Submission to the Select Committee Inquiry into Elder Abuse

Older Adult Mental Health Sub-Network

Introduction

The Older Adult Mental Health Sub-Network (OAMHSN) welcomes the opportunity to make a submission and appreciates the focus of this committee on this important issue.
This document is prepared by members of the steering group of the Older Adult Mental Health Subnetwork (OAMHSN) of the WA Mental Health Network (WA MHN), The Mental Health Network is co-sponsored by the WA Department of Health and the WA Mental Health Commission and overarching governance sits with the Mental Health Commission. The OAMHSN is currently led by Dr Helen McGowan, who was involved in the preparation of, and has endorsed, this document.

The OAMHSN steering group, which is chaired by Dr Angela McAleer and Ms Claire Bestow, is comprised of senior clinicians and managers who work with the elderly with mental health issues in primary, secondary and tertiary settings across the WA in both government and community managed organizations. The OAMHSN is also informed by consumers and carers who are engaged with older adult mental health services. The OAMHSN aims to build a community of practice that supports the development and delivery of high quality stepped care and integrated care for elderly people with mental health concerns and their carers. This submission is brief, but the OAMHSN welcomes any further involvement in the work of the Select Committee.

Background

Abuse of the elderly is not a new phenomenon, and while the World Health Organisation (WHO) has led some research and policy development there is a paucity of evidence in the Western Australian setting regarding the extent of the problem, the causes, and the effectiveness of public policy, education programs and targeted interventions in addressing the issues. There are many parallels with issues associated with the policy, legislative, police, legal , social and clinical responses to growing concerns regarding child sexual abuse and likely to be many lessons learned from the experiences of those involved. Abuse of the elderly is commonly perpetrated on vulnerable people by those who are responsible for their care or in a position of trust. The abuse is often hidden, associated with shame and under-reported. Responses from authorities have been inconsistent and the effectiveness of the responses has been variable and difficult to ascertain.

Definition and prevalence of elder abuse

Population studies indicate a wide variety of estimates of prevalence of elder abuse ranging from 3-10% of elderly people in Australia and overseas. This figure is affected by a range of issues including variation in the definitions of elder abuse, the methodology used, and the strategies used to address the problems of under-reporting and concealment.

WHO (2017) identifies elder abuse as 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. This type of violence constitutes a violation of human rights and includes physical, sexual, psychological, and emotional abuse; financial and material abuse; abandonment; neglect; and serious loss of dignity and respect.'

WA Alliance for Elder Abuse (reference) has defined elder abuse as 'any act which causes harm to an older person and occurs within an informal relationship of trust, such as family or friends. This can include financial or material abuse, emotional or psychological abuse, physical abuse, sexual abuse, social abuse, or neglect'. This is a narrower definition than that of some other jurisdictions where the abuse perpetrated by others such as paid carers, real-estate agents, financial advisors or other members of the community that may abuse the elderly is also included. Financial abuse is the most common form of abuse, but other types of abuse also need to be considered including emotional, social, physical, sexual, spiritual and neglect.

Evidence suggests that most abuse occurs within relationships of trust and care, but the OAMHSN would argue that any policy approach to addressing elder abuse should also include the abuse that is perpetrated by others, including paid carers, financial advisors or other members of the community. The OAMHSN would propose that a broader definition would be useful to allow the development of a policy response that is broadly targeted.

Risk factors for elder abuse

The risk factors for elder abuse fall broadly into 4 clusters, which relate to factors associated with:

- the victim
- the perpetrator
- the quality of the relationship between the victim and the perpetrator
- systems and services that have opportunity to prevent, monitor, and/or respond to elder abuse

Research evidence suggests that important victim factors include:

- vulnerability, such that the individual lacks the physical or cognitive capacity to defend themselves or protest about their treatment
- lack of knowledge regarding rights and legal authorities associated with power of attorney and guardianship
- being female
- social isolation
- dependency
- displays of difficult behaviour and/or demands for attention
- cognitive impairment
- decision-making disability
- physical disability
- inadequate housing conditions
- cultural values.

An individual is more likely to become a perpetrator of abuse if they:

- have a limited understanding of the older person's needs
- have limited training in caring for older people
- are dealing with their own personal stress (e.g. financial or social)
- have a lack knowledge of legal authorities and responsibilities, particularly regarding powers of attorney and guardianship
- suffer from their own psychiatric or psychological issues
- have had a pre-existing history of being a victim of physical or sexual abuse
- have a history of substance abuse
- are deliberately malevolent (though this is rare)
- have a cultural background is associated with increased risk.

An elderly person and a particular individual in a position of trust are more likely to have a relationship that is abusive if they have a history interpersonal conflict, domestic violence, sexual abuse or if the burden of care is considerable and the relationship is unsupported.

It seems therefore likely that a community is more likely to have an increased prevalence of elder abuse if there is not sufficient regulation, policy, legislation or resourcing to address the above listed factors. Other social and systemic factors include an attitude of ageism, such that the rights of the elderly are not equally recognised and supported, the elderly are isolated, carer burden is not considered a community responsibility, and/or there is insufficient resourcing provided for elder care, including training, support and supervision.

There is also research that suggests that carers and clinicians that encounter those who are victims of abuse do not report or follow up unless they are trained to identify subtle signs of abuse; are aware of their responsibilities, options and resources for reporting and following up these concerns, and appreciate that victims often deny that abuse is occurring.

Need for appropriate resourcing for agencies that can respond to allegations of elder abuse

A range of agencies that are skilled, well-connected and networked are required to provide a comprehensive and tailored response to the issues of elder abuse. Clinicians and services who have cared for elderly victims of abuse often report that individuals often do not wish to formally report abuse in order to preserve their relationship with the abuser. Victims do not necessarily want the abuser prosecuted or punished, but do want the abuse to stop. This means that the clinician or service provider is usually required to honour the client's wishes and rights to confidentiality and are not able to formally report the abuse (unless the victim lacks legal capacity to make that decision). Clinicians or service providers should attempt to address the issues informally, however if they lack the skills, time or access to resources and expertise to address the issues (which are often complex and emotionally charged) there may be risk of further harm to their client.

OAMHSN would therefore recommend that that any government response includes a focus on training service providers who come into contact with the elderly and ensuring that there is access to appropriate expertise to support services or take over the case if the service provider is unable to manage. This means appropriately resourcing services such as Advocare to provide support, advice, training that builds capacity in the community to respond to elder abuse. The same, or another, organisation could also provide case management and mediation where initial service providers lack the resources to do so and could also access legal and police services if a more formal response is requested or required. Other services that may need to be accessed for rare cases would be emergency housing, emergency carers and/or in- home domestic support, as in some cases the victim may need to be separated from the perpetrator urgently.

Other specific skills that may need to be accessed or developed would be a capacity to work with people who belong to a particular cultural group that increases the risks of isolation or victimisation. For example, in some cultures there is an expectation that the elderly will be cared for in the home of one of the children and the parent's assets will support the extended family. While this arrangement may be mutually advantageous and appropriate, the elderly person is at increased risk of abuse. Members of the LGBTI community have also voiced concerns regarding their vulnerability to discrimination in aged care facilities and from paid carers.

The OAMHSN notes that in institutions that provide care for the elderly, the standards for the reporting of assaults, abuse and restraint differ. While aged care, older adult mental health services, geriatric services and general hospital services are all governed by high standards, the levels of oversight and transparency – for example in the use of restraint, or the reporting required for assault perpetrated by patients - vary considerably.

Proposed responses to address elder abuse

The OAMHSN proposes a range of key initiatives to reduce the prevalence of elder abuse and to improve the capacity of the community and health care organisations to respond to those who are victims of abuse.

1. Government funded organisations that provide services for the elderly should be required to have policies in place that identify their response to managing the risks of elder abuse. This should include education and, if appropriate, training for specific staff and guidelines for assessment, managing and reporting any incidents of abuse that are identified
2. A community education campaign is required and should target multiple issues:
    - Educate the community regarding the elder abuse, including prevalence, stories of abuse, examples of subtle and early abuse, and advice on how to intervene and support. The program should aim to avoid blaming the victim or the perpetrator, but seek to highlight that these issues can occur when an elderly person is vulnerable and the carer lacks skills or support.
    - Educate the elderly and their family and carers regarding rights of the elderly and responsibilities of those who care for them.
    - Inform the families and carers regarding the range of supports available to assist with the burden of care. The campaign should also highlight the range of supports available for the elderly who are victims of abuse.
    - Educate the elderly regarding what they can do to avoid becoming a victim of elder abuse, including reducing dependency and isolation; planning for future security and getting independent financial advice before signing any documents; making informed decisions regarding future needs and advance care planning, and advising a number of trusted people of plans and decisions.
3. An education and training program that targets GPs, clinicians and other care providers regarding subtle signs of abuse, approaches to clarify any concerns, the need for informal and formal responses to any abuse that is identified, services that specialise in supporting or investigating elder abuse and any reporting laws and procedures.

4. Appropriate resourcing for specialised services that can provide an appropriate response to concerns about specific incidents of elder abuse. This should include specialist services that can support a formal response from police as required or a less formal response that can investigate and mediate with relevant parties to ensure an outcome that meets the needs and wishes of the victim. This requires appropriate resourcing for a specialist police unit, a specialised legal service, timely access to the State Administrative Tribunal as well as a community based organisation such as Advocare that could provide leadership, co-ordination and work collaboratively other services as required.
5. The community based organisation should also provide leadership and advocacy in addressing elder abuse in the community and could oversee community education programs, and maintenance of education, training and information resources.
6. Some specific information and education for the elderly should include resourcing for community based information sessions regarding the need for advance care planning and strategies to reduce their vulnerability to elder abuse.
7. Community based activities that reduce the social isolation of the elderly and maintain physical function and autonomy would target risk factors for elder abuse as well as optimise physical and mental well-being. Examples of this would be subsidised exercise programs for the elderly, walking groups, and social groups, however these programs are not universally available, are often dependent on particular local initiatives and are subject to funding cuts.
8. Supporting the elderly who are too frail to leave the home is also important and innovative programs that utilise web based approaches and social media should be considered, researched, implemented and evaluated.
9. Review the variation in protections for the rights of the elderly in all care settings, including aged care, hospital and mental health inpatient services.

References

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