That Elder Abuse be Considered Part of Family Violence

Thank you for taking the time to consider this submission. I am a Registered Division 1 Nurse with over 35 years' experience nursing in varied areas including, mental health, courts/correctional/prison nursing, general ward, drug and alcohol detox units and community settings. I have worked in nursing management both in Australia and New Zealand. I am currently one of two Drug and Alcohol Nurse Clinicians working in the Emergency Department for Western Health. I also work as a care-coordinator in the ED and deal on a daily basis with the elderly, drug and alcohol clients, domestic violence, social and complex medical clients, homelessness and other conditions that people present to the ED for help aside from acute medical complaints. My co-author, Joanne McArthur, is a Critical Care Registered Nurse with over 20 years experience working in the Intensive Care Setting. In addition to this she has further qualification and experience as an Occupational Therapist. Her work in this field is primarily in the public health system in acute and rehabilitation areas – largely in adult services but also in paediatric settings. Joanne is currently working as a Care Co-ordinator in ED dealing with the above mentioned client group – it is within these roles that Joanne and myself have identified the need to address the growing issue of elder abuse in our ageing population and within our developing health and community services.

This submission maintains that the elderly suffering abuse be considered "vulnerable people" and that because of the nature of the abuse i.e. occurs within a family setting, it falls under the remit of 'Family Violence'.

This submission comes out of a patient's presentation that occurred at [redacted] when an elderly lady was brought to the emergency department by ambulance after been seriously assaulted in her own home by her son. The son was her carer.

Since this time we have been tracking elderly patients, over the age of 65, presenting to the Emergency Department (ED) as a result of physical assault or because of medical conditions arising out of physical assault. The clients have all been living in the community. We have **excluded** those residents in aged care facilities.

While recognizing that elderly abuse also consists of emotional, financial, sexual and verbal abuse; because of the setting we work in we have only concentrated on the physical aspects of abuse. This is because we wanted to be able to readily identify abuse and to look at a specific area of abuse; that is, abuse that was obvious and could be clearly established within a short time frame.

To date we **identify two** cases of physical abuse coming through the ED each month. This number will not accurately reflect the actual numbers of people who come through the ED but are not identified as been abused.

Why this issue and what is are the implications for nurses and other health professionals working with the elderly in the health care setting?

The population of Australia and the developed world is living longer. By 2056 there will be an estimated Australian population of 42 million people increasing to an estimated 62 million by 2101.

The average age of death in 2011 was 79 for a male and 84 for a female. A child born today will have a life expectancy of 85 for a male and 88 for a female. A child born in 2056 will have an **average** life expectancy of 96 (female) and 93 (male). The pressure is on the health system to care for people in their own home, rather than inpatient facilities; this trend can only increase. Nursing homes are being divested to the private sector.

In 2009 13% or 2.8 million Australians were over the age of 65. This trend is also set to increase. With an aging population comes an increase in aged related health conditions. While medical advances might well relieve some conditions such as arthritis, other conditions such as dementia are still a long way off in having an effective treatment. In fact dementia is now the 2nd most common cause of death in Australia. This has been marked by an increase of over 126% since 2002 of dementia related deaths; Ischemic heart disease one and Cerebral Vascular Accidents at three. Now dementia at two has overtaken Lung cancer (now 4th), chronic lower respiratory disease (now 5th) and diabetes (6th) as leading causes of death. With a population that will live longer than ever before there will be added pressures including financial, environmental and social – all impacting directly on patients and their families. The rates of physical abuse will only increase.

	2004	2008	2013
Ischemic Heart Disease	1	1	1
Dementia	5	3	2
CVA	**2**	**2**	**3**
Lung Cancer	3	4	4
Chronic Lower Resp. Disease	4	5	5
Diabetes	8	6	6

So what is the current situation for nurses and health professionals working in inpatient settings who become aware of physical abuse occurring for their client?

At the moment there are **no** mandatory requirements to report elder abuse in any state in Australia. Indeed there is also no protected reporting. That is reporting in good faith when abuse is suspected. The only occurrences where nurses must report serious physical or sexual abuse is in *approved* aged

care facilities. The 2007 Aged Care Act states “an approved provider providing a service connected with residential aged care” are legally compelled to report both actual and suspected reportable assaults (physical and sexual), if suspected on reasonable grounds within 24 hours to a police officer or Secretary of the Department of Health and Aging. Residential aged care providers must also have in place systems that allow staff to make relevant reports.

This does **not apply to privately** owned facilities where residents rely on “whistle blowers” to report abuse to authorities.

However only a minority of the elderly live in residential care facilities – less than 25%. If abuse is identified for clients who are living at home or in the community then no such mandated or protected reporting exists.

Statistics for rates of abuse in Australia are vague. This is because there is no data that is specifically or centrally collected. It is indicated (partly based on overseas studies and with limited data from Australia) that between 3-5% of all people over the age of 65 and living at home suffer some form of abuse.

Don’t current laws exist that protect people from assault, intimidation, threats etc? Well yes – but who is responsible for making the initial complaint and how is a situation dealt with if an advocate reports an assault but the victim denies any such event occurred?

We need to go back to the 1970's and look at how child abuse and domestic violence was thought of and dealt with. These were the "invisible" years of abuse. It was the start of thinking of child abuse and domestic violence as a concept in legal terms. Courts viewed an assault in isolation and did not recognize a pattern of abuse or neglect. Nurses and doctors faced conflict for reporting, without parents or the child carers' permission, suspected assaults or injuries to police. Child protection within Department of Human Services did not exist. For domestic violence if the victim – usually a woman declined to make a complaint the police were powerless to act.

As attitudes and awareness changed and with pressure on the governments to act, laws were enacted that protected health professionals in reporting child abuse eventually spreading to other disciples such as teachers, social workers, child workers etc. Now it is mandatory for nurses to report actual or suspected child abuse to DHS. Failure to do so results in severe sanctions on the nurse for not doing so. Health workers are guided by hospital policy which is underpinned in legislation.

Police are empowered to act within domestic violence call outs. The victim is not required to make a complaint – the police will act on the victim's behalf regardless. This protects the victim and takes away the pressure they used to be under from their assaultive partner not to act.

Well, the 70's have arrived in relation to elder abuse.

The police and the courts currently fail to distinguish "Elder Abuse" as a cause of injury. There is no concept of elder abuse in law. Elder abuse is a term used more and more in professional circles but

generally only used by those working with the elderly in various guises – nurses, social workers, carers, service providers. There are no special statues in any state that cover elder abuse. It is not a specialty in law and can be difficult to prosecute because of the ill health of the victim, their social isolation and dependence on others (and the nature of the abuse often being subtle and difficult to identify).

Because reporting is not mandated or protected the data we rely on is under represented and at best an "educated estimate" or based on overseas figures. It is known that those 80 or older are up to 3 times as likely to suffer abuse. In 90% of cases the assailant is a family member (that is a grown child). Extended family members are less likely to abuse. In most cases the assailant lives with the victim and sons are most likely to physically abuse while daughters are more prone to verbal abuse and physical neglect. It's important to remember that abuse does not have to cause serious injury – It can be and often is ongoing events such as pinching, slapping, choking and so forth – assaults that are difficult to detect and leave no permanent mark or injury. This type of abuse can occur on a regular basis and often only revealed with a physical examination.

An example.

Mrs Smith (not her real name) was a 70 year old lady brought to the emergency department via ambulance due to extensive bruising and pain to the ███ side of her chest and ███ arm. X-rays showed she had █ fractured ribs and a fractured humerus. Initially we were told she had fallen. She appeared thin and emaciated and had a blank affect. She stood 5'2".

This lady lived with her son in her own home. She confided to the nursing staff on direct questioning that her son had pushed her to the floor and repeatedly kicked her. She stated that she was assaulted by him on a regular basis “whenever he got angry”. She also stated that he stole her medication (oxynorm) and pension money. This pattern had occurred over many years.

The son later came to the ED to see her. In front of the son she stated that she had fallen.

Once the son had left she again stated that it was he that had assaulted her. Her injuries were consistent with an assault.

BUT

She was adamant that the police or social agencies were not to be contacted because she was scared of the repercussions this would/might have on her. At this stage she appeared to be able to make decisions, and could give a good historical account of events.

She was admitted into hospital – later testing transpired that she was suffering the early stages of dementia. She remained in hospital until in 2013 she was transferred from hospital to a nursing home where she remains. Her son continues to live in her home.

The dilemma for nurses and doctors in this case were frustrating. Because Mrs Smith clearly stated she did not want police or government agencies involved; they were conflicted about reporting this situation. There was no guideline or identified pathway that the staff could follow in order to ensure this event was clearly identified and services required; actioned. This caused confusion and uncertainty. No

staff member was identified as who should do what – "is it my responsibility or someone else's". Are we breaking confidentiality, are we allowed to report this? Who do we refer this patient to for follow up? It was clearly documented in the medical file and ensured hospital social workers followed her up. Direct reporting of this assault could/would have breached medical confidentiality and gone against the patient's wishes. Staff were clearly unable to advocate for this lady in an effective manner. Mrs Smith could have gone home and continued for some years to remain at home with proper community support. This situation would have had the protection of the courts and would have legally empowered health professionals to react without fear of breaching ethical considerations such as medical confidentiality.

So who is responsible?

The United Nations in 2000 initiated The Global Action on Elderly Abuse. Most 1st world countries – including Australia signed onto it. Some countries such as the USA and some provinces of Canada responded with mandatory reporting of suspected or actual abuse to the police.

Other countries such as the Argentina, United Kingdom, Austria, Italy, New Zealand, Portugal, Norway, Sweden , Brazil and most EU countries implemented or are implementing polices of protected reporting which set in place clear mechanisms, policies and agencies to deal with elder abuse. This allowed health professionals to effectively advocate for aged clients. Much as child abuse is dealt with today. It empowers and protects the health professional and indemnifies them against action from perpetrators

both legally and professionally. The interests of the patient remain paramount and laws underpin and protect the actions of the nurse.

Australia responded by the Federal Government divesting its responsibility to the states and territories. State governments either did nothing stating that existing laws were in place against assault or drafted laws so narrowly so as to miss the dynamics between the assailant and the victim.

Each state has published a “guide” to elder abuse but overwhelmingly there has been profound silence or genial mumblings. This leaves the health professional in a quandary. Without legislation to underpin and support practice nurses are potentially exposed both professionally and personally if they decide to report abuse without legal support. Support and advice from professional bodies is vague and reliant on government recommendations. Best practice appears to be “tread carefully”.

The Victorian Government’s “ Elder Abuse Prevention and Response Guidelines for Action 2012-2014” form the Health Priorities Frame work 2012-2022 which focuses mainly on professional education, community education, provision of legal, referral and advocacy services.

The intended outcomes are:

i) Increased community awareness of elder abuse
ii) Empowerment of older people
iii) Active engagement of health professionals
iv) Coordinated multi-agency support

The funding for this was to come through the Ageing and Aged Care Branch of the Department of Health and Victoria Legal Aid.

One of the most interesting Strategic Outcomes is to have a referral network between specialist elder abuse and local support services. Also to develop and implement evidenced based referral practice models that are appropriate to the different types of elder abuse. The activity measure is to be the "number of referrals made by type of abuse".

Currently there is no active Specialist Elder Abuse Support Service that can effectively advocate on behalf of an abuse victim although Senior Rights in Victoria goes someway in fulfilling this role. However this agency lacks authority to deal with issues if the client does not consent to assistance.

The assumptions made in most of the guidelines is that an abused victim is able to rationally and coherently make a complaint or even identify what they experiencing is in fact abuse. While the guidelines use language such as "suggests, supports, encourages" for clients and healthcare workers it does not "indemnify, protect, mandate" or underpin professional responses in legislation.

In 20█ a 75 year old lady was brought into the emergency department by ambulance which was called for her by her son. She had a dislocated shoulder and multiple bruises and lacerations. She also had existing conditions of CVA, anemia, poor mobility due to an old fractured femur and an ileostomy.

She lived alone in a MOH unit on a CACPS package (Community Aged Care Package), had a case manager, and council cleaning and shopping support.

She used a █ wheeled frame and had a history of frequent falls.

On this day her son, his wife and their ███ children were visiting. An argument ensued. He dragged her down █ concrete steps into the garage where he threw her to the floor and proceeded to kick her and hit her with her walking stick.

She said she "thought she was going to die". She begged him to stop promising not to call the police. After the assault was over he called the ambulance stating she had fallen.

She was suffered shock, extensive bruising, cuts and grazes.

In hospital she remained adamant that the police, social workers and authorities were not to be informed. She said she was afraid of her son's reaction.

She also divulged that she had been physically assaulted on many occasion by her son over many years. She said he also stole medications at times and regularly took her pension.

Her case manager, Royal District Nursing Service and the council were informed, without consent of this assault but again no effective action could be enacted to prevent this occurring again.

The ironic factor in this case was that because the ███ children had witnessed the assault they were reported to Child Protection at the Department of Human Services due to a possible risk to the children.

This was done because nurses are not only ethically but **legally** bound to report adverse risk to children. In reporting this nursing staff are also legally protected from adverse outcomes from the alleged assailant or their family and the reporter is protected under law. The health of the child is paramount rather than the wishes of the abuser.

Practical steps for health professional currently include;

i) Involve a multidisciplinary approach (Aged Care Assessment Team, GP, social worker, Council services)

ii) Appoint a case manager

iii) Offer respite options

iv) Counselling

v) Inform client of legal rights

vi) Involve co residents re carer stress and offer support.

Abuse can occur because the family relative is under stress, not coping and unaware of services and help available. Some conditions such as chronic pain and dementia can be challenging and wear away the carer's ability to adequately cope with a relatives care. Cultural expectations and mores can be out of step with the reality of caring for another at home. Carers themselves can be alone and not supported. In many cases carers may not recognise this themselves and be reluctant to accept help.

Over the last three years we have seen elderly patients living at home present with;

i) Falls - due to pushing and assault by family members – causing fractured bones and exacerbating existing health conditions requiring hospital admissions.

ii) Dog bites – an elderly man was set upon by his sons dog causing multiple bites to his legs.

iii) Punches to the face – elderly wife assaulted by her husband whilst on the toilet.

iv) An elderly women with a fractured femur been kept two weeks at home bedridden, covered in faeces and urine and been fed Weetabix with whiskey.

v) 73yo lady punched and pinched by her daughter requiring wound dressings and IV antibiotics

vi) Elderly lady drugged by a “friend” and had her alter her will and bank details whilst influenced by diazepam (police informed with patients consent).

vii) Elderly been ‘stood over” for medications and pensions by family members

viii) Unexplained frequent falls with bruises and cuts - consistent with been assaulted.

Nursing remains one of the busiest professions and nursing staff are experts in multi-tasking and prioritising. So “things get done” if it is clearly documented and proscribed that in the event of X – Y gets done. If it is not my job” or does not fall under our mandate then more than likely the needed task or event will not occur. “I’m too busy, that’s not my responsibility, which policy supports this, I don’t know, and who do I contact and how” are often the common responses.

This identifies two main barriers – Low levels of Role Legitimacy ("not my job") – Staff do not believe or understand that elder abuse issues do not see it as a legitimate part of their job and Low Role Adequacy ("I don't know how"). How do I report or proceed to the next step? Because clear pathways are not identified and there is inadequate training in this area nurses and other health professional do not proceed with advocating with abused clients

Nurses will not report elder abuse not only because of the personal barriers but because it is not required as part of their job for the day. It is seen as outside the scope of practice not as per policy and procedure. The need to clearly lay out a course of action or requirement is paramount to ensure nurses have a clear road map to follow when dealing with suspected or obvious abuse.

In summary – Currently health professionals can advocate to various agencies including the Office of the Public Advocate, GP's, Department of Health Services, Veterans Affairs and other to agencies and councils but it must be done alongside the victim and with their consent (unless deemed not to have capacity). However the aged can be severely disadvantaged because of financial, health and social constraints that do not apply to younger, fitter, adults who can access more choices and have the freedom of movement, social independence and good health.

This disadvantage can also be applied historically to children. In 2015 the protection of Children is a paramount corner stone in a child's wellbeing. As the Australian population increase, lives longer and ages the issue of abuse will become even more of a challenge to nurses and the health profession. It does seem perplexing that mandatory reporting of physical and sexual abuse is required in **government**

run nursing homes but excluded in every other area of aged health care. Mandatory reporting requires the government to ensure adequate funding and the provision of staff and resources to deal with abuse.

Today nurses may report abuse if they feel it is warranted; but in doing so may expose themselves to legal and professional sanctions unless well supported by an organisation's polices and protocols. As more and more elderly utilise the health system and have contact with healthcare professionals then governments and professional bodies will be under more pressure to clearly underpin professional practice and allow effective advocacy for patients through legislation and the establishment of supporting bodies to ensure those people a quality of life in their aged years; the same as they experienced in their younger days.

If the Commission could consider the following:

i) That the elderly with compromised health or social conditions be considered "vulnerable people".

ii) That those over the age of 65 and have violent or threatening acts or neglect perpetrated on them by a relative be considered under "Family Violence".

iii) That health professionals are clearly guided in what action should take place when violence or threats of violence are revealed. This includes who to contact and what protection or support is then offered to the victim. Intervention could involve social worker input and the application of additional services to aid the care of the person at home and take stress off the carer.

iv) That legislation is enacted to protect the vulnerable and guide health professionals.

v) That Victoria adopts a process of "Protected Reporting" for health professionals and other involved agencies (social workers, council etc.) That is, reports can be made if they are done with reasonable evidence (physical or verbal) and in good faith in order to prevent further harm or to enhance the safety and wellbeing of the vulnerable person.

vi) That protected reporting does not require the consent of the victim.

Thank you for your consideration.

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