University of
South Australia

PREVALENCE OF ELDER ABUSE IN SOUTH AUSTRALIA

FINAL REPORT:
CURRENT DATA COLLECTION PRACTICES OF KEY AGENCIES

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1. EXECUTIVE SUMMARY

1.1 Understanding and awareness of elder abuse as a significant problem is well understood among key government and non-government agencies within South Australia, including its causes, indicators and effects. Each of the agencies interviewed collects data on cases of elder abuse to some degree. However, with the exception of the Aged Rights Advocacy Service (ARAS), every agency interviewed expressed some level of dismay at the current practices around, and capacity for, the collation and analysis of data held by agencies. With the exception of ARAS, there currently are no systematic processes for collating de-identified data for analysis at the agency level, and privacy laws are seen to inhibit the sharing of data between agencies. Consequently, access to prevalence data is presently limited.

1.2 Only one agency at the State level – ARAS - currently collates comprehensive data on the prevalence of elder abuse reported to that organisation. However, as not every victim of elder abuse would be reported to ARAS, it is impossible to identify the exact prevalence rates of elder abuse currently experienced by older South Australians, including which cases are reported to multiple agencies.

1.3 All agencies currently collect data for the purpose of assisting them to provide a specialist service to their clients and, where relevant, to report back to funding bodies. Data collected in this way is frequently contained in individual client or case file notes, which do not readily lend themselves to a simple process of collating and analysing de-identified data. However, on certain occasions, some agencies have attempted to analyse a selection of elder abuse case files. Indeed, for agencies such as Domiciliary Care SA, recent changes to their funding and casework under the new Consumer Directed Care (CDC) framework have further precluded the collection of data on elder abuse as they move away from a comprehensive case management approach to a system of managing specific incidents and issues.

1.4 While most agencies have data contained in individual case file notes, that data is not easily or readily accessible, comparable and able to be monitored for trends over time. Consequently, most agencies expressed a need for a more systematic approach towards data collection in relation to elder abuse.

1.5 Interviews with agency representatives highlighted the lack of consistent definitions of elder abuse between some agencies and throughout Australia as an historical barrier to the collection of prevalence data, and this point is supported in the literature. However, the definitions contained in the *Strategy to Safeguard the Rights of Older South Australians 2014-2021* are being used by agencies, which augurs well for future data collection and the use of consistent definitions in South Australia.

1.6 Because of the different approaches to collecting information in cases of elder abuse, not every agency has a set process for classifying what category of abuse has allegedly occurred, nor the specific demographic details of both the victim and offender details such as age, suburb, living arrangements, ethnic background etc. ARAS is an exception. However, all agencies interviewed had considerable experience in working with elder abuse victims and most agencies have the potential to provide access to a selection of de-identified case files as well as possible generic statistics. Such case files may be the only way of using qualitative data currently held by agencies to identify where an older person may have engaged with more than one agency. However, that assumes that clients have agreed to the sharing of their information and that files have not been de-identified. Without that information, it

would be difficult to identify where an individual case of elder abuse is being reported to multiple agencies, thus skewing any prevalence data.

1.7 The literature is replete with calls for better prevalence data to support stronger initiatives to safeguard older persons from abuse. The first stage of the current project has highlighted significant areas where improvements could be made to current data collection and collation processes, for the purposes of ensuring a consistent approach across agencies to the provision of de-identified data. This data could then be collated and analysed by the Office for the Ageing (OFTA) on an annual basis, monitoring trends in cases of abuse and assisting to build a better understanding of the extent and depth of the problem.

1.8 The lack of quantitative data should not deter initiatives at the state, national or local levels, especially as the literature clearly indicates the degree to which elder abuse remains largely a hidden problem in society. Stage Two of this project, based on the interviews of six older persons, provides a qualitative dataset that speaks to the lived experiences of victims of elder abuse. These interviews provide a rich narrative for understanding how vulnerable older persons experience abuse and its significant consequences for their daily lives. Thus, the absence of comprehensive prevalence data that could provide a statistical indication of the prevalence of elder abuse among older South Australians should not hinder strategies to develop more streamlined processes among agencies which will facilitate the collection, collation and analysis of de-identified data.

Recommendations

Recommendation 1.

Work should be undertaken with key agencies over the next 5 years to enhance their data collection practices, commensurate with their statutory and/or contractual mandates.

Recommendation 2.

OFTA should prioritise working with ARAS, as the key South Australian organisation responsible for collecting data on elder abuse, with the intention of enhancing their current database to improve the depth of analysis possible, increase our understanding of the risk factors for different individuals and groups and build OFTA's capacity to inform State policy and target intervention strategies.

Recommendation 3.

OFTA should also prioritise working closely with OPA and Domiciliary Care - both of which are specialist agencies with expertise in elder abuse and a history of advocacy in the field - to identify the most resource effective means of improving methods for capturing de-identified data on elder abuse, including information about the alleged victim and perpetrator, types of abuse and whether and what interventions took place. Information should also be collated where referrals to and from each agency occur, including where referrals come from and to which agencies referrals are made.

Recommendation 4.

Negotiations should be undertaken with the LSC, the Public Trustee and SAPOL to devise means for collecting, de-identifying and collating data on cases of alleged or suspected elder abuse, the types of abuse and details relating to both the alleged victim and perpetrator. Recognising that

each of these 3 agencies has very specific statutory mandates and responsibilities, education and training of staff should be prioritised before any system for data collection and management is implemented.

Recommendation 5.

The development and delivery of a systematic education and training program across SA Health should be undertaken, in order to improve the level of understanding of elder abuse and its signs among employees. Investigations should also be made as to whether and how the Safety Learning System could be adapted to capture instances of actual or suspected elder abuse. This should include reports of when matters are referred to SAPOL or other agencies such as ARAS or OPA.

Recommendation 6.

Within the next 5 years, OFTA should consider revisiting the recommendations of the *Closing The Gaps* Report and, particularly, the need for legislative reform.

2 PROJECT OVERVIEW & RESEARCH METHOD

2.1 Project Background

This project was initially proposed as an area for further research in the South Australian Government's *Strategy to Safeguard the Rights of Older South Australians Action Plan 2015 -2021*. The intention was to undertake a baseline prevalence study in South Australia, facilitated by a multi-disciplinary team of researchers from the University of South Australia, 'to identify how we can best capture the data we need to show how common elder abuse is in our state, and to clarify the risk factors in our community.'[1]

Following the establishment of a Steering Committee, the research team was able to use the expertise of Committee members to more clearly design the research project. From the outset, it was clear there would be difficulties in obtaining data from key agencies, other than the data collected by ARAS. The challenges in accessing information held by agencies stemmed from issues associated with legal professional privilege with respect to files held by the Legal Services Commission (LSC), to the lack of any systematic or consistent approach to collating de-identified data at an agency or state level. Only ARAS currently does this. Consequently, the biggest challenge presently posed with respect to obtaining such de-identified collated data largely rests with the fact that any data held by agencies is 'buried' in individual case file notes. Extracting that data would be challenging for many reasons – resources, privacy issues, questions about the applicability of the Information Sharing Guidelines to historical cases, and, in the case of the Legal Services Commission (LSC), potential issues of legal privilege. Indeed, the research team was unable to get timely approval from the South Australian Police to participate in the project in the early to mid stages of the research, and the Public Trustee declined to be interviewed, on the basis that it did not hold any relevant data: 'We have reviewed the draft list of questions and advise that we do not collect the data you are seeking. Accordingly, Public Trustee is unable to participate in the study at this time.'[2]

Against this context, the project was ultimately broken into 2 stages. Stage 1 involved semi structured interviews with key agencies, specifically the following:

- Aged Rights Advocacy Service (ARAS);
- Legal Services Commission (LSC);
- Domiciliary Care SA, Department for Communities and Social Inclusion;
- Office of the Public Advocate (OPA);
- The Aged Care Complaints Scheme;
- SA Health;
- Aged Care Assessment Program;
- South Australian Police (SAPOL).

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1 *Strategy to Safeguard the Rights of Older South Australian Action Plan 2015 -2021*, available at http://www.sahealth.sa.gov.au/wps/wcm/connect/6816e88048bf9ce9be6fff7577aa6b46/Safeguarding+Action+Plan+FINAL.pdf?MOD=AJPERES&CACHEID=6816e88048bf9ce9be6fff7577aa6b46 [accessed 9 August 2016].

2 Email from Debra Contala, Public Trustee, to Professor Wendy Lacey, Wed 16/12/2015 3:36 PM.

The first four, together with SAPOL and SA Health, are South Australian based agencies with some of their services funded jointly by both the State and the Commonwealth. ARAS (unlike the other three agencies) is, however, a separately incorporated entity and is not a statutory authority with reporting requirements through to either the Department of Justice or the Attorney-General's Department, nor is it a state government agency as, for example, is Domiciliary Care SA. The Aged Care Complaints Scheme is operated by the Commonwealth under federal law.

The interviews were designed to establish what, if any, data is collected on cases of reported or suspected elder abuse and how that data is managed, stored, collated and analysed. The research team's objective was to identify what data was actually collected by each agency in the process of their work with older persons. Because of privacy issues and the desire to obtain prevalence data, it was important to learn whether the information on cases of elder abuse was being de-identified, collated and analysed by each agency, and whether it was made available to other agencies. This is because only de-identified and collated data would be able to demonstrate trends in prevalence and could be shared with other agencies, recognising that many of the cases would have been historical, prior to the introduction of the relevant Information Sharing Guidelines (ISGs) and captured without the specific consent of the person to share that information for specific purposes.[3] The *Closing the Gaps Report* outlined how information sharing could have taken place in cases prior to the adoption of the ISGs, recognising that sharing of information would need to only occur in cases where either the consent of the person had been obtained, or in cases where imminent and serious harm could result from not sharing the information.[4] In the absence of such arrangements, agencies would have risked breaching the privacy of the person concerned, thereby exposing their agency to legal risk.

Recognising the challenges that the research team was likely to face in obtaining either qualitative or quantitative data from the relevant agencies, Stage 1 of the project was specifically designed to better understand current practices with regard to the collection of information on elder abuse cases. The intention was to identify current practices with respect to data collection and use, in order to identify a baseline for future research and monitoring, in addition to identifying areas for possible improvement that could potentially be led, facilitated or sponsored by OFTA. Stage 1 of the project was managed by the legally qualified members of the research team, both of whom have expertise in legal and administrative processes and policy frameworks.

Stage 2, by way of contrast, involved a series of interviews with six older persons who have experienced some form of elder abuse, either directly or indirectly. In depth interviews examined the lived experience of those older people and identified the risk factors which led to the abuse occurring, as well as the consequences for the daily lives of victims. This Stage was specifically led by the researchers within the team who are qualified social workers, with considerable experience in working with vulnerable groups. A therapeutic interviewing style was adopted, recognising the particular

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3 Information Sharing Guidelines, Office of the Guardian for Children and Young People, 2008.

4 South Australian Office of the Public Advocate and the University of South Australia Human Rights and Security Research and Innovation Cluster, *Closing the Gaps: Enhancing South Australia's Response to the Abuse of Vulnerable Older People* (Report for the Office for the Ageing and Disability Services, October 2011) at 60, available at: http://www.sa.gov.au/upload/franchise/Seniors/Office%20for%20the%20Ageing%20-%20Publications/Publications/Protection%20of%20Vulnerable%20Adults%20%E2%80%93%20Closing%20the%20Gaps.pdf. This Report discusses how Information Sharing Guidelines could apply to vulnerable older persons, but was authored before a Cabinet exemption from the Privacy principles was extended to all vulnerable persons.

vulnerability and sensitivity associated with elder abuse, especially where it takes place in a familial setting. This Stage of the project deliberately recognises the limitations in using quantitative statistical data to understand or explain a particular societal problem. It instead recognises that the lived experience of people told in a narrative form is just as compelling in identifying the causes, risk factors and the effects of social problems such as elder abuse.

Thus, a fundamental premise of this research is that it eschews a methodology which relies entirely on obtaining quantitative data, recognising that certain types of qualitative data are just as powerful in building an evidence base for future policy and intervention strategies, and in validating whatever quantitative data is available. For the purposes of this Report and the research upon which it is based, the definition of elder abuse is that used in the *Strategy to Safeguard the Rights of Older South Australians 2014 -2021* which provides as follows:[5]

> A general understanding is that it is an act that causes harm to an older person, carried out by someone the older person knows and trusts. This could be a family member, friend or carer. The harm could be accidental or deliberate.
>
> The World Health Organisation (WHO) defines elder abuse as … 'Abuse of older people is a single, or repeated action (commission), or lack of appropriate action (omission), occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person … It is a violation of human rights and a significant cause of injury, illness, lost productivity, isolation and despair.'

Types of Abuse

Physical

Non-accidental actions which results in the infliction of physical pain or injury to an older person.

Psychological

Psychological or emotional abuse is any language or actions designed to intimidate another person and cause fear of violence, isolation, deprivation or feelings of powerlessness. Such acts or words are intended to diminish a person's identity, dignity or self-worth.

Financial

Financial abuse involves the illegal or improper use and/or mismanagement of a person's money, property or resources.

Social

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

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5 *Strategy to Safeguard the Rights of Older South Australian Action Plan 2015 -2021*, available at https://www.sahealth.sa.gov.au/wps/wcm/connect/2e5d0e004459d5af88d9aa76d172935c/Strategy+to+Safeguard+the+Rights+of+Older+South+Australians+WEB+FINAL.pdf?MOD=AJPERES&CACHEID=2e5d0e004459d5af88d9aa76d172935c [accessed 9 August 2016]

Neglect

Involves the failure of a carer or responsible person to provide life necessities, such as adequate food, shelter, clothing, medical or dental care, as well as the refusal to permit others to provide appropriate care (also known as abandonment).

Sexual

Non-consensual sexual contact, language or exploitative behaviour.

Chemical

Chemical (or substance) abuse is any misuse of drugs, alcohol, medications and prescriptions, including the withholding of medication or over-medication.

As the Report of the NSW Parliamentary Committee Inquiry into Elder Abuse noted, the problem of elder abuse has recently gained prominence as a 'pressing social issue'.[6] Recognising this trend, the Committee cited Professor Susan Kurlle:[7]

> Elder abuse is the last form of family violence to come to public attention. It tends to be a hidden problem with most abuse occurring within the family home, at the hands of family members or carers, or others with whom there is a relationship of trust. It is associated with increased rates of hospital admission and admission to residential aged care facilities, and also with increased morbidity and mortality. Until the late 80s very little was known about its occurrence in the Australian community, but over the last 25 years research throughout the country has confirmed the significance of abuse as a social, medical and legal problem.

As has been previously recognised, while States and territories (excluding the Northern Territory) have existing policy frameworks and strategies for addressing elder abuse, many of them are inadequate in providing effective mechanisms for prevention, education and effective responses and/or remedies in cases of known abuse.[8] The recent NSW Inquiry into Elder Abuse, the current Australian Law Reform Commission[9] and the South Australian Inquiries[10] all indicate that elder abuse is an increasingly important issue at both the federal and state levels. However, effective legal and policy action has often been hamstrung by the patchy and minimal data available in Australia regarding the prevalence of abuse among older Australians.[11] This lacuna in Australian research has often been seen as a hindrance to effective policy action and, in many respects, it has had that effect. A recent Report by

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6 NSW Legislative Council, General Purpose Standing Committee No.2, *Elder Abuse in New South Wales*, 24 June 2016, at 26.

7 Ibid, citing Submission 37, Professor Susan Kurrle, at 1.

8 See Lacey, W, 'Neglectful to the Point of Cruelty? Elder Abuse and the Rights of Older Persons in Australia' (2014) 36 *Sydney Law Review* 99-130 at 126-130.

9 The Hon Senator George Brandis, *Safeguarding Older Australians*, Media Release, 24 February 2016; Australian Law Reform Commission, *Elder Abuse*, Issues Paper No 47, 15 June 2016, available at: https://www.alrc.gov.au/publications/elder-abuse (accessed 24 June 2016).

10 Hon Kelly Vincent MLC, *Elder Abuse Investigation Passes SA Parliament*, Media Release, 14 October 2015, available at: http://www.d4d.org.au/media-releases/2015-10-305-elder-abuse-investigation-passes-sa-parliament.php (accessed 24 June 2016.

11 Kaspiew, R, Carson, R, and Rhoades, H, *Elder abuse: Understanding Issues, Frameworks and Responses*, Research Report No. 35, Australian Institute of Family Studies, 2016, at 5.

the Australian Institute for Family Studies (AIFS) described the challenges associated with addressing elder abuse in a systematic way:[12]

> [E]lder abuse is a complicated construct, with varying conceptualisations, in part depending on the theoretical and disciplinary lens through which it is approached (section 2). From a definitional perspective, the lack of an agreed approach in various legislative, policy and practice frameworks is seen to inhibit the development of a coherent approach from the perspectives of both measurement and response. The absence of a consistent approach to elder abuse from a chronological standpoint is emblematic of a deeper need to consider how elder abuse and neglect should be conceptualised, and why it raises questions of public policy that are not dealt with adequately within existing private and public law frameworks (Clare et al., 2011). Considerations in relation to human rights principles and obligations are relevant in this respect; so too are considerations in relation to professional, institutional and personal accountability.
>
> Evidence about prevalence in Australia is lacking, though if international indications provide any guidance, it is likely that between 2% and 10% of older Australians experience elder abuse in any given year, with the prevalence of neglect possibly higher (section 3). In the absence of systematic empirical data, the dynamics, circumstances and effects of elder abuse are difficult to assess. However, the available evidence suggests that most elder abuse is intra-familial and intergenerational, with mothers most often being the subject of abuse by sons, although abuse by daughters is also common, and fathers are victims too. Financial abuse appears to be the most common form of abuse experienced by elderly people, and this is the area where most empirical research is available. Psychological abuse appears slightly less common than financial abuse, and seems to frequently co-occur with financial abuse, suggesting a pattern of behaviour analogous to grooming in the sexual abuse context. For some women, abuse in older age reflects the continuation of a long-term pattern of spousal abuse. Unlike other countries, such as America, the UK, Portugal and Israel, Australia does not have a strategy for measuring prevalence. In the absence of systematic data to shed light not only on prevalence but also on dynamics and effects among different groups and in different circumstances, the evidence base to support further development of policy and practice initiatives is underdeveloped.

As a consequence of this reality, numerous calls have been made for prevalence studies to take place in Australia, frequently seen as essential for driving reform. The following section surveys the literature and available data and, whilst recognising the importance of prevalence data in stimulating and informing the policy debate, also posits the view that alternative methodologies might be used to fill the gap.

[12] Ibid, at 46-47.

3. LITERATURE REVIEW

3.1 Introduction

Internationally there have been a number of studies that utilise large-scale random survey techniques to estimate the prevalence of abuse. However, there have been limited attempts to determine the prevalence of elder abuse in Australia. Notwithstanding this, there have been Australian studies which measure the incidence of elder abuse from data collected by service agencies. In addition, some Australian studies have used international prevalence estimates as a basis to estimate prevalence in Australia.

Much of the literature focuses on the lack of consistent definitions as a barrier to the collection of data. While much of the theoretical discussion uses a definition broadly consistent with the WHO (2002) definition, that definition does not neatly fit into agency requirements associated with data collection practices. Additionally there is some discussion that the definition is too broad in terms of both the range of ages covered and the types of abuse covered. The following tables provide an overview of the available studies on the prevalence of elder abuse.

3.2 Prevalence

Summary Table – Prevalence Primary Source studies

Source	**Methodology**	**Definition**	**Prevalence**
Burnes et al[13]	4156 respondents aged over 65 in New York State (UNITED STATES)		**Overall 4.6%** - Emotional 1.9% - Physical 1.9% - Neglect 1.8%
Cripps (2000)[14]	Random telephone survey population involving persons 65 and over in urban and rural SA, involving 1158 respondents (AUSTRALIA)	Not known	**Overall 2.7%** Of abuse: - Psychological 58.3 % - Financial 21.5% - Physical 12.2% - Social restriction 9.0% - Neglect 5.2% - Sexual 2.6%

[13] Burnes, D, Pillemer, K, Caccamise, P, Mason, A, Henderson Jr, C, Berman, J, Cook, A, Shukoff, D, Brownell, P, Powell, M, Salamone, A & Lachs, M (2015) 'Prevalence of and Risk Factors for Elder Abuse and Neglect in the Community: A population-Based Study' 63 *Journal of the American Geriatrics Society* 1906-1912,1906.

[14] Cripps, D, 'Australia's first randomised study of the prevalence and effects of elder abuse in the general community', Proceedings of the Australian Association of Gerontology Conference, Adelaide, October 25-27, 2000.

Gil et al (2014)[15]	Telephone survey of 1123 persons aged 60 and over in Portugal (PORTUGAL)	Any act of physical, psychological, financial, or sexual abuse, or neglect committed by a family member, friend, neighbour, acquaintance or paid professional against a person 60 or older during a 12-month period (not including stranger perpetuated acts).	**Overall 12.3%** - psychological 6.3% - financial 6.3% - physical 2.3% - neglect 0.4% - Sexual 0.2%
Kurrle et al (1992)[16]	Study of clients referred to ACAT in NSW (AUSTRALIA)	Not Known	**4.6%**
Kurrle et al (1997)[17]	Study of clients referred to ACAT teams in Qld, WA, NSW (AUSTRALIA)	Not Known, however definitional issues acknowledged	**2.3%**
Livermore et al (2001)[18]	Study of referrals to large regional aged care service in New South Wales (AUSTRALIA)	Not known	**5.4%**
Lowenstein et al (2009)[19]	Random survey of 1045 community urban dwellers age 65 and older (Israel)	Destructive and offensive behaviour inflicted on an elder person within the context of a trusting relationship	**Overall 18.4%**
Naughton et al[20]	2021 community dwelling persons over 65 (IRELAND)	WHO (2002)	**Overall 2.2%** - Financial 1.3% - Psychological 1.2% - Physical 0.5%

15 Martins Gil, AP, Kislaya, I, Santos, AJ, Nunes, B, Nicolau, R & Fernandes, AA, 'Elder Abuse in Portugal: Findings From the First National Prevalence Study' (2015) 27 *Journal of Elder Abuse & Neglect* 174-195.

16 Cited in Kurrle, S, & Naughtin, G, (2008) 'An overview of Elder Abuse and Neglect in Australia' (2008) 20 *Journal of Elder Abuse & Neglect* 108 – 125, 113.

17 Ibid.

18 Ibid.

19 Lowenstein, A, Eisikovits, Z, Band-Winterstein, T & Enosh, G (2009) 'Is Elder Abuse and Neglect a Social Phenomenon? Data from the First National Prevalence Survey in Israel', Journal of Elder Abuse and Neglect, 21:3, 253-277.

20 Naughton, C, Drennan, J, Lyons, I, Lafferty, A, Treacy, M, Phelan, A, O'Loughlin, A & Delaney, L, 'Elder Abuse and Neglect in Ireland: Results from a National Prevalence Study' (2012) 48 *Age & Ageing* 98-103.

			- Neglect 0.3% - Sexual 0.05%
O'Keefe et al[21] Biggs et al[22]	2111 interviews with survey respondents (UNITED KINGDOM) Respondents aged 66 and over living in private households reported that they had experienced mistreatment involving a family member, close friend or worker during the past year.	WHO (2002)	**Overall 2.6%** - Neglect 1.1% - Financial 0.7% - Psychological 0.4% - Physical 0.4% - Sexual 0.2%
		WHO plus mistreatment by neighbours and acquaintances	**4.0%**
Pillemer & Finkelhor (1998)[23]	Interviews with 2020 community dwelling older persons in the Boston Area (UNITED STATES)	Not Known	**Overall 3.2%** - Physical 2% - Chronic verbal aggression 1.1% - Neglect 0.4%

The above table indicates that prevalence studies vary from 2.2% of persons over 65 years, to 18.4% in a study conducted in Israel. However, removing the international studies from the above table, the prevalence statistics from Australian studies indicate a range of between 2.2% to 5.4%. And, while the WHO definition tends to be used most frequently to provide definitions of abuse, it is not certain that individual agencies – as opposed to the research teams evaluating prevalence data – adopt the same consistency in definitional approaches.

The lack of consistent data collection systems for the prevalence of elder abuse at both the South Australian and national levels is well acknowledged.[24] While noting the limitations of prevalence estimates, it is nevertheless recognised that such data are required to support resources and research on the issue.[25] The need for statewide data collection in South Australia has also been specifically highlighted in recent years.[26]

A number of Australian studies of client referrals to Aged Care Assessment Teams have previously been used to determine rates of prevalence in the community-dwelling older population.[27] A

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21 O'Keeffe, M, Hills, A, Doyle, M, McCreadie, C, Scholes, S, Constantine, R, et al, *UK Study of Abuse and Neglect of Older People: Prevalence Survey Report*, London: National Centre for Social Research, 2007.

22 Biggs, S, Manthorpe, J, Tinker, A, Doyle, M and Erens, B (2009) 'Mistreatment of Older People in the United Kingdom: Findings from the First National Prevalence Study' *Journal of Elder Abuse & Neglect* 21:1, 1-14.

23 Pillemer, K, & Finklehor, D, The prevalence of elder abuse: a random sample survey' (1988) 28 *Gerontologist* 51-57.

24 *Closing the Gaps,* above n 4, at 65; Kaspiew et al, above n 10 at 46.

25 Gilhooly, M, Dalley, G, Gilhooly, K, Sullivan, M, Harries, P, Levi, M, Kinnear, D & Davies, M, 'Financial Elder Abuse Through the Lens of the Bystander Intervention Model' (2016) 26 *Public Policy & Ageing Report*, 5-11.

26 *Closing the Gaps,* above n 4 at 16, 70.

27 Kurrle & Naughtin, above n 15.

randomised study of 1158 respondents in metropolitan and country Adelaide in the year 2000 revealed an overall prevalence rate of 3.7%. From those cases, 58.3 % were reported as psychological, 21.5% financial, 12.2% physical, 9.0% social restriction, 5.2% neglect and 2.6% involving sexual abuse. The study also found that 67.4% did not seek help for the abuse, citing the following reasons:

- They did not believe that anything would change;
- They were embarrassed;
- There was no-one in whom they could confide;
- They feared retribution.[28]

A United Kingdom study of elder abuse based on 2111 interviews found 2.6 % of people aged over 65 had experienced mistreatment from a family member, close friend or care worker (ie someone they trust). When broadened to involve incidents involving neighbours and acquaintances, overall prevalence rose from 2.6% to 4.0 %.[29]

Studies in the United States, reveal overall prevalence rates ranging from 3.2% to 4.6%.[30] However, more recent studies estimate higher incidence rates of elder abuse. An Irish study of 2021 persons over 65 living in community dwellings revealed that overall rates of elder abuse was 2.2%, with financial abuse at 1.3%, psychological abuse at 1.2%, physical at 0.5%, neglect at 0.3% and sexual abuse at 0.05%.

A telephone survey of 1123 person aged 60 and over in Portugal found that 12.3% of people surveyed had experienced elder abuse: 6.3% psychological; 6.3% financial; 2.3% physical; 0.4% neglect; and 0.2% sexual.

The following table outlines the estimated prevalence rates recorded in the secondary literature.

Prevalence data – secondary source studies

Source	**Methodology**	**Definition**	**Prevalence**
Clare et al[31]	Based on a range of international prevalence and incidence estimates.		**4.6 %** (ranging between 3.1% and 6 %)
Kaspiew (AIFS)[32]	Estimate from international indications		**3–10%** (neglect possibly higher)

28 Cripps, above n 13.

29 O'Keeffe et al, above n 19 at 3.

30 Pillemer et al, above n 20; Burnes et al, above n 12.

31 Clare, M, Blundell, B, and Clare, J, *Examination of the Extent of Elder Abuse in Western Australia: A qualitative and quantitative investigation of existing agency policy, service responses and recorded data*, Crime Research Centre, The University of Western Australia, April 2011.

32 Kaspiew et al, above n 10 at 46.

Seniors Rights Victoria[33]	Estimate based on from research literature.	over 60, consistent with WHO (2002)	**2 – 6 %**
WHO[34]	Background review of prevalence studies in middle to high income countries.	WHO (2002)	**Overall 2.2 – 14%** - Financial 1.0 – 9.2% - Psychological 0.7 – 6.3% - Physical 0.2 – 4.9% - Neglect 0.2 – 5.5% - Sexual 0.04 – 0.82%
Mysyuk et al[35]	Review of prevalence studies	Various definitions	**3–6%** Overall in Canada, Great Britain, Finland. **5.6%** Overall in Netherlands **1-10%** Overall in USA
Soonyara et al[36]	Review of articles on elder abuse from 1990 to 2011	Various definitions	Overall prevalence range from **1.1%** US to to **44.6%** in Spain. - Psychological: 1.15 (US) to 41.8% (Thailand) - Physical 0.1% (Spain) to 11.7% (Israel) - Sexual 0.6% (US) to 1.3% (Spain)
Gilhooly et al[37]	Review of studies on Financial Elder abuse	Various definitions	United Kingdom **0.7%** Australia **1.1%** Ireland **1.3 %** United States **2.7/ 4.7%; 5.2%; 6.4/23%** Spain **4.7%** India **5.0%** China **13.6%**

33 Joosten, M, Dow, B, and Blakey, J, *Profile of Elder Abuse in Victoria: Analysis of data about people seeking help from Seniors Rights Victoria. Summary Report*, National Ageing Research Institute in partnership with Seniors Rights Victoria, June 2015, 5.

34 World Health Organization, *World Report on Ageing and Health*. Geneva, 2015, available at: http://www.who.int/ageing/publications/world-report-2015/en/.

35 Mysyuk, Y, Westerndorp, RGJ, & Lindenberg, J, 'Added value of elder abuse definitions: A Review (2013) 12 *Ageing Research Review* 50-57.

36 Sooryanarayana, R, Choo, WY,& Hairi, 'A Review on the Prevalence and Measurement of Elder Abuse in the Community' (2013) 14 *Trauma, Violence, & Abuse* 316-325.

37 Gilhooly et al, above n 22 at 5-11.

The Australian Institute of Family Studies recently undertook a review of both Australian and international studies on the prevalence of elder abuse. That research found that international guidance would suggest that between 2% and 10% of older Australians experience abuse in any given year, with neglect being possibly higher than is currently recorded.[38] This project also found that elder abuse was overwhelmingly intra-familial, with mothers being the most likely victims.[39] Furthermore, abuse was most likely to be financial or psychological.[40]

Mysyuk et al found that studies had identified prevalence rates of between 4 and 6% in Canada, Great Britain and Finland, between 1 and 10 percent in the US and 5.6% in the Netherlands, but noted that the lack of consistent definitions meant that prevalence rates were inconsistent and incomparable.[41] An international review of prevalence studies of elder abuse from 1990 to 2011 demonstrates that wide variations in ranges of prevalence exist, from 1.15 to 44.6% overall, and that similarly wide variations exist in individual categories of abuse. However, it was found that a combination of differing methodologies combined with the lack of uniform definitions of elder abuse have contributed to the wide range of prevalence estimates.[42]

3.3 Incidence

By way of contrast, reviewing the incidence of elder abuse reports to agencies is an additional method for tracking prevalence data, even if only to monitor trends and patterns in the reporting of such cases. In this respect, Australian jurisdictions are becoming considerably more adept at monitoring such reports and the nature of abuse reflected in such reported cases. Clare et al calculated an average prevalence rate for Western Australia to be 4.6% (ranging between 3.15% and 6.0%) based on a review of international studies on prevalence and incidence.[43]

Incidence Rates – Summary Data

Source	Methodology	Definition	Incidence
Advocare[44]	Elder Abuse Information and Advocacy Cases: data collected from 10 elder abuse support agencies across Australia		SA – 942 Qld – 1266 NSW – 1191 Vic – 950 WA – 739 Tas – 337 ACT - 15

38 Kaspiew et al, above n 10 at 46.
39 Ibid.
40 Ibid at 47.
41 Mysyuk et al, above n 32.
42 Sooryanarana et al, above n 33.
43 Clare et al, above n 28.
44 Advocare, *Elder Abuse National Annual Report 2013-14*, available at: http://www.eapu.com.au/uploads/research_resources/Elder%20Abuse%20National%20Annual%20Report_2013-14.pdf (accessed 27 May 2016).

SA Elder Protection Program Annual Report 1994-5[45]	Enquiries to program	Enquiries about Elder Abuse	344 enquiries.
SA Elder Protection Program Annual Report 1995-6[46]	Enquiries to program	Enquiries about Elder Abuse	334 new enquiries 71 Re-referrals
Seniors Rights Victoria[47]	Calls to helpline		2236 Total calls to helpline 1206 – Elder abuse

The Advocare Annual Report data for the year 2013-14 lists calls to elder abuse helplines around Australia. However, the data for calls per state does not reflect relative populations of each state and it is likely that the data reflects the capacity of referral and advice services to deal with calls and the level of community awareness surrounding elder abuse, rather than the relative demand for those services.[48] The South Australian *Elder Protection Program Annual Reports* provide elder abuse figures and characteristics for the 1994-5 and 1995-6 financial years. Seniors Rights Victoria (SRV) listed the number of elder abuse calls to its helpline for the 2013-14 financial year in its submission to the Royal Commission into Family Violence.[49] From the Table above, it is clear that almost 54% of all calls to SRV in the previous year had involved cases of elder abuse.

Despite the lack of any comprehensive prevalence studies in Australia, the data which is currently being collated by elder abuse helplines, or agencies such as ARAS, indicate that the rates of elder abuse are either increasing or that people are more aware of elder abuse and the availability of services such as ARAS, or a combination of both. Until such time as Australia conducts a national study, or collates comprehensive data using a consistent approach to definitions and collection of data across the states and territories, the best estimates available indicate that somewhere between 2% and 10% of Australians over 65 years have experienced, or are experiencing, a form of elder abuse.

As already mentioned, a barrier to collating that data is the lack of consistent definitions of elder abuse, which is well documented in the literature.[50] However, it is not known to what extent this lack of consistent definitions is a significant barrier to the collation of data. Indeed, there is considerable consistency between policy frameworks across the Australian states and territories, with often only minor differences in wording or breadth.[51] However, this goes to the normative content of the sub-definitions of each category of elder abuse, and does not refer to the age where abuse becomes 'elder abuse', nor the differences between cultural groups which are required to effectively capture valid data. Clare et al have questioned why age necessarily matters and suggest that the determining characteristic should be capacity of the individual to take care of themselves.[52] It is also argued that

45 Domiciliary Care SA, *South Australian Elder Protection Program 1994-95 Annual Report*, 1995.
46 Domiciliary Care SA, *South Australian Elder Protection Program 1995-96 Annual Report*, 1996.
47 Seniors Rights Victoria, *Submission to Royal Commission into Family Violence*, 2015.
48 Advocare, above n 41.
49 Seniors Rights Victoria, above n 30.
50 Mysyuk et al, above n 32 at 50-57; Kaspiew et al, above n 10 at 2.
51 Lacey, W, above n 7 at 126-130.
52 Clare et al, above n 28 at 40.

the age characterisation of 'old' is not useful as definitions of old typically cover a broad range of ages from 65 to 85 with widely varying physical and cognitive capabilities.[53]

The most widely used definition is the World Health Organisation definition: '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'.[54] The use of the term abuse is also not universal, with a number of studies refer to 'mistreatment' rather than abuse,[55] and some legislative frameworks using the term 'harm' as opposed to 'abuse'.[56] In the event that any prevalence study is conducted across Australia, or replicated across state and territory jurisdictions within Australia, it is essential that a consistent approach is taken, in order to avoid distortions in the collation of data, as well as adapting parameters for capturing accurate data for diverse cultural groups, including Indigenous Australians.

4. CURRENT DATA COLLECTION PRACTICES OF KEY AGENCIES

4.1 Aged Rights Advocacy Service (ARAS)

The Aged Rights Advocacy Service Inc (ARAS) is a not-for-profit community based organisation, providing advocacy support since 1990 in South Australia, and funded by both the federal and state governments. It is an independent, rights based organisation that aims to promote and protect the rights and wellbeing of older people, through the provision of information, education, support, referral and representation. Of the agencies interviewed, only ARAS collates and analyses statistical data on elder abuse calls to their agency. The research team was provided access to statistics for the financial years of 2012-2013, 2013-2014, 2014-2015, 2015-2016 as well as having access to a paper delivered by ARAS at the 2000 Australian Association of Gerontology Conference. This paper discussed a randomised study of the prevalence and effects of elder abuse on the general population in South Australia.[57]

The Aged Rights Advocacy Service collects comprehensive data on the cases of elder abuse that are reported to it (data entry form at Attachment 1). While the organisation has been operating for more than 25 years, it has been hosting the Elder Abuse Prevention Phone Line Support and Referral Service since October 2015, funded by the Office for the Ageing. The Phone Line received 237 calls in its first 10 months of operation. This compares to 647 new cases being referred to ARAS in the 2015-2016 financial year, with a total of 718 people being assisted in that same timeframe. Statistics collated by ARAS indicate that the rates of elder abuse being reported to them have slightly increased in recent years, although, in 2000, ARAS reported offering a service to over 500 callers.[58] However, this figure

53 Kaspiew et al, above n 10 at 2; Kurlle et al, above n 15 at 112.

54 World Health Organisation, *Toronto Declaration on the Global Prevention Of Elder Abuse*, Geneva, 2002.

55 Burnes et al, above n 12; O'Keefe et al, above n 19.

56 See, for example, the Scottish *Adult Support and Protection Act 2007.*

57 Aged Rights Advocacy Service, 'Australia's First randomised Study of the Prevalence and Effects of Elder Abuse in the General Community', Paper presented at the Australian Association of Gerontology Conference, Adelaide, 26th October 2000.

58 Ibid.

included the provision of services to other agencies or service providers, so may have captured additional callers that ARAS have not captured in more recent statistics.

The following table shows the number of persons (described as 'consumers' by ARAS) assisted in a financial year, together with the number of new cases received. This data excludes Phone Line data which is discussed below.

Year	Consumers Assisted	New Cases	Cases finalised/withdrawn
2012-2013	566	535	525
2013-2014	681	669	738
2014-2015	654	612	602
2015-2016	718	647	664
TOTAL	**2619**	**2463**	**2529**

The number of new cases recorded in 2013-2014 shows a 25% increase in cases received by ARAS compared with the previous 12 month period. However, the year of 2014-2015 shows a decrease in new cases of around 8.5%. The data from 2015-2016 revealed an increase of 5.7% of new cases, some of which may be attributable to the introduction of the Hotline in October 2015.

However, based on 2011 CENSUS data, there were 260,600 South Australians over the age of 65 years, representing 16% of the State's population.[59] While the older population has continued to rise as a proportion of overall population since June 2011, based on the ARAS statistics the rates of elder abuse reported to ARAS were 0.2% in 2012-2013, 0.26% in 2013-2014, 0.23% in 2014-2015 and 25% in 2015-2016. However, the data captured by ARAS tells considerably more than simply providing a very blunt measure of prevalence.

ARAS defines elder abuse as 'any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. Abuse can include physical, sexual, financial psychological, social and/or neglect.'[60] Data collected on the victim includes details such as the person's name, age, gender, ethnicity, cultural background, home environment/living arrangements, with whom the person resides and the person's relationship to the alleged perpetrator. In addition, case notes will record the impact of the abuse on the victim and whether the person has a support network. Similar data is collected on the alleged abuser, as well as information that may assist in dealing with the unwanted behaviour, such as personal circumstances, motivation and whether there are issues that, if addressed, may prevent the abusive behaviour from continuing. In this context, ARAS identifies risk factors and needs with respect to both the victim and the alleged perpetrator. ARAS also collects data generally for persons aged over 65 years, but over 50 years for Aboriginal and Torres

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59 Australian Bureau of Statistics, 3235.0 Population by Age and Sex Regions of Australia 2011: South Australia, available at: http://www.abs.gov.au/ausstats/abs@.nsf/Products/3235.0~2011~Main+Features~South+Australia?OpenDocument#PARALINK6 (accessed 9 July 2016).

60 Aged Rights Advocacy Service, *Protocol for responding to abuse of older people living at home in the community*, March 2011, at 7.

Strait Islanders. In the 4 years examined, a total of 58 out of 1901 cases (just over 3% of all cases) involved people who either identified or were identified as being of Aboriginal or Torres Strait Islander descent. A further 326 (or over 17% of all cases reported in the 4 year period) were from culturally and linguistically diverse (CALD) communities. These figures have remained fairly stable in recent years.

Beyond ATSI and CALD backgrounds, ARAS also collects data on other factors which might highlight specific needs or risk factors, including the presence of dementia, disability, financial or social disadvantage, homelessness, residing in a rural or remote location, the presence of family conflict, caregiver stress, financial stress, isolation, mental health issues, and physical dependence or illness. The following Table shows the percentage of older persons where specific needs or risk factors were present, based on collated statistics from the 4 year period, based on a total of 2619 cases.

SPECIAL NEEDS/RISK FACTORS	OLDER PERSON	ABUSER
Dementia	534 (20.3%)	17 (0.65%)
Disability	444 (17.0%)	46 (1.8%)
Financial/Social Disadvantage	263 (10.0%)[61]	14 (0.5%)[62]
Homelessness	38 (1.45%)[63]	8 (0.31%)[64]
Rural/Remote Location	421 (16.1%)	260 (9.93%)
Caregiver/Caregiving Stress	127 (4.85%)	356 (13.6%)
Cognitive Impairment	723 (27.6%)	42 (1.6%)
Family Conflict	1593 (60.8%)	1669 (63.7%)
Financial Stress	849 (32.4%)	334 (12.8%)
Isolation	1141 (43.6%)	20 (0.76%)
Lack of Appropriate Services	440 (16.8%)[65]	29 (1.1%)[66]
Lack of Information	701 (27.8%)[67]	7 (0.3%)[68]
Language/Cultural Barriers	223 (8.5%)[69]	39 (1.48%)

61 Note, that this category has only been captured by ARAS since 2014.
62 Ibid.
63 Note that this category has only been explicitly measured since 2014 also.
64 Ibid
65 Ibid.
66 Ibid.
67 Ibid.
68 Ibid.
69 Ibid. However, during the 4 year period, a total of 30 (1.1%) used an interpreter.

Living with Abuser	441 (16.8%)[70]	18 (6.87%)[71]
Mental Health	1412 (53.9%)[72]	379 (14.5%)[73]
Physical Dependence	1091 (41.7%)	67 (2.6%)
Physical Illness	578 (22.1%)	42 (1.6%)
Psychological Dependence	1089 (41.58%)	76 (2.90%)
Self-Neglect	175 (6.7%)	40 (1.5%)
Substance/Alcohol Abuse	40 (0.76%)	283 (10.8%)

The ARAS statistics indicate that the following risk factors and special needs of older persons are the most commonly found in cases of elder abuse:

1. Mental Health and/or psychiatric illness (62.5% of cases)[74]
2. Isolation (43.6% of cases)
3. Physical dependence (41.7% of cases)
4. Psychological dependence (41.58% of cases)
5. Family Conflict (38.6% of cases)
6. Financial stress (32.4% of cases)
7. Lack of Information (27.8% of cases)
8. Cognitive Impairment (27.6 of cases)
9. Physical illness (22.1% of cases)
10. Dementia (20.3% of cases)

With respect to alleged abusers, the following risk factors and identified needs were most commonly present in cases reported to ARAS:

1. Family Conflict (63.7% of cases)
2. Mental Health & Psychiatric Illness (18.6% of cases)[75]
3. Caregiver stress (13.6% of cases)
4. Financial stress (12.8% of cases)
5. Substance/alcohol abuse (10.8% of cases)
6. Living in a rural/remote location (9.93% of cases)

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70 This factor has only been separately recorded as a risk factor by ARAS since 2014.

71 Ibid. However, the lack of correlation between older persons who asserted they were living with the abuser may simply indicate that ARAS collects more detailed information about the older person than the alleged abuser.

72 It should be noted that in the 2012-13 to 2014-15 financial years (3 years) psychiatric illness accounted for an additional 60 people.

73 It should be noted that in the 2012-13 to 2014-15 financial years (3 years) psychiatric illness accounted for an additional 71 people.

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7. Living with the victim (6.87% of cases)[76]
8. Psychological dependence (2.90% of cases)
9. Physical dependence (2.6% of cases)
10. Disability (1.8% of cases)

It is clear that a range of significant risk factors combine to make older persons vulnerable to abuse, whereas the single biggest factor for alleged abusers is family conflict (ie, separation, divorce, relationship breakdown). However, the presence of other stress factors for alleged abusers, whether financial, mental health related or based on caregiver stress can be significant factors which also contribute to the likelihood and prevalence of elder abuse. This compares with the significance of mental health and dependence for older persons (both physical and psychological), isolation, financial stress (which may well be linked with dependency on others), family conflict and the combined health issues of physical illness, disability, cognitive impairment and dementia. These factors are clearly significant indicators of risk for vulnerable older people, especially where family conflict is an issue between family members and carers. While the data collected by ARAS is quite comprehensive, a more qualitative evaluation method is necessary in order to understand how these risk factors interact in specific cases, resulting in the increased vulnerability of older people and higher incidence rates of elder abuse. Without such qualitative data to sit alongside the quantitative statistics, it is difficult to understand and, therefore, to educate the community, on what combination of factors can make a person susceptible to abuse or a perpetrator susceptible to harming, abusing or exploiting a vulnerable older person.

And, as the data clearly demonstrates, family members, particularly sons and daughters, are the most common perpetrators of abuse. In a total of 2619 cases reported to ARAS in the 4 year period, a total of 2225 cases involved a family member as the alleged abuser. This amounts to a staggering total of 85% of all cases reported to ARAS in the 4 year period. The Table below breaks those figures down across the 4 years, confirming that sons and daughters are the most common perpetrators (responsible for 55.25% of all cases of reported elder abuse to ARAS). When spouses, de-facto partners and former partners are taken into account, these 3 categories of family member accounted for a total of 65.98% (or two thirds of all cases).

FAMILY MEMBER	2012-2013	2013-2014	2014-2015	2015-2016	TOTAL (2619 CASES)
Son	190 (33.5%)	207 (30.39%)	195 (29.81%)	201 (27.99%)	793 (30.28%)
Daughter	123 (21.7%)	198 (29.07%)	156 (23.85%)	177 (24.65%)	654 (24.97%)
Spouse	70 (12.36%)	54 (7.92%)	52 (7.95%)	68 (9.47%)	244(9.32%)
Grandchild	26 (4.59%)	19 (2.79%)	27 (4.12%)	38 (5.29%)	110 (4.20%)

[76] Recognising the lack of correlation between the number of victims identified as living with an abuser (14.5% of all cases, compared with 8.26% of abusers).

Son in Law	16 (2.29%)	13 (1.90%)	11 (1.68%)	18 (2.51%)	58 (2.21%)
Daughter in Law	13 (2.29%)	17 (2.49%)	17 (2.59%)	18 (2.51%)	65 (2.48%)
Sibling (Brother)		1 (0%)	4 (0.61%)	5 (0.70%)	10 (0.38%)
Sibling (Sister)		2 (.29%)	8 (1.22%)	9 (1.25%)	19 (0.72%)
Niece/Nephew	10 (1.76%)	5 (0.73%)	14 (2.14%)	14 (1.95%)	43 (1.64%)
Multiple Family	34 (6.0%)	19 (2.79%)	11 (1.68%)	3 (1.53%)	67 (2.56%)
Step-Child		6 (0.88%)	21 (3.21%)	12 (1.67%)	39 (1.48%)
Other Family	30 (5.3%)	21 (3.08%)	18 (2.75%)	17 (2.36%)	86 (3.28%)
De-Facto Partner		12 (1.76%)	5 (0.76%)	7 (0.97%)	24 (0.91%)
Partner (Separated)		2 (0.29%)	8 (1.22%)	3 (0.42%)	13 (0.50%)
TOTAL	**512 (90.45% of 566 cases)**	**576 (84.58% of 681 cases)**	**547 (83.63% of 654 cases)**	**590 (82.17% of 718 cases)**	**2225 (85%)**

In addition to family members, the ARAS data indicates the propensity for carers (both formal and informal) to be an abuser of older people in their care. However, the ARAS statistics show that the rates at which abuse is being reported by carers has fallen significantly in the 4 year period reviewed, from 9.71% of all cases reported to ARAS in 2012-2013 to 2.51% in 2015-2016.

CARER	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**TOTAL (2619 CASES)**
Unpaid Carer (Family/Friend)	11 (0.19%)	9 (1.32%)	8 (1.22%)	10 (1.39%)	38 (1.47%)
Registered Carer	28 (4.94%)	6 (0.88%)	5 (0.76%)	4 (0.56%)	43 (2.05%)
Paid Carer (Private)	6 (1.06%)	8 (1.17%)	6 (0.91%)	2 (0.28%)	22 (1.05%)
Worker (Staff/Volunteer)	10 (1.76%)	5 (0.73%)	7 (1.07%)	2 (0.28%)	24 (1.20%)
TOTAL	**55 (9.71% of 566 cases)**	**28 (4.11% of 681 cases)**	**26 (3.97% of 654 cases)**	**18 (2.51% of 718 cases)**	**127 (4.85%)**

The remainder of perpetrators recorded by ARAS fall within the following categories, with the most significant being friends and neighbours. In this respect, it would be helpful if ARAS further defined the categories of 'friend' and 'neighbour', as well as 'other'. Indeed, given that these other categories comprise more than triple the number of cases involving all types of carers, further interrogation of each of these categories is warranted.

OTHER ABUSER	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**TOTAL (2619 CASES)**
Friend/Neighbour	48 (8.48%)	69 (10.31%)	46 (6.75%)	52 (7.24%)	215 (8.21%)
Other	7 (1.23%)	112 (16.59%)	20 (3.05%)	16 (2.23%)	155 (5.92%)
Private Business	20 (3.53%)	17 (2.49%)	9 (1.37%)	4 (0.56%)	50 (1.91%)
Unknown	5 (0.88%)	4 (0.58%)	2 (0.30%)	2 (0.28%)	13 (0.50%)
TOTAL	**80 (14.13% of 566 cases)**	**202 (29.66% of 681 cases)**	**77 (11.77% of 654 cases)**	**74 (10.31% of 718 cases)**	**359 (16.53%)**

The ARAS data in relation to the relationship of the abuser to the victim correlates interestingly with the risk facts and identified needs of both the older person and the abuser, reflecting the relationships of trust and dependency which often give rise to opportunities for abuse or exploitation in inter-familial settings. However, more needs to be done in relation to research which examines not just prevalence, risk factors and vulnerabilities, but in terms of the complex social and familial settings which give rise to situations of vulnerability for older persons, coupled with the circumstances in which that vulnerability is exploited. Understanding why family members become abusers can only be properly examined and understood through qualitative studies.

With respect to types of abuse recorded, it is clear from the ARAS data that abuse is frequently carried out in multiple forms. While the 4 year review period involved a total number of 2619 cases of reported abuse, there were 4755 incidents of different types of abuse reported to ARAS, meaning that for each case of abuse handled by ARAS, there involved an average of 1.81 types of abuse. While ARAS captures comprehensive data with respect to each reported type of abuse, it would be helpful to better understand how the different types of abuse are collectively or jointly used to harm or exploit an older person. Indeed, through mapping how different types of abuse are perpetrated in combination we would have a better sense of how elder abuse manifests. However, recording such levels of detail would require the collation of deeper data and more qualitative information about each case. While this is certainly possible, it would need to be effectively resourced for ARAS to be able to capture and collate that information.

TYPES OF ABUSE	2012-2013	2013-2014	2014-2015	2015-2016	TOTAL (4755CASES)
Psychological Abuse	421 (43.58%)	551 (44.36%)	541 (43.91%)	602 (47.36%)	2115 (44.48%)
Financial Abuse	312 (32.29%)	367(29.54%)	326 (26.46%)	350 (27.54%)	1355(28.50%)
Neglect	91 (9.42%)	116 (9.33%)	123 (9.98%)	122 (9.60%)	452 (9.51%)
Social Abuse	59 (6.10%)	75 (6.03%)	93 (7.55)	104 (8.18%)	331 (6.96%)
Physical Abuse	75 (7.76%)	108 (8.69%)	90 (7.31%)	86 (6.77%)	359 (7.54%)
Sexual	7 (0.72%)	3 (0.24%)	7 (0.56%)	1 (0.08%)	18 (0.37%)
Substance		3 (0.24%)	3 (0.24%)	6 (4.7%)	12 (0.25%)
Misuse of Powers of Attorney[77]		16 (1.28%)	42 (3.4%)	41 (3.2%)	99 (2.08%)
Reportable Assaults[78]		3 (0.24%)	7 (5.68%)		10 (0.21%)
Other	1 (0%)	3 (0.24%)			4 (0.08%)
TOTAL	**966 cases**	**1245 cases[79]**	**1232 cases**	**1271 cases**	**4755(100%)**

ARAS also collects data on victims and abusers including their geographical location, distinguishing between metropolitan Adelaide, rural and remote areas of South Australia, interstate, overseas or unknown. The great majority of both victims and abusers reside in the metropolitan area of Adelaide, with the large majority of the remainder residing in rural South Australia, as the next two tables demonstrate.

LOCATION OF OLDER PERSON	2012-2013	2013-2014	2014-2015	2015-2016	TOTAL (2513 CASES)
Metropolitan Adelaide	443 (79.67%)	543 (82.52%)	523 (83.94%)	541 (79.91%)	2050 (81.6%)
Rural SA	83 (14.95%)	97 (14.74%)	85 (13.64%)	111 (16.4%)	376 (14.96%)

77 For the purposes of this Report, misuse of a Power of Attorney is treated as a separate form of financial abuse, as ARAS appear to have counted such cases separately.

78 ARAS has not counted reportable assaults separately, presumably because they involve with sexual or physical abuse under the *Aged Care Act 1997* (Cth), or a breach of South Australia's criminal laws.

79 Note that ARAS appears to have miscalculated the number of incidences for abuse in its datasets for 2013-2014, reporting 498 types of abuse, instead of 511 (excluding reportable assaults).

Remote SA	27 (4.86%)	15 (2.27%)	5 (0.80%)	10 (1.5%)	57 (2.27%)
Interstate	0 (0%)	0 (0%)	6 (0.96%)	13 (1.92%)	19 (0.76%)
Overseas	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Unknown	2 (0.35%)	3 (0.46%)	4 (0.64%)	2 (0.29%)	11 (0.43%)
TOTAL	**555 cases**	**658 cases**	**623 cases**	**677 cases**	**2513 (100%)**

The following Table shows the same statistics, but for the alleged abuser.

LOCATION OF ABUSER	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**TOTAL (1853 CASES)**
Metropolitan Adelaide	293 (62.89%)	276 (78.63%)	386 (76.58%)	467 (75.57%)	1522 (82.14%)
Rural SA	75 (19.73%)	50 (14.24%)	59 (11.7%)	89 (14.40%)	273 (14.73%)
Remote SA	10 (2.63%)	3 (0.85%)	6 (1.19%)	12 (1.94%)	31 (1.67%)
Interstate	0 (0%)	6 (1.70%)	12 (2.38%)	20 (3.2%)	38 (2.05%)
Overseas	0 (0%)	0 (0%)	0 (0%)	1 (0.16%)	1 (0.05%)
Unknown	2 (0.52%)	16 (4.55%)	41 (8.33%)	29 (0.47%)	88 (4.75%)
TOTAL	**380 cases**	**351 cases**	**504 cases**	**618 cases**	**1853 (100%)**

ARAS no longer collects gender data on alleged abusers as a separate category, but does distinguish between different types of abusers who are also family members (sons, daughters etc). Data for 2013-2014 and 2012-2013 reveal an inconsistent picture with a 51% male to 49% female split in 2013-2014 but a 60% to 40% split in 2012-2013. Analysis of the Table above demonstrates that, among family members, sons are more likely to be perpetrators and the existing literature shows that women are much more likely to be the victims of abuse. It would be helpful, however, if ARAS continued to collect data on the gender of both the victim and the abuser, the latter appearing to have been discontinued in 2014.

Because dealing with elder abuse cases through the provision of support, referrals, representation and advocacy for victims is core business for ARAS, their policies, procedures and protocols are directly geared towards fulfilling those roles. However, ARAS also conducts broader training and community awareness training for health professionals, students and members of the community. While ARAS provides an independent service which is focussed directly on protecting the rights of older persons, they have limited capacity to support and advocate for older persons in forums such as the South Australian Civil and Administrative Tribunal (SACAT). Notwithstanding these limits, ARAS is responsible for compiling the most comprehensive data on the prevalence of elder abuse in South Australia. Their datasets contain a significant amount of critical information for monitoring the incidence of abuse and

trends over time, but those datasets could be enhanced through the collation of deeper data and the mapping of key factors in individual cases. Such information is necessarily more qualitative in nature and has obvious resource implications for an organisation such as ARAS.

4.1.1 Elder Abuse Prevention Phone Line Support and Referral Service

Data from the Elder Abuse Phone Line Support and Referral Service for its first 10 months of operation (October 2015 – July 2016) was made available to this study and, while preliminary, provides a rich source of information. Some of this information will be replicated in Aged Rights Advocacy Service data (above) as a total of 99 calls were referred to the service.

The data shows 237 calls over the 10 month period, with the highest number of calls (17.7%) coming in the second month of a 2 month advertising and promotional campaign (November 2015). Similarly, the second most popular month (June 2016 – 17%) coincided with a follow-up advertising and promotional campaign, highlighting the value of promotion to increase use of the service. Family members were the greatest source of enquiry (40.9%), followed by older persons (25.7%), service providers (17.7%) and friends (10.1%).

Older Persons

Almost two thirds of 226 persons experiencing abuse were female (65%) and one third male (35%). In 8 % of cases, abuse had been previously notified. The most common age range of persons experiencing abuse was 80 – 85 (21.2% of 217 responses), followed by 86 – 90 (18.0%), 76 – 80 (14.3%), 66 – 70 and 70 – 75 (9.2%), and 61 – 65 and 91 – 94 (6.9%). A total of 13.5% of cases involved a married couple or partners who were both alleged victims of the same perpetrator. The majority (51.7%) of older persons lived in a home they owned, with 18.0% in an aged care facility, 10.4 % in a rented home, 5.2% in a retirement village and 2.8% in retirement independent living units. A total of 87.6% of abuse predominately occurred in the same location as accommodation type. In 78.0% of cases, older persons lived in the metropolitan area, 16.4% in rural areas, and 0.9% in remote areas with 4.6% 'unknown'.

A figure of 80.2% of 207 cases of abuse involved a relationship of trust. Psychological/emotional abuse was the most common type reported (33.5%) of 385 abuse types reported, followed by financial/material (26.5%), neglect (10.6%), physical (9.6%), social (8.1%), misuse of Power of Attorney (5.5%), sexual (0.8%), scams (0.8%) and reportable assault (0.5%). In 75.7% of 140 cases there had been a history of abuse by the alleged abuser.

A total of 56.1% of 221 older persons were responsible for their own care, 24% were in the care of the alleged abuser, 7.7% in the care of another person/agency and 12.2% in the care of a combination of the alleged abuser and another person or agency. This means that in more than one third of cases (36.2%), the alleged abuser had some responsibility for the care of the older person.

A total of 101 of 162 older persons (62.3%) received their main source of income through the Age Pension, 27.8% were self-funded retirees, 6.2% were on the Disability Support Pension and 3.7% received their main source of income from other sources.

There were 136 instances of identified needs with respect to the older person. Dementia was the most common (35.3%) followed by regional/rural (14.7%), 'other disability' (10.3%), financial or social disadvantage (9.6%), CALD (8.1%), veteran (2.9%), ATSI and younger person with a disability (1.5%

each), remote (0.7%), and 'other' identified needs constituted the remaining 15.4%. In 7.6% of cases, a language other than English was spoken at home.

A total of 91 of 219 older persons were living alone (47.6%), 19.3% lived with a partner or spouse, 14.7% lived with a son, 9.9% with a daughter, 3.1% with multiple families, 2.1% with another family member, 1.6% with friends, 1% with a grandchild and 0.5% with a son-in-law.

There were 423 risk factors recorded in association with older persons. The most common was poor physical health/frailty (physical dependence) (20.1%), followed by family stress/conflict (18.2%), social isolation (13.0%), cognitive impairment (9.7%), dementia (8.5%), mental health issues (6.1%), geographic location (4.4%), living with alleged perpetrator (3.1%), history of abuse (2.4%), language/cultural barriers (2.4%), psychological dependence (2.1%), substance abuse/alcohol (1.2%), carer stress (1.2%), lack of information (0.9%), lack of appropriate services (0.9%), homelessness or at risk (0.7%), financial stress/dependence (0.7%), physical independence (0.5%), history of self-neglect (0.5%) and gambling (0.2%). In a further 3.1% of instances there was an unknown risk factor noted.

Of 165 older persons where an assessment was undertaken, 26.3% were found not to have capacity to make their own decisions. Where recorded, 64.3% of 115 persons had an Enduring Power of Attorney, (EPA) 38.9% of 54 had an Advance Care Directive (ACD), and 12.5% of 96 had an Administration or Guardianship Order (AGO) in place. Further detailed information regarding the use of ACDs, EPAs and AGOs is warranted.

Alleged Abusers

In 192 cases where known, 69.7% of alleged abuse was committed by 1 perpetrator, 17.7% by 2 perpetrators, 4.7% by 3 perpetrators and 7.8% by more than 3 perpetrators. There were 202 risk factors associated with alleged abusers. The most common was a history of psychological/emotional abuse (13.9%), followed by dementia (12.9%), mental health issues (11.4%), family stress/conflict (10.8%), addiction/substance misuse (alcohol and drugs) (8.9%), financial stress/dependence (7.4%), history of physical abuse (4.0%), history of theft/criminal activity (4.0%), debt burden/bankruptcy (4.0%), gambling (3.5%), social isolation (3.5%), addiction/gambling (3.0%), history of criminal justice intervention/imprisonment (2.0%), carer stress (2.0%), history of sexual abuse (1.5%), lack of appropriate services (1.5%), language/cultural Barriers (1.5%), cognitive impairment, 3 (1.5%), geographic location (1.0%), poor physical health/frailty (physical dependence) (1.0%) and homelessness or risk of homelessness (1.0%).

Where recorded, there was an almost even split of gender of alleged abusers with 50.6% being female and 49.4% male. Among perpetrators, 44.2% were employed, 20.4% were on Carer Allowance, 13.3% were unemployed/welfare recipient, 6.2% were receiving Disability Support Pension, and 15.9% were recorded as 'other' source of income.

Where the age of the alleged abuser was recorded (144 instances), the largest cohort was 50 – 54 years (25.7%), followed by 45 - 49 years (10.4%), 40 - 44 years (9.7%), 55 -59 years (8.3%), 60 – 64 years (8.3%), 65 – 69 years (6.9%), 70 – 74 years (6.25%), 35 - 29 years (5.6%), 30 -34 years (4.2%), 75 -79 years (4.2%), 21 – 24 years (2.8%), 25 – 29 years (2.8%), 80 – 84 years (2.8%), 20 years and under, 2 (1.4%) and 85 – 89 years, 1 (0.7%).

In 23.3% of 236 cases, the alleged abuser was the son of the older person, followed by daughter (22.0%), health professional (7.6%), neighbour (7.2%), female partner (6.8%), friend (4.7%), grandson (3.0%), daughter-in-law (2.5%), male partner (2.1%), son-in-law (2.1%), other relative (1.7%), granddaughter (0.8%), nephew (0.8%), acquaintance (0.8%), brother (0.4%), sister (0.4%) and niece (0.4%). In 8.9% of cases it was 'other' and in 4.2% of cases it was 'unknown'.

Data on the identified needs of abusers was more limited with 'other' being the highest category at (32.1%) of 56 responses. This was followed by financial or social disadvantage (16.1%), CALD (14.3%) regional/remote (12.5%), Aboriginal or Torres Strait Islander heritage (5.4%), dementia (5.4%), younger person with a disability (5.4%), other disability (5.4%), rural (1.8%) and veterans (1.8%).

Outcomes

The data records the outcomes of calls in the form of 'informal' (general information provided), 'formal' (referral to a specific service provider) and 'warm' (direct connection made to a service on the caller's behalf). The data shows that the most common referrals were to the Aged Rights Advocacy Service (99 referrals), SAPOL (54), the Legal Services Commission (51) and the Office of the Public Advocate (37).

Data is summarised in the tables below, noting that not all fields were collected for all calls, so percentages are calculated on total responses to each relevant question.

Total Monthly Calls

Month	**Calls**
October 2015 *promotional campaign in operation	19 (8.0%)
November 2015*promotional campaign in operation	42 (17.7%)
December 2015	14 (5.9%)
January 2016	25 (10.5%)
February 2016	22 (9.2%)
March 2016	16 (6.7%)
April 2016	15 (6.3%)
May 2016	19 (8.0%)
June 2016	41 (17.2%)
July 2016	24 (10.1%)
Total (10 Months)	**237 (100%)**

The following statistics were provided by ARAS:

	TOTALS
Preliminary Information	
Caller type	
(Self) Older Person	**61 (25.7%)**
Family Member	**97 (40.9%)**
Friend	**24 (10.1%)**
Neighbour/Acquaintance	**4 (1.7%)**
Service Provider	**42 (17.7%)**
Other	**8 (3.4%)**
Unknown	**1 (0.4%)**
TOTAL	***237***
Alleged abuse previously notified?	
Yes	**18 (8.0%)**
No	**206 (92.0%)**
Details of Older Person experiencing elder abuse	
Gender	
Male	**79 (35.0%)**
Female	**147 (65.0%)**
Age range	
· 50 – 55	**4 (1.8%)**
· 56 – 60	**4 (1.8%)**
· 61 – 65	**15 (6.9%)**
· 66 -69	**20 (9.2%)**
· 70 – 75	**20 (9.2%)**
· 76 – 80	**31 (14.3%)**
· 80 – 85	**46 (21.2%)**
· 86 – 90	**39 (18.0%)**
· 91 – 94	**15 (6.9%)**
· 95 -100	**3 (1.4%)**
· Unknown	**20 (9.2%)**
Couple:	
(Married or partners/spouses are BOTH alleged victims of the SAME perpetrator)	
Yes	**28 (13.5%)**
No	**179 (86.5%)**
Residence of older person:	
Resident of Aged Care facility	**38 (18.0%)**
Retirement Village	**11 (5.2%)**
Rented Home	**22 (10.4%)**
Own Home	**109 (51.7%)**

Retirement Independent Living Units (including housing co-operatives, associations and community houses)	**6 (2.8%)**
Boarding House	**1 (0.5%)**
Institution	**1 (0.5%)**
Unknown	**12 (5.7%)**
Other	**11 (5.2%)**
Location where abuse predominantly occurred:	
Same as Accommodation type	**183 (87.6%)**
Different from Accommodation type	**26 (12.4%)**
Relationship:	
Relationship of trust	**166 (80.2%)**
Non relationship of trust	**41 (19.8%)**
Type of abuse:(Select all that apply)	
	TOTALS
Financial/material	**102 (26.5%)**
Misuse of Power of Attorney	**21 (5.5%)**
Psychological/emotional	**129 (33.5%)**
Physical	**37 (9.6%)**
Sexual	**3 (0.8%)**
Social	**31 (8.1%)**
Neglect	**41 (10.6%)**
Reportable Assault	**2 (0.5%)**
Scam	**3 (0.8%)**
Other	**16 (4.2%)**
History of abuse of the older person by the alleged abuser(s)	
Yes	**106 (75.7%)**
No	**34 (24.3%)**
Responsibility for older person's care	
Self	**124 (56.1%)**
Alleged abuser	**53 (24.0%)**
Other person/agency	**17 (7.7%)**
Combination of alleged abuser and other person/agency	**27 (12.2%)**
Main source of income	
Age Pension	**101 (62.3%)**
Self-funded retiree	**45 (27.8%)**
Disability Support Pension	**10 (6.2%)**
Other	**6 (3.7%)**
Identified Needs	
Aboriginal or Torres Strait Island	**2 (1.5%)**

Dementia	**48 (35.3%)**
Financially or Socially Disadvantaged	**13 (9.6%)**
Younger Person with a Disability	**2 (1.5%)**
CALD	**11 (8.1%)**
Regional/Rural	**20 (14.7%)**
Remote	**1 (0.7%)**
Veteran	**4 (2.9%)**
Other Disability	**14 (10.3%)**
Other	**21 (15.4%)**
Language spoken at home	
English	**195 (92.4%)**
Italian	**2**
Greek	**3**
Vietnamese	**2**
German	**1**
Other	**8 (all 7.6%)**
Geographic Location:	
	TOTAL
Metro	**171 (78.0%)**
Regional/Rural	**36 (16.4%)**
Remote	**2 (0.9%)**
Unknown	**10 (4.6%)**
Living arrangement of older person	
Living alone	**91 (47.6%)**
With Spouse/partner	**37 (19.3%)**
With Son	**28 (14.7%)**
With Son-in-law	**1 (0.5%)**
With Daughter	**19 (9.9%)**
With Grandchild	**2 (1.0%)**
With other family member	**4 (2.1%)**
With Multiple Families	**6 (3.1%)**
With Friend/s	**3 (1.6%)**
Risk Factors:	
(Select all that apply)	
Geographic Location	**19 (4.4%)**
Social Isolation	**55 (13.0%)**
Poor physical health/frailty (Physical dependence)	**85 (20.1%)**
Mental Health Issues	**26 (6.1%)**
Cognitive Impairment	**41 (9.7%)**
Dementia	**36 (8.5%)**
Family Stress/Conflict	**77 (18.2%)**
Physical independence	**2 (0.5%)**

Psychological dependence	**9 (2.1%)**
Substance Abuse/Alcohol	**5 (1.2%)**
Gambling	**1 (0.2%)**
Homeless or At Risk	**3 (0.7%)**
Financial Stress/Dependence	**3 (0.7%)**
Carer's Stress	**5 (1.2%)**
Lack of information	**4 (0.9%)**
Lack of Appropriate Services	**4 (0.9%)**
Language/Cultural Barriers	**10 (2.4%)**
Living with Alleged Perpetrator	**13 (3.1%)**
History of Self Neglect	**2 (0.5%)**
History of Abuse	**10 (2.4%)**
Unknown	**13 (3.1%)**
Does the older person have capacity to make decisions?	
Yes	**120 (73.7%)**
No	**45 (26.3%)**
Enduring Power of Attorney?	
Yes	**74 (64.3%)**
No	**41 (35.7%)**
Advance Care Directives?	
Yes	**21 (38.9%)**
No	**33 (61.1%)**
Administration or Guardianship Orders?	
Yes	**12 (12.5%)**
No	**84 (87.5%)**
Details of Alleged Perpetrator/s of Elder Abuse	
Number of alleged perpetrators:	
One	**134 (69.7%)**
Two	**34 (17.7%)**
Three	**9 (4.7%)**
More than 3	**15 (7.8%)**
Risk Factors of Alleged Abuser/s: (Select all that apply)	
History of Physical Abuse	**8 (4.0%)**
History of theft/criminal activity	**8 (4.0%)**
History of sexual abuse	**3 (1.5%)**
History of psychological/emotional abuse	**28 (13.9%)**
History of criminal justice intervention/imprisonment	**4 (2.0%)**
Addiction- substance misuse (alcohol and Drug)	**18 (8.9%)**
Addiction- gambling	**6 (3.0%)**
Debt burden/bankruptcy	**8 (4.0%)**
Financial Stress/Dependence	**15 (7.4%)**
Geographic Location	**2 (1.0%)**
Social Isolation	**7 (3.5%)**

Poor physical health/frailty (Physical dependence)	**2 (1.0%)**
Mental Health Issues	**23 (11.4%)**
Cognitive Impairment	**3 (1.5%)**
Dementia	**26 (12.9%)**
Gambling	**7 (3.5%)**
Homeless or At Risk	**2 (1.0%)**
Family stress/Conflict	**22 (10.8%)**
Carer's Stress	**4 (2.0%)**
Lack of Appropriate Services	**3 (1.5%)**
Language/Cultural Barriers	**3 (1.5%)**
Income source of alleged abuser	
Employed	**50 (44.2%)**
Unemployed/welfare recipient	**15 (13.3%)**
Carer Allowance	**23 (20.4%)**
Disability Support Pension	**7 (6.2%)**
Other (please specify)	**18 (15.9%)**
Gender of alleged perpetrator/s	
Male	**116 (49.4%)**
Female	**119 (50.6%)**
Age of perpetrator/s:	
20 years and under	**2 (1.4%)**
21 – 24 years	**4 (2.8%)**
25 – 29 years	**4 (2.8%)**
30 -34 years	**6 (4.2%)**
35 - 29 years	**8 (5.6%)**
40 - 44 years	**14 (9.7%)**
45 - 49 years	**15 (10.4%)**
50 – 54 years	**37 (25.7%)**
55 -59 years	**12 (8.3%)**
60 – 64 years	**12 8.3%)**
65 – 69 years	**10 (6.9%)**
70 – 74 years	**9 (6.25%)**
75 -79 years	**6 (4.2%)**
80 – 84 years	**4 (2.8%)**
85 – 89 years	**1 (0.7%)**
Relationship to older person	
Partner – Male	**5 (2.1%)**
Partner – Female	**16 (6.8%)**
Son	**55 (23.3%)**
Daughter	**52 (22.0%)**
Brother	**1 (0.4%)**
Sister	**1 (0.4%)**

Grandson	**7 (3.0%)**
Granddaughter	**2 (0.8%)**
Nephew	**2 (0.8%)**
Niece	**1 (0.4%)**
Son-in-law	**5 (2.1%)**
Daughter-in-law	**6 (2.5%)**
Other relative	**4 (1.7%)**
Friend	**11 (4.7%)**
Neighbour	**17 (7.2%)**
Acquaintance	**2 (0.8%)**
Health Professional	**18 (7.6%)**
Other	**21 (8.9%)**
Unknown	**10 (4.2%)**
Identified Needs	
Aboriginal or Torres Strait Island	**3 (5.4%)**
Dementia	**3 (5.4%)**
Financially or Socially Disadvantaged	**9 (16.1%)**
Younger Person with a Disability	**3 (5.4%)**
CALD	**8 (14.3%)**
Regional/Remote	**7 (12.5%)**
Rural	**1 (1.8%)**
Veterans	**1 (1.8%)**
Other Disability	**3 (5.4%)**
Other	**18 (32.1%)**
Service/Referral Provided to Person Reporting Abuse:	
Informal	
	TOTALS
Informed Rights	**84**
Information given	**157**
Information posted or emailed	**7**
Support for self-Advocacy	**2**
Family members to assist	**28**
Friends to assist	**7**
Community groups (eg Church) to assist	**5**
Safety Plan	**2**
Formal	
	TOTALS
Advocacy Service (ARAS)	**84**
Aged Care Assessment Team	**24**
Aged Care Complaints Scheme	**7**
Centrelink (eg Social Worker)	**6**
Community Service	**9**
Community Legal Service	**2**

Counselling	**23**
Mediation	**23**
Family Support Services	**4**
GP/Medical Clinic	**35**
Home Support Services	**6**
Home Care Packages	**5**
Hospital	**4**
Housing SA	**3**
Justice Net	**2**
My Aged Care	**9**
Private Community Services	**2**
Respite Residential Aged Care	**6**
SA Community Legal Centres	**3**
TIA, Tenants Information & Advisory Service	**3**
Women Legal Services	**3**
Other (specify) -	**12**
	TOTALS
Service/Referral Provided to Person Reporting Abuse:	
Protective	
	TOTALS
Police	**53**
Legal Services Commission	**50**
Office of Public Advocate	**36**
Public Trustee	**12**
SA Civil and Administrative Tribunal	**17**
Financial Institution	**16**
Power of Attorney	**12**
Advance Care Directive	**1**
Enduring Power of Guardianship	**9**
Aged Care Complaints Scheme (ACCS)	**7**
Health and Community Services Complaints Commissioner (HCSCC) South Australia	**5**
Other (specify) ----------	**7**
TOTAL FOR MONTH	**225**
(Warm) Referral	
	TOTALS
Legal Services Commission	**1**
Office of Public Advocate	**1**
Advocacy Service (ARAS)	**15**
Aged Care Assessment Team (ACAT)	**1**
TIA, Tenants Information & Advisory Service	**1**
Police	**1**
Other (specify)	**1**
TOTAL FOR MONTH	**21**
Caller's Feedback	

None provided	**1**
Caller Outcomes: Positive	
(Caller indicated that as a result of contact with the Phone Line they);	
Feel more relaxed/less stressed about the matter	**35**
Now have options to consider that did not previously exist	**65**
Now know what to do	**23**
Feel more supported/confident in standing up for their rights	**41**
Feel that someone is listening to them/taking them seriously	**35**
Appreciate being able to unload their problem onto someone who listens	**78**
Feels stronger knowing that they can contact the Phone Line again if necessary	**47**
Is grateful for Phone Line assistance	**73**
Caller Outcomes: Negative	
(Caller indicated that as a result of contact with the Phone Line they):	
Are disappointed because they thought the Phone Line could assist/act for them	**18**
Don't know what use the Phone Line is if they can't help them	**6**
Was hoping that the Phone Line could tell them what to do	**2**
Thought the Phone Line would directly confront the alleged perpetrator and stop them doing what they are alleged to be doing	**4**

4.2 Aged Care Complaints Scheme

The Aged Care Complaints Scheme operates as part of the *Aged Care Act 1997* (Cth). Older persons living in residential care are subject to a scheme whereby serious physical assaults and sexual assaults are subject to a mandatory reporting scheme.[80] The Act also provides for the establishment of an Aged Care Complaints Commissioner and the Aged Care Complaints Scheme, in addition to a series of regulations to which are attached in scheduled Charters of Rights for both residents of federally funded aged care facilities and older persons receiving federally funded home care packages.[81] As others have described, however, these measures, no matter how important, have significant limitations:[82]

> Residents and recipients of aged care services have the benefit of Charters of Rights attached to the *Aged Care Act*. The User Rights Principles 1997 has scheduled to it the Charter of Residents' Rights and Responsibilities (sch 1), and — as a consequence of the User Rights Amendment Principles (2013) (No 1) — the Charter of Rights and Responsibilities for Home Care (sch 2).[83] The former includes such rights as the following:

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80 Section 63(1AA) of the Act imposes an obligation of residential care providers to report alleged or suspected 'unlawful sexual contact, unreasonable use of force or assault specified in the Accountability Principles and constituting an offence against a law of the Commonwealth or a State or Territory.'

81 See further, Lacey, above n 7, at 123-124.

82 Ibid.

83 Residential care providers have various obligations under the *Aged Care Act 1997* (Cth). Those obligations include an obligation to comply with the User Rights Principles (referred to in s 55(1) of the Act). These principles are made by the Minister under s 96(1), as specified in s 55(2). All principles made by the Minister under s 96.1 are done by legislative instrument. The current User Rights Principles were made in 1997, but have been amended on many occasions since, the most recent amendment being on 20 March 2013. Schedule 1 of those Principles is comprised of a Charter of Residents' Rights and Responsibilities. Schedule 2 comprises a Charter of Rights and Responsibilities for Community Care.

- to be treated with dignity and respect, and to live without exploitation, abuse or neglect;
- to live without discrimination or victimisation, and without being obliged to feel grateful to those providing his or her care and accommodation;
- to live in a safe, secure and homelike environment, and to move freely both within and outside the residential care service without undue restriction;
- to be treated and accepted as an individual, and to have his or her individual preferences taken into account and treated with respect;
- to maintain his or her personal independence;
- to maintain control over, and to continue making decisions about, the personal aspects or his or her daily life, financial affairs and possessions.

The Charter is laudatory and quite comprehensive. However, when considered alongside the mechanisms for its enforcement, its impact is significantly reduced. The Charters are not enforceable and are not accompanied by any scheme for seeking individual remedies for their breach.[84] The human rights requirements contained in the legislation, and the complaints scheme attached to it, act as mandatory conditions which are attached to accreditation for all providers. However, because they operate as obligations on providers, the failure to comply with them only has consequences for providers in the sense of potentially receiving Notices of Required Action.[85] There are no remedies for the complainant or victim of the breach other than through the Aged Care Complaints Scheme, which, as commentators have already observed, 'is not rights focussed and complaints tend to be steered to dispute resolution strategies thereby excluding sanctions and enforcement'.

The *Aged Care Act 1997* (Cth) is ultimately intended to operate as a regulatory framework for accrediting and monitoring aged care providers funded by the Commonwealth. It is an inherently weak framework for promoting the rights of older persons, including the right to be free from abuse and exploitation, given that it only provides for the reporting of serious physical and sexual assaults. The mandatory reporting scheme does, however, provide us with an indication of the number of reportable assaults noted in accordance with the Act.

In 2014–15, the Department received 2,625 notifications of reportable assaults nationally. Of those, 2,199 were recorded as alleged or suspected unreasonable use of force, 379 as alleged or suspected unlawful sexual contact, and 47 as both. With 231,555 people receiving permanent residential care in 2014–15, the incidence of reports of suspected or alleged assaults was 1.1 per cent.[86] However, this statistic needs to be viewed in context; it was only dealing with two categories of abuse and, even then, only addresses certain types of physical abuse.

The Aged Care Complaints Commissioner reported a total of 3725 complaints for the same period, with only 3% involving abuse (including social isolation, neglect, rough handling and deliberate

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84 See also Barnett, M, and Hayes, 'Not Seen and Not Heard: Protecting Elder Human Rights in Aged Care' (2010) *University of Western Sydney Law Review* 40.

85 See further Australian Government, Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997*, *2008–09*, (2009) 73–83 <http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-review-cis-09>; Barnett and Hayes, ibid, at 60–1.

86 Commonwealth of Australia (Department of Health), *2014-15 Report on the Operation of the Aged Care Act 1997*, (2015), 215.

abuse).[87] During this research project, the State Manager of the Department of Health confirmed that the only data publicly available on reportable assaults is that included in the Annual Report.[88] Accordingly, data relates mainly to physical and sexual abuse, where the onus lies with the service provider to make the report. According to information obtained in interviews during the study, there are approximately 15 reportable cases filed each week in South Australia. However, as previously mentioned, this information is primarily captured for the purposes of monitoring regulatory compliance with the *Aged Care Act 1997* (Cth), as opposed to securing remedial action for the individual victim and, it was acknowledged that the abuse needs to be at a certain scale to trigger reporting obligations under the Act.

While the Commonwealth Act provides a framework for the reporting of two types of abuse, the data captured is not comprehensive, nor is it dealt with independently. Frequently, providers are required to manage the reported abuse in accordance with their own policies and procedures and the data itself is not collated and analysed in a de-identified form. The Aged Care Complaints Scheme can review service providers from a systemic perspective, but it is still too early to determine the success of such systemic reviews.

Thus, the principal limits of the data collected by Commonwealth authorities in accordance with the *Aged Care Act 1997* (Cth) lies in the fact that it is incomplete, there are limited remedies available under Commonwealth law and the majority of providers can pay lip service to the requirements of the Act as a consequence.

Strengths of the system lie in the existence of data on reportable assaults in two categories of abuse over time, as well as the requirement for annual training on the requirements of mandatory reporting for all service providers. These strengths are undermined by the lack of comprehensive data and the inability to collate and analyse that data, as well as trends within it, from a systemic perspective, using de-identified case files. There exists potential for considerably more to be done with the data that is gathered, as well as the collection of more data. This could include an agreement for the Commonwealth Department of Health to work collaboratively with state policing authorities to capture and collate data on the consequences of a reported assault, including any subsequent criminal prosecutions. There also remains the need to review the independence of the complaints scheme and the extent to which service providers are self-regulating to a significant extent.[89]

4.3 Domiciliary Care SA

Domiciliary Care is an agency within the South Australian Department of Communities and Social Inclusion which is responsible for providing home care services from allied health and restorative services, to personal care, respite care and support. Their services are mainly for persons aged over 65 years (or 50 years if the person is of Aboriginal and Torres Strait Islander descent). However, persons living with chronic conditions under 65 years, and who are unable to secure disability services,

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87 Lamb, R, Aged Care Complaints Commissioner, 'Resolve, Protect, Improve – The importance of Complaints' Presentation to World Elder Abuse Awareness Day 2016 Conference, Adelaide Convention Centre, 16 June 2016 < http://www.sa.agedrights.asn.au>.

88 Email, Danny McAteer, Director, Aged Care Programmes, Aged Care Delivery – South Australia, Commonwealth Department of Health to Haemish Middleton, UniSA, Tue 14/06/2016 7:41 AM.

89 See further, Lacey, above n 7 at 124-126; Walton, M, *Review of the Aged Care Complaints Investigation Scheme* (October 2009) 12 ('*Walton Review*'), available at: http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-review-cis-09.

may be eligible for support and care from Domiciliary Care.[90] In accordance with their service role, Domiciliary Care has considerable experience in identifying and dealing with cases of elder abuse.

Together with ARAS, Domiciliary Care SA has possibly captured more data and trends with regard to the prevalence of elder abuse than other agencies in South Australia. From 1994-1996, the agency (then known as Domiciliary Care Services) was funded by OFTA to compile results on what was known as the 'Elder Protection Program' (EPP). In addition, in 2013 Domiciliary Care SA undertook the *Ngadluku Purkana Tirr-apinthi (Protecting Our Elders) Project*[91] to undertake research on the abuse of older indigenous people.

4.3.1 Elder Protection Program

Two Reports were issued under the Elder Protection Program, for 1994-1995 and 1995-1996. The impetus for the EPP was described in the 1994-1995 Report as follows:

> Agencies in South Australia have often assisted victims of elder abuse, without necessarily defining the problem as such. Nor have they always been able to alleviate the devastating and demeaning effects for older people. In recent years, however, there has been an emerging recognition of the problem, and a growing commitment in the community to ensure that older victims can access informed, prompt and practical support in their situations.
>
> This commitment led to the development in 1994 of the South Australian Elder Protection Program, with its unique design and operation allowing it to cater for a range of agencies and people who might encounter older victims of abuse. Elder abuse is complex, in its aetiology, its detection and in developing effective responses. The Elder Protection Program now provides a focal point for the development of expertise in this field.[92]

The EPP was coordinated by key representatives from the four Metropolitan Domiciliary Care Services and overseen by a Management Committee that included representation from key agencies: the Commissioner for the Ageing, SA Mental Health Services, the Office of the Public Advocate and Guardianship Board, Domiciliary Care and Rehabilitation Services, retirement villages, local government, Royal College of General Practitioners, Royal District Nursing Service, the South Australian Public Trustee, SAPOL and Council of the Ageing (COTA), among others.[93] Domiciliary Care hosted the EPP and coordinated the program. The EPP followed on from a 12 month project undertaken in 1992 called 'The Elder Abuse Project', where key personnel built on local, interstate and international research into elder abuse with the aim of developing a 'cohesive service response to the problem of elder abuse'.[94] Interestingly, the Vision for the EPP was '[t]o promote the rights and well

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90 See further: https://www.sa.gov.au/topics/community-support/in-home-care/domiciliary-care (accessed 10 July 2016).

91 Domiciliary Care SA, *Ngadluku Purkarna Tirra-Apinthi Project, January 2013 – February 2014, Final Report* (2014) (copy held on file at the University of South Australia Law School).

92 Powell, L, Commissioner for the Ageing, 'Foreword', *South Australia's Elder Protection Program Annual Report 1994-1995* (copy held on file at the University of South Australia Law School).

93 'Core agencies' for the purposes of the EPP included the following: Aged Care Assessment teams, the Fours Metropolitan Domiciliary care Services, Guardianship Board, Office of the Public Advocate, Major Teaching Hospitals, Intellectual Disability Services Council, Mental Health Services, Police, Public Trustee, Royal District Nursing Services. The Report acknowledged, however, that many additional agencies would be called upon to assist where required in individual cases; Ibid at 2-3.

94 Ibid, at 1.

being of older people with the overall aim of reducing abuse of the elderly'; a vision which mirrors closely the current *Strategy for Safeguarding the Rights of Older South Australians*. While the aim of the EPP was to develop a cohesive response framework for core agencies, the Annual Reports both highlight some known statistics regarding prevalence rates at the time.

In 1994-1995, there were 344 enquiries to the EPP, with the large majority (171 or 52%) coming from other core agencies, 69 (or 20%) from family and friends, 60 (or 17%) from another agency and 32 (9%) from the victim.[95] The authors noted that community referrals from non-agencies rose markedly when media publicity (which included pamphlets, print and radio media) was high.[96] A total of 68% of victims were female, 24% were male and 7% were couples (usually parents abused by other family members).[97] The most common age of the victims of abuse ranged from 70-79 years and a total of 16% of victims were from non-English speaking backgrounds.[98]

Like the data gathered more recently by ARAS, cognitive impairment was a factor in about 25% of cases of abuse and was relevant with respect to about 10% of abusers. Other patterns of similarity included the perpetrators of abuse (family members being the most common perpetrators and sons being the most frequent abuser within a family)[99] and the types of abuse (with psychological abuse the most common form, followed by financial, physical, neglect, social and sexual).[100] Even more interesting is the commonality between the statistics provided in 1995, with those recorded by ARAS 20 years later. Included here are the common risk factors identified in 1995 by Domiciliary Care:[101]

1. Dependency/vulnerability
2. Family conflict
3. Isolation
4. Dementia
5. Lack of support services
6. Caregiving stress
7. Physical illness
8. Psychiatric illness
9. Substance/alcohol abuse

In 1994-1995, Domiciliary Care accepted only 5% of enquiries into case management, although a further 16% were further investigated.[102] In the majority of cases, the coordinators were able to refer the caller to another core agency or other specialist agency for support.[103] However, in 56% of cases, the matters were handled by providing the caller with consultation, information and/or counselling.[104] Notwithstanding this fact, Domiciliary Care opened a total of 73 case files in response to the 344 enquiries, indicating that even the provision for further information and counselling was a resource intensive exercise that often required further investigation and action before the matter could be

95 Ibid, at 8.
96 Ibid, at 4-5, and 8.
97 Ibid, at 9.
98 Ibid.
99 Ibid, at 9.
100 Ibid, at 10.
101 Ibid, at 11.
102 Ibid, at 11.
103 Ibid.
104 Ibid.

either referred or resolved.[105] The EPP Coordinators also estimated that 35% of their time was spent working on the elder abuse enquiries each month.[106]

In the EPP 1995-1996 Annual Report, it was recorded that the Program had won a national violence prevention award, in addition to completing a 'computerised data collection system'.[107] Having received this report following the interviews, we can only assume that this data collection system was operated and managed by the four Domiciliary Care Coordinators, leading the EPP. However, there may be merit in conducting some follow up on this matter and whether or not multiple core agencies were also involved in data collection. The Annual Report also demonstrates that the EPP had sponsored a series of student research projects for social work students from the University of South Australia and Flinders University, as well as using the EPP to establish networks with interstate and overseas programs.[108]

In this second year of reporting on the EPP, it was noted that the Program had received 334 new enquiries and 49 re-referrals in 1995-1996.[109] According to the Report, the Program received 678 new enquiries in its first 2 years of operation, with 71 re-referrals. Comparing this categorisation of new and repeat cases, it might be worth considering how ARAS might also classify re-referrals differently, or, at least, clarifying with ARAS how they account for and record a return or repeat case. However, assuming that ARAS does count repeat callers in their datasets, we can compare the 3 year period of ARAS data which is reviewed above (1901 total cases between 2012-2013 and 2014-2015), with the 742 cases handled by Domiciliary Care between 1994-1995 and 1995-1996. In the ARAS figures, we see an average of 633.6 cases each year, whereas the EPP data indicates an average of 371 elder abuse cases reported/referred each year. This amounts to a 70.78% increase in the number of cases being reported to the relevant agency (Domiciliary Care in 1994-1996 and ARAS in 2012-2015) in an 11 year period. This increase could be explained by a number of factors, particularly community awareness and the level of advocacy and education carried out by core agencies, including ARAS, since its establishment. However, more detailed examination of the data would be required and a greater degree of understanding gained about the data collection practices of ARAS throughout the 1990s.

While the number of cases being reported to a relevant agency has certainly increased, it is difficult to verify the factors which have contributed to that increase. However, what the data from Domiciliary Care demonstrates is the often close correlation between the patterns over time in the types of abuse most commonly perpetrated (psychological and financial), the alleged abuser and their relationship to the victim (most frequently a family member), as well as the identified risk factors.[110] In the 1995-1996 Report of the EPP, the principal risk factors were identified in the following order:[111]

1. Dependency/vulnerability
2. Family Conflict
3. Isolation

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105 Ibid.

106 Ibid.

107 *Elder Protection Program Annual Report 1995-1996*, South Australia (copy on file at the University of South Australia Law School), at 2.

108 Ibid, at 6 and 5.

109 Ibid, at 7.

110 Ibid, at 9.

111 Ibid, at 10.

4. Dementia
5. Physical Illness
6. Caregiving Stress
7. Mental Illness
8. Lack of Support Services
9. Substance/alcohol abuse
10. Other

Although the EPP Reports are a very valuable resource of base prevalence data from the mid-1990s, a comment was made by the Domiciliary Care representative interviewed for this study that, '[u]nderstanding of the issue has not progressed a great deal [since then]'.

Domiciliary Care remains one of the key agencies in South Australia with considerable expertise in dealing with elder abuse. However, recent federal changes to the funding of aged care as part of the *National Health Reform Agreement* have fundamentally changed the way that the agency operates. Instead of using a case management system based on referrals from other agencies and health care professionals, service delivery is now based on Domiciliary Care directly obtaining referrals through the My Aged Care Contact Centre. This change will fundamentally shift the way that the agency is able to utilise its expertise in handling or identifying elder abuse cases.

Historically, Domiciliary Care has conducted regular training on elder abuse for its staff and they have had in place detailed policies and procedures for handling elder abuse cases. Since the recent reforms were announced, the agency has not conducted any training in 2016. In the view of Domiciliary Care, the new model of competitive tendering for cases will act as a disincentive to collaboration and identification of persons at risk of harm between agencies. In the view of the agency, highly vulnerable people need case management, but this is no longer permitted under the new framework.

It is not entirely clear from the information obtained for this study, why the EPP was discontinued. It may well have had some connection with the dis-establishment of the South Australian Commissioner for the Ageing in the 1990s, but may also be related to other policy factors at the time. It is clear, however, that Domiciliary Care has significant data on elder abuse, which is contained in individual case management files, often in the detailed notes within such files. To obtain, de-identify, collate and analyse that data would be resource intensive and beyond the current capacity of Domiciliary Care. However, this does not mean that the agency could not be funded to support that research, nor that a new approach towards the collection, collation and analysis of elder abuse data could not be supported and funded in the future. Consideration would need to be made, however, on the impact of new federal arrangements on the continued work of the agency in elder abuse cases.

4.3.2 Ngadluku Purkarna Tirra-Apinthi Project

This study, undertaken by Domiciliary Care SA during 2013-14, consisted of interviews with 51 service providers and 7 Aboriginal Community Group individuals. In total, 33 Aboriginal and 25 non-Aboriginal people participated in the study. Older people were defined as 45 and over. Elder abuse and subcategories were not defined for the study.[112]

[112] Domiciliary Care SA, *Ngadluku Purkarna Tirra-Apinthi Project, January 2013 – February 2014, Final Report* (2014) (copy held on file at the University of South Australia Law School), at 8.

The study found a high awareness of elder abuse with 56 out of 58 participants (96.5%) reporting an awareness of elder abuse.[113] Financial and emotional abuse were the main types of abuse of which respondents were aware (56 responses (96.5%)), followed by psychological (63.8%), exploitation of grandparents (60.3%), physical (44.8%), and neglect (44.8%). Other abuse (75.9%) included taking older people's medication, sexual abuse, selling property, taking over an older tenant's home or lateral violence (directed sideways to peers and often to those less powerful).[114]

The study listed a number of risk factors for abuse including:

- Ill health
- Stolen generations
- Dementia
- Looking after adult children and grannies
- Payday; Monday
- Social Isolation
- Incarceration of Adult Child/Children
- Loss and Grief
- Language barriers
- Gender (female)
- Overcrowding
- Family Violence
- Gambling – adult child
- Drugs and Alcohol – adult child
- Mental Health – adult child
- Disrespect – adult child
- Ageism/Racism
- Disability.

The study found that vulnerability was often intensified by language barriers, moving away from traditional lands to access medical services in larger population centres, dependence on others and racism. [115]

Reported impacts on families and communities included:

- Loss of culture; loss of respect
- Stress, depression and despair
- Isolation and social withdrawal
- People live in a state of crisis
- Responsibility falls on women – they take all the responsibility and the stress
- Distorted understanding of their rights when older people normalise the situation
- Do not look after self
- Cycle of poverty, gambling, addiction
- Constant reliance on older people as a resource
- Trauma over a period of time

113 Ibid, at 10.
114 Ibid, at 11.
115 Ibid, at 12

- Post-traumatic stress disorder because of threats to life
- People, talk to others about how they are treated
- Perpetuates the cycle of abuse
- Older people can't enjoy their old age.[116]

In addition to these findings the report noted that research into elder abuse in the indigenous community was in its infancy and participants were unfamiliar with the terms and definitions used in the study of elder abuse.[117]

4.4 Legal Services Commission

The Legal Service Commission (LSC) is established under the *Legal Services Commission Act 1977* (SA) to increase access to legal services for those who cannot afford private legal representation. The LSC has significant experience in assisting victims of elder abuse, where a form of legal redress is identified as an appropriate remedy. This advice increasingly relates to Advance Care Directives[118] and Enduring Powers of Attorney.[119] However, the LSC has established a comprehensive web presence that provides the community with detailed guidance on legal issues, receives 80,000 calls from the community each year and conducts 37,000 interviews. The LSC's Legal Advice line has 40 operators and much of the work of the Commission increasingly involves this type of service. How the Commission obtains personal data often depends on the nature of the matter and whether it is a phone enquiry or an interview with the client.

In terms of collating data, the LSC prioritises information that enables them to meet legal requirements under specific statutes, including the *Prevention of Abuse (Intervention Orders) Act 2011* (SA) and the *Evidence Act* (SA), but also that facilitates their obligation to be accountable to government for the prioritisation of cases. However, the LSC is required to observe obligations with respect to legal professional privilege and, as such, is not permitted to disclose privileged information, even to their reporting Minister. Thus, data held by the Commission is either contained in privileged individual case files, or in de-identified form for the purposes of reporting to government.

Looking at the LSC's practices from a global perspective, the collation of data is done on the basis of the provision of their services for a much broader purpose than monitoring trends, such as the prevalence of elder abuse. Indeed, matters are allocated on the basis of the legal issue raised by the client when accessing the Commission's services. This means that, in complex matters where multiple legal issues might arise, the file may well be classified according to the original legal issue raised. Furthermore, the LSC also confirmed that a matter involving elder abuse may well be classified as either a 'property matter' or as 'domestic violence', with no consideration at all as to the age of the victim. In addition, criminal matters are also categorised from the perspective of the perpetrator and the crime committed, which means that the age of the victim is not something which they can easily search for or analyse across their databases. In these respects, it was recognised that there remains a significant gap between how domestic violence cases are recorded and monitored, with how elder abuse cases are managed.

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116 Ibid, at 13.
117 Ibid, at 16.
118 *Advanced Care Directives Act 2013* (SA).
119 *Power of Attorney and Agency* Act 1984 (SA).

While the Commission's practices have significantly improved with respect to managing information, the impetus for this change has largely been driven by wanting to improve case management, to identify conflicts and be able to account for their funding by demonstrating various intervention strategies. Recognised barriers to recording detailed elder abuse prevalence data and trends evident within that data include the need for further software development, ensuring that the purpose of consultations is correctly identified by the lawyers, and ensuring that different types of abuse can be recorded without double-counting the number of cases of elder abuse. Many of these impediments could be addressed by the development of carefully drafted systems for recording information, together with education and training for employees.

The Commission also recognised that clearer, more consistent definitions, would facilitate better approaches to data collection and the provision of information services on the part of the Commission. At present, the definitions of elder abuse used in South Australia are only contained in policy instruments, as opposed to legislation, including in criminal law statutes and intervention orders legislation.

The Commission reported that the majority of cases which come to them involve financial abuse, with anecdotal feedback that these cases are often triggered by a sense of entitlement held by children towards an inheritance and the misuse of powers of attorney. It was acknowledged that many lay people who act as powers of attorney have no real understanding of their responsibilities. Hopefully the National Inquiry into Elder Abuse currently underway with the Australian Law Reform Commission will address the many problems associated with powers of attorney and their capacity to be used as a powerful instrument of abuse. The current review of South Australia's legislation should also assist in this regard.

Some of the current limitations around practices of the Commission which hinder its capacity to provide prevalence data include the following:

- The name of the victim is only taken where an interview in person is conducted;
- Gender is only known where a person meets for an interview, but is frequently guessed by receivers of phone enquiries;
- Ethnic and/or cultural background is only recorded for Aboriginal and Torres Strait Islander peoples;
- The person's home and living arrangements, as well as personal circumstances (including employment status, educational background, medical conditions etc) are only recorded where they are relevant for determining access to Legal Aid;
- Only clients who meet with lawyers in person are asked if they give permission for their information to be de-identified, for the purposes of research and analysis;
- The Commission does not record files in the traditional legal manner (hard copy files), with the exception of migration matters, and the software classifies cases by matter type;
- More information seems to be collected on alleged perpetrators (presumably for identifying conflicts of interest) where the Commission is acting for a defendant;
- The Commission will only report alleged cases of abuse where safety is in issue (recognising the lack of any legal obligation to report unless a serious crime is suspected). However, referrals will be made to other relevant agencies where appropriate, once legal advice and information has been provided.

Recognising these limitations, the Commission is keen to develop its data collection processes regarding elder abuse and does refer numerous cases to SAPOL, often where domestic violence is present and the consent of the woman has been provided. The Commission is also looking to develop policies, procedures and tools to assist lawyers to recognise and identify elder abuse.

Other limitations which inhibit the capacity of the Commission to provide support in cases of elder abuse relate to the fact that the Commission does no case work. Indeed, the Commission will not engage in any legal representation in civil cases unless the client is eligible for Legal Aid. Where they do not, matters are referred to JusticeNet (a pro bono community legal service and clearing house). The Commission also does not conduct any legal advocacy in courts or tribunals, although they can appear before SACAT regarding treatment and detention orders. According to the Commission, this type of work is increasing, but is very different to previous proceedings before the Guardianship Board.

Strengths of the Commission include its significant media and community education work in both civil and administrative matters, as well as criminal matters. The Commission actually has a very significant community education role under its Act. In addition, where they are able, the Commission provides free legal advice. The sheer breadth of the Commission's advice work means that they deal with matters such as fencing disputes and retaining wall issues between neighbours; they clearly have the capacity to capture data on a range of cases of possible elder abuse at the lower to mid-level range of seriousness. The Legal Chats which are hosted online, coupled with the phone line advice service provide a unique service to people residing in remote and rural communities, enabling the ability to capture data on elder abuse cases that are not escalated to the police or other specialist agency.

The anecdotal feedback from the Commission indicates that financial abuse is the most common, although they suspect that physical abuse is under-reported or is not being recorded properly as 'elder abuse'. In addition, the Commission is increasingly seeing cases dealing with powers of attorney.

It is clear that the Commission is in a particularly well-placed position to capture and collate significant amounts of data around the prevalence of elder abuse, whether those matters are ultimately prosecuted or go to trial. Being a specialist legal service, it is probably safe to assume that many victims of abuse will seek legal advice about how to handle a case of potential abuse or exploitation, without defining their treatment as 'elder abuse' and without calling a specialist advocacy service such as ARAS. However, there remain significant impediments to enabling the LSC to capture accurate and relevant data using their current software and recognising the tendency for lawyers to classify cases into recognised 'legal matters', without considering the potential for elder abuse (much of which is not technically a crime or necessarily unlawful). Thus, any changes to practices in how the LSC captures and collates de-identified data would require, not just significant resources to improve the availability and use of software, but extensive education and training on the categories and indicators of elder abuse, as well the major risk factors seen in such cases.

4.5 Office of the Public Advocate

The Office of the Public Advocate (OPA) is an independent statutory office reporting to the Attorney General. OPA can provide independent advocacy and support for people who lack mental capacity, including people who are subject to guardianship and administration orders, as well as people detained under the *Mental Health Act 2009* (SA). The Office administers functions under s 21 of the *Guardianship and Administration Act 1993* (SA). It provides advice, advocacy and dispute resolution

services for older people in matters regarding guardianship, advanced care directives and enduring powers of attorney.

Section 45 of the *Advance Care Directives Act 2013* (SA) and section 18A of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) give OPA a function for dispute resolution for advance care directives or health issues. These include the power to make declarations in relation to advance care directives. OPA is able to refer disputes regarding ACDs and health care to the South Australian Civil and Administrative Tribunal (SACAT).[120]

Data is collected by OPA relevant to enquiries within their mandate, with information disclosed by the enquirer and recorded in case files, recognising that OPA is subject to privacy laws and represents the person lacking mental capacity. This means that, without the consent of the individual concerned, OPA is limited in sharing information with other agencies or interested parties unless consistent with the Cabinet Exemption regarding privacy and the sharing of private information. Historically, OPA has been one of the state based agencies which has chosen to push its mandate to ensure that a vulnerable person is safeguarded from abuse. Recognising that mental capacity can fluctuate and cases are often complex, OPA is one agency which is often asked to provide support to vulnerable adults when its legislative mandate for doing so may be questionable. Thus, OPA would benefit from a review of state legislation from the perspective of addressing elder abuse.

Generally, enquiries to OPA involve seeking advice on the relevant Acts under which it has a specific role,[121] as well as the relevant processes for dispute resolution services. At present, there is no formalised system for recording elder abuse cases at OPA. While some enquiries may directly raise abuse as a concern, in many instances a suspicion of potential abuse is formed by OPA officers due to the circumstances surrounding the matter. For example, an older person may lack knowledge about their personal finances which may alert OPA staff to the possibility of potential financial abuse. In this respect, staff at OPA – like at Domiciliary Care – are attuned to identifying the signs and risk factors associated with elder abuse.

OPA acknowledged during the study that the most common issues of elder abuse dealt with by OPA include financial abuse (including misuse of powers of attorney), neglect of an older person and the many issues of vulnerability which are associated with being isolated from others. Like the reported statistics from ARAS and Domiciliary Care, OPA does not deal with many sexual abuse cases.

OPA currently does not engage in any analysis of abuse cases from a global, de-identified perspective. Nor is de-identified information shared with other agencies for the purposes of collating and tracking prevalence data. OPA made it clear during the study that it would be difficult to amend existing databases to collect data that is specific to elder abuse, particularly from a resource perspective. In addition, OPA often does not get notified of the outcomes of matters in which they are involved, which include acting as an independent advocate in guardianship and administration matters dealt with by SACAT. In this respect, they are not treated as an 'interested person' for the purposes of disclosing the outcomes of tribunal proceedings.

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120 *Advanced Care Directives Act 2013* (SA), s 46; *Consent to Medical Treatment and Palliative Care Act 1993* (SA), s 18D.

121 *Advanced Care Directives Act 2013* (SA), *Guardianship and Administration Act 1993* (SA), *Consent to Medical Treatment and Palliative Care Act 1993* (SA).

Interestingly, OPA does not have any formal policies or procedures for dealing with cases of elder abuse as they arise, and there is no formal training conducted; recognising that staff members are already highly specialised in dealing with vulnerable people. Together with the expertise of its staff, OPA has also benefitted from recent legislative amendments, including under the *Advance Care Directives Act 2013* (SA) where OPA has been conferred the power to make enquiries.[122] While SACAT can grant OPA authority to investigate certain matters, OPA still has no general power to investigate a case of elder abuse outside of their statutory context (which primarily relates to persons suffering from mental illness or mental incapacity). Thus, the view of OPA was that elder abuse needs an inter-disciplinary, multi-agency approach where lawyers and social workers can work collaboratively in order to safeguard vulnerable older persons. The absence of a single agency with the power to comprehensively manage cases of suspected or reported elder abuse was, therefore, seen as a major shortfall in the South Australian framework.

Like Domiciliary Care and, even the LSC, OPA collates detailed information pertaining to cases of elder abuse in individual case files. However, they are not necessarily classified as cases of elder abuse, as opposed to cases of guardianship, administration, contested powers of attorney etc. Thus, extracting de-identified case files would be resource and cost prohibitive, in addition to being technically complex. In order to obtain that information, significant resources would need to be allocated to analyse the data held by OPA.

4.6 SA Health

A number of agencies within the SA Health portfolio have interactions with vulnerable older persons and collect information that may be relevant to the understanding of elder abuse. However, as with other agencies covered in this study, the data is collected specifically for the service being provided by the SA Health agency which does not lend itself to being de-identified, collated and analysed for elder abuse research.

This study investigated the data collection practices of:

- Local Hospitals
- SA Ambulance Service
- Country Health
- Department for Health and Ageing's Safety Learning System

4.6.1 Local Hospitals

Data collection by Emergency Departments and the SA Ambulance Service is primarily for the purpose of providing acute care for health conditions that cause patients to seek help. The services will at times note potential risk factors for elder abuse. This would usually be where the reason for presentation raises suspicion, such as 'pressure injuries'. Issues of potential concern will be flagged and referred to the appropriate area of Health – eg social work. A referral may be made directly to the police if sufficiently serious and clear, but this would be rare. A hospital may also seek interim orders or to keep a patient in hospital where they consider they are at an immediate high risk of abuse.

122 Section 45.

Current practice is very reliant on the health worker attending the client for the recognition, recording and management of elder abuse. There is no formal framework and training to assist a health worker when they are unsure about whether to refer a case. These workers are operating in a busy and stressful environment that does not permit them time to investigate potential elder abuse and action that should or could be taken.

Abuse will more often be recognised in non-emergency services such as Community Geriatric services where a more holistic assessment of a patient's needs takes place. Such assessments will consider a patient's capacity to care for themselves and can pick up on issues of vulnerability and whether they are under any undue influence.

The purpose of collecting information is for the immediate care of the patient for the condition that they are presenting with at hospital. Potential elder abuse may not be the cause of the reason for presentation, but information collected may raise concerns. Where sufficient suspicion is aroused, referral to other appropriate areas may occur, but the collection of information is not by way of investigation and is only for the purposes of treatment.

Qualitative case notes are recorded on admission. These notes may include a full range of information that would assist in identifying elder abuse such as name, age, gender, place of residence, personal circumstances and the causes of injury or illness.

Similar information may be gathered on the alleged perpetrator, but is likely to be collateral information collected during the building of a case note for the patient. There may often be a reluctance to record 'abuse' in the absence of direct evidence. It is more likely that health professionals will use a general description such as 'not coping' to convey the clinical issue that care arrangements are inadequate without raising unsupported suspicions of abuse.

Admission databases vary across hospitals, for example the EPAS system has been in place at the Queen Elizabeth Hospital since mid-2016 and is being progressively rolled out over SA Health sites.

Regardless of the database, elder abuse data is unlikely to be available in a quantitative, de-identified form. While it may be possible to search records by 'age', a database search is unlikely to also be able to link that patient with parameters that identify 'abuse' and 'relationship of trust'. The latter categories are almost always going to be recorded in open text fields that require manual analysis to make the link with elder abuse. While the reason for presentation could be searched it would generally be described through a clinical description such as 'pressure injury' rather than the phrase 'elder abuse'.

4.6.2 SA Ambulance Service

Interaction with the SA Ambulance Service is similar to presentations at Emergency Departments with a focus on acute care of patients and little opportunity to investigate the patient's circumstances that trigger a call. However, ambulance officers may be well placed to identify signs of potential elder abuse with their access to a person's home and insight into their living and care arrangements.

SA Ambulance records data according to the acute nature of the issue requiring treatment (ie broken arm, bleeding, pressure sores etc). Data is mostly recorded at the time of the initial phone call and therefore is unlikely to record things going on behind the scenes in an older person's life.

SA Ambulance utilises the Safety Learning System, described below, but its use focuses on incidents involving staff rather than patients.

4.6.3 Country Health

Country Health SA administers multi-purpose service sites in rural South Australia. Those services include Residential Aged Care facilities, General Hospital services, General Practitioners and In-home Care. In-home care is provided through the My Aged Care system and is the funding and policy responsibility of the Commonwealth Government.

In-home carers have the greatest contact with older people, providing significant potential for recognising, recording and addressing instances of elder abuse. However, in-home carers tend to be less qualified than other health workers and would need training and education to recognise and manage suspected elder abuse. The tools to manage suspected abuse need to be immediately available, as workers do not have the time to do their own ad hoc research on how to deal with a situation. Further, where the signs of abuse are ambiguous and/or a worker does not wish to unnecessarily 'escalate' an issue, the lack of a readily available means to take further action becomes a barrier. Carers need a clear understanding of their responsibility and a framework in which to raise any concerns.

Registered nurses have less overall contact with older persons in the in-home setting but, due to higher levels of training, are more likely to pick up and respond to elder abuse.

At present the assessment recording systems are not likely to pick up elder abuse. It is more likely to be recognised and recorded by an assessor in a text field. This means that to identify cases of elder abuse would require manual review of database/case notes to identify the elements of elder abuse.

Country Health utilises data collections systems described elsewhere in this section: My Aged Care, Safety Learning System and Hospital Admission systems. It is also subject to mandatory reporting requirements under the *Aged Care Act 1997* (Cth) when providing residential aged care.

4.6.4 Safety Learning System

The Safety Learning System (SLS) is a database that is used across SA Health to improve service delivery by recording incidents and near-misses. It is a standalone system that does not link to other SA Health databases. Its purpose is the systemic recording and analysis of incidents to enable strategic approaches for the prevention of future incidents.

The system has been in place for six years. Over that period incidents have risen from approximately 20,000 to 55,000. The interviewee expressed the view that this was likely to be due to greater education and understanding of what constitutes an incident, rather than increases in incidence.

In terms of coverage, the SLS, has significant potential for capturing instances of elder abuse that come to the attention of SA Health agencies given that it is a single database that is used across multiple agencies. The system has the capacity to log concerns, action taken and record outcomes. However key information such as 'description of incident' is in a text field. Other fields such as 'challenging behaviour' and 'pressure wounds' might point towards elder abuse but would require manual analysis.

As part of this research a test search was run on the database to identify cases of elder abuse. The search did not generate useful information. Key reasons were:

- The system is designed to capture patient incidents during care in SA Health Facilities. It is therefore not well suited to capturing abuse that occurs outside facilities where the bulk of elder abuse occurs.
- The 'age' field is not well framed and there are technical difficulties with linking that field to full patient data and, therefore, to data required to meet the criteria for elder abuse.
- The way that data is categorised in the system does not align with the information sought in researching elder abuse.

The search also looked for 'neglect' and 'elder abuse' in free text fields. A small number of results were recorded but usually out of context ie 'staff member neglected to do X'. This highlights the difficulty of conducting electronic searches in open text fields.

It might be possible to adapt the Safety Learning System to include collection of data on possible elder abuse in a way that can be collated and analysed. If the necessary framework were in place this could include elder abuse as a mandatory 'notification' field. Such modification would need a mandate or direction to incorporate and would need to be supported by policy, procedure and training on how to respond to suspected cases of elder abuse. However, as with domestic violence, changes to criminal laws, policing, reporting and community awareness are often required to trigger practical changes, particularly in the provision of acute health care and emergency situations.

4.6.5 SA Health Summary

SA Health agencies are well placed to collect data having large volume contact with vulnerable older persons across a range of services including: In home assessments for My Aged Care, emergency attendances by SA Ambulance, local hospital attendances, rural General Practitioner services, rural aged care facilities and community social workers. Agencies within SA Health utilise databases that are designed to cope with large volumes of cases and report on specific areas of enquiry.

The issue for current collection of elder abuse data is that it is overwhelmingly not the focus of the information collected. Staff collecting information do not have the awareness, time available or the necessary framework to collect and analyse elder abuse data. Where relevant information is collected it is likely to be in open text fields that would require manual analysis to extract elder abuse data. In the cases where elder abuse information is specifically targeted, it is likely to be collected in individual client or case file notes for community care. Individual agencies tend to operate their own databases so it is not technically feasible to link relevant information on individual clients from different agencies that might enable systematic collation of de-identified data.

Further, because information is not collected for the purpose of elder abuse, access to it is usually restricted to use for the purpose for which it was initially collected. Even if it were technically possible to collect and analyse the data, there are legislative barriers to doing so. This can be further exacerbated where one agency is collecting information on behalf of another, for example, where SA Health collects data for the Commonwealth Department of Health. In these instances it may not be totally certain who 'owns' the data, so agencies are quite reasonably cautious in allowing access to it and the data tools are not adjustable.

4.7 Aged Care Assessment Program

SA Health undertakes assessments as part of the Commonwealth's Aged Care Assessment programme for in-home care, residential care and respite. Assessments are undertaken according to the *National Screening and Assessment Form (NSAF) Comprehensive Assessment*. Information gathered through the use of this form is collected and stored electronically. The form includes a specific question: 'There is a risk of, or suspected or confirmed abuse? [Yes or No]'. It should be possible to collate responses to this question to determine the number of assessments undertaken where elder abuse is a factor.

Vulnerability indicators that would assist in the understanding of elder abuse are also recorded in a 'Yes/No' format that should be easy to collate include the following:

- Aboriginal or Torres Strait Islander
- Veteran
- Change in family/carer support arrangements
- Refugee, asylum seeker or recent migrants without support
- Lesbian, Gay, Bisexual, Transgender, Intersex, or other gender diverse individuals
- Culturally and linguistically or ethnically diverse individual
- Socially isolated individual.

Further detail is recorded in an open text box that would require manual searches and analysis of the information entered.

Information collected in this process is protected by the *Aged Care Act 1997* (Cth), the *Privacy Act 1988* (Cth) and other law. The Commonwealth Department of Health has advised that information collected on the risk of elder abuse is not collated and therefore not available for analysis.[123]

Prior to the introduction of My Aged Care, information was collected through the *ACAT National Comprehensive Assessment Form.* This form included a question, '[i]s the client afraid of someone who controls or hurts them?' The response was recorded as either 'Yes/No', with an open field for providing a description of the abuse. Questions around 'Financial and Legal Details' and 'Carer Profile' may also yield information around elder abuse. However there is no systematic reporting and analysis of those fields, so it is likely that information would have to be manually extracted, with consequent resource implications. The information may also be subject to the privacy restrictions described above.

4.8 SOUTH AUSTRALIAN POLICE

The South Australia Police (SAPOL) provides a range of policing services 24 hours a day to keep South Australians safe and maintains a database of reports and incidents to support the provision of this service.

The SAPOL database undoubtedly contains much valuable information related to the prevalence of elder abuse, particularly as it relates to the more serious end of the spectrum of abuse, where cases involve either apparent or threatened criminal activity. There are, however, a number of significant challenges in accessing SAPOL data for the purpose of researching elder abuse. SAPOL identified that

[123] Email, Aged Care Reporting, Aged Care Policy Branch, Aged Care Policy and Regulation Division, Commonwealth Department of Health to Haemish Middleton, UniSA, Fri 18/11/2016 4:12 PM.

only a small percentage of data on criminal offending held on police information systems would fit the definition of elder abuse for this research and that identifying such information would require manual analysis of the system.[124] This would largely stem from the fact that criminal and intervention orders legislation has neither been designed nor reviewed with elder abuse in mind. However, older age can be treated as an aggravating factor at the point of sentencing in criminal matters. SAPOL's primary focus is on preventing and addressing offences against persons regardless of their age and there is currently no metric for recording elder abuse. SAPOL's involvement is triggered by the nature of the offence which, in the elder abuse context, is potentially most likely to involve physical or sexual assault.

SAPOL provided data for this study on offences committed where the victims were aged over 60.[125] The data is classified according to the Australia and New Zealand Offence Classification (ANZSOC) system. In its description of ANZSOC, the Australian Bureau of Statistics notes the difficulty in measuring abuse in the relationship context:

> Family and domestic violence is an important criminal incident type that is a government policy priority in most, if not all, jurisdictions and is an issue that needs to be represented statistically. However, family and domestic violence is a complicated construct to represent statistically using the ANZSOC, as a wide range of offending behaviours may be related to family or domestic violence, such as property damage, cruelty to animals, assault and/or sexual assault.[126]

Consistent with this overview, the categorisation of data provided to the study was too broad to isolate actions that would constitute elder abuse for the purposes of this research. Further, there was no linking data on the nature of the perpetrator, so it is not possible to identify offences as fitting within the definition of elder abuse.

SAPOL does provide a potential model for addressing elder abuse through its approach to domestic violence, in particular, with the use of the Multi Agency Protection System (MAPS). Domestic Violence incidents are treated with a specific line of investigation involving a risk assessment and a greater level of detail. Investigation does not require a crime to be attempted or committed; rather, a file is built on the situation enabling deeper understanding of the case and appropriate action to be taken. The perpetrator can be a child of the victim, so there may well be instances of elder abuse that are picked up by the MAPS program.

The 2014-15 SAPOL Annual Report includes the following report on MAPS:

> SAPOL developed in 2013-14, and established from July 2014, the innovative MAPS program aiming to protect vulnerable people through an integrated, multi-agency approach to domestic abuse and child protection, by monitoring serious and/or prolific domestic violence offenders.

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124 Correspondence Chief Superintendent Peter Harvey to Wendy Lacey 21 August 2016

125 Email Ms Cynthia Manners to Mr Haemish Middleton 26 September 2016

126 Australian Bureau of Statistics, 1234.0 - Australian and New Zealand Standard Offence Classification (ANZSOC), 2011 – Summary < http://www.abs.gov.au/ausstats/abs@.nsf/mf/1234.0> accessed 3 November 2016

In 2014-15, a MAPS Memorandum of Administrative Arrangement (MOAA) was established between SAPOL and the Department of Correctional Services, Department of Education and Child Development, Department of Communities and Social Inclusion and SA Health. The MOAA facilitates information sharing across agencies, for an integrated and timely response supporting improved safety and security of vulnerable people. Through the MOAA, MAPS has also established governance structures, processes for MAPS operations, administration functions and information protocols such as the Information Sharing Guidelines and Information Privacy Principles Instructions.

Police Issued Intervention Orders (PIIO) gives officers the authority to take immediate action to protect individuals and their families from physical violence and threatening and controlling behaviour. In 2014-15, SAPOL issued 2883 PIIO with 1066 applications to the court by police for an intervention order in the same period. Police again coordinated and chaired family safety meetings in support of the wider State Family Safety Framework, working collaboratively with many agencies and departments across the state to holistically support and provide services to victims of domestic violence.[127]

4.8 Other Data Sources

4.8.1 Ageing in South Australia: Aged Care Services Study

In early 2016, the University of South Australia Business School commissioned research into South Australia's Aged Community and Aged Care Sector. The research produced two reports:

- *Ageing in South Australia 2016: Insights from the Aged Care Sector*;[128]
- *Ageing in South Australia 2016: The Attitudes and Preferences of Consumers* (unpublished).[129]

The *Ageing in South Australia 2016: The Attitudes and Preferences of Consumers* study involved a random survey of 400 residents of rural and metropolitan South Australia aged over 65 (or 50 for Aboriginal and Torres Strait Islanders).

The study asked respondents whether they had experienced elder abuse. A total of 3.1% of respondents said that they had experienced elder abuse. This result sits in the middle of the range of estimates from Australian studies of 2.3% to 5.4% identified in the Literature Review (above).

The survey also looked into the types of abuse reported. The most common type was psychological abuse (46.7% of those who had experienced abuse), followed by social (19.9%), physical (17.8%),

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127 SAPOL, Annual Report 2014-15 < https://www.police.sa.gov.au/__data/assets/pdf_file/0005/244517/sapol_annual_report_20142015.pdf> (accessed 21 August 2016)

128 Andrew, J, Beer, A, Deng, X, Feo, M, Lacey, W, Lowies, B, Parker, D, Rofe, M and Zhu,Y (2016*) Ageing in South Australia 2016: Insights from the Aged Care Sector,* <http://unisabusinessschool.edu.au/globalassets/global/docs/ageing-in-sa-report-web.pdf>

129 Ageing in South Australia: Aged Care Services Study[129] – methodological report, Population Research and Outcome Studies, Discipline of medicine, Discipline of Health Sciences, University of Adelaide ROS July 2016 (unpublished).

financial (12.5%), sexual (8.5%), and neglect (1.9%). This is highly consistent with a randomised study conducted in 2000 (Cripps).

Participants were also surveyed about their familiarity with the concept of elder abuse and how they came to know about it. Two-thirds (67.4%) were familiar with the concept. Almost a quarter came to know about it through television or media (24%), 12.2% stated that it happened to a family member or friend, 6.4% witnessed it happen and 5.7% came to know about it through personal experience. The remaining responses to this question did not fit into any particular category.

The following table lists responses to elder abuse questions from the survey in the order those questions were asked.

Are you familiar with the concept of elder abuse?		
	Responses: 401	Yes: 67.4%
How did you come to know about elder abuse?		
Personal experience	Responses: 270	Yes: 5.7%
Happened to friend/family member	Responses: 270	Yes: 12.2%
Television/media	Responses: 270	Yes: 24%
Witnessed it happen	Responses: 270	Yes: 6.4%
Have you ever experienced elder abuse?		
	Responses: 361	Yes: 3.1%
What type of harm did you experience?		
Physical	Responses: 27	Yes: 17.8%
Sexual	Responses: 27	Yes: 8.5%
Financial	Responses: 27	Yes: 12.5%
Psychological	Responses: 27	Yes: 46.7%
Social	Responses: 27	Yes: 19.9%
Neglect	Responses: 27	Yes: 1.9%
Other	Responses: 27	Yes: 2.2%
Who was the perpetrator of the abuse?		
Child Son/daughter or step son or step daughter	Responses: 27	Yes: 31.3%

Spouse	Responses: 27	Yes: 11.7%
Carer	Responses: 27	Yes: 11.7%
Other	Responses: 27	Yes: 33%
	Responses: 27	Yes: 3%
	Responses: 27	Yes: 3%

4.8.2 SACAT

The South Australian Civil and Administrative Tribunal (SACAT) took over the functions of the Guardianship Board on 30 March 2015. From 20 March 2015 to 30 June 2015, SACAT received 374 applications for Administration and/or Guardianship orders and 100 applications to vary Administration and/or Guardianship orders.[130] Prior to SACAT being conferred jurisdiction, from 1 July 2014 to 28 March 2015 there were 4726 applications and 4393 orders relating to Guardianship.[131]

SACAT publishes certain decisions online that reflect the more contested and controversial matters considered by SACAT.[132] Due to their nature, cases involving suspected elder abuse are more likely to be in this category.

A manual review of 44 cases published online revealed that eight of those cases dealt with guardianship. Of those cases, three involved instances of possible elder abuse – two financial and one physical.[133]

4.8.3 Catalyst Foundation (SA)

Since March 2016, the Catalyst Foundation (formerly the Seniors Information Service) has been running a pilot project called *My Mediation Options.* The aim of the project is to recruit and train Community Champions within a number of CALD communities whom members of that community can approach to get advice on their options in situations that exhibit elder abuse.

The project will aim to recruit 10 community champions from among 30 CALD communities. During the project data will be collected on the knowledge and experience of elder abuse and actions taken to address it. The project is due to report in early to mid-2017.

130 SACAT Annual Report 2014-15, p29http://www.sacat.sa.gov.au/upload/Annual%20report_electronic%20version_FINAL.pdf accessed 21 October 2016

131 SACAT Annual Report 2014-15, p 36-38 http://www.sacat.sa.gov.au/upload/Annual%20report_electronic%20version_FINAL.pdf accessed 21 October 2016

132 SACAT Website accessed 21 October 2016

133 SACAT Website accessed 21 October 2016

5. PRINCIPAL FINDINGS

As this Report has highlighted, beyond the data collection practices of ARAS, there are myriad legal and practical issues associated with recording, de-identifying and analysing elder abuse data. Each agency has its own set of limitations whether they be statutory, contractual, related to the nature of service provided or resource based in nature. Consequently, a one size fits all approach to improving current practices must take these limitations and parameters into account.

There is also an important distinction between agencies with a statutory or contractual mandate to deal with matters where elder abuse may be occurring (ie, ARAS, OPA and Domiciliary Care), compared with agencies that operate under a requirement to provide much broader services (SAPOL, SA Ambulance Services, hospitals, LSC). With respect to these agencies, greater challenges may be encountered in encouraging changes to reporting and referral practices in cases where elder abuse is either evident or suspected. Accordingly, this Report recommends a nuanced approach be pursued by OFTA in working with different agencies over a 5 year period, with the goal of enhancing the collection and collation of data, which may then be analysed by OFTA from year to year. Furthermore, a critical aim of improving data collection practices by relevant agencies must enable OFTA to obtain a more sophisticated understanding of the variable risk factors for different individuals and groups within South Australia's older population. In order to improve our understanding of elder abuse, we must be able to move beyond simple prevalence data to a deeper, more nuanced understanding of the epidemiology of elder abuse for different cohorts. In this respect, targeted strategies can then be devised to minimise, prevent and address the risk factors which operate not just in isolation, but collectively, to increase a person's risk of experiencing elder abuse.

5.1 Definitions

All South Australian based agencies should be using consistent definitions. Those endorsed by OFTA in its *Strategy to Safeguard the Rights of Older South Australians* should be adopted, together with the internationally accepted definition of elder abuse, which locates such abuse within relationships of trust. This is not to downplay the significance of fraudulent acts and other types of abuse and unlawful behaviours perpetrated against older South Australians in other settings; it is simply to reflect the scope of current South Australian policy in this area

Consequently, agencies within South Australia should be recording information on the following categories of elder abuse: physical, financial, psychological, sexual, social, neglect and chemical/substance abuse. However, where financial abuse involves the abuse/misuse of a power of attorney – a widely recognised instrument of financial abuse - that should also be recorded, as ARAS currently does. In terms of chemical/substance abuse, depending on the circumstances, such abuse may constitute a category of either physical abuse or neglect. However, the *Closing The Gaps* Report highlighted the need to separately record the over-use or with-holding of medications and other substances given the anecdotal evidence indicating the rise of such types of abuse.

Based on the general understanding that elder abuse is 'an act that causes harm to an older person, carried out by someone the older person knows and trusts', the essential elements of elder abuse are:

- **Age (of victim); and**
- **Abuse (action); and**

- **Relationship of trust (perpetrator).**

In order to identify elder abuse at the most basic level these three parameters need to be collected in a manner that can be easily de-identified and collated. Few agencies have information collection and storage systems that enable this information to be collected in a manner that can report against these parameters.

Some data collection practices already include these parameters; that is, people are asked, 'is elder abuse occurring?' If available, this data more readily allows examination of elder abuse, however, it is influenced by the definition used to make the assessment of elder abuse.

Further data collected on the circumstances of the victim and the perpetrator allows greater understanding of the risk factors and potential preventative measures for elder abuse. However, the value of such datasets depends on how easily it can be collated and analysed. This again raises the technical and legal issues of whether the data can be electronically de-identified and collated and whether there are any legislative barriers to its use.

5.2 Purpose of data collection

The collection of data on elder abuse is not just an academic exercise; it serves two very important purposes. In the first instance, information that aids the understanding of elder abuse enables us to build a better picture of rates of abuse, risk factors, and possible strategies for targeting resources. This greater understanding then gives the potential to focus resources toward preventative measures and early intervention. Secondly, agencies reported that the collection of data, particularly where supported by training and education, served to increase the awareness and understanding of staff regarding the issues and risk factors around elder abuse, thus leading to better outcomes for patients/clients/consumers and greater satisfaction among staff.

An adapted Safety Learning System could provide an important model for an Elder Abuse Prevalence monitoring system where the collection of data, coupled with appropriate training, leads to increased awareness and identification of issues. This is demonstrated by the dramatic growth in reports to the SA Health SLS over its six years, which is attributed to greater recognition of incidents rather than a dramatic increase in the number of incidents. The system highlights the need for data collection to be supported by training and education on its use and that it will require long term collection of data to obtain robust statistics on incidence rates and general trends.

As already mentioned, any new strategies for enhancing the data collected on elder abuse cases in South Australia must be for deeper purposes than simply obtaining prevalence rates. It must also be for the purpose of obtaining a much deeper understanding of the factors which make older persons vulnerable to abuse, some of which relate to the older person directly, but many of which relate to variables over which the older person has little if any control or capacity to change (ie, mental health of carers, drug and gambling addictions of close family members, proximity to services and support structures). A deeper understanding of such factors and how they interact will provide a solid foundation for targeting strategies to both empower older persons as well as to provide access to services and support mechanisms designed to safeguard older South Australians.

5.3 Data Collection Practices

South Australia needs to develop clear, user-friendly and consistent strategies for the key agencies to collect, collate and analyse de-identified data regarding the prevalence of elder abuse. Any information technology system also needs to be able to capture where a case is successfully (or unsuccessfully) resolved by another agency to whom the matter is referred. At present, the capacity to track cases is almost impossible in South Australia and the ability to address this gap may be several years away, particularly for certain specialist agencies such as the LSC, hospitals and SA Health. The adoption of legal mechanisms (whether statutory or contractual in nature) which require significant changes in data collection practices may well be required in certain circumstances. However, in the meantime, it is possible for OFTA to work in collaboration with agencies and service providers to enhance current data collection practices.

At present, only ARAS captures a degree of comprehensive and collated, de-identified data. However, even for ARAS, that information is not totally comprehensive and their strategies could be enhanced to ensure that factors such as the gender and other characteristics of perpetrators is captured, and that cases are not captured more than once (ie, that re-referrals are separately recorded). There is also the potential for ARAS to capture and de-identify data which can then be analysed at a much deeper level. For example, ARAS currently records whether an alleged victim of elder abuse lives in a rural or remote location, is from a CALD community or is indigenous. However, the data provided for this research did not permit further analysis of the most common forms of abuse perpetrated against older people from such communities, nor what the most common risk factors were. Based on the understanding of the researchers, it is also not simple to extract or correlate from the data for analysis purposes. For example, we do not know whether the single most significant risk factor for single women who are victims of financial or physical abuse is living with a son or male relative, or whether that factor becomes a significant risk factor only where the male relative has gambling or substance abuse issues, which may well be exacerbated if the son or male relative suffers from mental health issues or is dependent on welfare. It may well be that data can and should be obtained which permits us to scale or estimate the level of risk for single older women, and for all older persons living in different circumstances. While ARAS currently captures the most comprehensive data on elder abuse in South Australia, there is certainly more that could be done to enhance the capacity for deeper analysis of the data which is presently collected.

Other agencies, including OPA, LSC, SAPOL, SA Health and, one would suspect, the Public Trustee, collect data that is potentially useful for developing a deeper understanding of elder abuse. However such data is limited in its utility because it is not collected for the purposes of identifying elder abuse and it is not collected in a manner which makes the data readily accessible in a de-identified and collated form. This is usually because the relevant data is buried in open text fields, case notes and case files that would require manual assessment, collation and analysis. Further, statutory privacy provisions can create both a real and perceived restriction on the use of data other than the purpose for which it was obtained.

Interviews with key agencies revealed that there was a real enthusiasm amongst staff for improving the understanding and approaches of agencies to elder abuse. The research revealed that staff will have a sense that something is not quite right, but are frustrated by a lack of clear authority and framework to deal with such issues.

There have been two studies in South Australia that have measured the prevalence of elder abuse through random population sampling (Cripps 2000, UniSA 2016). These studies have revealed prevalence rates of 2.7% and 3.1%. While there would be obvious benefits in conducting further research using random prevalence studies in South Australia, any proposals to conduct such a survey should wait for the outcome of the ALRC's National Inquiry into Elder Abuse. It may well eventuate that a national study will be recommended and supported by the federal government. Furthermore, there may be stronger reasons for South Australia to focus on enhancing the data collection practices of local agencies, which can then be overseen or coordinated by OFTA, to whom agencies would be required to share de-identified collated statistics on an annual basis. Whatever system for data collection is adopted, agencies should be able to identify where different types of abuse are recorded in individual cases, enabling a better understanding of which types of abuse tend to coincide (and beyond the oft-mentioned financial and psychological abuse). Furthermore, as already highlighted, more detailed mapping needs to be facilitated to enable a higher level of understanding of which risk factors, considered together, place an older person at particular risk. At present, the available data shows similar trends in terms of general risk factors over an 11 year period, but we presently know very little in respect to whether an older woman is more at risk of abuse if they have dementia and live with a male carer, or whether an older man is at considerable risk if they are physically dependent on a daughter who is their formal carer. In other words, the level at which available datasets measure the level of risk remains quite superficial. In this respect, the data needs to be captured and analysed at a more sophisticated level and qualitative studies need also to be conducted to verify the available data from a lived experience.

The greatest challenge to obtaining accurate, comprehensive and valid data is undoubtedly a question of resources, time and capacity. However, the relevant agencies in South Australia are already enthusiastic to make better use of their datasets and would potentially be open to suggestions for capturing, collating and facilitating the analysis of more comprehensive data. Given the breadth of responsibilities held by each key agency, their capacity to meet statutory and/or contractual obligations, together with limited resources and capacity, both expertise and resources would need to be dedicated to this issue. Governments have managed to do this with respect to domestic violence, so it is certainly achievable with respect to elder abuse.

Initiatives to collect data and take action to address elder abuse need high level (ministerial) endorsement. These initiatives require changes to information systems and work practices that need to be implemented consistently at an agency wide level and will also require greater co-ordination between agencies.

6 Recommendations

Recommendation 1.

Work should be undertaken with key agencies over the next 5 years to enhance their data collection practices, commensurate with their statutory and/or contractual mandates.

Given the impossibility of devising a data collection template or database that would be applicable to each of the key agencies, we would recommend that OFTA work with each agency to identify what

data could be easily collected, de-identified and provided to OFTA on an annual basis. The greatest challenge will be in devising ways of collecting data while recognising the resource implications in many, if not all, of the key agencies.

It is unrealistic to expect all agencies to collect the comprehensive datasets that ARAS are currently tasked with and agencies should be required to utilise their expertise to collect information which relate to both expertise and the public functions which they are required to perform. Thus, hospitals should not be expected to collect data on financial abuse and abuse of powers of attorney, but are well placed to identify possible cases of physical abuse, chemical/substance abuse, and neglect. The 5 year timeframe is intended to allow agencies to use opportunities for IT and database upgrades to build in the necessary collections fields and practices. However, a longer lead time will enable OFTA (and potentially other agencies such as ARAS), to devise, engage in and implement targeted education and training programs for staff.

This recommendation should be implemented on a nuanced basis, recognising that ARAS has the primary role for providing advice, support and referral services for people who are either experiencing or who have witnessed actual or suspected elder abuse.

Recommendation 2.

OFTA should prioritise working with ARAS, as the key South Australian organisation responsible for collecting data on elder abuse, with the intention of enhancing their current database to improve the depth of analysis possible, increase our understanding of the risk factors for different individuals and groups and build OFTA's capacity to inform State policy and target intervention strategies.

In terms of ARAS' data collection practices, Attachment 1 sets out the database template currently used by that agency. That database demonstrates that ARAS already collects significant amounts of information in cases of elder abuse, and uses the definitions set out in the South Australian Strategy. However, the capacity to undertake deep analyses of the information is less clear and statistical reports provided to the research team by ARAS demonstrates the capacity to collate prevalence and trend data over time, but at a relatively basic level. It may be the case that the data contained in the database is able to be interrogated and analysed at a much more complex and deeper level by singling out specific sub-categories and OFTA should work with ARAS to identify a series of sub-categories and questions that should be tested against the data. In doing so, it will be possible to identify supplementary questions to be added to the ARAS database, which are not limited to open-ended text boxes and which make subsequent analysis of the data much simpler.

From earlier studies commissioned by OFTA, we know that single women living in rental accommodation, for example, are particularly vulnerable and at risk of homelessness. Factoring in the results of those studies, additional questions will be able to be identified that will yield more detailed information about a person's capacity to self-protect or access support mechanisms and services, as well as to assist in identifying where the scale or number of risk factors is higher. Specialists with expertise in designing information technology systems and computer aided telephone interview questions would be able to provide the necessary expertise to design additional questions to further supplement the data obtained by ARAS and subsequently analysed by both ARAS and OFTA.

Consider, for example, single women, where additional questions could extend to the following:

1. Is the single women living alone?
    - Yes
        - For how long has the woman lived alone?
            - Less than 6 months
            - Less than 1 year
            - 1-2 years
            - 2-3 years
            - 3-4 years
            - 4-5 years
            - > 5 years (specify)
        - Did the woman come to be living alone as the result of any of the following circumstances:
            - Death of a partner/spouse
            - Divorce
            - Separation
            - Always lived alone
        - Does the woman receive regular visits from:
            - Family (specify who and how frequently)
            - Friends (specify who and how frequently)
            - Neighbours (specify who and how frequently)
    - No
        - With whom does the woman live?
            - Partner/spouse
            - Son
            - Daughter-in-law
            - Daughter
            - Son-in-law
            - Step-son
            - Step-daughter
            - Grand-son
            - Grand-daughter
            - Sister
            - Brother
            - Other relative (specify)
            - Male friend
            - Female friend
            - Other (specify)
2. Does the woman live in:
    - Own home
    - Rental accommodation
        - Does the woman live in:
            - Private rental accommodation
            - Public rental accommodation
    - Relative's home
    - Friend's home
    - Community housing
    - Retirement village
    - Residential park
    - Other (specify)
3. What support or care does the woman receive?
    - In home personal care
        - Who provides this service? (specify)
    - Home gardening services
        - Who provides this service? (specify)
    - Transport assistance
        - Who provides this service? (specify)
    - Assistance is attending medical appointments

        - Who provides this service? (specify)
    - Assistance with shopping
        - Who provides this service? (specify)
    - Other assistance (specify)
        - Who provides this service? (specify)
4. Where does the woman reside?
    - Metropolitan Adelaide (specify council area)
    - Outer Adelaide Suburbs
        - Northern suburbs
        - Southern suburbs
        - Adelaide Hills
    - Rural South Australia
        - Within an hour's drive of Adelaide (specify council area)
        - More than an hour's drive of Adelaide (specify council area)
    - Remote South Australia (specify council area)
5. Identify opportunities for social connection/social isolation:
    - Regularly attends local church (specify church group)
    - Regularly attends community group meetings such as CWA, council/community forums, Probus etc (specify)
    - Volunteers (specify where and how often)
    - Other (specify)

The questions above are simply an example of how the work of ARAS could be further supported to obtain more meaningful data. De-identified data could then be collated and provided to OFTA (or potentially a research consortium from South Australia's three Universities) for further analysis.

Additional information could be sought from ARAS which assists in tracking referrals to other specialist agencies. In spite of the ISGs, a client's authorisation could be obtained at the time of the initial contact to ARAS, which would allow ARAS to share personal information with another agency.

Recommendation 3.

OFTA should also prioritise working closely with OPA and Domiciliary Care - both of which are specialist agencies with expertise in elder abuse and a history of advocacy in the field - to identify the most resource effective means of improving methods for capturing de-identified data on elder abuse, including information about the alleged victim and perpetrator, types of abuse and whether and what interventions took place. Information should also be collated where referrals to and from each agency occur, including where referrals come from and to which agencies referrals are made.

Both OPA and Domiciliary Care are best positioned, after ARAS, to adapt their current reporting systems, in order to obtain de-identified collated data on elder abuse from each agency. Both agencies have specialist expertise in dealing with vulnerable older persons and a history of advocacy regarding elder abuse. Together with ARAS, SAPOL, and the Public Trustee, they represent critical bodies which comprise the Alliance for the Prevention of Elder Abuse (APEA) in South Australia. While OPA has a very specific statutory mandate to work with persons suffering from mental illness and mental incapacity, it also has an important role to play under the *Advanced Care Directives Act 2013* (SA). Domiciliary Care, while facing significant changes to its operations and federal funding, still has significant expertise and capacity in the area of elder abuse. It will also continue to come into contact with victims and perpetrators of elder abuse and should be encouraged to report on such matters on an annual basis to OFTA. Both OPA and Domiciliary Care will inevitably require additional resources

and support in order to adapt their current data management systems in order to achieve the desired outcomes. However, OPA's critical statutory role and Domiciliary Care's long-standing expertise, make them suitable recipients of additional resources.

The biggest challenge in adapting current data management strategies will be in identifying how information is collected and not buried in open-ended text boxes and case files. At the very least, systems which can easily be used to extract de-identified information from such case files and subsequently merged for analysis will be required. However, the practices already used by ARAS may provide a suitable template in the first instance, which can then be supplemented over time with additional questions in order to provide richer datasets.

It needs to be acknowledged that neither OPA nor Domiciliary Care have the breadth of responsibility for reporting on elder abuse as ARAS and should not be expected to provide the level of detailed information as proposed above with respect to ARAS. Indeed, each agency should tailor their data collection systems to complement the information accessed by ARAS and in a manner which is tailored to their statutory and contractual responsibilities. We would further recommend that OFTA, together with both OPA and Domiciliary Care, explore the possibility of student internships with all 3 Universities for the purposes of developing and maintaining data management systems.

Recommendation 4.

Negotiations should be undertaken with the LSC, the Public Trustee and SAPOL to devise means for collecting, de-identifying and collating data on cases of alleged or suspected elder abuse, the types of abuse and details relating to both the alleged victim and perpetrator. Recognising that each of these 3 agencies has very specific statutory mandates and responsibilities, education and training of staff should be prioritised before any system for data collection and management is implemented.

SAPOL, the LSC and the Public Trustee have been singled out for separate recommendations given the particular nature of their statutory roles, the many and varied demands on these agencies' limited resources, combined with the fact that priority targets are frequently set by government, and that each has particular legal obligations relating to privacy, the use of evidence and involvement in legal interventions. In the research team's view, these factors combine to distinguish these 3 agencies from both ARAS, OPA and Domiciliary Care. Furthermore, ARAS, OPA and Domiciliary Care each have very specific experience in working with, and obligations to support, vulnerable older persons experiencing elder abuse. This is not to say that other key agencies do not; only that their statutory obligations are considerably broader than those of ARAS, OPA and Domiciliary Care and safeguarding vulnerable older South Australians in particular circumstances is merely one.

The LSC provides an interesting case study, as it is one of the agencies which has onerous confidentiality requirements (in addition to obligations surrounding legal professional privilege), significant resource limitations and where its priorities are frequently determined by governments. The capacity of the LSC staff to collate de-identified data would require significant changes to its practices, particularly in how matters are classified and how elder abuse would even be captured in their systems. While not insurmountable, the LSC staff, who are mostly legally trained, would have to

undergo significant education and training on matters which are often not unlawful in a strict legal sense (many examples of social abuse and minor neglect would often fall into this category). Similar points could be made of SAPOL staff. However, domestic violence and children's protection provide clear examples of how the legal sector (including the LSC and SAPOL staff) can adapt to inter-personal violence and abuse.

While agencies such as the LSC, would be prohibited from sharing information which is the subject of legal professional privilege, the LSC could be encouraged to share de-identified statistics each year with OFTA, identifying how many referrals were made to them by ARAS (or other agencies such as OPA and Domiciliary Care), how many were referred to JusticeNet for resolution, how many proceeded to SACAT, and how many did not receive Legal Aid funding and were left unresolved. Such statistics would not breach professional privilege obligations, but would require a contact person at the LSC to coordinate referrals and report back to OFTA.

The LSC and the Public Trustee have particular areas of expertise, in particular, with both domestic violence and financial abuse. While the Public Trustee declined to participate in this study, both agencies have the capacity to contribute to our understanding of the prevalence of elder abuse and the varied factors which increase a person's vulnerability to abuse. The legal requirements attached to each agency present unique challenges in negotiating a way forward for the collection of de-identified data which can inform the work of OFTA, but there is considerable good will on the part of the LSC, in particular, to enhance their capacity as an organisation to contribute to understanding elder abuse and safeguarding vulnerable older South Australians. In this respect, we would recommend the development of targeted education and training programs for each of these agencies and that OFTA work closely with each to identify the most resource effective means of collating de-identified data which can then be used by OFTA to inform policy.

With respect to SAPOL, OFTA should explore what information could be obtained through minor adjustments to its data collection and reporting practices. As age of the victim can be an aggravating factor in sentencing criminals, it would be prudent if SAPOL (and potentially the Office of Public Prosecutions) maintained records of cases where crimes were committed against older South Australians and/or where older age impacted on the defendant's final sentence. There is also considerable potential if minor changes were made to how SAPOL maintain records in domestic violence cases, in order to capture data on cases where a victim is over the age of 65 (or 50 in the case of Indigenous Australians). Such minor changes would not necessarily burden SAPOL to a major extent but would build on the systems already in place.

Recommendation 5.

The development and delivery of a systematic education and training program across SA Health should be undertaken, in order to improve the level of understanding of elder abuse and its signs among employees. Investigations should also be made as to whether and how the Safety Learning System could be adapted to capture instances of actual or suspected elder abuse. This should include reports of when matters are referred to SAPOL or other agencies such as ARAS or OPA.

It is apparent that health care providers also play a significant front-line role in assisting and safeguarding older South Australians, including those who may be victims of, or susceptible to, elder abuse. While SA Health does not have a specific statutory role in identifying, reporting or prosecuting cases of elder abuse, many types of abuse will result in or exacerbate a victim's health and wellbeing. In many cases of physical and chemical/substance abuse, health services may well become involved. And, for the many older South Australians who do not reside in residential aged care facilities, mandatory reporting regimes will not necessarily be formalised. Thus, it is essential that health providers be engaged in assisting to identify cases of actual or suspected elder abuse.

While it is not the responsibility of health care providers to remedy the causes of family conflict or vulnerability which frequently underpin elder abuse, health workers and providers should be required to maintain records of when cases of actual or suspected elder abuse are reported or referred to other specialist agencies. De-identified, collated data could be made easily available to OFTA on an annual basis and the SLS appears to provide a sound platform to enhance the ability of health providers to capture such data, without placing an onerous burden on staff beyond the health care needs of patients. Given that OFTA is located with SA Health, it would seem that OFTA should play the lead role in advocating for such amendments to the SLS and for leading any education and training program prior to any changes being implemented. Notwithstanding the central role of OFTA in such processes, an open tender process could be undertaken enabling registered training providers and university experts to deliver such training.

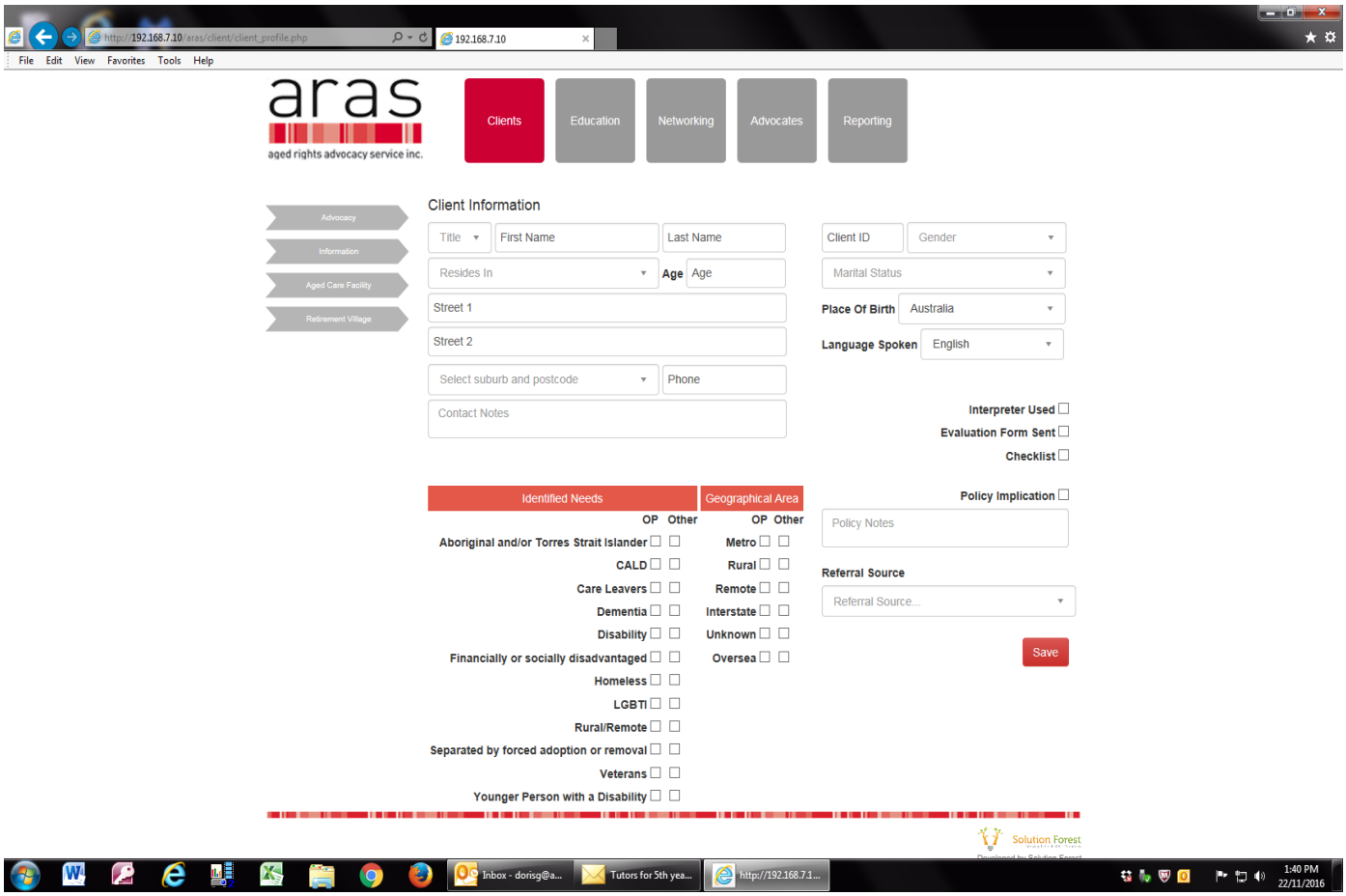
Recommendation 6.

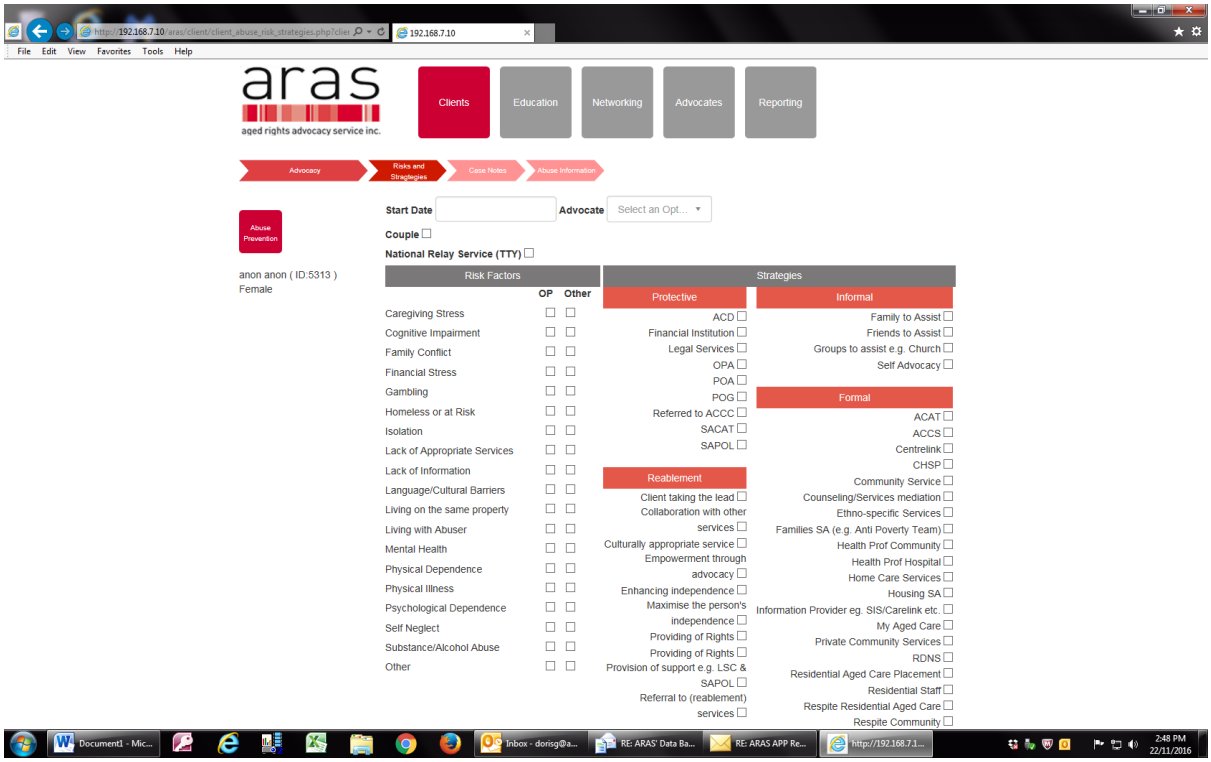
Within the next 5 years, OFTA should consider revisiting the recommendations of the *Closing The Gaps* Report and, particularly, the need for legislative reform.

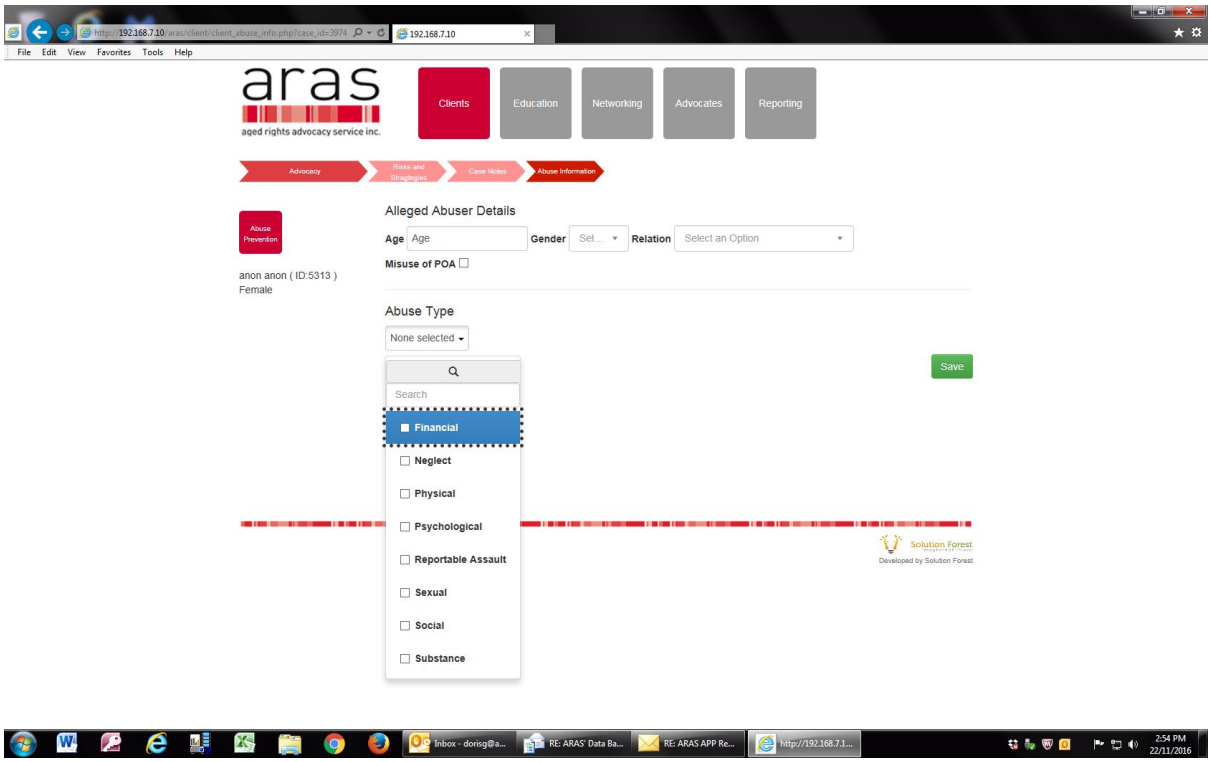
As more detailed data on the prevalence and epidemiology of elder abuse comes to light, and as community awareness builds of its prevalence both in South Australia and nationally, expectations will also rise. It is almost inevitable that the community and key agencies will demand a more comprehensive response from government, whereby roles and responsibilities are clear and where agencies can work collaboratively and in a timely manner to prevent and intervene early in cases of elder abuse. Given that South Australia has the highest proportion of older persons on mainland Australia, it will be essential that whichever party is in government, that South Australia's legal and policy environment is well designed and ready to effectively ensure that all vulnerable older persons are safeguarded from abuse, exploitation and neglect.

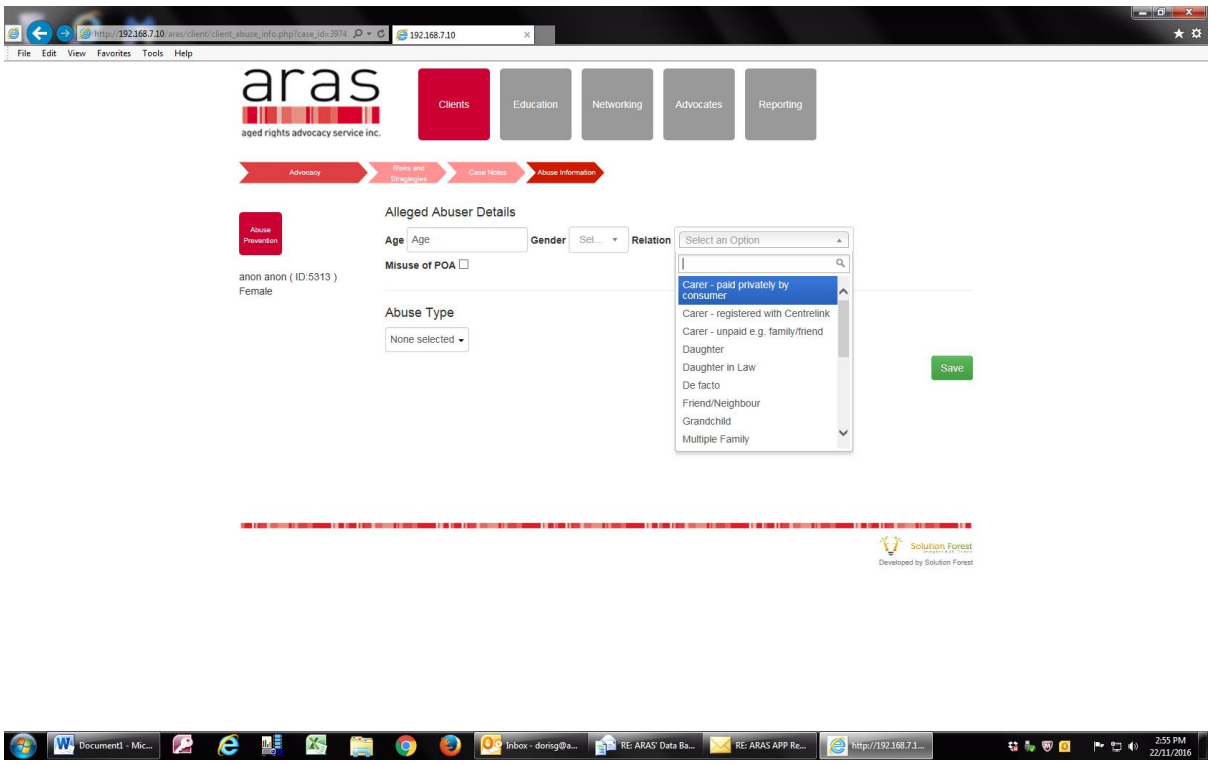
Attachment 1

Blank ARAS Data Entry Pages



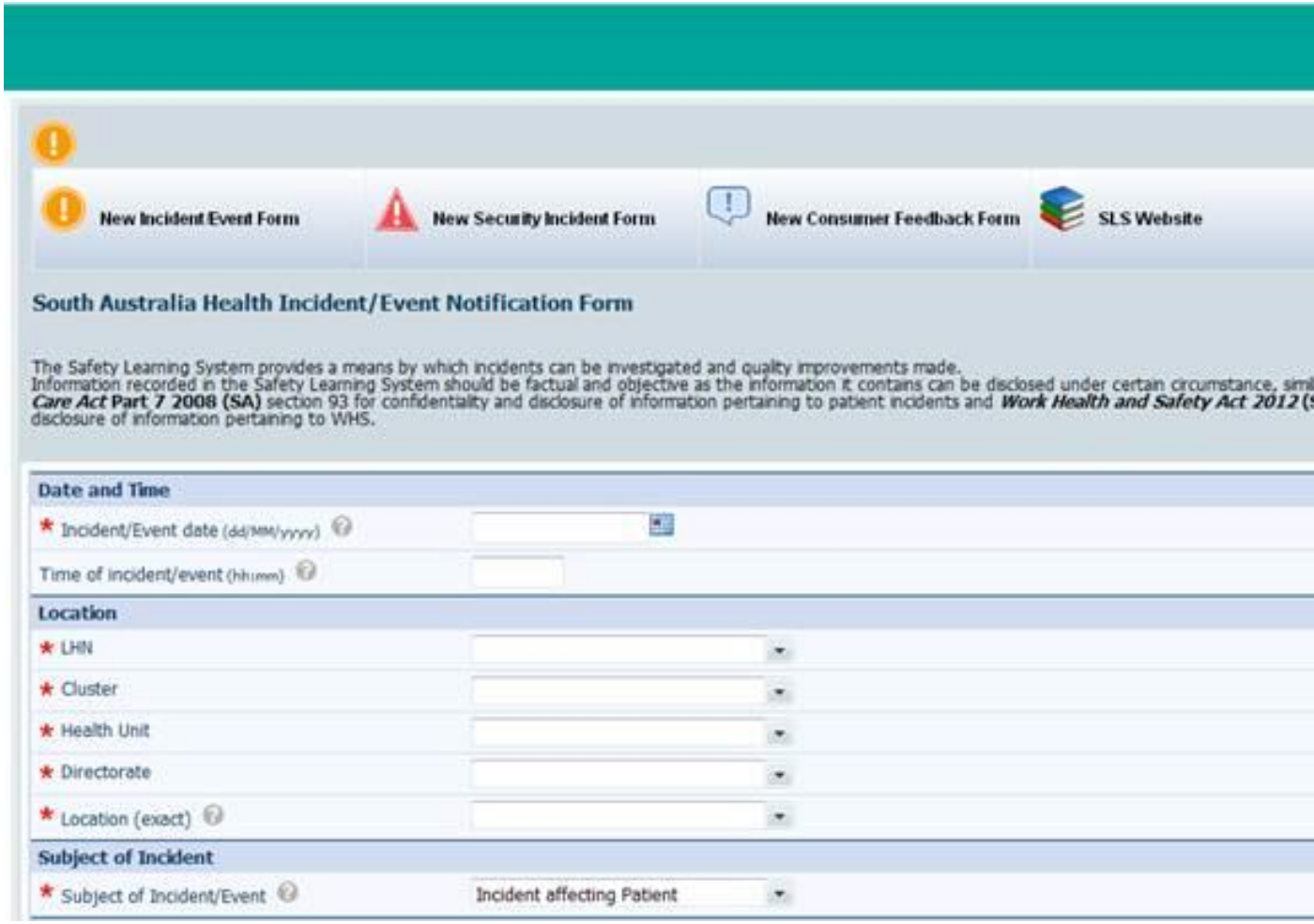



aras
aged rights advocacy service inc.
Clients
Education
Networking
Advocates
Reporting
Advocacy
Risks and Strategies
Case Notes
Abuse Information
Abuse Prevention
anon anon (ID:5313)
Female
Alleged Abuser Details
Age
Gender
Relation
Select an Option
Misuse of POA
Abuse Type
None selected
Search
Financial
Neglect
Physical
Psychological
Reportable Assault
Sexual
Social
Substance
Save
Solution Forest
Developed by Solution Forest


aras
aged rights advocacy service inc.
Clients
Education
Networking
Advocates
Reporting
Advocacy
Risks and Strategies
Case Notes
Abuse Information
Abuse Prevention
anon anon (ID:5313)
Female
Alleged Abuser Details
Age
Gender
Relation
Select an Option
Misuse of POA
Carer - paid privately by consumer
Carer - registered with Centrelink
Carer - unpaid e.g. family/friend
Daughter
Daughter in Law
De facto
Friend/Neighbour
Grandchild
Multiple Family
Abuse Type
None selected
Save
Solution Forest
Developed by Solution Forest

Attachment 2

Blank SA Health Safety Learning System Data Entry Form



Person Affected
For incident affecting worker this is the worker affected by injury or reporting a hazard/incident.

Type

* First name

* Surname

Gender

* Date of birth (dd/MM/yyyy)

Add Another

Description of the Incident/Hazard/Event

* What happened?

Ensure the description is short and factual, as it can be made public under certain circumstances.

* What was the outcome of the incident/event?

Short, factual description of the outcome. This should not include names or opinions and must be relevant to the event.

* Has this incident been disclosed to patient/family?

Notifier Details

* Professional Group	
First name	
Surname	
Telephone number	
E-mail address	

Incident Classification

* Level 1	Challenging behaviour
* Level 2	Staff behaviour to patient
* Level 3	
* Safety Assessment Code (SAC)	Physical abuse, or violence Verbal abuse or disruption
(Click here to view the Safety Assessment Code Matrix)	SAC:
* Result	

Challenging Behaviour

What is the primary condition underpinning the challenging behaviour?	
* Was the person subject to MH order or under care and control?	

Alleged Assailant

* Is there an alleged assailant for the incident?	Yes

Alleged Assailant Details

Type	
Subtype	
First name	