



Government of **Western Australia**
Department of **Health**

Guideline:

Responding to the Abuse of Older People (Elder Abuse)

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- Alliance for the Prevention of Elder Abuse WA (APEA:WA)
- Carer representative, North Metropolitan Health Service
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- Legal Aid WA
- Legal and Legislative Services, WA Health
- Neurosciences Unit, WA Health
- Office of the Public Advocate
- Older Adult Mental Health Sub Network Steering Group
- Older People's Rights Service
- Public Trustee
- State Administrative Tribunal
- WA Aged Care Advisory Council
- WA Centre for Health and Aging
- WA Country Health Service, Aged Care
- WA Country Health Service, Policy Development
- WA Local Government Association
- WA Network Prevention of Elder Abuse (WANPEA)
- WA Police

INTRODUCTION

Responding to elder abuse

This guideline has been developed in conjunction with the *Policy Responding to the Abuse of Older People (Elder Abuse)*, to assist Health Service Providers in the development of procedures in regards to identifying, assessing, supporting, referring and documenting elder abuse. It addresses the role of health professionals in responding to elder abuse to ensure that health services support older people at risk.

The Guideline aims to assist Health Professionals in:

- ⇒ raising awareness of elder abuse
- ⇒ identifying elder abuse
- ⇒ supporting and empowering those clients experiencing elder abuse
- ⇒ determining the safety of clients at risk of elder abuse
- ⇒ outlining appropriate referral pathways and support tools
- ⇒ ensuring the safety and wellbeing of both clients and WA Health staff.

Key points:

Elder abuse has a range of physical, psychological and financial consequences that can result in pain, injury and even death. It is associated with higher levels of stress and depression and an increased risk of nursing home placement and hospitalisation.¹ Elder abuse has been associated with many forms of psychological distress and increased mortality in its victims²

Elder abuse can be physical, sexual, financial, psychological or social abuse and can also be the result of intentional or unintentional neglect.³ The majority of elder abuse is intergenerational, with adult sons and daughters the most likely perpetrators.⁴ Both older men and older women are at risk of being abused, although older women are significantly more likely to be victims than older men (in part reflecting their greater representation in the older population).⁵ Research indicates that elder abuse occurs most often in a familial context.⁶ However, it can occur in other situations including Residential Aged Care Facilities (See Appendix C).

In 2011, the average prevalence rate of Elder Abuse for Western Australia was calculated to range between 3.1% and 6.0%, accounting for an estimate of approximately 12,500 victims.⁷ Figures show that the Western Australian population is ageing at a rate faster than the overall population is increasing.⁸ It is anticipated that the total number of victims over the age of 65 will increase by around 90% over the next twenty years, or approximately 24,000 victims. Without systematic intervention, Western Australia can expect the size of the elder abuse problem to almost double in the next two decades.⁹

Individuals who experience violence and abuse seek care from health professionals far more often and for a greater range of health problems than individuals who have not experienced abuse. Further, older people are significant users of health and disability support services. Health professionals are therefore in an ideal position to engage in early identification, support and referral of persons experiencing elder abuse.

¹ Kaspiew, R., Carson, R., & Rhoades, H. (2016). *Elder abuse: Understanding issues, frameworks and responses*. Melbourne: Australian Institute of Family Studies

² Clare, Mike, Barbara Black Blundell, and Joseph Clare. "Examination of the Extent of Elder Abuse in Western Australia." (2011).

³ Elder Abuse in New South Wales, 2016, Sydney, NSW, Legislative Council: General Purpose Standing Committee No.5

⁴ *Elder Abuse Protocol: Guidelines for Action*, 2018. Alliance for the Prevention of Elder Abuse: Western Australia

⁵ Kaspiew, Rae, Rachel Carson, and Helen Rhoades. 2016. *Elder Abuse*. Melbourne: Australian Institute of Family Studies.

⁶ Kaspiew, Rae, Rachel Carson, and Helen Rhoades. 2015. *Elder Abuse*. Melbourne: Australian Institute of Family Studies.

⁷ *Elder Abuse National Annual Report 2013-2014*. 2015. [Belmont, WA]: Advocare Incorporated.

⁸ Clare, Mike, Barbara Black Blundell, and Joseph Clare. "Examination of the Extent of Elder Abuse in Western Australia." (2011).

⁹ Clare, Mike, Barbara Black Blundell, and Joseph Clare. "Examination of the Extent of Elder Abuse in Western Australia." (2011).

A STEP BY STEP SUMMARY

Step 1: Identify

1. Address primary concerns of the client.
2. Attend to any medical issues that require immediate attention.
3. Be aware of factors that increase the risk or likelihood of an older person being abused.
4. Look for possible signs of abuse.
5. If you suspect a client is being abused, or if indicators suggest they are at risk, ask suggested screening questions.

GO to STEP 2

Step 2: Assess

1. Determine if client has decision making capacity. If not, does client have a substitute decision maker to act in their best interests? If suspected perpetrator is the substitute decision maker (SDM) then may need referral to State Administrative Tribunal for appointment of alternative SDM.
2. Assess risk factors.
3. Identify what protective factors are in place e.g. what other support services are currently involved with the family? Is regular respite for client and/or carer in place?

Telephone advice from the Elder Abuse Helpline (1300 724 679) may be helpful during preliminary risk assessment and can assist with referral decision-making.

GO to STEP 3

Step 3: Support and Referral

1. Identify what action is required to address their immediate safety.
2. Discuss options with client.
3. Where appropriate provide written and verbal information about elder abuse and services available in your area.
4. Where appropriate make referrals to external agencies.
5. Schedule a follow-up appointment if appropriate.
6. Consult with Line Manager.

If it is suspected that a possible crime may have been committed, for example, theft, fraud, neglect, sexual or physical assault, involving the police should be discussed and documented.

GO to STEP 4

Step 4: Document

1. Document clear and relevant evidence of abuse. Ensure accurate and objective recording of issues, information and observations.
2. Document intervention plans discussed with client/SDM. Document consent to plans.
3. Document outcome and referrals made in client records.

Be aware that records can be subpoenaed to court. Documents may be accessible under FOI to a person who has an appropriate interest.

STEP 1: IDENTIFY

1. Address primary concerns of the client
2. Attend to any medical issues that require immediate attention
3. Be aware of factors that increase the risk or likelihood of an older person being abused (see APPENDIX A: RISK FACTORS)
4. Look for possible signs of abuse (see APPENDIX B: POSSIBLE SIGNS OF ABUSE)
5. If you suspect a client may be a victim of elder abuse, or if indicators suggest they are at risk, direct questions should be asked to further ascertain their risk.

The following are useful screening questions:^{10 111213}

- *Are you alone a lot?*
- *How do you feel your (husband/son/daughter/other caregiver) is managing?*
- *Has anyone recently failed to help you or take care of you when you needed help?*
- *Are you afraid of anyone at home?*
- *Has anyone recently taken anything that was yours without your consent?*
- *Has anyone recently made you do things you didn't want to do?*
- *Have you recently signed any documents that you didn't understand?*
- *Has anyone recently threatened you?*
- *Has anyone at home ever hurt you?*
- *Has anyone recently touched you without consent?*

Considerations

Clients may not readily talk about their experience of elder abuse, but may discuss it when asked simple, direct questions in a non-judgemental manner and in a confidential setting. It is important to gain a client's trust through patience and support and to be open and honest to what can or cannot be done to assist them.

Do not talk to the client in the presence of the person suspected of the abuse. Ideally interview the client alone.

When talking to an older person about the abuse they are experiencing it is important to respond in the following way:

- be supportive – listen, believe and validate their experience
- give assurance of confidentiality and the limits
- provide reassurance that they are not at fault and that no one deserves abuse
- let them know they are not alone, that help is available. Provide information about how to get assistance
- provide information about help available for the abuser, such as drug and alcohol

¹⁰ RACGP, Elder Abuse Suspicion Index (EASI) <http://www.racgp.org.au/your-practice/guidelines/whitebook/tools-and-resources/6-elder-abuse-suspicion-index/>

¹¹ Elder Abuse Prevention Strategy, Policy Document, Office of Senior Victorians, 2011

¹² Family Violence Intervention Guidelines, Elder Abuse and Neglect, Ministry of Health, New Zealand, 2007

¹³ With Respect to Age: Victorian Government practice guidelines for health services and community agencies for the prevention of elder abuse, Aged Care Branch, Department of Human Services, Victorian Government, 2009

- or mental health services, respite, carer support or counselling
- inform them about the support you can offer now and in the future and follow up as agreed.

When responding to urgent medical issues related to intimate partner violence, refer to the [Guideline for Responding to Family and Domestic Violence](#) .

If there are any concerns in relation to clients' mental health, consult with your clinical supervisor or Treating Doctor for referral to appropriate and available services including General Practitioners.

STEP 2: ASSESS

1. **Determine if client has decision making capacity** (see Additional Information below). If it is determined that the client does not have decision making capacity, establish who can provide consent and request consent. Please note, if the suspected perpetrator is the guardian or enduring guardian, then legal intervention may be needed for an alternative substitute decision- maker. This would be done by applying to the State Administrative Tribunal (SAT).
2. **Assess risk.** Health professionals are responsible for conducting a preliminary risk assessment with person's possibly experiencing abuse in order to ascertain the likely level of immediate risk for the older person, make appropriate referrals and to help reduce the risk of further abuse. The safety, wellbeing and rights of the older person must always be the main focus.

Consider the following risk factors:

- Is there evidence of life-threatening injuries or danger of significant harm, death or homicide?
- Is there a risk of suicide or self-harm from the alleged abuser or abused?
- Is the alleged abuser present?
- Is the person afraid to go home or be left alone?
- Is the person unable to defend or care for themselves if left alone?
- Has a threat to kill or harm the abused person been made?
- Has any physical abuse increased in severity and/or frequency?

Other factors to consider:

- Is alcohol or substance abuse involved (by either the alleged abuser or abused)?
 - The client's assessment of their current level of safety i.e. is the client afraid to go home or to be left alone?
 - Identify if there are any other family members or carers who are at risk.
3. Identify **protective factors** e.g. what other support services are currently involved with the family? Is regular respite for client and/or carer in place? Is support available from other family members or friends?

Telephone advice from the Elder Abuse Helpline (1300 724 679) may be helpful during preliminary risk assessment and can assist with referral decision making.

Refer to the hospital or health service social worker who will assist with the assessment, coordination and planning to manage concerns regarding elder abuse.

Considerations

Risk of suicide or serious self-harm, consult with:

- Clinical supervisor; or
- Treating Doctor for referral to appropriate and available services including General Practitioners.

Additional Information

Assessing client's decision making capacity

Within the WA health system, appropriately qualified medical practitioners or other staff assesses decision-making capacity on a case-by-case basis depending on circumstances and access to resources. Refer to your relevant health services policies and procedures to assess decision making capacity e.g. Geriatrician, Psycho-geriatrician, Psychiatrist, Neurologist, Neuropsychologist, GP etc. The Kimberley Indigenous Cognitive Assessment (KICA) is also available as a validated cognitive screening tool for older Indigenous Australians living in rural and remote areas.

If a client's decision-making capacity is in dispute, they may need to be referred to the State Administrative Tribunal. Social Workers are often involved in facilitating this process. In cases where the older person has impaired decision-making capacity and you are aware that they have a legally appointed decision-maker (e.g. enduring power of attorney, guardian, enduring guardian, or administrator) it may be appropriate to discuss the situation with the relevant person. If you suspect a client's substitute decision maker is not acting in their best interest (e.g. suspected abuser), refer to the Office of Public Advocate for advice. See **APPENDIX D: FLOWCHART** for more details.

STEP 3: SUPPORT AND REFERRAL

Develop a care plan to ensure a client's immediate safety and prevent further abuse. Consider the following:

1. Has a possible crime been committed (for example, sexual or physical assault, theft, fraud, neglect), in which case involving the police should be discussed. Health professionals are not required to undertake an investigation into the suspected abuse as this is the responsibility of the WA Police Service.
2. Identify actions required to address the person's immediate safety. Suggested interventions include:
 - Crisis response e.g. admission to hospital, urgent respite care in a residential aged care facility
 - Safety planning (see **APPENDIX F: SAFETY PLANNING** for more information)
 - Legal intervention e.g. police involvement, support obtaining a Family Violence Restraining Order, application for guardianship or administration.
 - Provision of community support services e.g. day care, community care services, carer supports, Meals on Wheels etc.
 - Provision of respite e.g. in-home respite, day-centre respite, residential aged care facility
 - Counselling
 - Alternative permanent accommodation (for either the abuser or victim)
3. If safe to do so, provide written and verbal information where appropriate about elder abuse and services available in your area. See **APPENDIX E: USEFUL CONTACTS** for information on support services. Encourage clients to engage with other services for follow up support and/or counselling. Where appropriate make referrals to external agencies and schedule a follow-up appointment.
4. Consult with Line Manager and when available the health service social worker.

If a client does not disclose they are being abused, and it is suspected, where appropriate provide verbal and written information about appropriate support services, discuss a safety plan with them and offer the option of returning for another appointment. Ensure their suspected non-disclosure is documented clearly in the written record, along with any plans for follow-up that were initiated.

If the older person refuses any intervention and is considered to have decision-making capacity, their decisions and choices must be respected. Educate and support the older person, as required. Where appropriate provide verbal and written information regarding elder abuse and available services. Sometimes this must be done discretely to avoid alerting the abuser and causing negative repercussions for the older person. Continue to monitor the intervention if possible, and follow up as required.

While it is preferable that referrals are made with the client's consent, this may be overridden by the health professional's duty of care to ensure immediate safety of the client.

Considerations

Risk of safety or where immediate protection is required, consider referrals to:

- [Local Police services](#)
- [Refuge/emergency accommodation](#)
- [Domestic violence services](#)

Risk of suicide or serious self-harm, consult with:

- Clinical supervisor; or
- Treating Doctor for referral to appropriate and available services including General Practitioners.

WACHS staff:

For clients identified as high risk of suicide or serious self-harm WACHS staff must:

- Alert Senior Medical Officer immediately, for prompt assessment for consideration of referral under the [Mental Health Act](#).
- Alert community mental health team/ [RuralLink](#) (Free call 1800 552 002 – TTY 1800 720 101)
- Provide safe environment for client or others.

Additional Information

Prepare a list of local services and information – see **APPENDIX E: USEFUL CONTACTS**.

STEP 4: DOCUMENTATION

1. Document outcome and referrals made in client records.
2. Document intervention plans discussed and approved by client/SDM including evidence of Enduring Power of Attorney, Enduring Power of Guardianship or Advance Health Directive.
3. Ensure accurate and objective recording of issues, information and observations. Use verbatim where possible. Be aware that records can be subpoenaed to court or subjected to a Freedom of Information request.

Considerations

Confidentiality, Information Sharing and Exceptions

Older people and their caregivers should be advised that the health care team will treat their health information in confidence, including information shared during discussions and also the content of their medical records. However, they should also be advised there are some limits to confidentiality, such as where the law requires health professionals to provide a person's health information to third parties.

If you believe that you may need to share the patient's confidential information with third parties such as other agencies, explain this to the patient or caregiver (as appropriate) and seek their consent where possible.

Health professionals have a duty to maintain the confidentiality of all information that is directly or indirectly acquired, created or disclosed to them in the course of providing treatment or care to patients. This duty arises under common law, statute (such as the Health Services Act 2016), and in equity, and it underpins the therapeutic relationship between the health professional and patient.

This duty extends to other persons who come into contact with the information as part of the delivery of health care to the patient, including workers performing non-clinical duties.

There are a number of **exceptions** to the duty of patient confidentiality. Where an exception applies, information that is otherwise confidential may or must, as relevant, be disclosed to third parties.

These exceptions include where disclosures are made that are consistent with:

- (i) consent to disclosure given by the patient or their representative;
- (ii) a law which requires disclosure (such as a valid subpoena or court order);
- (iii) a law which permits disclosure (including disclosures that are permitted under the Health Services Act 2016 and Children and Community Services Act 2004);
or
- (iv) a 'public interest' exception which justifies disclosure to an appropriate person or authority. For more information, contact WA Health Legal and Legislative Services.

As above, confidential patient information may be disclosed to a third party if the patient has given his or her consent to that disclosure and the disclosure is made in accordance with the terms of that consent (for example, consent should clearly cover what information may be disclosed to whom). Where an adult patient does not have the capacity to consent to the disclosure of their confidential information, another person may be able to make the decision on their behalf. Generally speaking the appropriate person to consent to the disclosure of their confidential information will be either their Guardian or their Enduring Guardian.

However please note that the [Children and Community Services Act 2004](#) (Part 3, Division 6 'Information Sharing') was amended in 2014 and enables the exchange of relevant client information to authorised entities and prescribed authorities without a client's consent if the information is, or is likely to be, relevant to the:

- (i) wellbeing¹⁴ of a child or a class a group of children; or
- (ii) the safety of a person who has been subjected to, or exposed to, family and domestic violence.

[Patient Confidentiality Policy](#), WA Health, 2016

¹⁴ The wellbeing of a child includes: (a) the care of the child; (b) the physical, emotional, psychological and educational development of the child; (c) the physical, emotional and psychological health of the child; (d) the safety of the child.

APPENDIX A: RISK FACTORS

The causes of elder abuse are both complex and concealed. However, there are several factors that increase the risk of an older person being abused¹⁵. The existence of more than one of these factors places a person at higher risk of abuse. Key risk factors include: carer stress, family conflict, isolation, dependency, cognitive impairment and addictions.

Dependency

Vulnerability is increased when an older person depends on others for social, emotional, physical, financial and spiritual support. This dependency may hinder the person leaving the abusive situation or reporting the situation. Some perpetrators of abuse, who are dependent on the person they care for, may feel trapped or powerless and perpetrate abuse because of frustration or fear. Whilst clients who are abused are often dependent on others for all or part of their day-to-day care, the perpetrator of the abuse may also be dependent on the person in order to meet their own physical, psychological, social, emotional or financial needs.¹⁶

Isolation

Isolation renders older people more vulnerable to psychological, emotional, financial and physical abuse. Isolation also results in the abusive behaviour being less likely to be discovered and therefore perpetuated due to the absence of social and other networks around the older person. Caregivers, family members and potential victims who lack substantial social networks experience increased demand on a limited number of caregivers increasing stress and risk of elder abuse. This may lead to further isolation as both victims and perpetrators may avoid further social interactions out of shame or fear of discovery.

Family conflict

Abuse can be a continuation of domestic or family violence that re-emerges as abuse in the caring situation. Similarly, a child who was previously abused may now be a primary carer and repeat the cycle of abuse to a dependent parent or child. The association between experiences of elder abuse and previous traumatic events, including family and domestic violence, and child abuse is evident and suggests elder abuse reflects the perpetuation of complex familial dynamics. In some families violence is considered the normal reaction to stress, and it may continue from generation to generation. People are also at risk when two or more generations live together and intergenerational conflict exists.¹⁷

Cognitive impairment or other disability

Cognitive impairment and other forms of disability have a strong association with an older person being vulnerable to elder abuse. In particular, if a victim has dementia they are more at risk of experiencing financial abuse.

Addictions

Alcohol, prescription or illicit drug use, or gambling addictions on the part of the older person, family members or carer, may increase the risk of abuse and can contribute to family violence.

Carer stress

Caring for a person who is frail or who has special needs can be stressful. Carer stress, especially when other risk factors such as dependency, social isolation and substance abuse are present, can result in the carer's inability to cope with the needs and wishes of the older person,

¹⁵ *Australian Society for Geriatric Medicine, Position Statement No. 1, Elder Abuse, 2003*

¹⁶ Elder Abuse Prevention Unit, Uniting Care Community, <https://www.eapu.com.au/>

¹⁷ Elder Abuse Prevention Unit, Uniting Care Community, <https://www.eapu.com.au/>

resentment of the carer role and poor communication. A lack of other supports and services can also contribute to carer stress.

Language and cultural barriers

All other risk factors may be heightened by language and cultural barriers, including historical influences or immigration experience.

Perpetrator factors

Risk factors that may increase the risk of a person choosing to perpetrate abuse include mental health issues, alcohol and drug misuse, and being in a position of financial, emotional or relational dependence with the victim.

APPENDIX B: THE POSSIBLE SIGNS OF ABUSE

There are a range of indicators that may suggest a client is experiencing some kind of abuse or neglect. The presence of these indicators however, does not mean that abuse has taken place, but rather, should be used by staff to encourage further investigation. It is common for more than one type of abuse to occur in a situation, for example, psychological abuse commonly precedes or co-exists with other types of abuse¹⁸. Financial abuse is the most common form of abuse that older people experience¹⁹

Signs of financial abuse may include:

- There is an apparent inability to afford adequate food, clothing, housing, utilities or social activities
- Unusual activity in bank accounts
- No access to bank statements
- Not being able to pay normal accounts and having an accumulation of unpaid bills
- Fear, stress, and anxiety

Signs of neglect may include:

- Malnourishment and weight loss, hypothermia, overheating, or inappropriate clothing
- Injuries that have not been properly cared for
- Poor personal hygiene
- Abandoned or left alone for long periods
- Lack of social, cultural, intellectual, or physical stimulation
- Lack of safety precautions, or inappropriate supervision

Signs of emotional or psychological abuse may include:

- Shame
- Depression
- Confusion and social isolation
- Feelings of helplessness
- Unexplained paranoia
- Excessive fear
- Marked passivity or anger
- Anxiety

Signs of physical abuse may include:

- Discrepancies between an injury and the explanation of how the injury occurred
- The older person is described as 'accident prone' or has a history of injury, untreated injuries and multiple injuries, especially in various stages of healing
- Being seen by different doctors and hospitals/health services
- A delay in seeking care or reporting an injury

¹⁸ Elder Abuse Protocol: guidelines for action, APEA WA, 2018

¹⁹ Clare, Mike, Barbara Black Blundell, and Joseph Clare. "Examination of the Extent of Elder Abuse in Western Australia." (2011).

Signs of sexual abuse may include:

- Bruising around genitals
- Unexplained sexually transmitted infection
- Torn/stained/bloody underclothes
- Bruising on the inner thighs

Signs of social abuse may include:

- Sadness or grief at the loss of important relationships
- Withdrawal, listlessness, or lack of interaction with other people
- A lowering in self-esteem
- Appearing ashamed²⁰

²⁰ RACGP, Clinical Guidelines, Section 10.1 Elder abuse
<http://www.racgp.org.au/your-practice/guidelines/whitebook/chapter-10-specific-vulnerable-populations-the-elderly-and-disabled/section-101-elder-abuse/>

APPENDIX C: SPECIAL GROUPS

WA Health recognises that within the Western Australian population there are special groups that require special consideration in respect of the needs and treatment of individuals on presentation to WA Health Services.

A) OLDER ABORIGINAL PEOPLE

Considerations

Aboriginal people value an extended family and kinship system, and often have large families and kinship groups upon which they are able to draw support and assistance.

In assisting older Aboriginal people experiencing abuse it is important to apply a cultural understanding of Aboriginal health and wellbeing, to consider the cultural and social determinants impacting the individual and their community, and to understand the importance of consultation with family, community members and Aboriginal organisations.

Aboriginal men and women can expect to live 15.1 years and 13.5 years less than non-Aboriginal men and women respectively²¹. In addition, the prevalence of dementia in Aboriginal people aged over 45 years is three to five times that of non-Aboriginal people²². Given the significantly earlier onset of ageing and dementia in Aboriginal people, an Aboriginal person is considered to be older from 50 years and over²³.

Aboriginal people also experience poorer health status and higher levels of socioeconomic disadvantage than non-Aboriginal people. Therefore the health care and support needs of older Aboriginal people differ from those of non-Aboriginal people, and the use of services occurs at both higher rates and younger ages²⁴.

A cultural understanding of Aboriginal health

Aboriginal health and wellbeing is not just the physical health of an individual. Cultural, country, spiritual, family and community connectedness are central to the health and wellbeing of an individual and that of the community in which they live. It is a holistic and whole of life view.

Inclusive of these elements, healthy ageing for Aboriginal people also incorporates maximising their independence, and having access to culturally secure aged care and palliative care services.

Cultural determinants originate from a strength-based perspective and acknowledge that stronger connections to culture and country build stronger individual and collective identities, a sense of self-esteem, resilience and improved outcomes in social determinants. Cultural determinants include self-determination, connection to land, freedom from discrimination, importance and value of Aboriginal culture, protection from removal or relocation and promotion of language and cultural practices.

²¹ Australian Bureau of Statistics. (2013). *Life Tables for Aboriginal and Torres Strait Islander Australians, 2010-2012*. Cat no. 3302.0.55.003. Canberra: ABS.

²² Flicker, L and Holdsworth, K. (2014). *Aboriginal and Torres Strait Islander People and Dementia: A Review of the Research*. A Report for Alzheimer's Australia, Paper 41, Oct 2014

²³ Australian Institute of Health and Welfare 2011. *Older Aboriginal and Torres Strait Islander people*. Cat. no. IHW 44. Canberra: AIHW.

²⁴ Australian Institute of Health and Welfare 2011. *Older Aboriginal and Torres Strait Islander people*. Cat. no. IHW 44. Canberra: AIHW.

Social determinants are the factors that affect Aboriginal people's lives, including their health and wellbeing, such as whether the person is working, feels safe in their community, has a good education and has financial security. Social determinants also affect the community as a whole.

By recognising that Aboriginal people have a holistic view of health and wellbeing, services can work together to better acknowledge and address the impact of the cultural and social determinates of health.

Responding to abuse of older Aboriginal people

Each case is unique and assumptions should not be made based upon previous experiences or situations. Asking questions, understanding and clarifying cultural and social determinants specific to the individual and their community, and listening to the wishes and perspectives of the older Aboriginal person impacted by abuse is critical to a successful intervention.

The older Aboriginal person's community will often have the capacity and be best placed to deal with the abuse issue, drawing upon existing community networks, strategies and local support services. Taking a holistic approach by working with the individual and their community can lead to both short and long term positive outcomes that in turn help strengthen the capacity and wellbeing of the community.

It is important to ensure that appropriate extended family and community members are included in meetings and decision making. Where the affected older Aboriginal person is capable of making an informed decision, they should be consulted and give their consent on which individuals are involved in any assistance and interventions.

The inclusion of an Aboriginal health worker during any assessment and examination of the older Aboriginal person is highly recommended.

In addition, it should be a priority to liaise and partner with Aboriginal Community Controlled Health Organisations (ACCHO) and Primary Health Care Services (PHCS) including GPs and community support services. These organisations can help provide social and other support services to the individual and their community.

Working with local PHCS and ACCHOs, Aboriginal staff and extended family members will assist with and contribute to the provision of culturally secure service delivery. If required, interpreting services should also be utilised to avoid any language barriers.

Adopting a culturally secure approach to working with older Aboriginal people who may be experiencing abuse requires programs and services to:

- Identify and respond to the cultural needs of Aboriginal people
- Work within a holistic framework that recognises the importance of connection to country, culture, spirituality, family and community
- Recognise and reflect on how these factors affect health and wellbeing
- Work in partnership with Aboriginal people, families, communities and organisations.

B) CULTURALLY AND LINGUISTICALLY DIVERSE (CaLD) BACKGROUNDS

Care should be taken in respect to providing service which is culturally competent and gender-appropriate to an individual's CaLD background.

Considerations

Language barriers

People who are not fluent in English are at increased risk of elder abuse due to the difficulties in gaining information about services available, challenges when navigating complex service systems and communicating their needs. It is also vital that interpreters be involved to build understanding and relationships between the worker and the client. **Family members and/or friends should not at any time act as the interpreter for the older person.**

Social isolation

Whilst not being fluent in English can increase an older person's isolation and vulnerability to elder abuse, this is exacerbated by migration and loss of informal support networks. Cultural traditions as well as a desire to keep private matters within the family may also be barriers to seeking help.

Family dynamics

In some cultures, family and community are especially important for older people. CaLD older people are more likely to live at home with family for longer than Australian born older people. There is also preference among CaLD older people to work through issues within the family as they are often their sole providers of support. This dynamic can result in reluctance to report or disclose information about the abuse inflicted upon them. Culturally and linguistically diverse (CaLD) older people may also fear loss of face in their community for reporting a family member to authorities, and that disclosure may bring shame to the entire family in the eyes of the community.¹

Other risk factors for CaLD older people experiencing elder abuse include:

- reduced access to information, particularly through advanced forms of technology such as the internet;
- lower education and economic status;
- unwillingness to disclose mistreatment or neglect because of social stigma;
- cross-generational factors resulting in differing expectations of care and support;
- lack of knowledge of Australian laws and services;
- lack of awareness of what constitutes elder abuse; and
- a strong preference for remaining in the community rather than moving into institutional care.

C) COMMONWEALTH FUNDED RESIDENTIAL AGED CARE FACILITIES (RACF) OR HOME CARE PACKAGES (HCP) IN THE COMMUNITY

A care recipient (with or without cognitive impairment) in a RACF or receiving a HCP has two pathways in relation to an allegation or suspicion of a reportable assault (physical/sexual) by another care recipient or staff member:

1. Care recipient or family member can report the alleged assault to the RACF or HCP Service Provider. Then the RACF/HCP Service Provider has a mandatory obligation to report this allegation to the Commonwealth Department of Health – see link <https://agedcare.health.gov.au/ensuring-quality/aged-care-quality-and-compliance/guide-for-reporting-reportable-assaults>

What is a reportable assault?

A reportable assault as defined in the Aged Care Act (section 63-1AA) means:

- unlawful sexual contact with a resident of an aged care home, or
- unreasonable use of force on a resident of an aged care home.

For further information contact the Commonwealth Department of Health on:

Compulsory reporting line: **1800 081 549**

Email: compulsoryreports@health.gov.au

2. If they are not comfortable with raising the allegation with the RACF or HCP Service Provider, the care recipient or family member can contact the Aged Care Quality and Safety Commission directly to lodge a complaint – see link <https://www.agedcarequality.gov.au/making-complaint/lodge-complaint>

For further information contact the **Aged Care Quality and Safety Commission on 1800 951 822.**

NOTE:

The Aged Care Quality and Safety Commission is an independent aged care regulatory body, responsible for the approval, accreditation, assessment, monitoring, compliance and complaints management for all Commonwealth subsidised aged care providers.

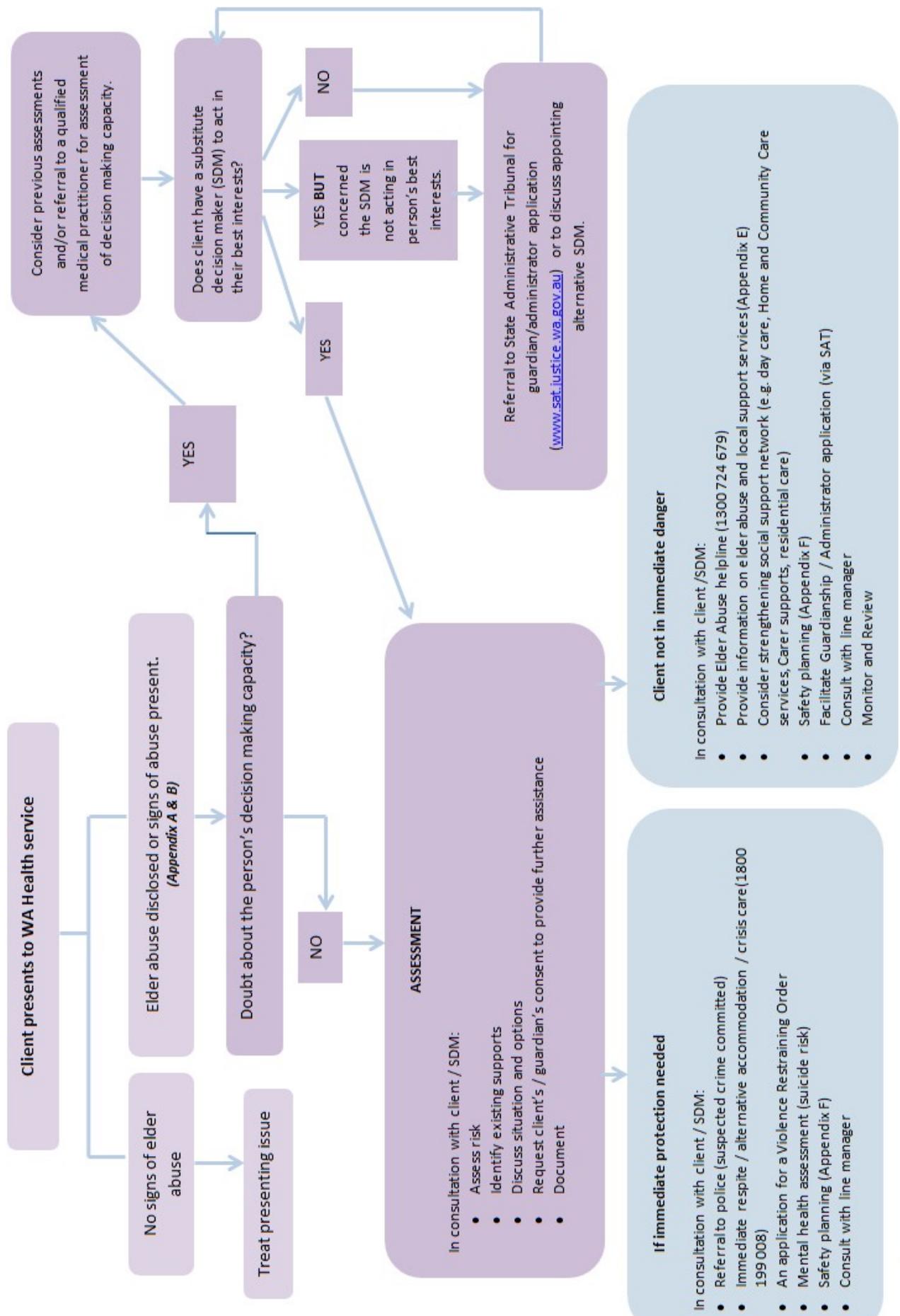
Anyone seeking to discuss their existing complaint or lodge a new complaint will contact the Commission on 1800 951 822.

FOR WACHS STAFF:

For policy and guidance on abuse perpetrated by WACHS staff or volunteers in Residential Aged Care Facilities or in the person's own home, refer to WACHS Approved Provider Compulsory Reporting of Assault on the Older Person Policy.

For policy and guidance on abuse perpetrated by family, friends or unpaid carers, refer to WACHS Identifying, Preventing and Responding to Abuse of Older People Policy.

Appendix D: Flowchart



Document intervention plan, outcome and referrals made

Appendix E: USEFUL CONTACTS

Emergency		
Ambulance, Fire	Police 000 (24/7)	For emergency responses.
Police	131 444 (24/7) www.police.wa.gov.au	For non-emergency responses, e.g. to report a crime.
Crisis Care	Crisis Care (08) 9223 1111 (24/7) 1800 199 008 (24/7) Family Helpline: (08) 9223 1100 (24/7) 1800 643 000 (24/7) www.dcp.wa.gov.au/ crisisandemergency/pages/ crisiscare.aspx	Information and short-term counselling for people in crisis needing urgent help to ensure the wellbeing of a child, escape domestic violence, information on available refuge and accommodation options, emergency financial assistance and general counselling. The Family Helpline provides more targeted counselling and information for families with relationship difficulties.
Women's Domestic Violence Helpline	9223 1111 or 1800 007 339 (free call)	State-wide 24 hour service. This service provides counselling and support, information, advice, and safe accommodation if required.
Men's Domestic Violence Helpline	9223 1199 or 1800 000 599 (free call)	Provides counselling, information and advice for men who are concerned about becoming violent or abusive. Information and support also available for men who have experienced FDV.
Elder Abuse Advocacy and Support Services		
Elder Abuse Helpline	1300 724 679 (free call)	Support and advice for older people and/or family members / carers. Monday – Friday 8:30am – 4:30pm. Confidential
Advocare	(08) 9479 7566 1800 655 566 www.advocare.org.au	Support and advocacy for older people who are being abused, or at risk of being abused.
State Administrative Tribunal (SAT)	(08) 9219 3111 or 1300 306 017 www.sat.justice.wa.gov.au	The SAT considers applications for the appointment of a guardian or administrator, or both, to a person with a decision-making disability. SAT also considers applications for intervention into Enduring Powers of Attorney. Application forms can be obtained from the SAT website www.sat.justice.wa.gov.au . In cases where there is no other suitable and willing person, SAT may appoint the Public Advocate as guardian.

		Guide for professional applicants in Guardianship and Administration Proceedings.
Office of the Public Advocate	1300 858 455 www.publicadvocate.wa.gov.au	Provides guardianship services when the Public Advocate is appointed guardian of last resort. Investigates concern about the abuse, neglect or exploitation of adults with decision-making disabilities and reports to the SAT on whether a guardian or administrator is required. Provides information, advice, and training on guardianship, administration, Enduring Powers of Attorney, Enduring Powers of Guardianship and protecting vulnerable adults, including a telephone advice service and an after-hours service for urgent matters.
Older People's Rights Service	Mirrabooka: (08) 9440 1663 Joondalup: (08) 9301 4413 https://www.nsclegal.org.au/legal-help_services/elder-law-services/	Legal advice, information and legal advocacy; short-term counselling and referral for older people with capacity experiencing abuse or those at risk of abuse
Citizens Advice Bureau	Ph: (08) 9221 5711 Monday to Friday, 9:30am – 4pm. www.cabwa.com.au	Mediation; legal advice; Justice of the Peace available; assistance with WA No Interest Loan Scheme applications.
Public Trustee	Wills, Deceased Estates & Enduring Powers of Attorney: 1300 746 116 Administration & Represented Persons: 1300 746 212 www.publictrustee.wa.gov.au	Offers independent, professional trustee and asset management services. These include Will and Enduring Power of Attorney drafting, deceased estate administration, executor support, financial administration and trust management services.
Respite Services		
Carers WA	1800 242 636 Carers' Counselling Line: 1800 007 332 www.carerswa.asn.au	Provides a confidential telephone counselling service to support carers. Also offers assistance in organising or being referred for respite

Carer Gateway	1800 422 737 https://www.carergateway.gov.au/	Carer Gateway is a national online and phone service that provides practical information and resources to support carers. The interactive service finder helps carers connect to local support services.
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Commonwealth Respite and Carelink Centres	1800 052 222	An Australian Government initiative aimed at providing information, support and referral to community and respite services for older people, people with disabilities and their carers. The aim of the program is to support carers in their caring role including providing emergency respite and support independent living in the community for older people, people with a mental illness and people with a disability. There is also information on culturally appropriate services and contact can be made through TIS for non-English speakers
Safe at home program	North West Metro: 9562 4453 North East metro: 9344 2370 South East metro: 9227 6616 South West metro: 9527 6872 South West Region: 9791 2894 Wheatbelt: 9622 7321	Provides support for women experiencing domestic violence who are referred by Police to stay in their housing, when safe to do so. Workers assess safety and support needs of women and children and provide funds to stabilise housing and increase security.
Other Aged Care Support Services		
Aged Care Quality and Safety Commission	1800 951 822	Receives complaints about the quality of care or services delivered to people receiving aged care services subsidised by the Australian Government.
Alzheimer's Australia WA	(08) 9388 2800 Dementia Helpline: 1800 100 500 www.fightdementia.org.au/Western-Australia.aspx	Specialist dementia education, information, training, and services including respite, counselling and social support.
My Aged Care	1800 200 422 (M-F: 8am – 8pm, Sat: 10am - 2pm) www.myagedcare.gov.au	A national online and phone service with information about aged care services, and what services people may be eligible for.
Legal Support		
Women's Resource and Engagement Network (WREN)	Phone: 9306 8700 Fax: 9306 8733 Email: wren@nsclegal.org.au	WREN is a specialist domestic violence unit and health justice partnership servicing the north east metropolitan area. WREN provides free legal and non-legal support to financially disadvantaged women living in the Cities of Stirling, Swan, Joondalup and Wanneroo who are experiencing family violence.

Legal Aid WA	1300 650 579 www.legalaid.wa.gov.au	Information, advice and other legal help. The type and amount of help depends on the person's financial situation, the legal problem and available resources.
Aboriginal Support Services		
Aboriginal Legal Service	1800 019 900	
Aboriginal Health Council of Western Australia (AHCWA)	(08) 9227 1631 www.ahcwa.org.au	Provides advice on local Primary Health Care Services, including Aboriginal controlled health services.
Kimberley Interpreting Service (KIS)	Broome: 08 9192 3981 Kununurra: 08 91693161 www.kimberleyinterpreting.org.au	Kimberley Interpreting Service (KIS) provides interpreters accredited by the National Accreditation Authority for Translators and Interpreters in more than 18 Kimberley and central desert Indigenous languages.
Multicultural Services		
Multicultural Women's Advocacy Service	9328 1200 (metro wide)	
Office of Multicultural Interests	6551 8700	
Telephone Interpreter service	13 14 50	

APPENDIX F: SAFETY PLANNING

A safety plan is a plan of action to help someone protect themselves from abuse. It includes steps to improve safety and strategies for responding to or escaping abusive behaviour when it happens. Of course, safety planning is not a guarantee of safety, but it can help to talk, plan and prepare. Safety planning can help an older person feel more confident and in control, reducing fear and stress. It may also be likely that the older person has managed the abuse for years and already has some ways of staying safe.

Encourage and support the older person to work through the plan (or develop their own) and to keep it accessible. Offer ongoing support and encourage the person to review their safety plan often.

Start by talking about who the older person can talk freely and openly with and who can give them the practical support they need.

Personal safety measures to consider:

- Getting a personal safety alarm
- Asking neighbours to be alert for any signs of a problem
- Establishing a code to signal neighbours or friends that they need to call 000
- Keeping a list of up-to-date telephone numbers
- Getting a mobile phone, (perhaps a user-friendly, easy-read model)
- Making a safe place where the older person can retreat—with radio, TV, music etc.
- Consider talking to the Police about the person's safety and applying for a Violence Restraining Order (VRO).

Home safety matters to consider:

- Improving outside lighting
- Changing locks and giving keys to trusted people (remember home care workers and consider a key safe)
- Adding a telephone, perhaps in the bedroom, perhaps a large-digit model.

Financial safety matters to consider:

- Reviewing who has access to bank accounts, including via internet banking and ATM cards
- Avoiding keeping cash in the house or having a place to lock it up, along with any other valuables.
- Opening a separate bank account to improve independence
- Setting up direct debits or Centrepay so that bills are automatically deducted at an affordable regular amount
- Saving a bit of money if possible.

Other safety matters to consider:

- Getting involved in a support group or in meaningful activity.
- Identifying supportive friends or family who the person may call if they are feeling down or need support
- Identifying appropriate cultural or faith-based supports
- Ways of reducing the older person's dependency on the abuser, for example by arranging home care services.
- Consider joining a community visitor or telephone chat scheme, such as Red Cross Telechat, or a community register scheme. (Contact the local police station or local council for details)

Planning for an emergency:

- Think about where the person can go in an emergency, where they can stay and who may lend them money or support.
- Prepare an 'emergency bag'. Include essential items from the list of personal items in the person's safety plan.
- Develop a code the person can use to signal others that they need help. Share it with trusted neighbours or family members who can act in an emergency.
- Think about the safety of pets—removing them to safety and caring for their needs
- Leave important items with someone they trust. This may include money, spare keys, clothes and copies of important documents.
- Plan an escape route—safe ways out of the home. It can help to visualise or practice the route.²⁵

²⁵ Elder Abuse Tip Sheet: Safety Planning with Older People, Senior Rights Victoria, 2013

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