



# A Guide for Elder Abuse Protocols

Developed for Community Service Organisations  
*By the UnitingCare Community's Elder Abuse Prevention Unit*



## DISCLAIMER

The information contained in this document is general information only and does not constitute legal advice.

Organisations should ensure that any protocols developed for use within their own agencies are consistent with any other legal requirements such as those relating to privacy and confidentiality.

While all attempts have been made to ensure the accuracy of the information contained in this document at the time of its production, no guaranty as to the accuracy is given.

The Elder Abuse Prevention Unit and its agents do not accept any responsibility for consequences following from the use of this information, whether unforeseen or otherwise.

### Acknowledgements

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## INFORMATION ON ELDER ABUSE

RIGHTS OF OLDER PEOPLE	ELDER ABUSE	RISK FACTORS	ASSESSMENT GUIDELINES	PRINCIPLES OF INTERVENTION
<p>Every adult has a right to self determination. United Nation's Principles for Older Persons include the rights for:</p> <ul style="list-style-type: none"> <li>• Independence</li> <li>• Participation</li> <li>• Care</li> <li>• Self-fulfillment</li> <li>• Dignity</li> </ul>	<p><i>"Elder Abuse is 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".</i> (World Health Organisation 2002)</p> <p>Abuse can be <b>physical, sexual, financial, psychological, social or neglect.</b></p>	<ul style="list-style-type: none"> <li>• Dependency</li> <li>• Family conflict</li> <li>• Isolation</li> <li>• Physical health issues</li> <li>• Mental health issues</li> <li>• Impaired capacity</li> <li>• Carer stress</li> <li>• Addictions</li> <li>• Language and cultural barriers</li> </ul>	<p>Consider:</p> <ul style="list-style-type: none"> <li>• Is it an emergency</li> <li>• Capacity</li> <li>• Consent</li> <li>• Type and prevalence of abuse</li> <li>• Health &amp; functional status</li> <li>• Relationship to abuser</li> <li>• Existing supports</li> <li>• Other services involved</li> </ul>	<ul style="list-style-type: none"> <li>• Client safety is paramount</li> <li>• Self-determination Vs Duty of care</li> <li>• Culturally sensitive</li> <li>• Client focused</li> <li>• Holistic approach</li> <li>• Consider all options including legal/police</li> <li>• Confidentiality to be respected but not a barrier to action</li> </ul>

## RESPONDING TO ELDER ABUSE

**NOTE: FOR RESIDENTIAL AGED CARE THERE MAY BE FURTHER REQUIREMENTS UNDER THE AGED CARE ACT (SEE OVER)**

EMERGENCY - LIFE THREATENING SITUATION No Consent Required	Has Capacity		Impaired Capacity	
<ul style="list-style-type: none"> <li>• Police, ambulance, hospital called as appropriate</li> <li>• Liaise with emergency service</li> <li>• Follow agency protocols.</li> </ul> <p>Once Safety is addressed / Emergency resolved return to "Has Capacity" or "Impaired Capacity" Pathway as appropriate</p>	<ul style="list-style-type: none"> <li>• Is interpreter or Cultural Advisor required</li> <li>• Discuss situation and options with client</li> <li>• Assess risk, existing support etc.</li> <li>• Document</li> <li>• Request clients consent to provide further assistance</li> </ul>	<ul style="list-style-type: none"> <li>• Is interpreter or Cultural Advisor required</li> <li>• Discuss situation and options with client</li> <li>• Assess risk, existing support etc.</li> <li>• Document</li> <li>• Determine who can provide consent</li> <li>• Include client in decisions if practical</li> </ul>		
	<h3 style="text-align: center;">Consent</h3> <ul style="list-style-type: none"> <li>• Document client's consent</li> <li>• Explore interventions and safety</li> <li>• Implement interventions e.g.:                             <ul style="list-style-type: none"> <li>- Make referrals</li> <li>- Arrange assistance</li> <li>- Advocate as required</li> </ul> </li> </ul>	<h3 style="text-align: center;">No Consent</h3> <ul style="list-style-type: none"> <li>• Document client's non consent</li> <li>• Provide referral options &amp; contacts</li> <li>• Provide safety information/plan</li> <li>• Consider whether duty of care is met</li> </ul>	<h3 style="text-align: center;">Consent</h3> <ul style="list-style-type: none"> <li>• Document client's and/or decision maker's consent</li> <li>• Explore safety and interventions</li> <li>• Implement interventions e.g. make referrals, arrange assistance</li> <li>• If no decision maker or the decision maker is the abuser, refer to OAG or QCAT</li> </ul>	<h3 style="text-align: center;">No Consent</h3> <ul style="list-style-type: none"> <li>• Document client's and or decision-maker's non consent</li> <li>• Address emergency</li> <li>• Refer to Office of Adult Guardian (OAG) or QCAT</li> <li>• Consider whether duty of care is met</li> </ul>
	<b>FOLLOW UP AS REQUIRED</b>		<b>FOLLOW UP AS REQUIRED</b>	

## STATEWIDE PHONE NUMBERS (SEE OVER FOR LOCAL NUMBERS)

EMERGENCY	Elder Abuse Prevention Unit		
<b>POLICE AMBULANCE HOSPITAL  000</b>	Office of the Adult Guardian	1300 651 192	9am-5pm + message bank, Mon to Fri
	Qld Civil and Administrative Tribunal	1300 653 187	
	Qld Aged & Disability Advocacy	1300 753 228	
	Commonwealth Carelink Centres	1800 818 338	
	dvconnect Womensline	1800 052 222	
	dvconnect Mensline	1800 811 811	24 hr - 7 days
	Mental Health Information Service	1800 600 636	9am-Midnight - 7 days
	Lifeline Telephone Counselling	1800 674 200	
	Public Trustee Qld	13 11 14	24hr 7 days
	Seniors Enquiry Line and Grandparent's Info Line	07 3213 9288	
	Alzheimer's Assoc of Qld Helpline	1300 135 500	9am-5pm + message bank, Mon to Fri
	Translating and Interpreting Service	1800 639 331	24hr 7 days
	Aged Care Complaints Investigation Scheme	131 450	24hr
	1800 550 552		



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■ CONSENT			
■ NO CONSENT			

This document follows the “Pathways for Addressing Elder Abuse” chart.

## INTRODUCTION

In the second decade of the twenty first century, the serious social issue of elder abuse has attained a high level of awareness in the community, and all aged care service providers need to regard it as their duty of care to respond to any elder abuse experienced by their clients. Government, community agencies, health professionals and residential aged care facilities each play an important part in the prevention, and the appropriate and timely identification and management, of elder abuse.

The Elder Abuse Prevention Unit (EAPU) has developed this resource to assist organisations in Queensland to develop their own protocols to address this growing social issue.

Although the document is specifically directed to assist paid and voluntary community based organisations, other services such as Residential Aged Care Facilities, individual professionals such as General Practitioners and complex systems such as Hospitals and Financial Institutions can benefit from the information provided.

The Elder Abuse Prevention Unit (EAPU) is a State-wide Service funded by the Queensland Department of Communities and operates within the Older Person's Programs of UnitingCare Community. The EAPU provides:

- Free training sessions to community organisations and students in relevant tertiary studies,
- Awareness Raising sessions to community groups,
- Peer Support Network providing training Teleconferences, resources and Newsletters to support remote or isolated workers and
- A confidential Helpline 1300 651 192; the first port of call for providing support, information and referrals for anyone experiencing or witnessing the abuse of an older person or for accessing other EAPU Services.

The Elder Abuse Helpline operates Monday to Friday 9:00am to 5:00 pm toll free from anywhere in Queensland. Callers may remain anonymous and Telephone Interpreting Service (TIS) is available.

### What are a Policies, Protocols and Procedures?

**Policy** is an overarching statement or commitment that an organisation wants to make about a particular issue.

**Protocols** are a guide about how an activity should be performed.

**Procedures** are the detailed way in which the protocols are to be carried out by staff working within the organisation.

A Policy will therefore set out the agency's stance about elder abuse, the Protocol is the overall guide on how and when the procedures are to be undertaken while the Procedures around this policy will set out the activities, forms, etc that need to be carried out. All three areas are therefore important as the policy provides the 'legitimacy' for an organisation's workers to undertake certain tasks while the protocols and procedures ensure the activities are undertaken with regard to, for example, client/worker safety, best outcomes, efficiency and other legislation and policies that may apply.

If your agency doesn't yet have a specific elder abuse policy it would still be possible to develop the protocols as every agency has some policies that would apply to elder abuse type situations. The first step therefore is to gather any agency policies that may apply to elder abuse situations such as those relating to client safety, domestic violence, confidentiality and so on. Most organisations have value statements and the like, which sit above the policies and are also useful.

### Why have Protocols?

For those agencies that don't yet have a specific elder abuse policy, the process of developing elder abuse protocols can be the first and very best step in developing a sound and holistic policy on elder abuse. A 'ground up' approach to policy development usually engages, and has more support from the front line workers than a 'top down' approach. Policies, Protocols and Procedures documents serve a number of purposes in organisations. They provide guidelines for staff in the performance of their duties, they assist management to be aware of some of the hurdles faced by staff in their daily routines and most importantly, they provide a baseline of acceptable behaviour that endeavours to protect everyone; clients, staff and the organisation.

### Who should be involved in the development of Protocols?

It is important that management retains responsibility for the development of organisational protocols. Equally important is that staff at all levels to whom the protocol applies are given an opportunity to provide feedback on the document and how it will impact on their work. If a protocol is too onerous, it will be more difficult for staff to perform their duties.

If the protocol is very rigid then staff can become hamstrung and unable to act in a manner consistent with the best interests of a particular client. However, if a protocol is too broad, it will not provide a clear base line of acceptable behaviour thereby increasing risk to the organisation, staff and clients.

Therefore, the Protocols document should provide sufficient detail to inform staff of the behaviours and circumstances covered by a protocol, but also should be broad enough to enable them to use their professional judgement in the performance of their duties. However, while endeavouring to reach a workable balance it is paramount to avoid ambiguity in instructions.

### **What should Protocols look like?**

A protocol should be clear and not ambiguous, and it is often useful for the same information to be provided in a number of different ways; For example, the protocol may be provided in a written script with the same information also provided in a flow chart and then in a document that staff can complete in any given situation that will guide them through the agency's protocol e.g. an incident form.

### **What should Protocols cover?**

Protocols should cover one discrete topic, such as elder abuse. The supporting procedures or guidelines should provide more detailed information that assist staff to determine the applicability of the protocols to any given situation and then the steps staff should take in responding to the situation. Protocols should also contain a clear list of other organisational documents that staff should be aware of in the application of the protocols.

The topic covered by the protocols should be clearly defined. In this case, the protocols must identify what constitutes elder abuse, including the specific signs with examples; the relationship between the parties in which the alleged behaviour occurred; the information that staff should collect; the guidelines for making a decision whether an action should be taken; how information should be documented and reported. It is the decision of each organisation whether behaviour by their staff towards clients is covered by the elder abuse protocols or whether that relationship is more appropriately dealt with by a code of conduct.

When developing protocols about elder abuse, there are four discrete needs that have to be balanced:

1. The needs of the client who is the subject of concern;
2. The needs of the staff member who is responding to or identifying the concern;
3. The need of the organisation to fulfil its responsibilities to the client, the staff member and the organisation as a whole; and
4. The perpetrator. It is appropriate that any response to elder abuse is holistic.

Management have a responsibility to ensure that the policies and procedures are provided to staff and that they are familiar with the content and with their rights and responsibilities. A protocol and the supporting procedures should provide clear guidance about levels of responsibility. Responsibility for action should be reflective of a person's position in the hierarchy of the organisation. For example, where there is concern about a client's capacity where the client has no family or friends and decisions about his care and other life matters need to be made, the staff member who provides a service in the home has a responsibility to accurately report matters of concern and events that demonstrate the client's level of capacity. Management of the organisation have a responsibility to collectively view the reports and make a decision about the extent to which action needs to be taken to protect the client. For example, it would be a decision of management, in consultation with ground staff, whether to make a direct application to the Guardianship and Administration Tribunal for a declaration of capacity or the appointment of a guardian or administrator, or to firstly approach the general practitioner for a letter or report to support the application. It is the organisation, as a series of individuals providing a service to a client, who make the application, not just the person who signs the application form.

### **Responsibilities of Ground Staff**

Within a community organisation, particularly when staff is performing caring roles with sometimes very vulnerable clients, it can be difficult for staff to balance their obligation to their employer as well as protect clients. Staff should feel well supported by management with the result that staff considers themselves one of a group of people responsible for the care of clients rather than as the sole provider of care. The relationship exists between the organisation, represented by the employee, and the client, not between the client and the employee.

Staff should feel supported to report any suspicious behaviour or activity. Often, abuse is more clearly identifiable when a series of reported events paint a picture of a client's situation. The same picture may provide insight into the capacity of a client to make decisions. Where documentation is standardised, comparisons between events are easier.

All further information follows and crossed referenced with the **Pathways for Addressing Elder Abuse**, which is included in this package.

Well developed Protocols need to benefit everyone: the organisation, the staff, the client and client's family.

# INFORMATION ON ELDER ABUSE

## ELDER ABUSE

The abuse of older people is a worldwide recognised issue.

Elder abuse can be defined 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” (World Health Organisation 2000).

Elder abuse can take various forms such as psychological, financial, physical, social, sexual abuse and neglect.

Relationships of trust include family and friends of the older person but increasingly the relationship between community support workers, such as domiciliary nurses and home help, have come to be recognised as trusting in nature and are therefore covered by this definition. Please refer to the section on “who does it cover” to address the issue of relationship between the perpetrator and victim.

### Overview of elder abuse

Elder abuse is located within the context of the Domestic and Family Violence paradigm which, along with child abuse and domestic violence, is underpinned by issues of power and control. There are similarities between the three domains of abuse but each stage of life needs its own framework for understanding and addressing specific issues. Research into elder abuse estimates that anywhere from 2.6% to 8% of older people experience some form of elder abuse in any one year; however this could be just the tip of the iceberg.

### Types and signs of elder abuse

1. **Psychological (emotional, mental, verbal) abuse:** is the infliction of mental anguish, fear and feelings of shame and powerlessness.

Behaviours include: verbal intimidation, humiliation, harassment, shouting, threats of various forms, withholding of affection and removal of decision-making powers.

Signs include: Loss of interest in self and environment, passivity and apathy towards another person, fearfulness, lack of eye contact, ambivalence or nervousness around another person, reluctance to talk openly, helplessness and resignation.

2. **Financial abuse:** is the illegal or improper use of an older person's finances or assets without their informed consent.

Behaviours include: misappropriation of assets, money or valuables, forced changes to legal documents, the denial of access to personal funds, forging signatures, misuse of a bank card and misappropriation of an Enduring Power of Attorney.

Signs include: loss of valuables, unprecedented transfer of funds, the improper attainment of Enduring Power of Attorney, loss of the bank card or a cheque book and the sudden inability to pay bills or purchase necessities.

3. **Physical abuse:** is the infliction of physical pain, injury or force and the deprivation of liberty

Behaviours include: slapping, hitting, bruising, pushing and shoving, physically restraining and over & under medicating.

Signs include: discrepancies between injury and explanation, burns, bruising, injuries at different stages of healing and being seen by different doctors or hospitals.

4. **Social abuse:** is the intentional prevention of an older person from having social contact with family or friends or accessing social activities of their choice.

Behaviours Include: Moving the older person away from family and friends, forbidding access to visitors, denying the use of the phone or monitoring calls and cutting off activities without explanation and many other controlling behaviours.

Signs include: Unexpected cancellation of services, non attendance at activities the person regularly attends, constant and close presence of the carer/family member, a high level of gate-keeping by the suspected abuser.

5. **Sexual abuse:** is sexually abusive or exploitative behaviour or any behaviour that makes the older person feel uncomfortable about their body or gender.

Behaviours include: rape, indecent assault, sexual harassment, the use of sexually offending language and touching inappropriately

Signs include: bruising around genitals, unexplained venereal disease, torn/stained/bloody underclothes, bruising on the inner thighs, difficulty in walking or sitting, huddled and fear of being touched.

6. **Neglect:** is the failure of a care giver to provide the necessities of life to a person for whom they are caring. Neglect can be unintentional or intentional. Both have the same adverse affect on the abused and cannot be excused or condoned. However, it is important to note the difference between the two types as it assists in choosing the most appropriate interventions.

Behaviours include: **Unintentional Neglect** - when a carer does not have the skills, knowledge or physical ability to care for the person or they lack knowledge of the supports available to them. **Intentional Neglect** - when an older person is abandoned or not provided with adequate food, clothing or water or when there is a refusal by the carer to allow other people to provide necessary care.

Signs include: malnourishment, dehydration, lack of social contact or activities, smelling of poor hygiene, clothing in poor state, colds and chills, lacking glasses, dentures or hearing aids, pressure sores, abandoned.

When addressing situations of suspected elder abuse it is important not to jump to conclusions as the same symptom could have many different causes, one of which is Elder Abuse. Regardless of the signs and whether an intervention was undertaken, it is important to document the situation. It will establish the case history and will assist in justifying timely interventions to improve the holistic wellbeing of the client.

## RISK FACTORS

- Dependency – The older person may fear the loss of the carer or being moved to an aged care facility or of experiencing retaliation if they complain. They could be in a co-dependant relationship with the abuser. The carer may be dependent on the accommodation and income of the older person. The older person may still be the carer for an intellectually impaired, mentally ill or emotionally immature adult who abuses them.
- History of family conflict and dysfunction – could involve many unresolved issues, learned behaviours through intergenerational violence, a continuation of domestic violence with role reverses or an opportunity for “pay back”.
- Isolation – no one to get help from and no one to witness the abuse, not being aware of options and services, no support networks.
- Physical health issues – increased dependency or increased burden of care on the carer.
- Mental health issues – human rights including confidentiality issues that exclude the carer from information,

non-compliance with medications, conflicting rights and needs between the person and the carer. The older person could experience mental health issues or be living with a person with mental illness.

- Impaired capacity - diminished capacity to report and to be believed, increased opportunity for being abused, increased abuse of the carer due to uncontrolled behaviours, issues of determining capacity or the level of capacity.
- Carer stress – may lead to unintentional or intentional abuse. The abusive actions of carers are not to be condoned, however, the carer could be the abused or in need of information and support.
- Addictions – alcohol, prescriptive or illicit drugs or gambling addictions affecting the older person, the carer or the person who lives with the older person.
- Language and cultural barriers – all the risk factors mentioned above could be compounded by increased level of isolation through language barriers and increased dependence due to cultural values, historical influences and/or the emigration experience.

When addressing elder abuse it is important to utilise a holistic, non-punitive and non-judgemental approach. In most cases people wish to retain important relationships with significant people, therefore by addressing the unmet needs of the alleged abuser as well as the abused person, the situation could improve for the client. It is also important to recognise that many carers go out of their way to care for the person in their care and they could be the ones who allow themselves to be abused, may need information and support, or could experience physical or cognitive health issues.



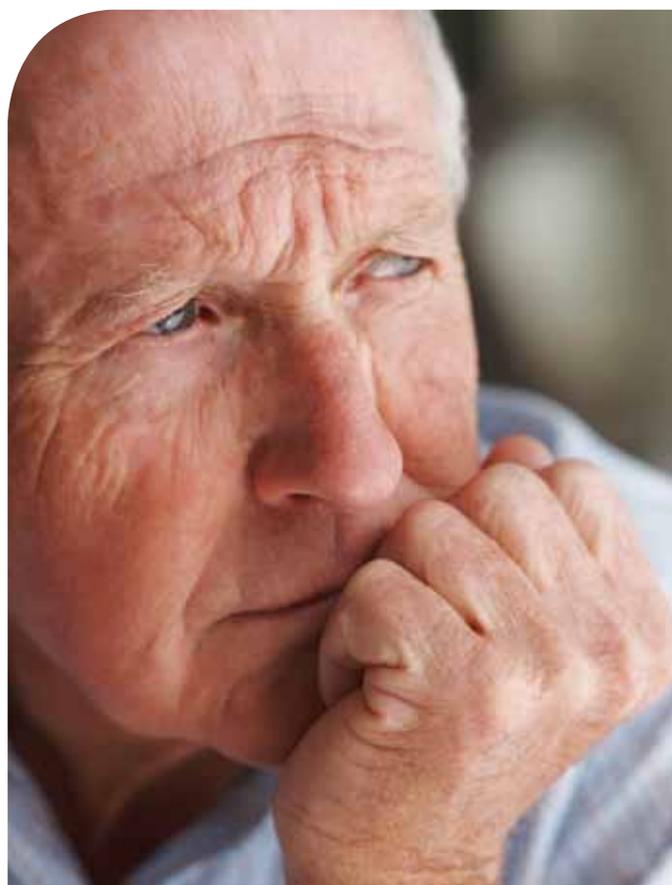
## RIGHTS OF OLDER PEOPLE

Addressing Elder Abuse is Human Rights based, by recognising that all adults have the right to self determination regardless of their age, eccentricity or life choices, which others may not agree with. Older people have the right to make decisions, take risks or refuse supports and interventions as long as they have the cognitive capacity to make informed decisions and can understand the consequences of their decisions.

The United Nations Principles for Older Persons, based on the International Plan of Action on Ageing 1982, state that older persons should be able to enjoy human rights that include full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and quality of their lives.

The principles include the right for Independence, Participation, Care, Self-fulfillment and Dignity (see appendix A)

With the advancement of science and medicine, many people with long term physical, mental, intellectual or sensory impairments live longer and reach older age, and consequently could be experiencing elder abuse. Therefore we need to base our approach to elder abuse also on the United Nations Convention on the Rights of Persons with Disabilities. The purpose of the Convention is to promote, protect and ensure the full and equal enjoyment of all human rights by persons with disabilities and to promote respect for their inherent dignity (see appendix B).



## ASSESSMENT GUIDELINES

The Assessment Guidelines is a tool that assists staff and management to address the situation professionally. It guides them to observe the situation objectively and to report appropriately internally, as well as making decisions about accessing external intervention.

Appropriate documentation and reporting by staff, assist the manager in working out the next step of action. Workers do not need to be overwhelmed by the complexity of the situation as they do not carry the burden of response. Their important role is being the “eyes and ears” of their organisation and their timely and appropriate reporting plays a vital role in bringing the matter to attention.

### The things to consider include:

- Cognitive capacity (refer to Has Capacity and Impaired Capacity)
- Consent of the client – even if the client has some impaired capacity it is important to include them in addressing the situation and to get their consent if and when practical. For health care decisions follow the chart Who Can Make Health Care Decisions in Qld. (see Appendix C). When it is an emergency e.g. life threatening situation, there is no need to get client’s consent to call the police and/or ambulance.
- Client’s health and functional status – can they protect themselves or get help if the situation gets worse? If it is not an emergency now, can the client protect themselves or call for help if the situation worsens?
- Relationship to the alleged abuser – is it enmeshed? Is there co-dependency? Does the client care about the abuser’s wellbeing and wish to protect them? Would the client like to retain the relationship?

The alleged abuser may not be your client and you may not be able to provide them with information or assist them. However, by providing the abused client with information that can assist the alleged abuser, you could empower your client to undertake the intervention and not see it as selfish or self centred.

- What other supports are in place – informal (family, friends, cultural community, religious leader), and formal (G.P, other organisations, legal service, appointed Guardian).
- Are there other services involved in their care? Exchanging information with other services may clarify the situation, like adding pieces to a puzzle, and justify whether or not to act and how.

A host of assessment and suspicion-index of elder abuse tools are available for health care professionals. An example of a suspicion index tool is included in appendix E.

## PRINCIPLES OF INTERVENTION

The Principles of Intervention can be seen as a “Balancing Act” that determines whether the service provider needs to intervene, what type of intervention is required and how urgent it is to act.

The principles include the following:

- Client safety is paramount - although Elder Abuse is generally not as violent or life threatening as domestic violence and could be subtle, safety always needs to be considered so the intervention does not worsen the client's situation. For example – leaving printed information that can be found by the abuser, calling client by phone when the abuser is at home or leaving case notes at the client's home. If the situation is considered to be life threatening, access to the client is denied and all other approaches have failed, then emergency response needs to be undertaken
- Client's right for Self-Determination – needs to be balanced with the service provider's Duty of Care.
- Culturally appropriate – applying cross-cultural sensitivity is necessary for building trusting relationships with the client and their family in order to break down barriers to communication, information and acceptance of intervention. Workers need to be aware of their own values, belief system and biases so they are accepting of other people's way of life. However, when a behavior is illegal or criminal, no one can hide behind cultural or religious beliefs to justify it.
- Client focused – the intervention has to address the client's needs even if the abuse is unintentional or the client is the abuser. If the situation is of self abuse or abuse outside trusting relationships (behaviors that are outside the elder abuse definition) it is still the service provider's duty of care to address the situation by following the same principles of intervention and assessment guidelines.
- Holistic approach – by addressing the unmet needs of the abuser or the conflicting needs between the abused and the abuser, the situation could improve for the client. Providing the abused person with information about what can assist the abuser could empower them to accept the intervention even if it entails legal options.
- Legal options and law enforcement need to be offered – regardless of the assumption that older people do not wish to involve the police or the legal system, workers' obligation is to provide them with these options or provide a referral for accessing them. Clients may choose to utilise legal options immediately or in the future if the situation gets worse. Knowing their rights can increase clients' self esteem and confidence when addressing the situation.
- Confidentiality is to be respected – however, it needs to be balanced with the possible consequences of not acting. Also, care workers need to remember that:

Confidentiality is between the organisation and the client, not between the worker and the client. Workers need to document and/or report all matters of concerns to the person in charge.

Although workers need to be encouraged to establish good relationships with the clients, they should always act as professionals who represent an organisation and not as friends, so as not to blur the boundaries between the two.

Organisations have responsibility to protect the privacy of their clients; however, confidentiality should never be a reason for failing to respond to issues of abuse. Where an adult has capacity (discussed below), issues of confidentiality may make it difficult to provide a response however, it needs to be weighed against the possible consequences of failing to act. Sharing relevant information with the GP and other organisations involved in the care of the client is justifiable in abusive situations. The organisation will need good processes of documentation and support for staff to demonstrate

Confidentiality with the client needs to be respected but also needs to be balanced with the risks facing the client. You need to consider the consequences of not sharing relevant and crucial information with other services involved in the client's care, and of not acting.



## RESPONDING TO ELDER ABUSE

### EMERGENCY – LIFE THREATENING SITUATION No Consent Required

- Police, ambulance, hospital called as appropriate
- Liaise with emergency services
- Follow agency protocols

Once safety is addressed/emergency resolved, follow the 'Has Capacity' or 'Impaired Capacity' pathway as appropriate.

During the preparation of a protocol document, it is important to consider the types of circumstances in which staff may be confronted by an emergency. For example, where a person is at serious risk of physical injury or serious damage to property, the discretion of staff should be limited and it should be mandatory that the police are called, without seeking permission from the clients and not having to consider client's capacity. Where a person has been harmed and is injured, the discretion should also be limited and seeking medical assistance and contacting the police and ambulance should be mandatory. Having a clear organisational protocol about what constitutes an emergency means that staff is less vulnerable to pressure from clients who may be acting out of fear or shock. Clear protocols allow staff to slightly distance themselves from the decision while still maintaining the trusting relationship with the client.

At an emergency situation, staff safety is paramount and all interventions need to be activated after taking staff safety into consideration.



## HAS CAPACITY

- Is an interpreter or cultural advisor required?
- Discuss situation and options with client
- Assess risk, existing support etc.
- Document
- Request client consent to provide further assistance

## CAPACITY

The issues of capacity, guardianship, administration and attorneys are often very complex. This part begins by providing definitions of these concepts. It is important that you note the differences between the various roles that people may perform as guardians, administrators and attorneys. Although these differences seem small, they are significant and will often be the deciding factor for your agency's response.

The Guardianship and Administration Act 2000 defines that Capacity for a person for a matter means that the person is capable of –

- Understanding the nature and effect of decisions about the matter; and
- Freely and voluntarily making decisions about the matter; and
- Communicating the decisions in some way.

It is necessary for a person to be capable of all three components of the definition for them to be considered to have capacity. Capacity is described as a rebuttable presumption. This simply means all adults are presumed to have the capacity to make decisions for themselves. If you want to suggest that an adult does not have the capacity to make decisions for themselves, then you need to have evidence to demonstrate that. Evidence that an adult does not have the capacity to make decisions about a matter includes the following, in no particular order of importance:

- Letter or statement from a general practitioner on the basis of a known medical history;
- reports or assessments from specialists regarding the impact of a particular diagnosis, either the impact on the particular individual, or known progression of a particular disease;
- Reports from allied health staff including registered nurses, occupational therapists, physiotherapists, or psychologists with reference to specific examples of behaviour in daily functioning that may demonstrate the person has capacity or demonstrate a basis for questioning the person's capacity. Observations and documentation of any change in a person's behaviour over a period of time can be very useful and insightful.

Capacity is a legal definition; however it is assessed by the medical sector and is often declared as blanket assessment that the person either has or has no capacity. However its legal definition relates to Capacity for a Matter therefore is described as matter-specific. An adult may have capacity for some things but not for others. For example, a person may have the capacity to manage a pension but not to make complex investment decisions; a person may have the capacity to decide what to wear but not to decide where they should live. The adult may need to establish capacity to make a will or to change an Enduring Power of Attorney. These considerations are important if you are asked to provide an opinion about a client's capacity to make decisions; either by the Adult Guardian, QCAT or anyone else.

Capacity Guidelines for Witnessing of Enduring Powers of Attorney document can be useful as a guide for forming an opinion on a person's capacity for other matters as well. You can access it through the Department of Justice website following the link -

<http://www.justice.qld.gov.au/justice-services/guardianship/power-of-attorney/enduring-power-of-attorney/making-an-enduring-power-of-attorney>

### Issues concerning substitute decision making

Where a client has a GUARDIAN OR ADMINISTRATOR appointed by QCAT, and the concerns relate to the actions of the GUARDIAN OR ADMINISTRATOR, then the response by the agency is relatively straight forward. The Adult Guardian has a statutory responsibility to investigate allegations of abuse, neglect or exploitation of adults with impaired capacity. Where a guardian or administrator has been appointed, the Tribunal has already decided that the adult lacks capacity in relation to the matters for which the guardian or administrator is appointed and so two options are available to the agency: a referral to the Office of the Adult Guardian for investigation; or an application to the Guardianship and Administration Tribunal for a review of the appointment of the guardian or administrator. Referrals to the Office of the Adult Guardian are confidential; applications to the Tribunal usually are not.

Where a client has made an ENDURING POWER OF ATTORNEY, an agency may need to consider the following

### Concerns about financial matters:

- a. An enduring power of attorney for financial matters can begin immediately upon appointment. This means that the attorney can make financial decisions even while the adult still has capacity. If this is the case then it is up to the adult to revoke the appointment if the attorney has acted inappropriately, make a new appointment and seek legal advice to recover the assets.
- b. If the powers of the financial attorney begin only if and when the adult loses capacity, then three possible circumstances could apply.
  - i. Firstly, if the adult has capacity, then the attorney has no authority to act and it is up to the adult to revoke the appointment if the attorney has acted inappropriately, make a new appointment and seek legal advice to recover the assets.
  - ii. Secondly, if the adult does not have capacity for financial matters, then a referral should be made to the Office of the Adult Guardian for investigation of the actions of the attorney. Referrals to the Office of the Adult Guardian for investigation are confidential.
  - iii. Thirdly, the adult's capacity for financial matters is unclear but there are reasons to question it. In this situation, you should consider the following options:
    1. Requesting a cognitive capacity assessment;
    2. Contacting the general practitioner;
    3. Making an application to the Guardianship and Administration Tribunal for a declaration of capacity.

### Concerns about personal/health matters:

The powers of an attorney for personal/health matters can only begin after the adult has lost capacity to make personal/health decisions.

- a. If the adult has capacity to make personal/health decisions and the attorney has acted inappropriately, then the adult may revoke the existing document and make a new enduring power of attorney appointing another attorney. In these circumstances, the existence of an enduring power of attorney is irrelevant.
- b. If the adult does not have the capacity to make personal decisions, or a new document, then a referral should be made to the Office of the Adult Guardian for investigation of the actions of the attorney. Referrals to the Office of the Adult Guardian for investigation are confidential.
- c. Where the capacity of the adult is questionable and there is evidence to suggest the adult does not have capacity, you need to consider the following options:
  1. Requesting a cognitive capacity assessment;
  2. Contacting the general practitioner;
  3. Making an application to QCAT for a Declaration of Capacity.

The service provider needs to keep a certified copy of the Enduring Power of Attorney to refer to about: who the attorney is/are; what power they have; are there any limitations on the power; when does the power begin and are the decisions to be made severally, jointly or as a majority if more than one attorney appointed. Service providers are prohibited by law from being a client's attorney. Service providers need to be proactive in upholding their client's general and health principles (Guardian and Administration Act 2000). They may need to challenge the attorney/guardian/administrator and anyone else if their actions contradict these principles and harm the client in any way. See appendices C and D.

### Interpreter and Cultural Advisor

Elder abuse can impact on people from all ethnic, cultural and religious backgrounds and it happens to older people across the world.

Immigration and resettlement issues experienced by older people from Culturally and Linguistically Diverse Background (CALD), could increase their vulnerability to elder abuse due to language and cultural barriers, which compound general risk factors. They could become more isolated, more depended on family, lack aware of available supports and less likely to identify abuse and report it.

Therefore, it is paramount to address these cultural barriers prior to undertaking any action when abuse is detected, unless the situation is a life threatening emergency. Addressing the situation with cross-cultural sensitivity and the use of accredited interpreters, when in need, can establish trust with the client and their family and increase the possibility for cooperation and positive outcomes.

Most CALD older people use family members as interpreters, however in cases of elder abuse it is not appropriate. It is also important to use accredited interpreters when discussing medical, financial and legal matters to ensure accurate and objective exchange of information.

Similar caution and cultural awareness has to be exercised when the client is an older person from Aboriginal or Torres Straits Islander background. In this case it is the impact of historical experiences on the client, directly or vicariously, as well as current issues, which could create barrier to communication and acceptance of interventions. In some situations the use of a cultural adviser can provide access and cooperation with the client and their family.

For more information please refer to the relevant section under "Specific Groups" in this document.

## CONSENT

- Document client's consent
- Explore interventions and safety
- Implement interventions e.g.:
  - make referrals, arrange assistance, advocate as required

## CONSENT

The issue of consent is a common area of confusion when responding to situations of elder abuse: consent to obtain assistance for a client; consent to contact the police etc. From a legal perspective, consent is a relatively straight forward issue: all adults have the right to self determination and can accept or refuse services, assistance, medical care or a life saving operation, as long as they have the capacity to make a decision about the matter. All adults are presumed to have capacity and do not have to prove it or agree to undertake an assessment. On the other hand, service providers do not need the client's consent to contact the police or the ambulance in times of an emergency and a life threatening situation. However, in a practical sense, the client may refuse police or ambulance intervention; therefore engaging in this type of intervention too early in the process can be counter productive. Staff of community organisations are sometimes the only external contact for isolated older people living in the community. Any action taken without the agreement of the client may jeopardise the relationship with them, resulting in termination of the service and in increased isolation of the client. Ultimately, the tension for agencies is to strike an appropriate balance between the obligation to respect the client's right to self-determination and the organisation's duty of care, both legal and ethical, to prevent foreseeable harm caused to the client.



## NO CONSENT

- Document client's non-consent
- Provide referral options and contacts
- Provide safety information
- Consider whether Duty of Care is met

## NO CONSENT

A client who has capacity but refuses to consent to intervention poses most of the agonising decisions that service providers need to make.

When it is clear that the client has capacity and that they are not being coerced, intimidated or threatened by the abuser – the service providers need to distance themselves emotionally from the situation and follow the agency protocols, based on the No Consent Pathway.

## DUTY OF CARE

The term Duty of Care refers to just one element in a Negligence action under the Civil Law e.g. being sued for damages caused by negligence.

Duty of Care is the duty owed by individuals and organisations to their clients, to do what is reasonable in order to prevent or avoid foreseeable harm to their client. Breach of Duty of Care occurs when harm to the client results from the actions or inactions of the individual worker or the organisation. Breach of Duty of Care also covers harm that was caused to the client by giving them advice outside the service's expertise, which causes harm.

In order to establish a Breach of Duty of Care, it is necessary to verify that a duty of care was owed to the person, that there was a breach of that duty and that it was the breach of that duty that resulted in harm to the person. (Donoghue v Stevenson, 1932) It is well established that organisations providing paid or voluntary services to individuals owe a duty of care to those individuals and their carers and families, by taking reasonable steps to prevent harm to the client.

Duty of Care needs to extend beyond the legal framework that protects the organisation and the workers from litigation. It needs to cover the moral and ethical framework of the individual worker and the organisation. If elder abuse of a client is known to the worker and the organisation but they do nothing about it, they may never be held liable; however, the abuse could continue indefinitely and their client will continue to be harmed.

## IMPAIRED CAPACITY

- Is an interpreter or a cultural adviser required?
- Discuss situation and options with client
- Assess risk, existing supports etc.
- Determine who can provide consent – Attorney? Guardian? Administrator?
- Include client's indecisions if practical

## IMPAIRED CAPACITY

Capacity is defined legally (see definition above) but is assessed by a medical practitioner, which is not always consistent with the definition. Impaired capacity is fluid and often progresses and deteriorates over a long period of time. People have presumption of capacity under the law and the right for self determination; therefore, client's wishes need to be taken into consideration as much as possible. Best practice is always to follow the general and health principles as outlined in the Guardianship and Administration Act 2000. (See appendices C and D)

**For more information please refer to the Has Capacity section above.**

## CONSENT

- Document client's and/or decision maker's consent
- Explore safety and interventions
- Implement interventions e.g. make referrals, arrange assistance
- If there is no decision maker or if the decision maker is the abuser – refer to the Office of Adult Guardian (OAG) or to Queensland Civil and Administrative Tribunals (QCAT)

Information about OAG and QCAT see GLOSSARY

## NO CONSENT

- Document client's and/or decision maker's non consent
- Address emergency
- Refer to the Office of the Adult Guardian or QCAT
- Consider whether Duty of Care is met

See all relevant information listed above.

## SPECIFIC GROUPS

**There are some general guidelines to consider when dealing with any cultural group. They include:**

- No culture is homogenous, therefore, it is never appropriate to generalise about a person on the basis of perceived or 'known' cultural norms. Within each group, every person needs to be addressed as an individual.
- Elder abuse protocols need to increase workers awareness of broad cultural issues that could contribute to increased risk of elder abuse.
- Cross-cultural training will assist workers to develop closer working relationships with clients so they can be trusted by them with disclosure of elder abuse and with considering proposed interventions.

Workers need to be aware of their own values and belief system so they do not impose them on their clients.

## ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

The term Elder Abuse could have a different connotation in these communities specifically because Elder is a term of respect and not necessarily of age, therefore not every older person is an Elder.

Another point to consider is that due to shorter life expectancy in these communities, and other health and lifestyle issues, people may be considered old at an earlier age than in other communities. The third general point to consider is that the concept of family could be much broader and include non-blood related people.

In Australia's recent history, many government and non-government reports have been prepared on the issue of violence in Aboriginal and Torres Strait Islander communities. Aboriginal and Torres Strait Islander older people could experience elder abuse as any other older people around the world; however, they also may have issues and challenges specific to their history, both recent and distant. They could include geographical location, social structures, culture and language as well as the various individual differences that exist within members of each, community. It is also recognised that certain factors add significantly to a higher risk of elder abuse and many of these factors are present in Aboriginal and Torres Strait Islander communities. Specifically: social disadvantage, family breakdown and endemic violence result in high levels of family violence. (Gordon, 2002) Other factors include the historical impact of forced removal of children, premature ageing and lower life expectancy, lack of access to culturally appropriate services, alcohol and drugs use, reduced levels of respect for elders due to a breakdown of family obligation, loss of identity and self-esteem and abusive styles of conflict resolution. (Gordon, 2002)

It is important that any organisational protocols in relation to staff interaction with Aboriginal and Torres Strait Islander communities are specific to the needs of the local community. It may not be appropriate for an administrative base in a major centre to prepare proscriptive protocols for staff in remote locations. However, there is always a baseline of behaviour that is unacceptable, in terms of both staff behaviour and in relation to abuse in interpersonal relationships. Culture alone is never an excuse for abuse, but needs to be considered for building trusting relationships with clients.

**There are some specific points that your organisation can consider when preparing its elder abuse protocols:**

- Issue of collective vs individual financial ownership and recognising the fact that many older community members never have had the opportunity to manage finances and own property ;
- Beliefs about particular health issues such as mental illness, disability and dementia;
- Mistrust of authority, which may be influenced by the historical experience of the person, their family or the broader community.
- The importance of providing interventions within the client's community.
- The increasing need for organisations to provide proactive responses for people living in remote communities including the higher hands-on involvement of the services in monitoring interventions.
- Fear of being removed from home or the community, attributed to the cultural belief that the family has the obligation to provide care, and to revisiting the trauma of the stolen generation by being removed again.
- The need to work with cultural advisors and local community workers;
- Focusing on projects that promote the regaining respect for elders and building intergenerational respectful relationships.
- Utilising holistic interventions that meet the needs of all involved, including the alleged abuser.

## **CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUND PEOPLE**

Elder abuse is a universal phenomenon and affects people across the world in both developed and developing countries. Older people may experience elder abuse in their countries of origin; however, in the process of immigration they could be at higher risk of elder abuse due to compounded issues language and cultural barriers.

**Some of the additional risk factors may include:**

- Low-level of English proficiency, affecting communication in giving and receiving information and in expressing thoughts and feelings.
- Culturally accepted gender roles.
- Lack of knowledge of the legal system, complaints mechanisms, eligibility for financial and other assistance, availability of services and so on.
- Increased social isolation and increased dependence on family.
- Reluctance to discuss family dysfunction or conflict outside the family.
- Differing expectations of family obligations to provide care to ageing parents.
- Breakdown of intergenerational relationships due to varying levels of acculturation.

**Additionally, there are some other points that organisations can be mindful of when preparing a protocol to respond to elder abuse:**

- Values around the primacy of family harmony and expectations of filial respect;
- Issues of confidentiality, or lack of, within one's own community;
- Collective vs individual financial ownership;
- Beliefs around health matters such as mental illness, disability and dementia;
- Mistrust of authority due to personal experiences or historical context
- It is not always appropriate to use family members as interpreters, especially children, when discussing medical, legal or financial matters or in situations of elder abuse.
- When collecting personal data about the client, it could be beneficial to expand the document and include a Culturagram; it could include such information as: reasons for immigration, length of time in Australia, age at time of immigration, language spoken at home and proficiency, contact with community of origin and some personal history.
- The possibility of clients' reversion to their language of origin.

The resources page contains information on arranging an interpreter.

## RURAL AND REMOTE PEOPLE

This group is not defined by culture or language but by the remoteness and isolation of their residence. As mentioned above, risk factors for abuse include isolation, dependence and loss of identity and self-esteem. These issues could be compounded by geographical distance from services and other resources, resulting in less available and timely options and interventions. Increasingly, farming communities are recognising the impact that poor succession planning has on family relationships and economic outcomes. Some research suggests that a dominant patriarchal ideology in farming communities often results in the distribution of farming estates to the eldest son, to the total exclusion of other offspring (Rural Law Online, 2005 & Crosby, 1998). This can lead to dissatisfaction, uncertainty and bitterness. Early dialogue about this issue can significantly improve the capacity of a family to address succession planning in a way that maintains familial relationships and prevents isolation, unnecessary financial dependence and loss of value for older farmers. This is an example of the benefits of focusing on holistic responses to elder abuse.

## TYPES OF INTERVENTIONS

### GENERAL COMMENTS

The response to any given situation may vary in complexity. It is useful for your organisation to have a series of principles or guiding statements to use when deciding which action to take when abuse is suspected or confirmed.

#### These could include:

- Obtaining and acknowledging the views of the adult;
- Considering the capacity of the adult to make decisions and take action to protect themselves;
- Considering objectively what the wishes of the adult would have been, whether we agree with them or not.
- The importance of preserving the adult's familial or other relationships;
- The importance of maintaining a relationship between the organisation, its staff and the adult and their family;
- The importance of maintaining an adult's cultural and linguistic environment;
- Respect for cultural values, traditions and customs;
- Legislative requirements;
- Confidentiality.

You or your staff may be able to identify more. Having a big picture of the purpose of your intervention assists everyone to stay focussed on making appropriate decisions about what, if any, action should be taken.

The underlying principle for working with older people is **HAVING THE RIGHT ATTITUDE**, i.e. respect for the individual, not stereotyping, not making assumptions, not rushing to protect and not jumping to conclusion about capacity. Appropriate **KNOWLEDGE** and **SKILLS** can be acquired and increased with time, to enhance one's capacity to address the situation and to respond.

## LEGAL INTERVENTIONS

Currently there are no specific elder abuse laws at either a State level in Queensland or Federally.

However, elder abuse can be addressed through the current civil and/or criminal legislation if and when appropriate.

Legal options have to be offered to the client with referrals to a legal service.

- **Civil Intervention**- the abused adult (or a person on their behalf), is the one who needs to bring the matter before a court to make an Order and / or Judgment
- **Criminal Intervention**- the police can also step in to protect the abused adult.

NB: Sometimes a Civil Intervention can lead to a Criminal Intervention, as with Protection Orders as detailed below.

### Protection Orders

A Protection Order provides the abused adult with a civil court order that set conditions around the abuser's behaviour. If the Protection Order is breached i.e. the abuse continues, it becomes a criminal matter. There are two (2) types of Protection Orders that the abused can apply for – the one applied for depends on the abuser i.e.

1. Related abuser - *Domestic and Family Violence Protection Act 1989*
2. Unrelated abuser – *Peace and Good Behaviour Act 1982*

#### 1. Related abuser - *Domestic and Family Violence Protection Act 1989*

##### Relationship

To apply for the Protection Order the abused adult and the abuser must be related for example:

- A spousal relationship - including a former spouse, de facto partner or former de facto partner and same-sex relationships;
- Family relationships - related by blood or marriage
- Intimate personal relationships - fiancé, dating relationships etc
- Informal care relationships - the adult is dependant upon another for help with a daily living activity inc. when the carer receives a Centrelink allowance or pension, excludes services provided by home-care agencies whether or not a fee is paid for the service.

## **Behaviours constituting Domestic Violence i.e. elder abuse**

Behaviours regarded as domestic violence i.e. elder abuse includes:

- wilful injury
- wilful damage to property
- intimidation and harassment
- indecent behaviour
- threatening to commit any of the above acts
- the abuser getting a person unrelated to the adult to commit any of the above acts

**Example:** Financial Abuse by means of intimidation and harassment could happen when a son, who lives at home, repeatedly asks his parents for money in the presence of his friend who is aggressive in his language and actions [http://www.caxton.org.au/sails\\_slash.html](http://www.caxton.org.au/sails_slash.html)

### **Who can apply?**

The abused adult can apply or someone on their behalf e.g. a friend, the police or a welfare worker.

### **Continuing Abuse – breach of the order**

If the abuse continues after the court makes the Protection Order then this is a criminal offence that the police may prosecute i.e. it is the abuser's actions, not the victim's that create the criminal matter.

## **2. Unrelated abuser – Peace and Good Behaviour Act 1982**

• Peace and Good Behaviour Orders are similar to Protection Orders except the two parties are unrelated i.e. can be taken against a neighbour, a house mate, a work mate or any other associate. The order does not cover harassment and verbal abuse. For more details <http://www.caxton.org.au/Peace%20and%20Good%20Behaviour%20Order%202005.pdf>

### **Civil Action**

The abused adult can sue someone if their actions have caused financial loss e.g.:

- Their attorneys appointed under the Powers of Attorney Act 1998 (Qld) who have violated their powers and duties under an Enduring Power of Attorney
- A family member who is taking their money, valuables etc.
- Someone who is forging their signatures on cheques
- Personal injury can also cause financial and physical damages and the abuser can be sued for the loss resulting from that injury

NB - time limits apply to civil actions therefore these actions require independent legal advice and possibly legal representation.

### **Criminal Law**

Most forms of elder abuse can also be considered a criminal offence. Often the abused adult is unwilling to approach the police about the actions of their abuser when it is someone they have a trusting relationship with.

The police can and may prosecute an abuser without the support of the abused but this is very difficult therefore it is often unlikely to occur.

### **Compulsory Reporting of Elder Abuse in Qld**

Currently compulsory reporting of Elder Abuse applies only to **residential aged care providers** that receive funding from the Federal Government, and is limited only to any unlawful sexual contact or unreasonable use of force under the *Aged Care Act 1997 (Commonwealth)*.

Any allegation or suspicion of unlawful sexual abuse or unreasonable force must be reported within 24 hours of the allegation being made to:

- the Police
- the Department of Health and Ageing via the Aged Care Complaints Scheme on **1800 550 552**

All other types of abuse must be reported internally, dealt with and documented appropriately. Direct complaints by staff or members of the community can be made to the Department of Health and Ageing about all types of abuse e.g.:

- mistreatment and neglect
- lack of response to complaints
- inadequate care and services at the facility.

For more details visit the Office of Aged Care Quality and Compliance <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-quality-about-consumer.htm>

Compulsory reporting does not apply to community based services, however, services that provide CACPs, EACH and EACHD packages fall under this Act, which requires the provider to document the incident and detail how it was responded to.

However, staff and any community member can lodge a complaint about the organisation directly with the Aged Care Complaints Scheme at any time, with a whistle protection protection.

Criminal offence – technically speaking, most forms of abuse are also a criminal offence. However, for various reasons, people are often unwilling to make a formal complaint to the police about the actions of a person with whom they have a trusting relationship and, as stated before, makes it very difficult for the Police to successfully prosecute.

## **Conclusion to legal options**

Most forms of elder abuse can involve a legal intervention, although the client may or may not choose to utilise it. The service provider needs to be proactive and offer their client a referral for appropriate legal advice.

**It is imperative that any instances of abuse are:**

- well documented; and
- the intervention taken is based upon a well considered and ethical framework that has regard to the often conflicting areas of the abused adult's rights and safety.

## **SOCIAL INTERVENTIONS**

It is well established that one of the risk factors of elder abuse is social isolation and dependence on others for support and care. Hence, a strategy of reducing a person's vulnerability to abuse is to create a larger social support network for them, their carers and family. It may be that in some circumstances this is the most appropriate response and in itself will alleviate the abuse.

When an abuser actively seeks to minimise the extension of social, medical or other supports for the older person, through refusal to pay for day respite, cancelling existing services or making the home an unpleasant place for visitors, then making attempts to increase the support network will not be an adequate response and other strategies will need to be considered.

## **MEDICAL INTERVENTIONS**

Where a person has suffered physical injury as a result of abuse, they should always be provided with medical attention. The level of response will be determined by the severity of injury so emergency response could be considered. Further, general practitioners are often a good source of referral information. Many older people hold their general practitioner in high esteem. They may be more likely to accept information from their doctor or to take steps to minimise the abuse following advice, as a prescription, from their doctor.

## **CARERS SUPPORT**

In many abusive situations there is no caring relationship between the abuser and the abused. When there is a caring relationship, the carer could be either the abused or the abuser. When the carer is the abuser, follow the assessment guidelines and principles of intervention.

When the carer is being abused, provision of support and information are necessary, whether the carer is your client or not. Offering assistance to the carer has to be done very sensitively, respectfully and one step at a time. Some older people could resent strangers coming into their home and 'doing their job'. They could see it as their final failure to manage their life, as a sign of incompetence, as a threat of separation between them and the person they care for or as the loss of their role in life. It is important to clarify to your client that your intention is to keep them at home for as long as possible and to support them only when and where required.

In supporting the carer one needs patience to allow the carer time to accept help that has previously been rejected.

Sometimes the carer needs support to accept that regardless of their promises to the person they care for and guilt feelings, a time could come when the best option is to utilise residential aged care or other alternate accommodation options.

## **“DOING NOTHING” IS STILL DOING SOMETHING**

“Doing nothing” doesn't mean ignoring the situation and regarding it as not your responsibility; It is a response that should be considered rather than treating it as a failure to address a situation and hope it goes away or somebody else deals with it. There may be occasions when the most appropriate response is to choose not to act immediately but rather to continue monitoring the situation. It is better for a service to stay in a client's life so they can watch out for developments and be available for support or if asked for help. When the service is being seen as overstepping the fine line their service could be discontinued, thus leaving the client isolated.

It is very important for ground staff to make good records of observations and concerns and for having a constant dialogue with the management. As mentioned above, doing nothing should be a considered response that may be more accurately described as monitoring a situation in anticipation of further developments or identifying the most appropriate response in a non-emergency situation.

## RESOURCES TO ASSIST WITH THE APPLICATION OF THE PROTOCOL

It is useful for protocols to include resources to assist staff in the application of the document to their daily routines. Below are some resources that might be useful for your agency.

- Case studies – a sample of case studies can be included in the Protocols to clarify the appropriate response to various situations, specific to your workplace. You could include cases that your organisation has previously experienced and that clearly demonstrate the operation of your organisation's policies and procedures.
- Other policies, procedures and protocols – references to other relevant organisational policies, procedures and protocols.
- Information about other relevant organisations.
- Frequently asked questions – a series of questions that staff often ask, with short answers, will help staff to quickly see the application of the protocol to their daily jobs.
- Tick and flick sheets – will help staff to appropriately document their concerns and actions to ensure they protect the interests of their clients while also meeting their obligations to the organisation.
- “Who can make Health Care decisions in Queensland?” chart – see appendix C
- “Pathways for addressing elder abuse” chart.



## GLOSSARY

**Power of attorney:** is a document made by a person, with capacity (the principal), that authorises another person to make only financial decisions on their behalf. A power of attorney operates ONLY while the principal has capacity to make financial decisions.

**Enduring power of attorney:** is a document made by a person, with capacity (the principal), that authorises one or more persons to make financial and/or personal and health decisions on their behalf. An enduring power of attorney continues when the principal loses capacity. An attorney's power for personal matters may only begin after the principal has lost the capacity to make decisions about personal matters. An attorney's power for financial matters begins immediately when the document is made unless the form states otherwise.

**Adult Guardian:** is a statutory officer charged with protecting the rights and interests of adults with impaired capacity. This means that the Adult Guardian is a position created by a law and is not a government employee. The Adult Guardian answers to Parliament and may only be removed by the Governor General. The Adult Guardian has specific powers and functions under the law, which include acting as guardian for adults when appointed by QCAT. The Adult Guardian's other functions include investigating allegations of abuse, neglect and exploitation of adults with impaired capacity; making representations on behalf of adults with impaired capacity; educating about guardians, administrators, powers of attorney and enduring powers of attorney; acting as a personal attorney when appointed under an enduring power of attorney; mediating between attorneys, or between guardians or attorneys and health providers; and acting as statutory health attorney of last resort (s175 GAA) For more information visit: [www.justice.qld.gov.au](http://www.justice.qld.gov.au)

**Public Trustee:** is a statutory officer with many functions relating to financial matters only. The Public Trustee may be appointed as an administrator by QCAT to manage some or all of an adult's financial affairs. The Public Trustee's other functions include acting as a financial attorney under an enduring power of attorney; making wills and enduring powers of attorney; managing payouts made to people following accidents and injuries; managing the financial affairs of minors; acting as executor of wills and managing the estates of people who die without a will (i.e. intestate). For more information visit [www.pt.qld.gov.au](http://www.pt.qld.gov.au)

**Qld Civil and Administrative Tribunal (QCAT)** – Its roles include the appointing of guardians and administrators; making declarations of capacity; making declarations about enduring documents including their validity; giving advice or directions to attorneys, guardians and administrators; consenting to the withholding or withdrawal of life-sustaining measures; consenting to special health care; approving the use of restrictive practices and consenting to the sterilisation of a child.

For more information visit: [www.qcat.qld.gov.au/guardianship-qcat-decisions-about-adults.htm](http://www.qcat.qld.gov.au/guardianship-qcat-decisions-about-adults.htm).

**Guardian:** is a person appointed by the Qld Civil and Administrative Tribunal (QCAT) after an adult has lost capacity. A guardian may be appointed to make only some or all personal decisions on behalf of the adult.

**Administrator:** is a person appointed by the Civil and Administrative Tribunal (QCAT) after an adult has lost capacity. An administrator may only be appointed to make some or all financial decisions on behalf of an adult.

**Telephone and Interpreting Service (TIS) National** – TIS National is an interpreting service, provided by the Department of Immigration and Citizenship, for people who do not speak English and for the English speakers who need to communicate with them. TIS National has more than 30 years of experience in the interpreting industry, and has access to over 1900 contracted interpreters across Australia, speaking more than 170 languages and dialects. TIS National is available 24 hours a day, seven days a week for any person or organisation in Australia requiring interpreting services. It provides immediate telephone interpreting services, as well as pre-booked telephone and on-site interpreting. TIS National recommends that interpreters should be used to ensure accurate communication between people who have different language needs:

- because effective professional practice requires both parties to have a clear understanding of each other.
- because in times of crisis or stress, a person's second language competency may be affected.
- because all Australians have the right to access services freely available to English speaking Australians – irrespective of their ethnic background and first language preference.

Interpreting tasks are assigned to contracted interpreters based on their accreditation standard, geographical location and availability. Priority is given to interpreters with National Accreditation Authority for Translators and Interpreters (NAATI) professional accreditation or recognition when allocating assignments.

Requests can also be made for male and female interpreters in sensitive or gender-specific interpreting assignments.

**TIS National general Telephone: 131 450**

**Doctors Priority Line 1300 131 450** – medical practitioners, specialists and pharmacists can register for this free telephone interpreting service which operates 24 hours a day, seven days a week

For more information visit the Department of Immigration and Citizenship website:  
[www.immi.gov.au/living-in-australia/help-with-english](http://www.immi.gov.au/living-in-australia/help-with-english)

## APPENDIX A UNITED NATIONS PRINCIPLES FOR OLDER PERSONS

To add life to the years that have been added to life, the United Nations General assembly adopted the following Principles for Older Persons on 16th December 1991 (Resolution No.46/91).

### I) Independence

1. Older Persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family & community support and self-help.
2. Older persons should have the opportunity to work or to have access to other income-generating opportunities.
3. Older persons should be able to participate in determining when and at what pace withdrawal from the labour force takes place.
4. Older persons should have access to appropriate educational and training programs.
5. Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
6. Older persons should be able to reside at home for as long as possible.

### II) Participation:

7. Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
8. Older persons should be able to speak and develop opportunities for service to the community and serve as volunteers in positions appropriate to their interests and capabilities.
9. Older persons should be able to form movements or associations of older persons.

### III) Care:

10. Older persons should benefit from family and community care and protection in accordance with each society's systems or cultural values.
11. Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.
12. Older persons should have access to social and legal services to enhance their autonomy, protection and care.
13. Older persons should be able to utilise appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a human and secure environment.
14. Older persons should be able to enjoy human rights and fundamental freedoms when residing in shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

### IV) Self-Fulfilment:

15. Older persons should be able to pursue opportunities for the full development of their potential.
16. Older persons should have access to the educational, cultural, spiritual and recreational resources of society.
17. Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.
18. Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and valued independently of their economic contribution.

"People are created to give something back to the world. The best way to solve problems is to work together with compassion towards betterment of human life through helping improve the quality of all individuals".

## APPENDIX B

### CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

For the full convention visit the following website:  
<http://www.un.org/disabilities/convention/conventionfull.shtml>

#### Article 1 - Purpose

The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

#### Article 3 - General principles

The principles of the present Convention shall be:

- a. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
- b. Non-discrimination;
- c. Full and effective participation and inclusion in society;
- d. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- e. Equality of opportunity;
- f. Accessibility;
- g. Equality between men and women;
- h. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

#### Article 5 - Equality and non-discrimination

1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.
2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.
3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.

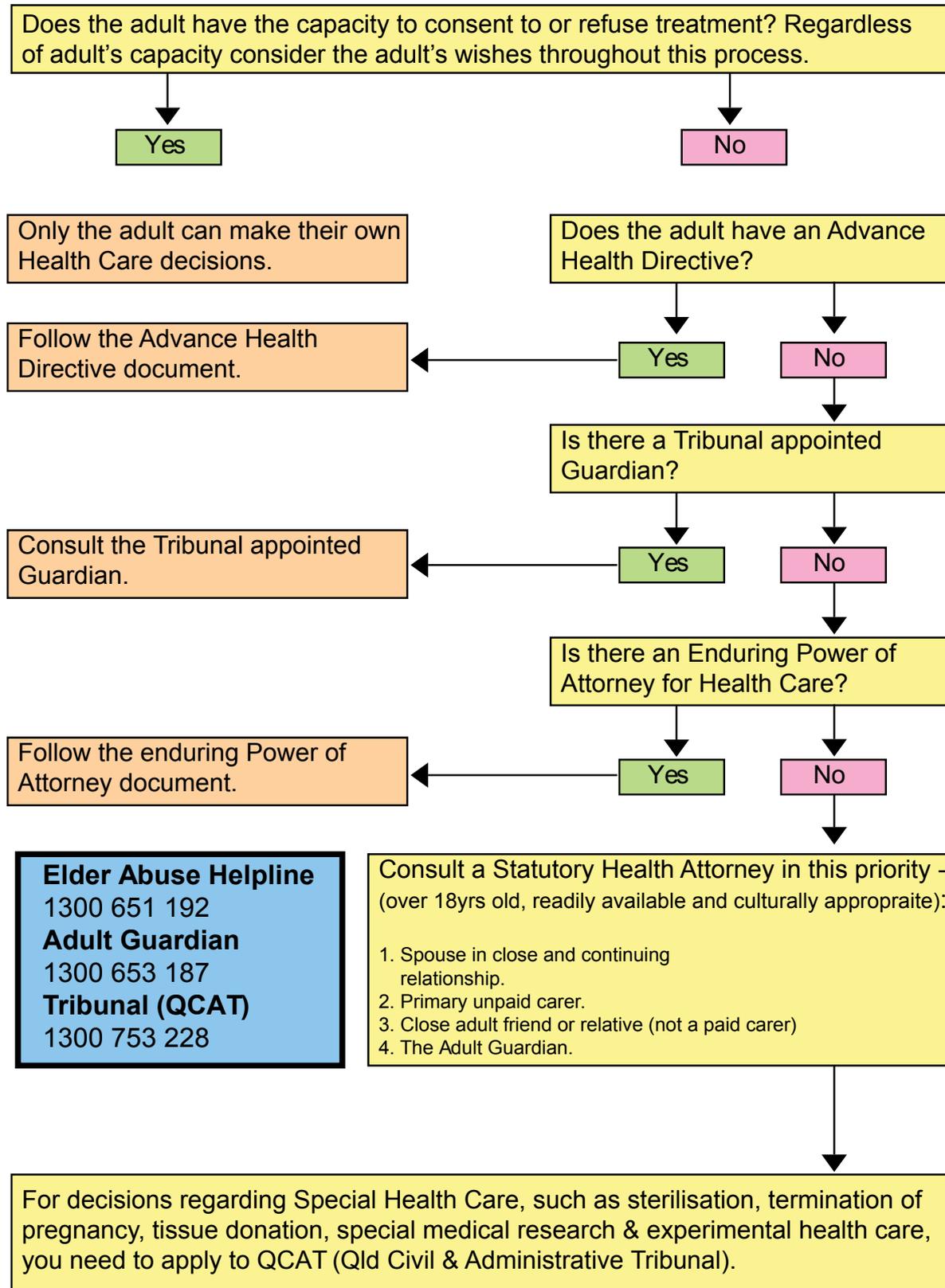
4. Specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.

#### Article 16 - Freedom from exploitation, violence and abuse

1. States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.
2. States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive.
3. In order to prevent the occurrence of all forms of exploitation, violence and abuse, States Parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities.
4. States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.
5. States Parties shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

## APPENDIX C

### WHO CAN MAKE HEALTH CARE DECISIONS IN QLD?



This flowchart is a visual representation of The Guardianship and Administration Act 2000, Chapter 5 (Health matters and special health matters) Division 2 (Health care and special health care – consent) sections 65 and 66.

It is also recommended to refer to the following section of the act

### **Health care principle (when making a decision)**

Copied from Guardianship and Administration Act 2000 (Schedule 1, Part 2 Section 12)

- (1) The **health care principle** means power for a health matter, or special health matter, for an adult should be exercised by a guardian, the adult guardian, the tribunal, or for a matter relating to prescribed special health care, another entity—
- (a) In the way least restrictive of the adult's rights; and
  - (b) Only if the exercise of power—
    - (i) Is necessary and appropriate to maintain or promote the adult's health or wellbeing; or
    - (ii) Is, in all the circumstances, in the adult's best interests.

Example of exercising power in the way least restrictive of the adult's rights— If there is a choice between a more or less intrusive way of meeting an identified need, the less intrusive way should be adopted.

- (2) In deciding whether the exercise of a power is appropriate, the guardian, the adult guardian, tribunal or other entity must, to the greatest extent practicable—
- (a) Seek the adult's views and wishes and take them into account; and
  - (b) Take the information given by the adult's health provider into account.
- (See section 76 of the G&A Act 2000 re Health providers to give information).
- (3) The adult's views and wishes may be expressed—
- (a) Orally; or
  - (b) In writing, for example, in an advance health directive; or
  - (c) In another way, including, for example, by conduct.
- (4) The health care principle does not affect any right an adult has to refuse health care.
- (5) In deciding whether to consent to special health care for an adult, the tribunal or other entity must, to the greatest extent practicable, seek the views of the following person and take them into account—
- (a) A guardian appointed by the tribunal for the adult;
  - (b) If there is no guardian mentioned in paragraph (a), an attorney for a health matter appointed by the adult;
  - (c) If there is no guardian or attorney mentioned in paragraph (a) or (b), the statutory health attorney for the adult.

This document is based on the Qld Guardianship and Administration Act 2000 and Powers of Attorney Act 1998. While every effort was made to verify its accuracy, the eapu recommends contacting the guardianship areas listed. Updated versions and other resources will be made available from time to time on the eapu website [www.eapu.com.au](http://www.eapu.com.au). Feedback and resource/service requests are welcome via the website.

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## APPENDIX D

### General Principles

(Guardianship and Administration Act 2000 (Qld) s.11, Schedule 1; Powers of Attorney Act 1998 (Qld) s.76, Schedule 1.)

Queensland's guardianship legislation requires that people who make decisions for adults with impaired capacity need to apply the following 11 principles:

#### 1. Presumption of capacity

An adult is presumed to have capacity for a matter

#### 2. Same human rights

- (1) The right of all adults to the same basic human rights regardless of a particular adult's capacity must be recognised and taken into account.
- (2) The importance of empowering an adult to exercise the adult's basic human rights must also be recognised and taken into account.

#### 3. Individual value

An adult's right to respect for his or her human worth and dignity as an individual must be recognised and taken into account.

#### 4. Valued role as member of society

- (1) An adult's right to be a valued member of society must be recognised and taken into account.
- (2) Accordingly, the importance of encouraging and supporting an adult to perform social roles valued in society must be taken into account.

#### 5. Participation in community Life

The importance of encouraging and supporting an adult to live a life in the general community, and to take part in activities enjoyed by the general community, must be taken into account.

#### 6. Encouragement of self-reliance

The importance of encouraging and supporting an adult to achieve the adult's maximum physical, social, emotional and intellectual potential, and to become self-reliant as practicable, must be taken into account.

#### 7. Maximum participation, minimal limitations and substituted judgment

- (1) An adult's right to participate, to greatest extent practicable, in decisions affecting the adult's life, including the development of policies, programs and services for people with impaired capacity for a matter must be recognised and taken into account.

(2) Also, the importance of preserving, to the greatest extent practicable, an adult's right to make his or her own decisions must be taken into account.

(3) So, for example:

(a) The adult must be given any necessary support, and access to information, to enable the adult to participate in decisions affecting the adult's life; and

(b) To the greatest extent practicable, for exercising power for a matter for an adult, the adult's views and wishes are to be sought and taken into account; and

(c) A person or other entity in performing a function or exercising a power under this Act must do so in the way least restrictive of the adult's rights.

(4) Also, the principle of substituted judgement must be used so that if, from the adult's previous action, it is reasonably practicable to work out what the adult's views and wishes would be, a person or other entity in the performing a function or exercising a power under this Act must take into account what the person or other entity considers would be the adult's views and wishes.

(5) However, a person or other entity in performing a function or exercising a power under this Act must do so in a way consistent with the adult's proper care and protection.

(6) Views and wishes may be expressed orally, in writing or in another way, including, by example, by conduct.

#### 8. Maintenance of existing supportive relationships

The importance of maintaining an adult's existing supportive relationships must be taken into account.

#### 9. Maintenance of environment and values

- (1) The importance of maintaining an adult's cultural and linguistic environment, and set of values (including any religious beliefs), must be taken into account.
- (2) For an adult who is a member of an Aboriginal community or a Torres Strait Islander, this means the importance of maintaining the adult's Aboriginal or Torres Strait islander culture and linguistic environment, and set of values (including Aboriginal tradition and Islander custom), must be taken into account.

#### 10. Appropriate to circumstances

Power for a matter should be exercised by a guardian for an adult in a way that is appropriate to the adult's characteristics and needs.

#### 11. Confidentiality

An adult's right to confidentiality of information about the adult must be recognised and taken into account.

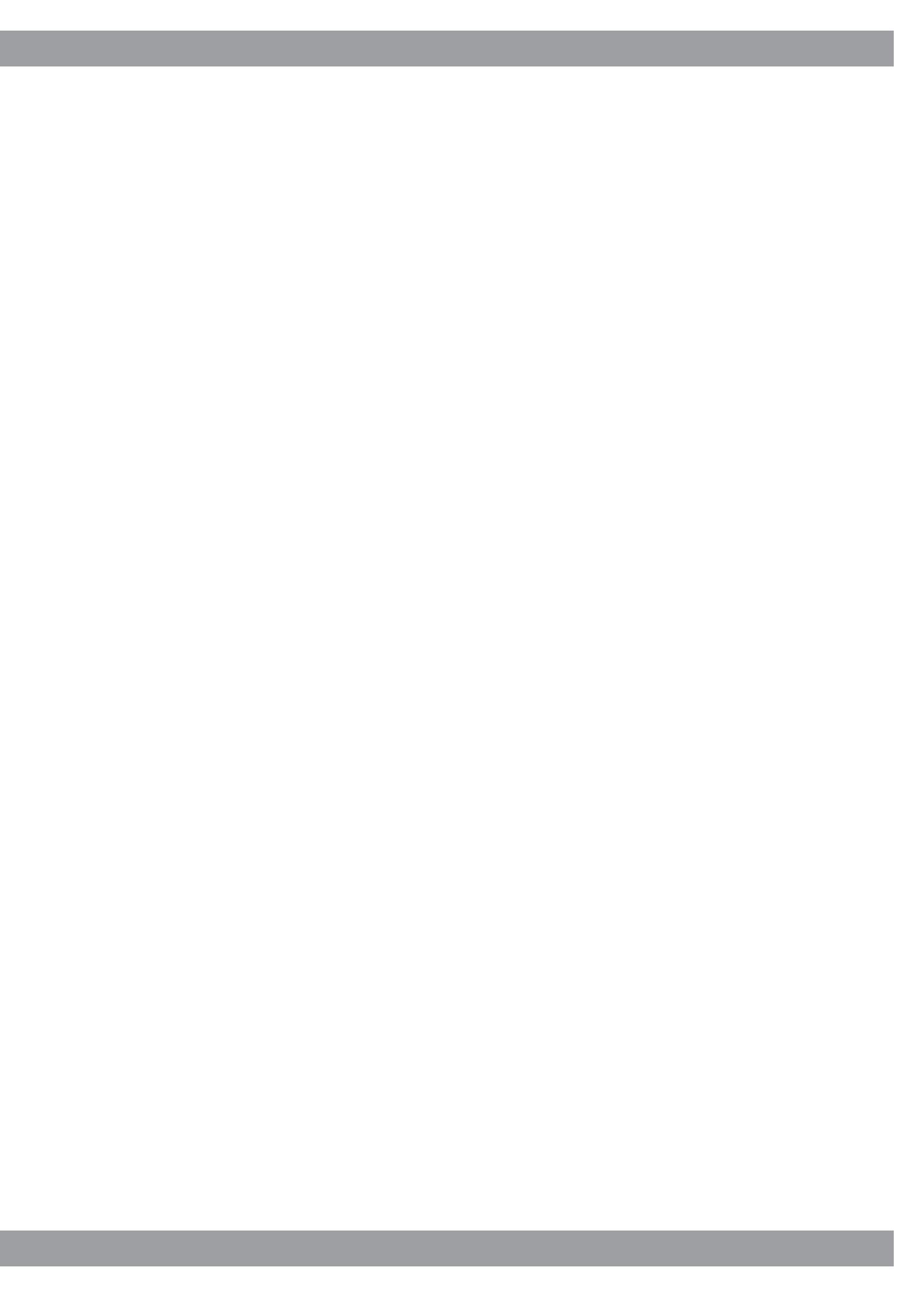
## APPENDIX E

ELDER ABUSE SUSPICION INDEX			
EASI Questions Q.1-Q.5 asked of patient; Q.6 answered by doctor Within the last 12 months:			
1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	yes	no	did not answer
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	yes	no	did not answer
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	yes	no	did not answer
4) Has anyone tried to force you to sign papers or to use your money against your will?	yes	no	did not answer
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	yes	no	did not answer
6) Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	yes	no	did not answer

The EASI was developed\* to raise a doctor's suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services, adult protective services, or equivalents. While all six questions should be asked, a response of "yes" on one or more of questions 2-6 may establish concern. The EASI was validated\* for asking by family practitioners of cognitively intact seniors seen in ambulatory settings.

\*Yaffe MJ, Wolfson C, Lithwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI) ©. Journal of Elder Abuse and Neglect 2008; 20(3) 000-000. In Press. Haworth Press Inc: <http://www.HaworthPress.com>

© The Elder Abuse Suspicion Index (EASI) was granted copyright by the Canadian Intellectual Property Office (Industry Canada) February 21, 2006. (Registration # 1036459) Mark J.



# “Promoting the right of older people to live free from abuse.”

## Elder Abuse Prevention Unit Contact Details

### Helpline

1300 651 192

### Interstate

P: 07 3867 2525

E: [eapu@uccommunity.org.au](mailto:eapu@uccommunity.org.au)

W: [www.eapu.com.au](http://www.eapu.com.au)

### Mailing Address

P O Box 2376 Chermside  
Central Qld 4032

The **Elder Abuse Prevention Unit (EAPU)** is a Queensland wide program provided by UnitingCare Community and funded by the Queensland Department of Communities. The EAPU works from a Human Rights perspective and provides:

- **A Helpline** (1300 651 192) for information, support and referrals to people who experience, witness or suspect elder abuse.
- **Training** for service providers and vocational studies students (free for community based and educational institutions).
- **Awareness Raising and Information Sessions** for community groups, to raise awareness of elder abuse and promote preventative strategies (free).
- **Peer Support Network (PSN)** for rural and remote workers; providing opportunities to participate in free professional training through teleconferences, information updates, newsletters etc.
- Data collection and research
- **Network participation and support** for service providers in communities and multicultural groups seeking to address elder abuse.



**Elder Abuse Prevention Unit**

UnitingCare Community Values  
Compassion | Respect  
Justice | Working Together  
Leading through Learning

UnitingCare Community Services  
Lifeline | Child and Family Care  
Counselling | Crisis Support  
Disability Support | Social Inclusion