conditions of Grant. The day-to-day operational management of ACAP rests with the Victorian Department of Human Services central office through protocols negotiated with the Commonwealth.

The core objective of ACAS is to assess comprehensively the needs of frail older people, including those who suffer from signs and symptoms of early ageing.

ACAS multidisciplinary teams include health professionals (such as medical officers, social workers, nurses, occupational therapists and physiotherapists) who comprehensively assess for restorative and potential care options, and facilitate access to available care services.

ACAS is strategically placed to assess the health status and social circumstances of large numbers of frail older people. In Victoria, over 60,000 assessments are completed annually. Two-thirds of those clients accepted as referrals were aged 80 years and over, with over 70 per cent living in the community.<sup>32</sup> ACAS does not have an ongoing case management role, but is available for secondary consultations to other agencies.

Assessment outcomes include eligibility for high or low care support via a Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH), and Extended Aged Care at Home Dementia (EACHD) and/or residential respite or transition care or residential aged care. Cases are also referred to community aged care services for assessment, such as HACC-funded or Department of Veterans Affairs-funded programs.

ACAS accepts referrals from agencies, for example, GPs, residential aged care services, hospitals and community agencies or from family, friends or self-referral. The assessment process includes an older person's family, their social environment as well as their medical condition.

#### Role in relation to elder abuse

The Aged Care Assessment Service accepts referrals from neighbours, friends or family expressing concern about an older person they know. The consent of the person being referred is preferred.

ACAS responds by assessing the situation to ascertain what might be happening from the older person's perspective. This usually involves a home visit by ACAS for a comprehensive assessment.

ACAS may refer the matter to another service provider (for example, VCAT, HACC provider), depending on the case at hand.

Contact	Phone/Fax/Email
<b>Aged Care Assessment Services (ACAS)</b> The <i>Business and Government White Pages</i> —listing in the 'age page'	
<b>Commonwealth Carelink Centre for ACAS</b> Website: <a href="http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-contacts-acat-acatindx.htm">www.health.gov.au/internet/main/publishing.nsf/Content/ageing-contacts-acat-acatindx.htm</a>	Phone: 1800 052 222

### 7.1.6 Family violence services

Human service agencies, police and justice services (including family violence services) are required to work together to provide coordinated and streamlined responses at the local level to victims of family violence, regardless of where the support comes from.

<sup>32</sup>Victorian MDS 2008–09.

A referral pathways protocol between Victoria Police and the Department of Human Services local family violence service providers was established to ensure consistency when responding to violence. Other organisations involved with an older person will also be included via a local interagency protocol.

The definition of family violence includes violent, threatening, patterned and repeated use of coercive or controlling behaviour that occurs in current or past family, domestic or intimate relationships. This includes physical assaults, power and control tactics used along a continuum in concert with one another, direct or indirect threats, sexual assault, emotional and psychological torment, economic control, property damage, social isolation and behaviour that causes a person to live in fear.<sup>33</sup>

### The Victorian Family Violence Risk Assessment and Risk Management Framework

The framework describes how the assessment of risk to victims of family violence must be structured and informed by the victim's assessment of their own safety, evidence-based family violence risk factors and professional judgment (refer to *Example 10: Assessing risk* in *3.1.2 Assessment*).

The framework was developed to:

- better identify and respond to family violence
- promote a common understanding of the issues underpinning family violence
- include risk assessment practice guides and tools for specialist and mainstream professionals.

While abusive behaviour by a male partner towards a female partner is the most common form, family violence extends to abuse by any family member against any other member, whether partner, child, parent, grandparent or other relative.

Older people require the same assessment process as all other age groups. Abuse of older people can include a continuum of behaviours (financial, physical, emotional and the deprivation of basic rights). Assessment must include the particular context affecting the older person, for example, the presence of dementia and the particular relationship with the alleged perpetrator (that is, whether the suspected perpetrator is a carer or other family member).

Assessment workers should be confident that an older person has the mental capacity to make their own decisions and give consent. If there is doubt, appropriate specialist referrals must occur for testing, guardianship or advocacy, as appropriate (refer to *10.2 Mental capacity testing* in *Definitions*).

Risk to an older person and the carer must be assessed—regardless of the type of abuse.

### Intervention orders

From 1 July 2006 to 30 June 2007, 939 people aged 65 or older applied for intervention orders, representing 3.86 per cent of the 24,305 finalised intervention orders in that year. Women comprised 54.5 per cent (511) of this 65-or-older age group, and men 45.5 per cent (428).<sup>34</sup>

Older people making use of intervention orders to prevent mistreatment by other family members are more likely to seek orders against their children and grandchildren than against their partners. This could be either 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.

Based on Magistrates Court intervention order statistics,<sup>35</sup> three different points can be noted, although there are data gaps and overlaps, so definitive conclusions cannot be made. However:

<sup>33</sup> Department of Victorian Communities, Office of Women's Policy, 2005, *Reforming the Family Violence System in Victoria. Report of the Statewide Steering Committee to Reduce Family Violence*.

<sup>34</sup> Prepared by Court Services, Department of Justice. Source: *Crimes—Family violence data cube as at 3 October 2007*.

<sup>35</sup> For further data on intervention orders, refer to: [www.magistratescourt.vic.gov.au](http://www.magistratescourt.vic.gov.au), follow the prompts to 'Intervention orders' then 'Statistics'.

- the ‘classic’ form of family violence, spouse abuse by a husband, may not be confined to younger couples
- older women are as likely to seek protection from abusive children as from abusive husbands
- older men are much more likely to seek protection from abusive children than from wives.

### The Family Violence Protection Act 2008 replaces the Crimes (Family Violence) Act 1987<sup>36</sup>

The Family Violence Protection Act 2008<sup>37</sup>:

- replaces the system of family violence intervention orders established by the Crimes (Family Violence) Act 1987 for family members
- seeks to maximise the protection and safety of persons who have experienced family violence
- promotes the accountability of perpetrators of family violence for their actions.

#### Broader definition of ‘family member’

The Act broadens the definition of ‘family member’<sup>38</sup> to include:

- a current or former spouse or domestic partner
- a person who has, or has had, an intimate personal relationship with the relevant person
- a current or former relative
- a child who normally lives or has lived with the relevant person
- a child of a person who has, or has had, an intimate personal relationship with the perpetrator of violence.

The term ‘family member’ is also broadened to include, for example, a relative according to Aboriginal or Torres Strait Islander tradition or contemporary social practice.<sup>39</sup>

#### Broader definition of family violence

The Family Violence Protection Act 2008 also extends the definition of ‘family violence’ to behaviour that is physically or sexually abusive, emotionally or psychologically abusive, threatening or coercive, or in any other way controls or dominates the family member and causes that family member to fear for their safety or wellbeing or for the safety or wellbeing of another person.

Examples of behaviour that may be considered family violence for the purposes of the Act include:

- causing a child to hear or witness, or otherwise be exposed to the effects of, family violence
- coercing a family member to relinquish control over assets and income
- removing or keeping a family member’s property without permission, or threatening to do so
- threatening to disclose a person’s sexual orientation to the person’s friends or family against the person’s wishes
- threatening to withhold a person’s medication
- preventing a person from making or keeping connections with the person’s family, friends or culture, including cultural or spiritual ceremonies or practices, or preventing the person from expressing the person’s cultural identity
- threatening to commit suicide or self-harm with the intention of tormenting or intimidating a family member.

<sup>36</sup> The Family Violence Protection Act 2008 replaced the Crimes (Family Violence) Act 1987 and came into effect December 2008. Refer to [www.familyviolence.vic.gov.au/Home](http://www.familyviolence.vic.gov.au/Home) for further information.

<sup>37</sup> Source Victorian Government Solicitor’s Office (VGSO) Client Newsletter, The Family Violence Protection Act 2008, October 2008.

<sup>38</sup> Refer to the Family Violence Protection Act 2008, Section 8.

<sup>39</sup> Refer to the Family Violence Protection Act 2008, Section 10.

### **Family violence safety notices**

Importantly, the Act empowers the police to issue family violence safety notices. These notices are for use outside of court hours and provide police with another tool to ensure that immediate protection is available when police respond to an incident.

Family violence safety notices may include the same conditions as a family violence intervention order and last until the application for a family violence intervention order is brought before the court.

### **Applying for an intervention order**

The Act enables the affected family member to apply to a Magistrates Court for an intervention order prohibiting the offender from continuing the harmful conduct. The affected family member can apply personally, or an application can be made on behalf of that person by a member of the police force or another person.

For information about who can apply for a family violence intervention order, refer to Section 45 of the Family Violence Protection Act 2008.

The Act contains provisions to grant an exclusion order designed to prevent the perpetrator from returning to the family home if needed.

Family violence agencies provide support for women who experience violence through the court process. Family violence workers in the Heidelberg and Ballarat courts provide support to older people who may be victims and are seeking family violence interventions.

Many acts of family violence will constitute criminal offences under other legislation, for example, the Crimes Act 1958 and the Summary Offences Act 1966.

### **Victim support**

The Victims Support Agency coordinates the Department of Justice family violence initiatives. A victim of crime has suffered physical or emotional injury, or financial loss because of a crime.

Older people may be less likely to report crime.

The Victims Assistance and Counselling Program provides immediate crisis response to victims of crime in person and by telephone. Outreach services, crisis response, practical support, court support, referral and coordination of specialist support groups are provided, responding to individual needs.

Eligible victims of crime may access short-term counselling through the Victims Assistance and Counselling Program to assist recovery.

The Victims of Crime Assistance Tribunal (VOCAT) considers applications for financial assistance for victims of violent crime committed in Victoria. Interim awards can be made quickly without the need for a hearing before a magistrate in some cases. For elderly victims, this may enable them to receive assistance for their immediate safety or urgent medical expenses.

The Victims Assistance and Counselling Program can also assist victims with their application to VOCAT.

### **Role in relation to elder abuse**

All family violence services are available to service providers, older people, family members and people living in the community in relation to elder abuse.

The type of family violence service response required is determined on a case-by-case basis.

Family violence service providers work in cooperation with health services and other community-based organisations as part of a local agency response to elder abuse.

Contact	Phone/Fax/Email
<b>Women's Domestic Violence Crisis Service of Victoria</b>	Phone: 9373 0123 (24 hrs) statewide
<b>Immigrant Women's Domestic Violence Service</b>	Phone: 9898 3145 statewide
<b>Elizabeth Hoffman House Aboriginal Family Violence Services</b>	Phone: 1800 015 188 (24 hrs)
<b>Women's Information Referral Exchange</b>	Phone: 1300 134 130 statewide
<b>The Victims of Crime Helpline</b>	Phone: 1800 918 817
<b>Federation of Community Legal Centres</b> Website: <a href="http://www.communitylaw.org.au/cb_pages/clc_quick_guide.php">www.communitylaw.org.au/cb_pages/clc_quick_guide.php</a>	Phone: 9654 2204 statewide
<b>Local Family Violence Outreach Services (Metropolitan):</b> Eastern Region (Ringwood) Northern Region (Heidelberg) Southern Region (Frankston, Mentone, Cranbourne, Peninsula) Western Region (Footscray)	Phone: 9870 5939 Phone: 9457 5087 Phone: 9791 6111 Phone: 9689 9588
Assistance is available to men who are violent towards family members. Police will refer to local men's behaviour change programs or to the Men's Referral Service.	Phone: 1800 065 973
<b>Family Violence Coordination Unit, Department of Planning and Community Development</b> Level 5, 1 Spring Street, Melbourne 3000 For a printable copy of family violence risk assessment referral information, refer to website: <a href="http://www.office-for-children.vic.gov.au">www.office-for-children.vic.gov.au</a>	

### 7.1.7 Victoria Legal Aid

Victoria Legal Aid (VLA) is a statewide organisation that helps people with their legal problems. They focus on helping and protecting the rights of socially and economically disadvantaged Victorians.<sup>40</sup>

VLA is funded by the Commonwealth and state governments, but remains independent from government. VLA can assist in areas of criminal law, family law and some civil law matters.

VLA have lawyers in offices in most major metropolitan and country regions, and also fund private lawyers to provide legal services to the public. VLA is a statutory authority established by legislation called the Legal Aid Act 1978 (Vic).

#### Role in relation to elder abuse

All VLA services would be available, as assessed by VLA, for older people, family members and others concerned about elder abuse. Free legal services include:

- information over the phone
- a public law library
- publications and workshops
- legal advice
- lawyers on duty at many courts and tribunals.

<sup>40</sup> For further information refer to: [www.legalaid.vic.gov.au/](http://www.legalaid.vic.gov.au/)

In some cases, VLA can also provide ongoing legal assistance to:

- pay a lawyer to give advice, help reach agreement, or speak for a person in court
- go to the family dispute resolution service.

Contact	Phone/Fax/Email
<b>Victorian Legal Aid (Lawyers and Legal Services)</b> Legal Information Service operates 8.45 am to 5.15 pm, Monday to Friday. 350 Queen Street, Melbourne 3000 Website: <a href="http://www.legalaid.vic.gov.au/298.htm">www.legalaid.vic.gov.au/298.htm</a>	Phone: 9269 0120 or 1800 677 402 (freecall for country areas)

### 7.1.8 The Victorian Equal Opportunity and Human Rights Commission

The Victorian Equal Opportunity and Human Rights Commission (the Commission) administers:

- the Equal Opportunity Act 1995<sup>41</sup> (currently under review)
- the Racial and Religious Tolerance Act 2001.<sup>42</sup>

The commission's role is to:

- help to resolve individual and representative complaints about discrimination, sexual harassment and racial and religious vilification by offering a conciliation process that is confidential, impartial, free and simple
- undertake projects and activities aimed at eliminating discrimination and racial and religious intolerance
- conduct research and provide legal and policy advice.

The commission also performs a number of important functions under the Victorian Charter of Human Rights and Responsibilities Act 2006,<sup>43</sup> including:

- educating people about human rights and the charter<sup>44</sup>
- preparing an annual report to the attorney-general on the operation of the charter
- providing advice to the attorney-general on issues relating to the operation of the charter.

The commission also has the right to intervene in proceedings before any Victorian court or tribunal in which a question of law arises that relates to the application of the charter or the interpretation of a statutory provision in accordance with the charter. The commission does not have the power to investigate individual complaints about breaches of the charter.

The commission is not a tribunal or court. It helps people to resolve complaints by mutual agreement, but does not prosecute, make judgments for or against either side, or award compensation.

The commission is an independent statutory body that reports to the Victorian Parliament through the state attorney-general.

<sup>41</sup> [www.dms.dpc.vic.gov.au/Domino/Web\\_Notes/LDMS/PubLawToday.nsf/95c43dd4eac71a68ca256dde00056e7b/FFDF2614F930DB2ACA25725100015560/\\$FILE/95-42a047.pdf](http://www.dms.dpc.vic.gov.au/Domino/Web_Notes/LDMS/PubLawToday.nsf/95c43dd4eac71a68ca256dde00056e7b/FFDF2614F930DB2ACA25725100015560/$FILE/95-42a047.pdf)

<sup>42</sup> [www.humanrightscommission.vic.gov.au/publications/rrtaact2001](http://www.humanrightscommission.vic.gov.au/publications/rrtaact2001)

<sup>43</sup> [www.dms.dpc.vic.gov.au/Domino/Web\\_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/54D73763EF9DCA36CA2571B6002428B0/\\$FILE/06-043a.pdf](http://www.dms.dpc.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/54D73763EF9DCA36CA2571B6002428B0/$FILE/06-043a.pdf)

<sup>44</sup> Charter education workshops provided by the Commission: [www.humanrightscommission.vic.gov.au/human%20rights/Charter%20workshops](http://www.humanrightscommission.vic.gov.au/human%20rights/Charter%20workshops)

### Role in relation to elder abuse

The main services of the commission that are relevant to elder abuse are:

- assistance with complaint resolution for individuals or representatives about discrimination, sexual harassment and racial and religious vilification, by offering a conciliation process that is confidential, impartial, free and simple
- education and advice about equality of opportunity, racial and religious tolerance and human rights
- policy advice.

Contact	Phone/Fax/Email
<b>Victorian Equal Opportunity and Human Rights Commission</b> Level 3, 380 Lonsdale Street, Melbourne 3000 Website: <a href="http://www.humanrightscommission.vic.gov.au">www.humanrightscommission.vic.gov.au</a>	Phone: 9281 7111 or 1800 134 142 (toll free) Fax: 9281 7171 TTY: 9281 7110 Email: <a href="mailto:information@veohrc.vic.gov.au">information@veohrc.vic.gov.au</a>

### 7.1.9 The Victorian Health Services Commissioner (HSC)

The Office of the HSC was established in 1988 as an independent statutory authority to receive and resolve complaints about health service providers, and also complaints about disclosure of health information and access to health information. The HSC powers are set out in the *Health Services (Conciliation and Review) Act 1987* and also the *Health Records Act 2001*.

Key features of the HSC process:

- it is impartial and confidential
- participation in the complaints process is voluntary
- complaints are resolved through cooperation
- HSC encourages open discussion, with all parties asked to give their point of view
- it can be an alternative to legal proceedings
- HSC does not charge fees.

The Health Services 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.

Complaints may be lodged by a consumer, a person chosen by the consumer, or anyone who the HSC considers has sufficient interest in acting on behalf of a client (including a health professional or OPA). Most complaints begin with a telephone call, followed by a written statement.

If the complaint involves a registered health service provider, the matter will also be discussed with the relevant registration board, and may be referred to them for action.

### Victorian Charter of Human Rights and Responsibilities

The HSC is a statutory partner with the Victorian Equal Opportunity and Human Rights Commission in promoting and considering the Charter of Human Rights and Responsibilities Act 2006 in assessing complaints it receives.<sup>45</sup>

<sup>45</sup> For additional information refer to: [www.equalopportunitycommission.victoria.gov.au/human%20rights/default.asp](http://www.equalopportunitycommission.victoria.gov.au/human%20rights/default.asp)

### Role in relation to elder abuse

A matter involving abuse or unreasonable health care of an older person can be referred to the HSC if a health service provider perpetrates the abuse. A health service provider is defined in the *Health Services (Conciliation and Review) Act 1987*, and includes doctors, nurses, hospitals and residential care services within the meaning of the *Health Services Act 1988*.

Once a complaint has been lodged, the HSC will mediate between the complainant and the health service, or may refer the matter to another organisation. For instance, matters involving supported residential services are routinely discussed with the Department of Human Services. Complaints about RACS are discussed with the Commonwealth Aged Care Complaints Investigation Scheme.

Contact	Phone/Fax/Email
<b>Health Services Commissioner, Complaints and Information</b> Level 30, 570 Bourke Street, Melbourne 3000 Website: <a href="http://www.health.vic.gov.au/hsc">www.health.vic.gov.au/hsc</a>	Phone: 8601 5200 or 1800 136 066 Fax: 8601 5219 TTY: 1300 550 275 Email: <a href="mailto:hsc@dhs.vic.gov.au">hsc@dhs.vic.gov.au</a>

### 7.1.10 Dementia services

Dementia is the term used to describe the symptoms of a large group of illnesses which cause a progressive decline in the ability of a person to remember, to think and to learn.<sup>46</sup>

A range of dementia programs provide support to health professionals, people living with dementia, their carers, and families. Some of these programs are:

#### Extended Aged Care at Home Dementia (EACHD)

EACHD packages assist people with dementia who experience difficulties in their daily life because of behavioural and psychological symptoms associated with their dementia. To access an EACHD package a person must first be assessed and approved by an Aged Care Assessment Team.

#### National Dementia Support Program

The National Dementia Support Program, run by Alzheimer's Australia, provides the following services and programs:

- the National Dementia Helpline and referral services
- dementia and memory community centres
- early intervention programs, such as the Living with Memory Loss Program
- advice, counselling and support services
- awareness-raising services, including activities such as Dementia Awareness Month
- education and training
- support for people with special needs, including the Dementia Cross Cultural Network and new activities for Aboriginal and Torres Strait Islander people.

<sup>46</sup> Australian Government, Department of Health and Ageing website: [www.health.gov.au/internet/main/publishing.nsf/Content/Dementia-1](http://www.health.gov.au/internet/main/publishing.nsf/Content/Dementia-1)



## Dementia behaviour management advisory services

In June 2008, Dementia Behaviour Management Advisory Services (DBMAS) were established by the Commonwealth Government, in each state and territory, to improve the quality of care for people with dementia and their carers where the behaviour of the person with dementia impacts on their care.

These services assist staff in residential aged care homes and in community care settings to improve dementia care. St Vincent's Health (in partnership with Alzheimer's Association (Victoria) and the National Ageing Research Institute (NARI) provides this service in Victoria.

DBMAS Victoria is an advice, assessment, intervention, education and specialised support service available 24 hours a day, to assist:

- family carers
- staff and volunteers of Commonwealth Government-funded aged care services
- other clinicians providing care (for example, general practitioners, staff of mental health services for older persons, residential aged care facilities)
- care recipients are also clients of DBMAS Victoria where the behaviour of the person with dementia impacts on their care
- the person with dementia is receiving or seeking care through Australian Government-funded aged care services.

Contact	Phone/Fax/Email
<b>Extended Aged Care at Home Dementia (EACHD) packages</b> <b>Aged and Community Care Information Line</b> Website: <a href="http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-dementia-eachguidelines.htm">www.health.gov.au/internet/main/publishing.nsf/Content/ageing-dementia-eachguidelines.htm</a>	Phone: 1800 500 853 (freecall)
<b>National Dementia Helpline and referral services</b>	Phone: 1800 100 500 (freecall)
<b>National Dementia Support Program Alzheimer's Australia</b> Website: <a href="http://www.alzheimers.org.au">www.alzheimers.org.au</a>	Phone: 1800 015 188 (24 hrs)
<b>Dementia Behaviour Management Advisory Service (Vic)</b> <b>St Vincent's Hospital (Melbourne)</b> St George's Campus, 283 Cotham Road Kew, Victoria 3101 Website: <a href="http://www.carersouth.org.au/news/items/248417-upload-00001.pdf">www.carersouth.org.au/news/items/248417-upload-00001.pdf</a>	Phone: 1800 699 799 Fax: 03 9816 0432 Email: <a href="mailto:dbmas@svhm.org.au">dbmas@svhm.org.au</a>

### 7.1.11 Victorian HACC assessment services

Organisations funded to provide HACC assessment services offer in-depth investigation or screening to HACC-funded providers who require a more comprehensive assessment.

There are 100 designated HACC-funded assessment services located around Victoria via the following HACC service outlets: most local councils, community nursing (for example bush nursing centres, RDNS), allied health, community health and health services, two Aboriginal services and an ethno-specific service.

The HACC assessment framework sets out revised program policy for assessment as a HACC-funded activity. It details the requirements for the delivery of living-at-home assessments, which include home-based holistic assessment of need and service-specific assessments as key components.

The framework also describes related processes which are critical adjuncts to assessment for specific client groups. For further information refer to: [www.health.vic.gov.au/hacc/downloads/pdf/framework.pdf](http://www.health.vic.gov.au/hacc/downloads/pdf/framework.pdf)

Client care coordination is provided for a subset of HACC clients with complex needs or circumstances who require a service response from more than one agency, including interagency care planning.

Supported access describes the role that ethno-specific, multicultural and Aboriginal organisations play in supporting clients to access mainstream services. Refer to Future Directions in Culturally Appropriate Access to HACC Program Core Services at: [www.health.vic.gov.au/hacc/projects/cegs\\_future.htm](http://www.health.vic.gov.au/hacc/projects/cegs_future.htm) for additional policy information.

The goal of the HACC assessment framework is to support and build good practice in delivering living-at-home assessments, and to support designated HACC assessment services to build alliances with other key assessment providers, such as ACAS, community health and agencies providing supported access. These alliances will ensure a more coordinated and streamlined approach to assessment based on person-centred care.

### Role in relation to elder abuse

HACC-designated assessment services can assist with more in-depth assessment and screening for HACC-funded providers. They also draw on expertise with other key assessment providers and others to assist in decision making and approaches to address elder abuse on a case-by-case basis.

Contact	Phone/Fax/Email
<p><b>Department of Human Services, general enquiries</b> Ask for the Department of Human Services regional office contact number applicable to your service. Having rung the region, ask for the regional aged care manager. Website: <a href="http://www.dhs.vic.gov.au/contact.htm#general">www.dhs.vic.gov.au/contact.htm#general</a></p>	Phone: 1300 650 172
<p><b>Local municipal councils provide HACC services, and are listed alphabetically in the White Pages under ‘aged care services’.</b></p>	
<p><b>Direct2Care</b> Website: <a href="http://www.health.vic.gov.au/hacc/assessment.htm">www.health.vic.gov.au/hacc/assessment.htm</a></p>	Phone: 1300 121 121

## 7.1.12 Victorian State Trustees Ltd

State Trustees assists people with their financial needs so they can make the most of their particular opportunities.

The State Trustees’ range of services include will-making, trustee, executor and personal financial administration.

### Role in relation to elder abuse

State Trustees provide information and assistance for older people, service providers and family members regarding financial matters.

Contact	Phone/Fax/Email
<p><b>State Trustees Ltd</b> 168 Exhibition Street, Melbourne 3000 Website: <a href="http://www.statetrustees.com.au">www.statetrustees.com.au</a></p>	Phone: 9667 6444

### 7.1.13 Mensline Australia

This national service provides information, support and referral for men who want to talk about family and relationship concerns. The service is open 24 hours a day and can be called from anywhere in Australia for the cost of a local call.

#### Role in relation to elder abuse

This service is available for men requiring information, support or referral of any kind in the case of suspicion or allegations of elder abuse.

Contact	Phone/Fax/Email
<b>Mensline</b> Website: <a href="http://www.menslineaus.org.au">www.menslineaus.org.au</a>	Phone: 1300 789 978

### 7.1.14 The Commonwealth Government Aged Care Complaints Investigation Scheme (CIS)

The Aged Care Complaints Investigation Scheme is available to anyone who has a complaint or concern about a Commonwealth Government-subsidised aged care service (residential or community care), including:

- residents of aged care services –high care (nursing homes) or low care (hostels)
- people receiving Community Aged Care packages (CACPs), Extended Care in the Home packages (EACH) or flexible care
- relatives, guardians or legal representatives of those receiving care.

The Complaints Investigation Scheme:

- is a free service which investigates concerns raised about the health, safety and/or wellbeing of people receiving aged care services funded and regulated under the Aged Care Act 1997
- has the power to investigate these concerns and require the service provider, where appropriate, to take action
- can refer issues that may be more appropriately dealt with by others (for example, police, nursing and medical registration boards).

Contact	Phone/Fax/Email
<b>Aged Care Complaints Investigation Scheme</b> For concerns about services funded under the Aged Care Act 1997 Website: <a href="http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-complaints-index.htm#Introduction">www.health.gov.au/internet/main/publishing.nsf/Content/ageing-complaints-index.htm#Introduction</a>	Phone: 1800 550 552

### 7.1.15 Elder Rights Advocacy (ERA) Victoria

The Commonwealth Government, Department of Health and Ageing (DoHA), began funding independent advocacy services in 1989. Elder Rights Advocacy Victoria (ERA, formerly Residential Aged Care Rights before February 2007) is a non-government organisation funded by the Commonwealth Government that provides advice and support to care recipients, or their nominated representatives, to understand their rights and be involved in decisions affecting their life and raise issues of concern about their care.

ERA may support the complainant to pursue resolution with the appropriate authorities, for example, the police, management of a community or residential aged care service or DoHA complaints investigation scheme.

### Role in relation to elder abuse

ERA provides advocacy support on behalf of people receiving services provided under the Aged Care Act 1997, which includes residential aged care, Community Aged Care Packages (CACPs) and Extended Aged Care at Home (EACH) programs.

ERA is obliged to report allegations of 'reportable abuse' (including suspected or alleged physical and sexual assault) to the police and DoHA.

Contact	Phone/Fax/Email
<b>Elder Rights Advocacy (ERA)</b> Level 4, 140 Queen Street, Melbourne 3000 Website: <a href="http://www.era.asn.au/contact_era.html">www.era.asn.au/contact_era.html</a>	Phone: 9602 3066 or 1800 700 600 Fax: 9602 3102 Email: <a href="mailto:era@era.asn.au">era@era.asn.au</a>

## 7.1.16 Victorian Aboriginal services

There are a range of Aboriginal services and Aboriginal peak bodies addressing the issues and needs of Aboriginal people living in Victoria. Many generic or mainstream organisations are funded to provide services to a diverse population, including culturally and linguistically diverse (CALD) and Aboriginal people. Some generic organisations receive funding to provide services specifically targeted to Aboriginal people.

Support may be sought by older Aboriginal people, their carers, family or members of the community from generic or Koori-specific services. Much will depend on the choice of an older person and the circumstances they experience.

### Role in relation to elder abuse

Abuse of elder and respected other Aboriginal people is a concern within Aboriginal communities, non-Aboriginal communities and for governments. A range of strategies are in place to address a broad range of issues in Aboriginal communities, of which this aspect of abuse is just one (refer to [1.4.1 Abuse of older Aboriginal people](#)).

When discussing or negotiating with Aboriginal communities, it is necessary to recognise and involve elders and respected community members, as well as communicating with Aboriginal community organisations. Aboriginal organisations should be the first communication point for advice and direction, including the respected elder contacts.

Regional Indigenous family violence support workers may be able to provide additional assistance and advice regarding Indigenous family violence.

The organisations listed below, along with other Aboriginal and generic services, can assist with cases of abuse of older Aboriginal people.

Contact	Phone/Fax/Email
<b>Aboriginal Affairs Victoria (AAV)</b> Department of Planning and Community Development Level 9, 1 Spring Street, Melbourne 3000 (GPO Box 2392, Melbourne 3001) Website: <a href="http://www1.dvc.vic.gov.au/aav/">www1.dvc.vic.gov.au/aav/</a>	Phone: 9208 3333 Phone: 1300 366 356

<b>Aboriginal Community Elders Service</b> (supporting Aboriginal people in nursing homes) 5 Parkview Avenue, East Brunswick 3057	Phone: 9383 4244
<b>Aboriginal Family Violence Prevention and Legal Service (FVPLS)</b> Level 1, 210 Lonsdale Street, Melbourne 3000	Phone: 9654 3111 or 1800 105 303 Fax: 9654 1076 Email: <a href="mailto:information@fvpls.org">information@fvpls.org</a>
<b>Regional Indigenous family violence support workers</b> Department of Human Services Statewide Coordinator, Indigenous Family Violence Strategy <b>Melbourne:</b> Level 9, 50 Lonsdale Street, Melbourne 3000 <b>Barwon-South West:</b> Shop 2, 109 Lava Street, Warrnambool 3280 <b>East Gippsland:</b> PO Box 486, Bairnsdale 3875 <b>Central Gippsland:</b> 64 Church Street, Traralgon 3844 <b>West Gippsland:</b> 70 Smith Street, Warragul 3820 <b>Grampians:</b> Corner Mair and Doveton Streets, Ballarat 3350 <b>Loddon Mallee North:</b> 253 Eleventh Street, Mildura 3500 <b>Loddon Mallee South:</b> 37 Rowan Street, Bendigo 3552 <b>Hume:</b> 26 Church Street, Benalla 3672 <b>Eastern Metropolitan:</b> 883 Whitehorse Road, Box Hill 3128 <b>Southern Metropolitan:</b> Level 2, 122 Thomas Street, Dandenong 3175 <b>North and West Metropolitan:</b> 145 Smith Street, Fitzroy 3065	Phone: 9616 8028 Phone: 5561 9475 Phone: 5150 4514 Phone: 5177 2500 Phone: 5624 0639 Phone: 5333 6993 Phone: 5022 3111 Phone: 5434 5555 Phone: 5832 1500 Phone: 9843 6163 Phone: 9213 2443 Phone: 9412 5390
<b>Victorian Aboriginal Legal Service Cooperative Limited</b> (including information about Koori courts) 6 Alexandra Parade, Fitzroy 3065	Phone: 9419 3888 Fax: 9419 6024 Email: <a href="mailto:vals@vals.org.au">vals@vals.org.au</a>
<b>Aboriginal Planning Officers and Koori Hospital Liaison Officers</b> Koori Human Services Unit, Department of Human Services 20–50 Lonsdale Street, Melbourne 3000 Website: <a href="http://www.health.vic.gov.au/koori/contact.htm">www.health.vic.gov.au/koori/contact.htm</a>	Phone: 9096 7032 Email: <a href="mailto:koori@dhs.vic.gov.au">koori@dhs.vic.gov.au</a>
<b>Victorian Aboriginal Community Controlled Health Organisation</b> 5–7 Smith Street, Fitzroy 3065 Website: <a href="http://www.vaccho.org.au/index.asp">www.vaccho.org.au/index.asp</a>	Phone: 9419 3350 Fax: 9417 3871 Email: <a href="mailto:enquiries@vaccho.com.au">enquiries@vaccho.com.au</a>
<b>Aboriginal Housing Board of Victoria</b> Narrandjeri House 125–127 Scotchmer Street, North Fitzroy 3068	Phone: 9482 4585 Fax: 9482 3964 Email: <a href="mailto:ahbv@vicnet.net.au">ahbv@vicnet.net.au</a>

### 7.1.17 Ethnic Communities Council of Victoria

The Ethnic Communities Council of Victoria (ECCV) was established in 1974 as a voluntary community-based organisation, and is now a broadly based, statewide, peak advocacy body representing ethnic and multicultural communities in Victoria.

ECCV has a volunteer executive and chairperson and full-time professional staff running various programs and services.

ECCV's role includes supporting, consulting, liaising with and providing information to Victoria's ethnic communities. ECCV delivers policy projects for key partners in areas such as multicultural policy, aged care programs and skilled migration strategies.

### Role in relation to elder abuse

ECCV may act as a point of contact to refer health services and community-based organisations to ethnic organisations and multicultural communities, which could assist with understanding discreet cultural behaviours, values and expectations in the context of an abusive situation.

Contact	Phone/Fax/Email
<b>ECCV Statewide Resources Centre</b> Level 2, 150 Palmerston Street, Carlton 3053 Website: <a href="http://www.era.asn.au/contact_era.html">www.era.asn.au/contact_era.html</a>	Phone: 9349 4122 Fax: 9349 4967 Email: <a href="mailto:eccv@eccv.org.au">eccv@eccv.org.au</a>

## 7.2 Government programs

This section presents some Commonwealth and state government regulated, funded or managed programs which, due to the nature of their roles, have varying capacities to respond to elder abuse.

### 7.2.1 The Victorian Department of Human Services (DHS)

#### Home and Community Care (HACC)

The Home and Community Care (HACC) program is jointly funded by the Commonwealth and Victorian governments under the *Home and Community Care Act 1985*. HACC provides community care services to frail aged and younger people with disabilities and their carers, and aims to:

- provide a comprehensive, coordinated and integrated range of basic maintenance and support services for frail aged people, people with a disability and their carers
- support these people to be more independent at home and in the community, thereby enhancing their quality of life and/or preventing inappropriate admission to long-term residential care.

HACC-funded services include nursing, allied health, meals and other food services, domestic assistance, personal care, home maintenance, transport, respite care, counselling, support, information, advocacy and assessment.

The Victorian HACC program provides funding to approximately 500 agencies to support over 220,000 frail older people and people with disabilities. Organisations funded to provide HACC services include not-for-profit organisations, local governments, church organisations and charitable bodies.

Many agencies funded to provide HACC services also receive funds to provide other programs such as Commonwealth Government CACPs, EACH and EACHD packages, Victorian community health and health promotion services.

#### Community Care Access Points–Direct2Care

The Victorian and Australian governments are working together to improve access to community care services. This involves the identification and development of ‘Access Points’ which can be easily recognised by people seeking services, or information about services.

Currently, people may access community care in a number of ways, such as via a referral from a general practitioner, direct contact with a service provider, or through information from a friend, relative or neighbour.

In Victoria, the primary aim is to make it easier for frail older people, younger people with disabilities, their carers, families and friends to find their way around what can sometimes be a confusing system. The Access Point will be a place where people can get information about and help with a variety of questions and concerns. It will also be a place where people can explore options and discuss short, medium and long-term goals.

The Access Point will also support service providers who work with older Victorians, younger people with disabilities and their carers who may require information about other services in the community to assist them in meeting their clients' needs.

### Primary Care Partnerships (PCPs)

The state government has funded the Primary Care Partnership Strategy which has the following priorities for the 31 Primary Care Partnerships:

- Partnership Development
- Integrated Health Promotion
- Service Coordination
- Integrated Chronic Disease Management

Each PCP represents a specific region within Victoria forming voluntary alliances with a range of service providers who are referred to as PCP members.

PCP members include community groups, funded agencies and organisations such as: Divisions of General Practice, local governments, hospitals, community health centres, health services, universities, schools, sporting clubs, churches, charities, and other government and non-government organisations.

Each PCP operates slightly differently, governing their own membership types/levels to meet the distinctive needs of its voting member and affiliate agencies.

Service providers are motivated to become members of PCPs to improve relationships and build networks, as well as achieve better health and wellbeing outcomes for the community.

### Aged persons mental health teams (APMH)

APMH teams provide community-based psychological, behavioural, social and functional assessments and a corresponding range of therapeutic interventions, rehabilitation and case management for older people with severe and enduring mental health issues. The service provides an intake point for the aged psychiatry service and is delivered through multidisciplinary teams.

The APMHS provide services to people 65 years or older:

- who have or appear to have a severe mental health issues
- whose behaviour cannot be managed by other aged care service providers in a less intrusive manner
- who have severe psychiatric or behavioural difficulties associated with organic disorders, such as dementia.<sup>47</sup>

### Role in relation to elder abuse

Agencies providing HACC services will respond to suspicion of elder abuse. The expectation is to act, not ignore suspicion or allegations of abuse.

Providers of HACC services are well placed to act on abusive situations, including monitoring the situation, particularly while other services to support daily living are provided (for example, personal care, day programs, volunteer transport or meals).

HACC assessment services may also support further investigation or screening if abuse is suspected by HACC-funded programs (refer to [7.1.11 Victorian HACC assessment services](#)).

<sup>47</sup>Victorian Department of Health and Ageing, 1996, *The Framework for Service Delivery Aged Persons Services*, pp. 25–42.

PCPs are ideally placed to promote the prevention of elder abuse by encouraging the development of agency policy and procedures, initiating the local interagency protocols with their members, broader sectors and other PCPs as well as promoting community awareness raising programs.

Aged persons mental health services are primarily for people with long-standing mental health issues who are over 65 years of age, or who have developed functional illnesses, such as depression and psychosis in later life. They also provide services for people with psychiatric or severe behavioural difficulties associated with organic disorders, such as dementia.

APMH services can provide discreet knowledge about the mental health of an older person if required, on a case-by-case basis.

Contact	Phone/Fax/Email
<p><b>Department of Human Services, general enquiries</b> Ask for the Department of Human Services regional office contact number applicable to your service. Having rung the region, ask for the regional aged care manager. Website: <a href="http://www.dhs.vic.gov.au/contact.htm#general">www.dhs.vic.gov.au/contact.htm#general</a></p>	Phone: 1300 650 172
<p>Local municipal councils provide <b>HACC services</b>, and are listed alphabetically in the <i>White Pages</i> under ‘aged care services’. Website: <a href="http://www.health.vic.gov.au/hacc/hacc_victoria/index.htm">www.health.vic.gov.au/hacc/hacc_victoria/index.htm</a></p>	
<p><b>Community Care Access Points–Direct2Care</b> Website: <a href="http://www.health.vic.gov.au/agedcare/services/accesspoints.htm">www.health.vic.gov.au/agedcare/services/accesspoints.htm</a></p>	Phone: 1300 121 121
<p><b>Primary Care Partnerships</b> Ask for the Department of Human Services regional office contact number applicable to your service. Having rung the region, ask for the regional PCP manager. Website: <a href="http://www.health.vic.gov.au/pcps/about/index.htm">www.health.vic.gov.au/pcps/about/index.htm</a></p>	Phone: 1300 650 172
<p><b>Aged Persons Mental Health Services (APMHS)</b> Ask for the Department of Human Services regional office contact number applicable to your service. Having rung the region, ask for the regional APMHS manager. Website: <a href="http://www.health.vic.gov.au/mentalhealth/services/aged/index.htm">www.health.vic.gov.au/mentalhealth/services/aged/index.htm</a></p>	Phone: 1300 650 172

## 7.2.2 The Victorian Department of Planning and Community Development (Office of Senior Victorians)

The Office of Senior Victorians (OSV) is responsible for developing and advising on government policy relating to older people and the ageing of the population. The office works collaboratively with a range of government and non-government partners to achieve its objectives.

The Victorian Government recognises that safeguarding the independence and dignity of older people requires collaboration from a range of its agencies.

### Role in relation to elder abuse

In the context of the Victorian Government Elder Abuse Prevention Strategy, the Department of Planning and Community Development (DPCD), OSV, has lead agency responsibility for:



- developing and maintaining a whole-of-government policy framework on prevention and response to elder abuse
- ongoing monitoring of implementation, evaluation and research
- lead role in developing and providing elder abuse services such as Seniors Rights Victoria, in partnership with Victoria Legal Aid (VLA). Refer to [7.1.1 Seniors Rights Victoria \(SRV\)](#) for additional information.

Contact	Phone/Fax/Email
<p><b>Department of Planning and Community Development, Office of Senior Victorians</b></p> <p>GPO Box 2392V, Melbourne 3001</p> <p>Website: <a href="http://www.seniors.vic.gov.au/web19/osv/dvcosv.nsf">www.seniors.vic.gov.au/web19/osv/dvcosv.nsf</a>  <a href="http://www.seniors.vic.gov.au/web19/osv/dvcosv.nsf/headingpagesdisplay/elder+abuse+prevention">headingpagesdisplay/elder+abuse+prevention</a>  or <a href="http://www.seniors.vic.gov.au">www.seniors.vic.gov.au</a></p>	<p>Phone: 9208 3333</p> <p>Fax: 9208 3870</p> <p>Email: <a href="mailto:enquiries@seniors.vic.gov.au">enquiries@seniors.vic.gov.au</a></p>

### 7.2.3 The Victorian Department of Justice (DoJ)

#### Integrated family violence services

Responding to family violence more effectively is a key component of the Victorian Government's social policy action plan released in 2005: *A Fairer Victoria: Creating opportunity and addressing disadvantage*.

This approach is underpinned by a gendered analysis and principles of equity and access for vulnerable groups, to ensure greater consistency between different services throughout the state, and improve capacity to meet service demand.

The Family Violence Division of the Magistrates Court was created in June 2005 under the *Magistrates Court (Family Violence) Act 2004*. These operate in two locations: Heidelberg and Ballarat, and three specialist family violence services are provided by the Frankston, Sunshine and Melbourne Magistrates courts.

#### Magistrates Court of Victoria family violence and stalking protocols

The Magistrates Court appointed a supervising magistrate to oversee the court's jurisdiction in 2002, and has since developed and regularly reviewed the court's family violence and stalking protocols. This ensures that the court develops consistent, efficient and transparent court processes and procedures in relation to complaints for an intervention order at all Victorian Magistrates and Children's Court locations.

#### Procedures under the Family Violence Protection Act 2008

The Family Violence Protection Act 2008 establishes a system of protection for those who have experienced violence from a family member.

This Act replaces the Crimes (Family Violence) Act 1987 (refer to [7.1.6 Family violence services](#)).

The Statewide Steering Committee to Reduce Family Violence (SSRFV) noted that a strong and enforceable police and justice response for men who use violence, implemented within the context of an integrated multi-agency response, has been found to be effective in achieving long-term reductions in the incidence of family violence.<sup>48</sup>

<sup>48</sup> Farha, T, 2003, *Arrest and Prosecution Policies for Domestic Violence: Literature Review*, Victoria Police, August 2003.

### Consumer Affairs Victoria (CAV)

Consumer Affairs Victoria (CAV) provides consumer protection for Victorians regarding products and services. CAV advises on consumers' rights and responsibilities and who to contact when dealing with businesses and buying products in Victoria, for example:

- buying and selling cars and property
- renting a house, flat or building
- managing credit and debt
- shopping over the Internet
- fundraising
- current consumer scams and how to avoid them.

### Role in relation to elder abuse

A range of Department of Justice (DoJ) services support older people in abusive situations, including:

- community safety
- crime (policing, family violence, victims, the justice system)
- courts
- sentencing
- consumer protection and business regulation.

Contact	Phone/Fax/Email
<b>Department of Justice (DoJ)</b> Website: <a href="http://www.justice.vic.gov.au/wps/wcm/connect/DOJ+Internet/Home/About+Us/">www.justice.vic.gov.au/wps/wcm/connect/DOJ+Internet/Home/About+Us/</a>	Phone: 8684 0000 or 1300 365 111
<b>Consumer Affairs Victoria (CAV)</b> Website: <a href="http://www.justice.vic.gov.au/wps/wcm/connect/DOJ+Internet/Home/Consumer+Protection/">www.justice.vic.gov.au/wps/wcm/connect/DOJ+Internet/Home/Consumer+Protection/</a>	Phone: 1300 558 181 Email: <a href="mailto:consumer@justice.vic.gov.au">consumer@justice.vic.gov.au</a>

## 7.2.4 The Commonwealth Department of Health and Ageing

The Commonwealth Department of Health and Ageing (DoHA) has funding and regulatory responsibility for services under the National Health Act (NHA) 1953, the *Aged or Disabled Persons Care Act 1954 (the ADPCA)*, the Aged Care Act 1997 and the Home and Community Care Act 1985.

### *Aged Care Act 1997*

- residential aged care (RACS), CACPs, EACH and EACH dementia
- the Aged Care Standards and Accreditation Agency
- for information about quality standards that apply to residential aged care providers funded under the Aged Care Act 1997 refer to: [www.health.gov.au/Internet/main/publishing.nsf/Content/ageing-quality-about.htm](http://www.health.gov.au/Internet/main/publishing.nsf/Content/ageing-quality-about.htm)
- the Elder Rights Advocacy Service—refer to [7.1.15 Elder Rights Advocacy \(ERA\) Victoria](#).

### **Home and Community Care Act 1985**

- The HACC program jointly funded by the Commonwealth, state and territory governments. States and territories administer the HACC program.

### **Respite programs**

- Commonwealth carer respite centres
- National Respite for Carers program (NRCP)
- Carelink.

### **Aged Care Assessment Services**

The primary role of ACAS is the comprehensive assessment of frail older people to facilitate access to aged care services funded under the Aged Care Act 1997.

There are 18 ACAS teams in Victoria. Refer to [7.1.5 Aged Care Assessment Services \(ACAS\)](#).

### **Community Care Reform—The Way Forward**

In 2002 the Department of Health and Ageing (DoHA) initiated a review of a number of government-funded community aged care programs resulting in *A New Strategy for Community Care—The Way Forward*. One of the reform components was a directive of the Council of Australian Governments (COAG) to develop a nationally consistent way to assess consumers for HACC and community aged care services.

The DoHA, in partnership with state and territory governments and the community care sector, is developing a nationally consistent screening/assessment process called the Australian Community Care Needs Assessment (ACCNA) and the Carer Eligibility and Needs Assessment (CENA). This process considers the relationship between the client and carer, including the ongoing sustainability of support offered by a carer and opportunities to assist this relationship.

Further development and testing of the ACCNA—Revised and CENA—Revised is currently being undertaken based on feedback from the Access Points Demonstration Project staff, service providers, clients and carers, and aims to conclude in 2009 with a final validated version.

### **National Dementia Support Services**

A range of dementia programs provide support to health professionals, people living with dementia, their carers, and families. Areas of focus include:

- dementia research
- prevention activities
- early intervention programs
- improved care initiatives
- support for the primary care sector to diagnose and better manage dementia
- Extended Aged Care at Home Dementia (EACHD) packages
- dementia-specific training for aged and community care staff and residential care workers, carers and community workers such as police and ambulance officers.

### **Role in relation to elder abuse**

The Commonwealth Government Department of Health and Ageing, as funder and regulator of several services, has a discrete role regarding addressing abuse of older people for programs funded under the Aged Care Act 1997. In particular, compulsory reporting and protection requirements commenced on 1 July 2007 following amendments to the Aged Care Act 1997 (the Act).

Amongst other things, these amendments compulsorily require approved providers of residential aged care services to:

- report to the police and to the DoHA incidents involving alleged or suspected reportable physical or sexual assaults
- take reasonable measures to ensure staff members report any suspicions or allegations of reportable assaults to the approved provider (or other authorised person), to the police or the Department of Health and Ageing
- take reasonable measures to protect the identity of any staff member who makes a report and protect them from victimisation.

The report must be made within 24 hours of the allegation, or when the approved provider starts to suspect a reportable assault. A reportable assault is defined in subsection 63-1AA(9) of the Act and in Section 3 of the *Guidelines*, and includes unlawful sexual contact and unreasonable use of force.

The *Compulsory Reporting Requirements for Providers of Residential Aged Care* services are one part of an approved provider's responsibilities under the Act to provide a safe and secure environment.

In the context of services provided to people living in their own homes in the community, the common national assessment system ACCNA-R and CENA-R, as well as other components of *The Way Forward*, should contribute to an enhanced capacity to identify and act on suspicion of elder abuse.

Support services and initiatives in areas such as dementia and respite all contribute to a better understanding of the impact of health conditions on older people while living in their own homes in the community and those who care for them.

Such initiatives assist providers of community based services to plan, coordinate and provide appropriate service responses to older people and their carers, particularly where challenging behaviours present.

Contact	Phone/Fax/Email
<b>The Aged and Community Care Information Line</b>	Phone: 1800 500 853
<b>For general information on Commonwealth Government DoHA services for older people</b> Website: <a href="http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-whatnew.htm-copy2">www.health.gov.au/internet/main/publishing.nsf/Content/ageing-whatnew.htm-copy2</a>	
<b>Information on the Compulsory Reporting Guidelines for providers of residential aged care services</b> Website: <a href="http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-quality-guidelines-cr-ap.htm">www.health.gov.au/internet/main/publishing.nsf/Content/ageing-quality-guidelines-cr-ap.htm</a>	
<b>For more information about the new national assessment project and reforms to community care, visit <i>A New Strategy for Community Care–The Way Forward</i></b> Website: <a href="http://www.health.gov.au/communitycare_thewayforward">www.health.gov.au/communitycare_thewayforward</a>	Email: <a href="mailto:thewayforward@health.gov.au">thewayforward@health.gov.au</a>
<b>For more information about Dementia services and initiatives</b> Website: <a href="http://www.health.gov.au/internet/main/publishing.nsf/Content/Dementia-1">www.health.gov.au/internet/main/publishing.nsf/Content/Dementia-1</a>	Phone: 1800 100 500
<b>Commonwealth Carelink Centres</b> Community Aged Care Packages (CACPs) and Extended Aged Care at Home (EACH) services	Phone: 1800 052 222
<b>Commonwealth carer respite centres</b>	Phone: 1800 059 059
<b>Commonwealth carer resource centres and national respite for carers (NRCP)</b>	Phone: 1800 242 636

## 7.2.5 The Commonwealth Department of Veterans Affairs

The Department of Veterans Affairs (DVA) is a major purchaser of health care and support services for the veteran community. Rather than providing services directly, DVA has contracts with key organisations, which are expected to deliver a high standard of service.

Veterans Home Care is a program of the Department of Veterans Affairs that helps veterans and war widows and widowers enjoy a healthier lifestyle and remain living at home longer, similar to HACC services.

### Role in relation to elder abuse

Where elder abuse is suspected, DVA clients should raise the matter through their service provider's usual complaints system, or through the appropriate Commonwealth or state authorities.

Contact	Phone/Fax/Email
<b>Department of Veterans Affairs (DVA)</b> Website: <a href="http://www.dva.gov.au/health/homecare/mainvhc.htm">www.dva.gov.au/health/homecare/mainvhc.htm</a>	Phone: 133 254
<b>Returned and Services League (RSL) of Australia (Victorian branch)</b> A contact point for veterans and their families. Website: <a href="http://www.rslvic.com.au">www.rslvic.com.au</a>	Phone: 9655 5548 Email: <a href="mailto:agedcareinfo@rslvic.com.au">agedcareinfo@rslvic.com.au</a>

## 7.3 Training considerations

Key findings of the Department of Human Services' 2005 review of the 1995 guide indicate that much of the expertise in detecting and responding to elder abuse cases lies with regional workers in various health and community-based agencies. The workforce in both community and institutional settings (for example, hospitals and residential aged care services) is diverse, with differing levels of education, interpersonal skills and professional expertise.

The need to provide updated, regular elder abuse prevention training is essential to support the human services workforce, which has a relatively high turnover rate. While some Department of Human Services regions provide training on elder abuse, others do not. Whether the training is provided across disciplines or sectors could also be considered in line with the multisectoral and multidisciplinary approach adapted in Victoria.

When considering training or information sessions on abuse, be clear about:

- the values underpinning a service response to an older person
- how the older person is being treated, valued and informed of their rights
- what practice principles apply to planned interventions.

Victoria has adopted an empowerment approach where the rights of an older person come first, supporting them to make their own decisions and choices.

Incorporating the spirit and intention of the Victorian Charter of Human Rights and Responsibilities in the service response to the abuse of an older person is essential. This is important because the Victorian Charter is now in place, but also because older people are empowered adults who can make their own decision and choices.

This whole-of-Victorian-government approach aims to support consistency in addressing elder abuse with the development of a strategy through the implementation of 11 recommendations (refer to [Section 9: Recommendations from the Victorian Government response to the Report of the Elder Abuse Prevention Project](#)). Recommendation 6 states that resources should be provided to deliver training and support to agencies to complement prevention and community education strategies.

Appropriate components to look for in a training package addressing the prevention of abuse toward older people include:

- how to identify instances of abuse
- how to work effectively with suspicion of abuse
- providing appropriate responses based on empowering older people
- identifying appropriate places and organisations to make referrals, drawn on their expertise or include in case coordination response
- how to access assistance from other professional services
- managing the denial of abuse by an older person and/or alleged perpetrators of the abuse
- privacy issues of all concerned
- confidentiality
- duty of care
- rights of the person being abused
- empowering older people, including people with a disability
- identify and understand cultural barriers and awareness
- accessing legal protection, including available local legal and support networks
- supporting the abused
- supporting the primary carer
- supporting staff working with the abused
- supporting staff working with the alleged perpetrator
- managing conflict between professional/primary carers and the older person
- managing family conflict.

Information included in this guide could also be used to educate and inform older people, staff (for example, as part of induction programs) and volunteers about:

- what constitutes elder abuse
- agency policy and process for raising concerns about abuse (of self or a friend)
- suggestions for dealing with abuse
- key contacts for advice or assistance (within and outside the organisation)
- how to identify someone who may be experiencing abuse.

To achieve engagement, commitment and understanding of staff to address suspicion of or incidents of abuse, it may be useful to involve staff in contributing to the development of policies and procedures by workshopping the topic as part of team-building activities, such as strategic program or policy planning days.

Workers might also benefit from participating in training on suggested behaviours and signs against each type of abuse as referred to in [Section 2: Types of Abuse and Risk Factors](#).

It may be useful to use the Victorian interagency response framework (refer to [Figure 1: Victorian interagency response framework](#)) and the local interagency protocol, referring to the different experiences and concerns of staff relating to various case circumstances.

## 8

## Case studies

## Overview

The case studies below illustrate some situations where abuse has occurred, but are certainly not stereotypical. They were drawn from World Health Organization, United Nations, United Kingdom, American and Australian literature and Victorian experience.

## 8.1 Abuse by a carer

A distinction is drawn here between a carer, and a care worker or volunteer who might be employed or under the auspice of a health service, local government, not-for-profit or private organisation providing services to older people and to carers.

In the context of this discussion, a carer can be a family member, friend or neighbour. A minority of carers may deliberately mistreat the person they care for due to the demands of their caring role.

Possible elements include:

- an older person is substantially dependent on the carer
- the likelihood that mistreatment is not necessarily linked to the amount of care provided
- the demands of caring may be continuous
- the carer may not be coping with the demands of caring
- the carer is often remorseful and shocked by their behaviour
- the carer often has no previous history of maltreatment or abuse
- harm may be intentional or unintentional
- the impact of carer behaviour or treatment can cause physical or psychological harm or neglect.

Four types of situations that could be attributed to ‘carer stress’:

The daughter responsible for the 24-hour care of her father with Alzheimer’s disease who threw a dish at him after his afternoon feeding took two hours.

The wife of a man with a recent leg amputation who screams at him to move faster while helping him to the bathroom (Breckman and Adelman p. 60).

A 79-year-old woman suffering from heart disease, Parkinson’s disease and dementia who 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 residential aged care placement could be made (*No Innocent Bystanders* p. 32).

A 76-year-old man, frail and suffering slight confusion, who 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 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).

Two situations below indicate neglect by a carer which may or may not be intentional or deliberate or due 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 an aged care home because of 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 refused 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 such cases, an older person will be substantially dependent on the person responsible for the neglect.

Typical interventions will involve either providing extra support for the carer, or finding alternative carers. Two of the cases described above could equally have fallen within the category of family violence.

## 8.2 Family violence

In the context of family violence, an older person is not necessarily dependent.

Possible elements include:

- destructive family relationships
- the perpetrator is usually a partner, adult child, or other family member
- a dysfunctional family relationship is often long standing
- family violence may have been a long-term feature of the family's life
- the impact is usually physical or psychological harm.

If the older person and the perpetrator are partners, and the older person is dependent, the difference between this situation and abuse by a carer may be a matter of interpretation. Case (including risk) assessment, will be significant to determine the appropriate type of intervention and its efficacy.

The typical partner abuse situation is likely to be long standing and difficult or impossible to resolve satisfactorily. The 'presenting problem' of abuse will be attributable to this dysfunctional relationship, rather than simply being a response to the stresses of caring.



Mr Washington, age 74, was hospitalised 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).

### 8.3 Abuse by a dependent adult

In this instance of abuse, an older person is not necessarily frail.

Possible elements include:

- an older person's adult child may have a behavioural disorder associated with mental health issues, alcoholism or acquired brain damage, or an older person's partner may have dementia
- a perpetrator has disability or behavioural issues that explain continuing dependence on an older person
- an older person feels responsible for the perpetrator's welfare
- the impact of abuse may be physical, psychological or financial harm or neglect.

In this instance, the abuser is the elderly person's son or daughter, and has some form of disability, which is the main reason for their continuing dependence.

Mr and Mrs O'Reilly, aged 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).

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

## 8.4 Abuse by a person with dementia

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).

Possible elements include:

- destructive family relationships
- the demands of caring may be continuous
- an older person is substantially dependent on the carer
- the carer may not be coping with the demands of caring
- the carer may not be receiving adequate support to support the caring role
- the carer is often remorseful and shocked by their behaviour
- the carer often has no previous history of abuse
- harm may be intentional or unintentional
- the impact of carer behaviour or treatment can cause physical or psychological harm or neglect.

Typically, one member of an elderly couple has dementia and behaves abusively towards their partner who is their primary carer. For example:

'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 carer (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 occur in all types of relationships including same-sex, transgender and male/female relationships. In the latter, where males are usually stronger physically, female caregivers may feel intimidated. A recent study found that, in a sample of 24 spouses and 15 non-spouses of dementia sufferers, 14 female elderly spouses claimed that 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 for example:

Violence has been conceptualized differently in dementia 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 carer 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 older person cannot justify the response of the caregiver, the development of primary prevention strategies requires a better understanding of both patient and carer behaviours (Paveza et al. p. 493).

## 8.5 Conflict in a shared household

In this type of situation, an older person may not be particularly dependent on other members of the family, therefore the problem is not one of carer stress. Rather, the issue may be that an older person feels trapped in a household that they are no longer the head of, or have the degree of independence desired.

Possible elements include:

- an older person has been moved into or is sharing the household with an adult relative or child or vice versa—there might also be partners involved with families of their own
- these types of living situations may cause conflict around autonomy or the right to make decisions
- the situation has become intolerable for one or both parties
- an older person or other party requires help to find alternative accommodation
- the basis of the shared arrangement is unclear
- step-family arrangements may contribute to the complexity of the situation
- the impact is psychological or financial harm.

The aim of the intervention in this type of situation will usually be to help an older person 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.

Beyond the issue of how accommodation is physically shared, older people speak of how changes in social roles have created situations where they end up abused or neglected.

Some claim that formerly, women remained at home and were the primary carers for children and dependent older adults and looked after the household. When that relationship changes and all adults in the family go out to paid jobs there is minimal capacity left for caring, which may result in emotional neglect and often physical neglect of older people. Stress levels in the home are often high, due to the pressures on the middle generation, who come home from their jobs and lack patience in relating to and caring about their older family members. The result can be often verbal and sometimes even physical abuse.

Many older people—even while naming and discussing such behaviour as abusive—excuse their children. They recognise that their children are living under a great deal of stress and instead place the primary blame on government social and economic policies.<sup>49</sup>

## 8.6 Financial exploitation

Possible elements include:

- destructive family relationships
- greed of family members
- adult children expecting to receive aspects of inheritance on their terms
- reluctance by the older person to contact police when perpetrators are family members
- harm is generally intentional
- the impact is usually psychological harm, though other forms may also be evident for example, neglect.

<sup>49</sup> Refer to the World Health Organization, 2002, *Missing voices: views of older persons on elder abuse*, WHO/INPEA, Geneva.

The following four cases are drawn from VCAT records:

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 in going fee to a residential aged care service (low-level care). 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 VCAT 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) (refer to definitions [10.6 Enduring powers of attorney \(financial\)](#) and [10.7 Enduring powers of attorney \(medical treatment\)](#)), 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 VCAT, who revoked the EPA as not being in Mrs D's interests and appointed 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 supported residential service. 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 VCAT may need to become involved and intervene.

## 8.7 Physical abuse

Types of abuse rarely exist in isolation from one another. This means that if suspicion or evidence exists of some type of abuse, then symptoms and behaviours could indicate physical or psychological abuse as well as neglect.

Possible elements include:

- destructive family relationships
- harm is generally intentional
- the impact is often physical and psychological harm
- for professional staff (no matter where they work) should be alert and act on suspicion, but not assume a particular cause exists
- multisector and multidiscipline case coordination provides a fuller case history and offers the capacity to manage presenting circumstances more effectively
- the perpetrator is usually the partner or adult child
- a history of abuse exists.

Mrs Smith is a resident in a high care aged care facility, is physically dependent and has lost the means of effective communication and unable to advocate for her own needs.

Her daughter spends significant time at the facility and insists on independently providing as much care for her mother as possible. This includes washing, changing of incontinent aids, dressing, assistance with meals and drinks and pressure area care.

The daughter confidently states she is able to provide the care for her mother when she is visiting the facility without staff assistance. She constantly expresses to staff how much she loves her mother and how important it is for her to be with her mother as much as possible.

Staff at the facility allowed the daughter to attend to these needs in the belief that they are supporting the caring relationship. The daughter often talks about how she previously cared for her mother when her mother was at home.

At different times staff of the facility have noticed some bruising and mild abrasions on Mrs Smith and have put this down to her general frailty and thinning skin that bruises easily.

One afternoon a newly employed staff member checks on Mrs Smith to see if the daughter needs any assistance with her mothers care. The staff member forgets to knock on the door before he enters and finds the daughter in the throes of slapping her mother.

The daughter is very defensive on being approached and angry at the intrusion of the staff member into her mother's room.

The situation escalated and it became clear that staff had spoken to the daughter previously about being careful when tending to her mother, noting that at times she was very abrupt or not as careful as she could be, when providing care to her mother.

Staff also did not feel they had the right to intervene or interfere too much in the care that the daughter was providing when in the facility.

At a later date it transpired that Mrs Smith had been removed from the care of her daughter at home some years earlier, following substantiated complaints by neighbours to the police that Mrs Smith was being physically abused by her daughter.

## 8.8 Sexual abuse

Possible elements include:

- harm is generally intentional
- destructive family relationships may already exist
- the capacity of all service providers to recognise and manage aspects of trauma in an older person is important
- service providers need to understand the complexity of sexual abuse and its impact on an older person
- respect for individuals' values and rights is important
- older people and their ongoing relationship with family members need to be recognised

The following two examples highlight a range of considerations for discussion:

Ms S, a 62-year-old woman, was forced to perform oral sex by a stranger, something she had never done before. She told the police she had been raped and was taken to the hospital for a sexual assault forensic exam.

Ms S was so ashamed about performing oral sex that she told no one the assault had been oral. As can be expected, the vaginal exam showed no signs of assault, and the police became suspicious of Ms S's claim.

Eventually the woman's sexual assault case was dropped. Only in counselling months later, after questioning about how the assault happened, did the woman break down and disclose that she had been orally assaulted.

Dorothy is a 68-year-old widow. Her son, Tony is separated from his wife and his adult son, James, moved into Dorothy's house. Although space is limited, Dorothy was happy with the arrangement because it meant she now had company.

About a month later, Dorothy came home one day to find Tony watching pornographic videos. She told him clearly she did not approve of this and would not allow it in her house. Tony made light of the situation and continued watching the videos several times each week. James also started watching the videos with his father.

Dorothy took to locking herself in her room when these movies were on, as she found the situation distressing.

During a visit to her practitioner, the doctor noticed that Dorothy looked upset and displayed symptoms of depression. Dorothy disclosed to the doctor what had been happening and said she did not know what to do.

The doctor assisted Dorothy in thinking through her options regarding this case of sexual harassment, including seeking assistance from other family members, friends and the police. The doctor would support Dorothy whatever her decisions were.

## 8.9 CALD background

Service providers should provide client-centred care in all cases of service response. When elder abuse is a concern, it is even more important to implement this approach. When the older person has a culturally and linguistically diverse background additional understanding and awareness must be taken into account pertinent to the culture and life course of the older person.

Possible elements include:

- destructive family relationships may already exist
- older people and their ongoing relationship with family members need to be recognised
- respect for individuals' values and rights is important
- multisector and multidiscipline communication and consideration
- staff need to recognise and act on suspicion of criminal activity
- staff need to understand discreet cultural norms and expectations
- established agency elder abuse policy and procedures are important
- the establishment of local interagency elder abuse protocols may assist.

The following example highlights a range of considerations for discussion:

Older woman with a Polish background (Mrs P) living at home with her only child, now adult son.

Mrs P receives a range of services, such as brokerage via EACH from a mainstream service; HACC social support (Planned Activity Group (PAG) and one-on-one from an ethno-specific service), the family local GP; specialist medical services, alternative medical services, pharmacies and hospital emergency departments were involved.

Mrs P verbally indicated (speaking in Polish) to the PAG coordinator that her son was hitting her. Mrs P stated he was nervous. The PAG coordinator was also employed by an ethno-specific service.

The PAG coordinator consulted with senior management at the ethno-specific service about the best way to proceed. A senior manager with previous experience in a related sector recommended the development of a monitoring strategy for Mrs P to address suspicions, as well as ensuring any workers employed by their agency were safe.

Mrs P made excuses for her son's behaviour: 'He is my son, he is always nervous.'

This was brought to the attention of the manager in the ethno-specific service and strategies were put in place to ensure the safety of staff in the client's home while the PAG was closed for a number of weeks over the Christmas period.

Mrs P came to the PAG just before Christmas with a red mark on her face.

The case manager from the other community aged care service, then informed Mrs P's son that the ethno-specific service was concerned about abuse towards Mrs P by him.

The son contacted the ethno-specific service aggressively wanting to make a complaint about staff refusing to come into the home. The manager maintained the policy of the service regarding the balance between duty of care of staff and privacy of Mrs P. The son accused the manager of making allegations that he was molesting his mother, which the manager had not referred to at all.

Through brokerage services, a one-on-one social support worker (who could speak Polish) was allocated to work with Mrs P while the PAG was closed. The support worker attended doctors appointments with the son and Mrs P; visited the house with other workers as well as accompanied Mrs P on walks in her local neighbourhood.

The support worker was deliberately not told of suspected abuse of Mrs P prior to the first visit to Mrs P's home. The manager did not want to pre-empt or influence an outcome, leaving the situation open to see what the direct care worker would ascertain from her own experience. The manager ensured before the visit that the worker was not at risk and was safe.

The manager met with the worker the next day and asked for information on how the first visit went. The direct care worker said she thought Mrs P was being abused by her son as Mrs P had told her (in Polish) that she was being hit.

The worker was then informed of what was known of the alleged abusive situation. The manager ensured that an aspect of the monitoring approach was that the worker would never be isolated in the house with the son and Mrs P. The worker agreed to this.

The manager discovered that other service providers had decided to withdraw services from the home as staff did not feel safe and the son was aggressive. This information nor the reason for the decision to withdraw services had been shared with other providers. Threats against other service providers by the son also continued to come to light throughout the process.

The PAG manager contacted the other community care service providers to discuss management of the situation.

As this was occurring over the Christmas period, a case management meeting was not possible until two weeks after Christmas. Who was to attend needed to be well thought through. In some circumstances it would be appropriate for the primary carer to attend if it is clear that discussion around service support, respite opportunities and the general situation concerning alleged abuse would warrant this approach.

In this instance the case management meeting occurred without the son present, enabling providers to discuss the situation in general and management strategies like what role each organisation would take, who would coordinate matters between all services involved and tease out the perpetrator's motives. The police had not been involved.

The manager of the ethno-specific service checked back on client case notes to get a better idea of past service provision and found that the son had taken Mrs P out of a nursing home.

A joint application by two agencies was made to VCAT and OPA for the appointment of an independent guardian.

Apart from suspicion of physical abuse the following day-to-day situation was occurring:

- the son was taking his mother (Mrs P) around to GPs for prescriptions to meet her health needs, but the son would not let Mrs P take her medications as prescribed
- the son forced Mrs P to wear and walk in ill-fitting shoes that did not assist with her swollen legs and feet which were part of her health condition
- the son would not let Mrs P sleep at home during the day when she was tired, he kept her awake
- the son kept Mrs P away from workers who could speak Polish
- Mrs P's health in general was deteriorating and she was often in hospital emergency departments, and would then go home.

The family GP was treating Mrs P. The son always attended GP appointments with Mrs P. The situation was not seen as empathetic to the needs of Mrs P.

Mrs P's health deteriorated to the point where she was admitted to hospital. Mrs P died in hospital.

The process to appoint an independent guardian came through after Mrs P's death.

### Lessons learned

- Planned, well-considered action within an agency and between agencies is essential.
- All providers involved with the older person should be involved in planned case management or care coordination meetings tasks, such as understanding roles, perpetrator management, gathering information and arriving at a similar understanding of what the allegations of suspicions are.
- Draw in additional relevant expertise as soon as possible, including cultural consultation where appropriate, to help understand cultural context of statements, behaviours, values and family expectations.
- Agencies should be clear about a practice response, as to where privacy ends and duty of care for all parties involved commences.
- An improved understanding of elder abuse, family/carer dynamics and appropriate responses required.

## 8.10 VCAT cases

VCAT frequently deals with financial affairs, protecting people, particularly older people, from financial exploitation. Refer to [7.1.2 The Victorian Civil and Administrative Tribunal—Guardianship List \(VCAT\)](#) for further information.

Possible elements include:

- possible pre-existing unhealthy family relationships
- older people and their ongoing relationship with family members
- legal representation for the older person
- communication between multiple jurisdictions and agencies
- advocates to pursue and act on behalf of older people when required.



Many of the hearings occur because the (non-disabled) applicant wants legal authority to do something which the applicant already believes is in the person with a disability'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 an aged care 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 and Tait p. 57).

In other cases there may be a dispute between family members about the most appropriate way to handle an older person's financial affairs. Such disputes may or may not involve allegations that someone has acted or is likely to act dishonestly, for example:

One case involved an 81-year-old woman, Mrs M, living in a residential aged care home (high care). Her grandson had visited her husband who was living in the low-care section of the aged care home, and taken away some key documents such as a will, signed cheques made in the grandson's name, and taken 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.



## 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 \(Office of Senior Victorians\)](#).

## 10

## 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.<sup>50</sup>

<sup>50</sup> 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.<sup>51</sup>

## 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.<sup>52</sup>

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);<sup>53</sup> and

<sup>51</sup> Ibid.

<sup>52</sup> *The CCH Macquarie Concise Dictionary of Modern Law*.

<sup>53</sup> *Wrongs Act 1958 (Vic) Section 48(3)*.

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

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 attorney<sup>55</sup>
- 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.

<sup>54</sup> Wrongs Act 1958 (Vic) Section 48(1).

<sup>55</sup> 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.<sup>56</sup>

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.<sup>57</sup> 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.

<sup>56</sup> Medical Treatment Act 1988 (Vic) Section 5B.

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



## Acronyms and abbreviations

AAV	Aboriginal Affairs Victoria
ACCO	Aborigine Community Controlled Organisations
ACAS	Aged Care Assessment Service
ANPEA	Australian National Prevention of Elder Abuse Network
APATT	Aged psychiatric assessment and treatment teams
APMH	Aged persons mental health teams
CACPs	Community Aged Care Packages
CASA	Centre Against Sexual Assault (CASA House)
CDMS	Cognitive, dementia and memory services
CHC	Community health centres
DHS	Department of Human Services (Victoria)
DoHA	Department of Health and Ageing (Commonwealth)
DoJ	Department of Justice
DPCD	Department of Planning and Community Development (Victoria)
DVIRC	Domestic Violence and Incest Resource Centre
EACH	Extended Aged Care at Home
EACHD	Extended Aged Care at Home Dementia
EAPU	Queensland Elder Abuse Prevention Unit
EPA	Enduring power of attorney

ERA	Elder Rights Advocacy Victoria
FCR	Facility cost relief funding
FVA	Family violence advisers
FVLO	Family violence liaison officers
FVMO	Family violence management officers
GP	General practitioner
HACC	Home and community care
HSC	Health services commissioner
IAG	International Association of Gerontology
IHP	Integrated health promotion
INI	Initial needs identification
INPEA	International Network for the Prevention of Elder Abuse
OPA	Office of the Public Advocate
OSV	Office of Senior Victorians (DPCD)
PCP	Primary care partnership
RACS	Residential aged care service
SAVVI	Supported Accommodation for Vulnerable Victorians Initiative
SCTT	Service coordination tool templates
SOCAU	Sexual Offence and Child Abuse Unit
VACCHO	Victorian Aboriginal Community Controlled Health Organisation





## Legislation (Acts) mentioned in this guide

Aged Care Act 1997

Aged or Disabled Persons Care Act 1954

Charter of Human Rights and Responsibilities Act 2006

Commonwealth Government Aged Care Act 1997

Crimes (Family Violence) Act 1987

Equal Opportunity Act 1995

Family Violence Protection Act 2008

Guardianship and Administration Act 1986

Health Act 1958

Health Professions Registration Act 2005

Health Records Act 2001

Health Services (Conciliation and Review) Act 1987

Health Services Act 1988

Home and Community Care Act 1985

Information Privacy Act 2000

Instruments Act 1958

Legal Aid Act 1978

Magistrates Court (Family Violence) Act 2004

Medical Treatment Act 1988

National Health Act 1953

Privacy Act 1988

Racial and Religious Tolerance Act 2001

Summary Offences Act 1966

Wrongs Act 1958

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