



LASA
LEADING AGE SERVICES
AUSTRALIA
The voice of aged care

ELDER ABUSE – A NATIONAL LEGAL RESPONSE

Australian Law Reform Commission

LASA Member Briefing Paper
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Leading Age Services Australia

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Leading Age Services Australia (LASA)

Leading Age Services Australia (LASA) is the national peak body representing and supporting providers of age services across residential care, home care and retirement living. Our vision is to enable a high performing, respected and sustainable age services industry delivering affordable, accessible, quality care and services for older Australians. We represent our Members by advocating their views on issues of importance and we support our Members by providing information, services, training and events that enhance performance and sustainability.

LASA's membership base is made up of organisations providing care, support and services to older Australians. Our Members include private, not-for-profit, faith-based and government operated organisations providing age services across residential aged care, home care and retirement living. Our diverse membership base provides LASA with the ability to speak with credibility and authority on issues of importance to older Australians and the age services industry.

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Leading Age Services Australia (LASA)	2
Introduction	4
1. A National Plan to combat elder abuse	5
Health Professionals.....	6
2. Aged care	7
3. Enduring Appointments	14
4. Safeguarding Adults at Risk.....	15
5. Omitted sections of the report	16
6. Conclusion.....	16

Introduction

Leading Age Services Australia (LASA) presents this Member Briefing Paper to the Australian Law Reform Commission's (ALRC) final report *Elder Abuse – A National Legal Response* (the report) published in May 2017

Elder Abuse – A National Legal Response has 432 pages and makes 43 Recommendations. The ALRC chose the concepts of dignity, autonomy and safeguarding to frame the report's content. In its report, the ALRC focuses on (1) a proposed National Plan to combat elder abuse (2) the settings in which abuse may occur (3) activities which may trigger abuse and (4) agencies and institutions well placed to discover abuse. The report contains the sections listed below:

1. A National Plan to combat elder abuse
2. Aged care
3. Enduring appointments
4. Family agreements
5. Superannuation
6. Wills
7. Banking
8. Guardianship administration
9. Health and National Disability Insurance Scheme
10. Social security
11. Criminal justice responses
12. Safeguarding adults at risk.

The World Health Organization (WHO) defines elder abuse as: 'a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person'. It can take various forms such as physical abuse, psychological or emotional abuse, financial abuse, sexual abuse, and neglect.

The WHO estimates the prevalence rate of elder abuse in middle to high income countries to range from 2% to 14%¹. The ALRC reports an older person's risk factors for abuse to be: significant disability, poor physical health; mental disorders, such as depression; low income or socioeconomic status; cognitive impairment; and social isolation. A community attitude of ageism further contributes to the incidence of elder abuse. Elder abuse is often committed by a family member of the older person – notably by adult children, spouses or partners. The ALRC believes that the formulation of a policy response to elder abuse should be informed by initiatives to prevent family violence².

LASA read the report, identified the Recommendations of most relevance to Members, presenting these in the Member Briefing Paper. Note is made of the Recommendations not included in the Member Briefing Paper. Incorporated are LASA comments and questions which may trigger Member reflection.

¹ World Health organization, *The Toronto Declaration on the Global Prevention of Elder Abuse* (2002).

² ALRC (2017) *Elder Abuse- A National Legal Response*, p. 20.

1. A National Plan to combat elder abuse

(Omitted was Recommendation 3-2)

Recommendation 3–1 The Australian Government, in cooperation with state and territory governments, should develop a National Plan to combat elder abuse. The Plan should:

- (a) establish a national policy framework;
- (b) outline strategies and actions by government and the community;
- (c) set priorities for the implementation of agreed actions; and
- (d) provide for further research and evaluation.

LASA comment: The ALRC uses the concept of a National Plan to emphasise the need for a national approach to elder abuse and to provide a coordinating framework for Commonwealth, state and territory initiatives. LASA supports the development of a coordinated, national approach because it is most likely to result in an effective response.

LASA question: Would a nationally valid definition of abuse and neglect be a useful inclusion in the proposed national policy framework?

Recommendation 3–3 The National Plan to combat elder abuse should identify goals, including:

- (a) promoting the autonomy and agency of older people;
- (b) addressing ageism and promoting community understanding of elder abuse;
- (c) achieving national consistency;
- (d) safeguarding at-risk adults and improving responses; and
- (e) building the evidence base.

Recommendation 3–4 The National Plan should take into account the different experiences and needs of older persons with respect to:

- (a) gender;
- (b) sexual orientation;
- (c) disability; and
- (d) cultural and linguistic diversity.

The Plan should also take into account the experiences and needs of:

- (a) older Aboriginal and Torres Strait Islander people; and
- (b) older people living in rural and remote communities.

LASA comment: The goals listed in Recommendation 3-3 are appropriate to the issue at hand. LASA supports the building of an evidence base as this will enable well- targeted policies and programs to stop and/or prevent elder abuse.

LASA question: Should the experiences of homeless people as a particular group be included for special consideration? Are there other ‘forgotten people’ that should be considered?

Recommendation 3–5 There should be a national prevalence study of elder abuse to build the evidence base to inform policy responses.

LASA comment: LASA supports a national prevalence study as this would give an insight into how many elderly people are affected by violence and in which setting older people are more likely to be exposed to abuse and neglect. LASA prefers that reforms to the way abuse in residential and home based aged care is monitored, investigated and addressed be delayed until data describing the nature and size of the problem is available. This data would facilitate the formulation of evidence-based policy to effectively address elder abuse in aged care and all other settings.

LASA question: Could providers of aged care contribute to a prevalence study? Would confidentiality requirements make a contribution difficult or impossible?

Health Professionals

The ALRC sees health professionals playing an important role in identifying and responding to elder abuse. As frontline service providers, they have regular contact with older people. However, health professionals often only have a small window of opportunity to assist. This may be due to an older person's reluctance to discuss the abuse or neglect they are suffering, or due to limited opportunities to seek assistance. The ALRC believes that health professionals should work under clear policies and well-developed referral pathways which enable them to provide effective assistance to the abused person. Health-justice partnerships may have great potential in responding to elder abuse. They can involve arrangements such as a formalized partnership with a community legal service or a service network employing a lawyer.

Barriers that limit a health professional's ability to identify and respond to elder abuse include: difficulty detecting elder abuse, limited knowledge of and access to appropriate referral pathways, and concerns about breaching privacy laws.

The ALRC suggests that training should be available to overcome some of these barriers. Training should address:

- recognition of elder abuse;
- how privacy laws apply (state and territories);
- referral pathways available; and
- multidisciplinary responses to elder abuse.

THE ALRC believes that initiatives relating to training and referral pathways for health professionals should be undertaken under the proposed National Plan to combat elder abuse.

LASA question: THE ALRC focusses on health professionals. However, in private homes in particular, care workers can also detect elder abuse. What education, training and role regarding the detection of and intervention in elder abuse should care workers have? Would an Aged Care- Justice partnership be useful? If yes, how could it be funded?

2. Aged care

No Recommendations were omitted from this section.

Recommendation 4–1 Aged care legislation should provide for a new serious incident response scheme for aged care. The scheme should require approved providers to notify to an independent oversight body:

- (a) an allegation or a suspicion on reasonable grounds of a serious incident; and
- (b) the outcome of an investigation into a serious incident, including findings and action taken.

This scheme should replace the current responsibilities in relation to reportable assaults in s 63-1AA of the *Aged Care Act 1997* (Cth).

Recommendation 4–2 The independent oversight body should monitor and oversee the approved provider's investigation of, and response to, serious incidents, and be empowered to conduct investigations of such incidents.

LASA comment: LASA believes that the ALRC's Recommendation for a new serious incident response scheme could be going too far by placing new and extended reporting responsibilities on providers. LASA is concerned that these responsibilities are proposed without empirical evidence as to their necessity or effectiveness in preventing elder abuse in aged care. As stated under Recommendation 3-5, LASA would prefer any change to the regulatory framework to be informed by actual evidence as to the nature and size of the problem in aged care. LASA is generally of the view that the existing legislative frameworks and reporting processes can be relied upon to prevent abuse in the residential care setting.

The forthcoming Carnell Report in response to the incidents at the Oakden facility is likely to make recommendations that are of relevance here. It is critical that cost-benefit analysis is undertaken of reforms in this area.

As one alternative, LASA considers that improvements in training, culture and the existing reporting mechanisms may improve providers' ability to further keep older people safe from abuse. Members may want to consider whether the improvements suggested below would improve providers' ability to further protect older people.

1. National standards for staff training on what constitutes elder abuse, how to prevent it, deal with it and report it should be introduced. All aged care staff should undergo training that meets the national standards annually.
2. The reporting mechanisms for elder abuse should be made easy to use.
3. ACFI funding should reflect the quality and number of staff required for the management of difficult behaviour displayed by some people with dementia. The effective management of aggressive and violent behaviours by qualified staff would further reduce the incidence of assaults on fellow residents perpetrated by residents with dementia.
4. More specialist facilities should be made available for residents with stage 6 and 7 dementia who display severely disturbed and aggressive behaviours. The availability of more of these facilities

would enable aged care providers to transfer severely disturbed residents to facilities well equipped to care for residents with such special needs.

5. Overseeing bodies responding to alleged elder abuse in residential aged care should implement a culture of quality improvement rather than in the main placing blame on institutions or individuals. LASA believes that a blaming approach impedes an honest investigation of serious incidents and without careful assessment effective responses cannot be formulated.

LASA question: Would the above proposed set of improvements in abuse prevention be effective in the residential and home setting? Are there other, more effective improvements? If reporting of incidents of abuse is made easier may this result in more such incidents being reported? Is the Department of Health likely to respond punitively if more incidents are reported? What type of government response do providers consider to be supportive rather than punitive?

Recommendation 4–3 In residential care, a ‘serious incident’ should mean, when committed against a care recipient:

- (a) physical, sexual or financial abuse;
- (b) seriously inappropriate, improper, inhumane or cruel treatment;
- (c) unexplained serious injury;
- (d) neglect;

unless committed by another care recipient, in which case it should mean:

- (e) sexual abuse;
- (f) physical abuse causing serious injury; or
- (g) an incident that is part of a pattern of abuse.

LASA comment: Recommendation 4-3 identifies new ‘serious incidents’ requiring reporting, including inappropriate, improper, inhumane or cruel treatment, unexplained injury and neglect. However, Recommendation 4-3 omits detail about the potential perpetrators the Recommendation includes and the degree of abuse deemed a ‘serious incident’. Are providers of residential aged care responsible for reporting alleged or actual abuse perpetrated not only by staff and fellow residents but also by residents’ family and other associates? When is an action a simple misdemeanour and when does it constitute a ‘serious incident’? If a family member is being observed to take \$20 out of the relative’s purse without permission, does this constitute a misdemeanour or a reportable ‘serious incident’ of financial abuse? Clarification of the range of potential perpetrators included in this regulation is essential so providers of residential aged care can gauge their potential responsibilities under the proposed changes to legislation. Also required is clarification of the degree of abuse deemed a ‘serious incident’. For the home care setting Recommendation 4-4 clearly identifies that reportable ‘serious incidents’ are those committed by a staff member.

LASA believes that case studies could be used to provide clarification of what constitutes a ‘serious incident’ in the operational setting. Further, any introduction of a reporting new scheme should come with funding to train aged care staff in the requirements of the new scheme. An appropriate

research body could investigate the grey areas of what does and what does not constitute such a 'serious incident'. Further required is the development of standards for staff education to enable staff to identify 'serious incidents' as well as the remedial and preventive actions to be undertaken.

LASA questions: Would the inclusion of many more types of reportable 'serious incidents' require providers' to increase the surveillance of their residents? May this intrude into residents' privacy? How should 'a pattern of abuse' be defined? If providers have to report a 'serious incident' committed by another care recipient as well as their response, what are the implications?

Recommendation 4-4 In home care or flexible care, 'serious incident' should mean physical, sexual or financial abuse committed by a staff member against a care recipient.

LASA comment: That providers of home care report and respond to 'serious incidents' their staff commit is a new requirement the ALRC proposes. The definition for 'serious incident' in home care or flexible care excludes types of incidents included for the residential care setting. Excluded incidents are: seriously inappropriate, improper, inhumane or cruel treatment; unexplained serious injury; and neglect. The ALRC does not provide a reason for excluding these incidents for the community setting. Maybe the ALRC assumes that consumers will change providers if consumers perceive being abused. Can this market-based process be relied upon to provide safety from abuse for older people who are sufficiently frail to require the highest-level care package? Evidence from the UK indicates that many older consumers of care services appear to be reluctant to or experience difficulties with taking on the role of active consumer³.

Clarification by the ALRC of what constitutes physical, sexual or financial abuse in the home care and flexible care setting would be helpful for providers when seeking to ensure their consumers' safety.

LASA question: Do providers require guidance regarding their and their employees' obligations under the law if witnessing that their clients are subjected to physical, sexual and/or financial abuse by other care providers and/or other persons? What are providers' obligations if they suspect such abuse?

Recommendation 4-5 An act or omission that, in all the circumstances, causes harm that is trivial or negligible should not be considered a 'serious incident'.

LASA comment: A clarification on what type of harm is likely to be considered trivial or negligible by the law would assist aged care providers to enact their reporting responsibilities.

LASA question: Would the definitions of 'serious incident' and 'not a serious incident' result in a scheme that truly focuses on serious incidents and does not overload providers with reporting responsibilities? (Also see LASA comment under Recommendation 4-6).

³ Rodrigues, R.J. & Glendinning, C. 2014. *Choice, competition and care: Developments in English social care and the impacts on providers and older users of home care services*. <https://doi.org/10.1111/spol.12099>.

Recommendation 4–6 The serious incident response scheme should:

- (a) define ‘staff member’ consistently with the definition in s 63-1AA(9) of the Aged Care Act 1997 (Cth);
- (b) require the approved provider to take reasonable measures to require staff members to report serious incidents;
- (c) require the approved provider to ensure staff members are not victimised;
- (d) protect informants’ identities;
- (e) not exempt serious incidents committed by a care recipient with a pre-diagnosed cognitive impairment against another care recipient;
- (f) authorise disclosure of personal information to police.

LASA comment:

- a) LASA agrees with the definition of staff member being retained as s 63-1AA(9) of the Aged Care Act 1997 (Cth), a welcome continuity for providers.
- b) While the term ‘reasonable measures’ is used in item 5 of section 63-1AA of the Aged Care Act, LASA considers this term to be too vague to give providers sufficient guidance as to the requirements under the proposed legislation. LASA suggests that examples be provided that clarify what constitutes ‘reasonable measures’.
- c) Recommendation 4-6 would be clearer if it spelled out whether the obligation to protect informants from victimization refers to only staff members reporting a ‘serious incident’ or also includes people visiting the facility. Are volunteers considered staff with concomitant obligations or are they regarded as visitors? Should this sentence be amended to read:
 - (c) require the approved provider to ensure informants are not victimised.
- d) LASA agrees that informants’ identities be protected.
- e) Not to exempt ‘serious incidents’ committed by a care recipient with a pre-diagnosed cognitive impairment from reporting is a major departure from current reporting arrangements. LASA believes that current arrangements under Part 7 *Circumstances in which requirement to report allegation or suspicion of reportable assault does not apply* in the *Accountability Principles 2014* should be maintained. LASA considers ensuring residents’ safety from fellow residents who display violent behaviour is a key quality of care outcome requiring a continuous quality improvement approach.

Recommendation 4–7 The Department of Health (Cth) should commission an independent evaluation of research on optimal staffing models and levels in aged care. The results of this evaluation should be made public and used to assess the adequacy of staffing in residential aged care against legislative standards.

LASA comment: Having an evidence base for the intensity of staff support required in both, residential and home-based aged care would be useful as long as all relevant factors are considered. It may somewhat help to settle the conflicts and disagreements between funders and providers of aged care. But factors the work would need to recognise include that there are different models of care - optimal staffing levels will depend on variables such as available technology and innovation, staff skills and training, and the needs profile of the clients.

The Resource Utilization Study currently being undertaken by the University of Wollongong is a first step in the direction of understanding the resources required to care well for elderly residents.

Nevertheless, LASA opposes mandated staff ratios. Our position on this issue aligns with the expectations of our Members. Our position and public advocacy on this issue is also consistent with the Australian Government’s 2011 Productivity Commission Report *Caring for Older Australians*. This report found that “While there are superficial attractions to mandatory staffing ratios, there are also downsides. An across-the-board staffing ratio is a fairly ‘blunt’ instrument for ensuring quality care because of the heterogeneous and ever-changing care needs of aged care recipients — in the Commission’s view it is unlikely to be an efficient way to improve the quality of care. Because the basis for deciding on staffing levels and skills mix should be the care needs of residents, it is important that these can be adjusted as the profile of care recipients changes (because of improvements/deteriorations in functionality and adverse events, etc). Imposing mandated staffing ratios could also eliminate incentives for providers to invest in innovative models of care, or adopt new technologies that could assist care recipients”.

LASA questions: Who should fund such a study? What caveats should be placed on its focus and considerations? If the Federal Government is unwilling to fund such a study, what could be alternative sources of research funding?

Recommendation 4–8 Unregistered aged care workers who provide direct care should be subject to the planned National Code of Conduct for Health Care Workers.

Recommendation 4–9 There should be a national employment screening process for Commonwealth-regulated aged care. The screening process should determine whether a clearance should be granted to a person to work in aged care, based on an assessment of:

- (a) a person’s criminal history;
- (b) relevant incidents under the recommended ‘serious incident’ response scheme;
- and
- (c) relevant disciplinary proceedings or complaints.

LASA comment: The ALRC considers that providers should not make the final decision about prospective employees’ suitability to work in aged care. The ALRC suggests that an ‘appropriate independent organisation’ be introduced that undertakes the national employment screening process for aged care (p.141 of the report). The ‘independent organisation’ would investigate whether a person has a criminal history and/or adverse findings from the ‘serious incident’ scheme

and search for any disciplinary or complaint action by registration or complaint bodies. The ALRC reports that most stakeholders suggested that three years would be an appropriate time for work clearances to remain valid. A screening process that takes into account non-criminal information requires establishing significant data bases by complaints bodies as well as the proposed 'serious incident response scheme'. It could be an expensive scheme. Are aged care providers or aged care workers expected to pay for it?

LASA questions: Is there any other industry considered incapable of selecting appropriate employees? Would the proposed national employment screening scheme support greater public confidence in the aged care industry? May a lack of confidence in the integrity of employees in the sector motivate people to eschew using aged care services, instead seeking assistance through family and friends? Would voluntary participation in a 'national employment screening process' enhance providers' competitiveness? How would the costs of this scheme be defrayed? Would it be possible to link this to other existing schemes and augment them as needed e.g. the ACT working with vulnerable people check?

Recommendation 4–10 Aged care legislation should regulate the use of restrictive practices in residential aged care. Any restrictive practice should be the least restrictive and used only:

- (a) as a last resort, after alternative strategies have been considered, to prevent serious physical harm;
- (b) to the extent necessary and proportionate to the risk of harm;
- (c) with the approval of a person authorised by statute to make this decision;
- (d) as prescribed by a person's behaviour support plan; and
- (e) when subject to regular review.

Recommendation 4–11 The Australian Government should consider further safeguards in relation to the use of restrictive practices in residential aged care, including:

- (a) establishing an independent Senior Practitioner for aged care, to provide expert leadership on and oversight of the use of restrictive practices;
- (b) requiring aged care providers to record and report the use of restrictive practices in residential aged care; and
- (c) consistently regulating the use of restrictive practices in aged care and the National Disability Insurance Scheme.

LASA comment: The ALRC intends Recommendation 4–10 to set high standards of care by discouraging the use of restrictive practices. However, much of what the ALRC proposes with regards to restraint is already being practiced. The ALRC further recommends that the Australian Government include additional safeguards such as are included in the Victorian Disability Act 2006. The ALRC suggests an independent Senior Practitioner for aged care who provides expert leadership on and oversight of the use of restrictive practices. It is unclear whether the Senior Practitioner should provide this oversight on a national, state or provider level. Victorian disability service regulation on which this Recommendation was modelled, requires disability services to appoint an 'authorized program officer' who must approve restrictive practices before they can be used. Further, the ALRC recommends that aged care providers would be required by law to record and

externally report the use of restrictive practices. The ALRC does not identify which body should receive these reports.

Again, the Carnell Report may deal with issues in the area and will need to be reviewed in this context.

LASA question: THE ALRC is right when describing the current regulatory approaches as a patchwork of federal, state, territory regulation and organizational policies. Would the national approach the ALRC proposes improve older peoples' protection from unwarranted restrictive practices?

Recommendation 4–12 The Australian Government should further consider Recommendation 6–2 of ALRC Report No 124 Equality, Capacity and Disability in Commonwealth Laws, that aged care laws and legal frameworks should be amended consistently with the National Decision-Making Principles set out in that Report.

LASA comment: Recommendation 6-2 in ALRC Report 124 says: 'The *Aged Care Act 1997* should be amended to include provisions dealing with supporters and representatives consistent with the Commonwealth decision-making model'. This report recommends a shift from substitute decision-making based on the 'best interests' standard to supported decision-making based on the person's 'will, preferences and rights'. This substitute decision-making model is based on following principles: 1. The equal right to make decisions; 2. Support in decision-making 3. The will, preferences and rights of persons must direct the decisions affecting their lives; and 4. Safeguards to prevent abuse and undue influence.

LASA questions: If these principles were enshrined in aged care law, would they significantly change current practice in decision-making for people with dementia? Would the principles underpinning supported decision-making be difficult to implement? Are current safeguards against undue influence in decision-making sufficient?

Recommendation 4–13 Aged care legislation should provide that agreements entered into between an approved provider and a care recipient cannot require that the care recipient has appointed a decision maker for lifestyle, personal or financial matters.

LASA comment: The ALRC takes a strong stance against agreements between a provider and a care recipient that *require* the care recipient to appoint a decision maker for lifestyle, personal or financial matters. The Commission considers such requirement to be an inappropriate encroachment on older peoples' decision-making rights. Instead, the ALRC believes that people entering residential aged care should be encouraged to make such arrangements (p.152 of the report).

LASA question: If implemented, would Recommendation 4-13 significantly affect Members' operations?

Recommendation 4–14 The Department of Health (Cth) should develop national guidelines for the community visitors scheme. The guidelines should include policies and procedures for visitors to follow if they have concerns about abuse or neglect of care recipients.

LASA comment: The ALRC recommends that national guidelines with standardised policies and procedures be developed for community visitors to follow should they become aware of abuse or neglect.

LASA question: Would the implementation of the new guidelines affect the relationship between providers and community visitors? What benefits would national guidelines bring? Would national guidelines make it more difficult for providers to include community visitors in the provision of care?

3. Enduring Appointments

(Omitted was Recommendation 5-2)

Recommendation 5–1 Safeguards against the misuse of an enduring document in state and territory legislation should:

- (a) recognise the ability of the principal to create enduring documents that give full powers, powers that are limited or restricted, and powers that are subject to conditions or circumstances;
- (b) require the appointed decision maker to support and represent the will, preferences and rights of the principal;
- (c) enhance witnessing requirements;
- (d) restrict conflict transactions;
- (e) restrict who may be an attorney;
- (f) set out in simple terms the types of decisions that are outside the power of a person acting under an enduring document; and
- (g) mandate basic requirements for record keeping.

Recommendation 5–3 A national online register of enduring documents, and court and tribunal appointments of guardians and financial administrators, should be established after:

- (a) agreement on nationally consistent laws governing:
 - (i) enduring powers of attorney (including financial, medical and personal);
 - (ii) enduring guardianship; and
 - (iii) other personally appointed substitute decision makers; and
- (b) the development of a national model enduring document.

LASA comment: The ALRC writes that tightening or ‘enhancing’ witnessing requirements for enduring documents has been an important reform in state and territory legislation in recent years. Key features of enhanced witnessing include limiting the professionals who are authorised to witness enduring documents (i.e. doctors, lawyers, police officers, Justice of the Peace etc.) and requiring witnesses to certify as to the nature of the principal’s understanding of the document (‘legal capacity’) and the fact that the document was signed voluntarily. Enhanced witnessing aims to assist in ensuring that enduring documents are made and operative only in circumstances genuinely authorised by the principal (e.g. an older person). The ALRC proposes that a compulsory online national register of enduring documents may assist in reducing elder financial abuse.

The ALRC proposes that a person should be ineligible to be an enduring attorney if the person is, or has been, a care worker, a health provider or an accommodation provider for the older person. LASA

is surprised at the ALRC's negative view of care workers and health providers. It leaves the impression that a main motivator for people to enter careers the care and health industries is the opportunity to 'groom' older people out of their nest egg.

LASA questions: Would the proposed tightening of witnessing requirements create issues for recipients of aged care for example, because of difficulties with accessing a person qualified to be a second witness? Do Members agree that past and present care workers and health providers and accommodation providers should be ineligible to become an enduring power of attorney? Should past carers become eligible after a lapse of 12 or 24 months or once additional safeguards such as two signatories are introduced? Would a national register of enduring documents have benefits for providers?

4. Safeguarding Adults at Risk

(Omitted were Recommendations 4-2 and 4-4 to 4-6)

Recommendation 14–1 Adult safeguarding laws should be enacted in each state and territory. These laws should give adult safeguarding agencies the role of safeguarding and supporting 'at-risk adults'.

Recommendation 14–3 Adult safeguarding laws should define 'at-risk adults' to mean people aged 18 years and over who:

- (a) have care and support needs;
- (b) are being abused or neglected, or are at risk of abuse or neglect; and
- (c) are unable to protect themselves from abuse or neglect because of their care and support needs.

Recommendation 14–7 Adult safeguarding laws should provide that any person who, in good faith, reports abuse to an adult safeguarding agency should not, as a consequence of their report, be:

- (a) liable civilly, criminally or under an administrative process;
- (b) found to have departed from standards of professional conduct;
- (c) dismissed or threatened while their employment; or
- (d) discriminated against with respect to employment or membership in a profession or trade union.

Recommendation 14–8 Adult safeguarding agencies should work with relevant professional bodies to develop protocols for when prescribed professionals, such as medical practitioners, should refer the abuse of at-risk adults to adult safeguarding agencies.

LASA comment: One reason why the ALRC proposes safeguarding services is that people who commit abuse often try to impede the provision of care and undermine the abused person's autonomy. Adult safeguarding laws would be state and territory based. The ALRC intends that the inclusion of adults in need for 'care and support' in the definition of 'at-risk' should be understood broadly. It would include frailty. The ALRC does not intend to confine the definition of 'at-risk' to people eligible for social services. The proposed state and territory safeguarding agencies would constitute a 'one-stop-shop' for matters of elder abuse. The ALRC considers that safeguarding agencies should be able to investigate cases either after receiving a complaint or referral or on their own initiative and coordinate other relevant agencies and services.

In any such State and Territory draft legislation there should be regulatory impacts statements which includes analysis of the costs and benefits of such approaches as well as facilitating consultation with stakeholders.

LASA questions: Would an agency which is a one-stop shop for matters of elder abuse be useful for providers of aged care, particularly home care? Should certain key personnel of providers of home care become prescribed professionals (see Recommendation 14-8)

5. Omitted sections of the report

Sections of the report deemed of no direct professional interest to LASA Members are excluded from this Member Briefing Paper. The excluded sections are:

- Family Agreements: this section has two Recommendations.
- Superannuation: this section has four Recommendations.
- Wills: The section has one Recommendation.
 - LASA question:* Do providers of aged care have a responsibility to protect residents if they suspect that activities undertaken to change a will may involve the resident being coerced? How can providers best exercise such responsibility?
- Banking: The section has one Recommendation.
- Guardianship and financial administration: The section has two Recommendations.
- Health and National Disability Insurance Scheme: Relevant content from this section relating to health professionals detecting and reporting elder abuse is presented in the section A *National Plan to combat elder abuse* on page 6 of this Member Briefing Paper.
- Social security: the section has three Recommendations.
- Criminal justice responses: This section contains no Recommendations.

6. Conclusion

The ALRC recommends extensive reforms to the laws protecting older people in the community and those receiving aged care services at home or in the residential care setting. Recommendations for the aged care setting includes additional monitoring for providers of aged care through:

- (1) an independent oversight body for the new 'serious incident' response scheme;
- (2) an independent organisation undertaking employment screening; and
- (3) an independent Senior Practitioner for aged care overseeing restraining practices.

Further proposed, but not specific to the aged care sector, is an adult safeguarding agency in each state and territory. LASA is not convinced that additional legislated oversight of the aged care sector as proposed by the ALRC will improve the protection of older people in aged care from abuse and neglect. The reported incidence of suspected or alleged abuse in residential aged care at 1.2% is already low⁴. While LASA would prefer to see all forms of elder abuse in aged care completely eliminated, LASA does not believe that this is best achieved through more legislated monitoring. Rather, LASA would like to see best practice approaches to the prevention of abuse trialled, funded and widely introduced.

⁴ Commonwealth of Australia (Department of Health) 2016, 2015-16 *Report on the operation of the Aged Care Act 1997*.

