SERVICE-DRIVEN APPROACHES TO PREVENTING AND RESPONDING TO ELDER ABUSE IN NORTHERN TASMANIA

Final Report for Research Preventing Elder Abuse North

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Preventing Elder Abuse Tasmania

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Key finding

On completion of the workshops in the south and north of the State, the research has made it manifestly clear that service level response to elder abuse is under strain. There are currently no solutions to the problems participants are dealing with. Participants work very hard between themselves to resolve problems, but this is *ad hoc* and reliant on personal connections and interests. We are aware that the Department of Justice has researched and prepared a report for the Attorney General regarding adult safeguarding legislation and options for establishing an investigatory body for elder abuse in Tasmania.

It is our primary recommendation for the State to establish a complaints investigation body with power to:

- **Investigate**
- **Adjudicate**
- **Make determinations, and**
- **Enforce those determinations.**

How many Janet Mackozdis (Vignette 1, p13) will it take before the State enacts the recommendations of Coroner McTaggart's 2018 report[1] (Appendix 4)?

Summary for Report_North

- This is a report on the eleven research workshops involving practitioners with responsibility for the welfare of older Tasmanians, conducted for the project Service Driven Approaches to Preventing and Responding to Elder Abuse in Northern Tasmania (DoCT Reference SS03152, Research Preventing Elder Abuse North).
- Ethics approval HREC_20112; THS Site Authorisation: SSA/007/TASLGH/THS-2020
- By way of background to the research, the story (Vignette 1, p.13) of the death of Mrs Janet Mackozdi, who died of hypothermia in July 2010 while sleeping in a converted shipping container, encapsulates the complexity of elder abuse prevention in Tasmania. In previous research, PEAT identified a trail (Figure 2, p.10) of interactions with aged care, GPs, pharmacies, allied health, banks and real estate agents. At some points concerns were raised, but the family was able to convince services, for example the GPs they visited, that they could care for Mrs Mackozdi. The story of Mrs Mackozdi highlights the breadth of services involved in an older person's life. How these services recognise and respond to possible cases of elder abuse is the basis of the research reported here.
- This background, and previous research by Preventing Elder Abuse Tasmania, informed the research question: What is the flow of recognition and responses to elder abuse in key relevant Tasmanian agencies and institutions?
- At the start the workshop discussions, workshop participants were asked to express their understanding of elder abuse in the context of their service. All the cases described by participants were complex and reflected the breadth of abuses described in the literature. However, what was striking is that they all included an intentional or unintentional financial abuse element—similar to the cascade of events leading to the death of Mrs Mackozdi's (Vignette 1).
- Throughout the discussions, the experience and 'people' skills of the participants were key to recognising and responding to the 'hidden' nature of elder abuse of their clients.
- In the workshops, participants discussed what they believed to be a general lack of awareness of what constitutes elder abuse by their older clients, and even 'normalisation' of elder abuse in their client communities.
- Participants were generally positive about the Tasmanian Government elder abuse awareness campaign and thought it would help 'perpetrators' recognise that what they were doing was abuse.

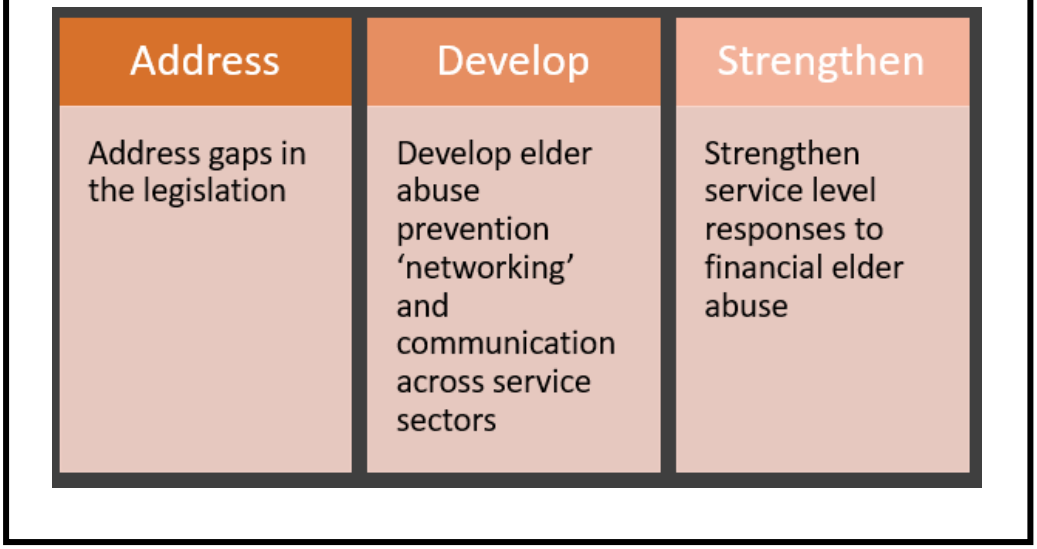
[1] FINDINGS and RECOMMENDATIONS of Coroner Olivia McTaggart following the holding of an inquest under the Coroners Act 1995 into the death of: Janet Lois Mackozdi
https://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0018/440280/Mackozdi,-Janet-Lois-latest-version.pdf

- Financial abuse was considered to be 'very common' and participants reported issues such as lack of awareness or understanding of their rights, costs, access and understanding of technology (to use on-line services), and criminal behaviour such as using the older person's login details to steal money from their account as increasing the risk of such abuse.
- Institutional abuse came to light in regard to housing affordability (e.g. independent living unit costs); aged care services availability (e.g. shortfall in home care packages); government policy that does not improve services, e.g. transport, for older Tasmanians; limited access to specialist geriatric health services; limiting definitions of client eligibility for home services (e.g. no funding for 'welfare' checks); abuse by people given power of attorney and difficulties for the older person to remove that authority.
- While expressing frustration with the 'problems' of responding to elder abuse, overall participants were passionate about making a difference for their clients.
- The material raised so many issues about deficiencies in our system and its inability to meet older people's needs. Participants in the study were overwhelmed by the problems they were trying to deal with, to which there are no current solutions available because of the multiple failings of the system. This includes inadequate housing and care options.
- Referral pathways discussed included the Elder Abuse Helpline, Senior Assist, hospital admission; outreach services (through multipurpose centres (MPC)); mediation services; and police.
- Most participants were aware of police welfare checks but had not used them out of concern about making the older person's situation worse with their abuser/s.
- Assessment of capacity emerged as a significant barrier to dealing with elder abuse throughout the discussions. Participants agreed that the process was onerous, making it very hard to get an assessment done, and required skills that some participants felt unable to provide. The Tasmanian Law Reform Institute has provided an extensive review of assessment of capacity in the 'Review of the Guardianship and Administration Act 1995 (Tas)' (2018).
- There is no specific 'elder abuse' crime in Tasmania, nor specific legislation addressing elder abuse in Tasmania. This has implications for dealing with elder abuse in terms of its recognition and responding to it. All participants raised concerns around the limitations of legislation in Tasmania. In particular, the limited definition of family violence in Family Violence legislation and the need for adult safeguarding legislation. One of the recommendations arising from this research is a robust review of existing and missing legislation to support services that prevent elder abuse in Tasmania.
- Over the course of the research, it became evident that professional networks provided the strongest referral links across the State. These networks were either 'formal' e.g. SEAPAC, or more usually 'informal' e.g. professional networking by social workers. In the workshops, all participants discussed how important it was to their services to engage with other agencies to coordinate responses; this is central to elder abuse prevention.
- All participants wanted more resources to increase their capacity to help their older clients at risk of elder abuse. The cases are complex and talking to older people themselves takes time. Also, the response to the abuse is not simple. Making sure the wishes of the older person are respected is more complex than simply extracting them from the situation, for example. Services are experiencing an increasing complexity of cases due to the ageing of the population, as well as increasing community awareness that there is help available.
- This research found no 'north/south' difference in how services respond to suspected cases of elder abuse. Differences do arise due to distance from major population centres and services; access to a MPC/Primary Health Care with allied health services on-site; transport availability; social and rural isolation. Participants with experience across the state noted that the type of agency tends to be the same regardless of region, with some minor differences in the type of programs available.

Recommendations from Report_North

Participants in the eleven workshops reported here proposed over fifty responses to the elder abuse factors raised in the discussions. Of these, the three main areas requiring change focus on legislation, networking and financial abuse (see Figure 1). The key actions proposed correspond with these three main areas. These recommendations accorded with the findings of the research conducted in Southern Tasmania.

Figure 1: Report (Northern Tasmania) key recommendations



At each workshop, participants raised concerns about gaps in legislation, and compared inaction toward elder abuse with the powers available under the Family Violence Legislation. It was also very clear that there were, despite the best efforts of individuals, too many barriers to networking in the best interests of their older clients. Finally, the overwhelmingly common factor in all the stories of elder abuse shared in the workshops was financial abuse. Mrs Janet Mackozdi's life (Vignette 1, p.13) started to unravel when the greed of her children overcame their filial duty to her. As her bank balance diminished, so did her quality of life.

Key actions to address recommendations:

KEY ACTION 1: Address gaps in the legislation

1.i—Establish a complaints investigation body with power to investigate; adjudicate; make determinations; and enforce determinations.

1.ii—Change the definition of family violence in the Family Violence Act, which is currently limited to intimate partners, so that it extends to other forms of and perpetrators of family violence.

1.iii—Enact the recommendations (Appendix 4) of the Coroner's investigation and report into the death of Mrs Janet Macozdi.

KEY ACTION 2: Develop elder abuse prevention networking and communication across service sectors

2—Build on the success of the "No wrong door/The Right Place[2]" program to identify and strengthen current formal and informal connections between services

and improve access to services for older Tasmanians. program to identify and strengthen current formal and informal connections between services and improve access to services for older Tasmanians.

KEY ACTION 3: Strengthen service level responses to financial elder abuse

3—Impose a duty on financial institutions to act on their suspicions of inappropriate access to accounts. A public investigatory and regulatory authority should be established by legislation for this purpose. Define financial institutions to include any body, whether incorporated or unincorporated, that has dealings with an elder person's finances.

Background

Tasmania is an 'ageing' state, with the highest proportion of people over 65 in Australia. This trend will continue with increasing life-expectancy, and an on-going loss of younger Tasmanians to the mainland for work, coupled with an increasing influx of sea- and tree-changers in older age groups. Tasmania already has a population with significant, known risk factors for elder abuse (Tasmanian Government 2012; Jervis et al. 2016). These concerns have prompted the State Government to seek to respond comprehensively to the increasing risk of elder abuse, in hand with national reforms (Australian Government 2019) already underway.

In line with international trends, the national review has recognised that elder abuse is multi-sectorial and that preventing and responding to elder abuse is not the sole responsibility of, for example, health or justice government departments. All sectors need to respond in a co-ordinated way as elder abuse is not 'just' financial or physical (often multiple forms of abuse are perpetrated in the same case). It is both difficult to investigate and to prosecute. While the community may be horrified by accounts of elder abuse, this response may sometimes be tempered by feelings that it is too terrible to believe—much like the initial responses to child abuse.

Through Tasmanian, multi-sector research conducted by the University of Tasmania Preventing Elder Abuse Tasmania (PEAT) research group, it was established that while individual services (State, Commonwealth and NGO) have elder abuse policies and processes for responding to cases of elder abuse, these have largely arisen independently of existing State policy (Tasmanian Government 2012; 2019) directions. The service-level responses have been moulded by the context of the service, including access to other services and community supports. The research identified that at the service level there is expertise and a passion to resolve issues recognised as elder abuse, but there is an equal amount of frustration with the perceived lack of support or co-ordination by State Government and slowness of and uncertainty about known response and legal pathways. It was also found that several services have, or are developing, their own policies and protocols for responding to elder abuse without any reference to State policy (Lawrence, Henning, Banks 2016). Moreover, policies and procedures are not always implemented at the institutional level.

The research question has been informed by previous research by PEAT as well as a review of the literature (Appendix 3).

Research Question

1. What is the flow of recognition and responses to elder abuse in key relevant Tasmanian agencies and institutions?
    a. To what extent, and how, are existing policies and protocols (both of services and institutions) in relation to elder abuse embedded in work practice at the service and institutional level? How can the current State protocol and response/referral flow-chart be updated to meet the needs of all sectors to the fullest possible extent?

Research Method

The underlying methodology for this project is known as 'participatory' research (qualitative). Put simply, the researchers—and the participants (in this case, those people working directly with older Tasmanians)—share perspectives and knowledge to develop outcomes together. Participants in this project workshopped, on-line, the flow of recognition and responses of their service organisations to elder abuse. The workshops were facilitated on-line by the PEAT senior research fellow (Dr Suanne Lawrence) and then transcribed, for content analysis by the PEAT research team. All data was de-identified and grouped by organisation type (see Table 1) and region (North or South).

Ethics approvals for this research: HREC_20112; THS Site Authorisation: SSA/007/TASLGH/THS-2020.

Table 1: Services that have older Tasmanians as clients, grouped by organisational type and number of participating services state-wide.

GACHS Government Acute & Community Health Services	**NGOACHS** NGO Acute and Community Health Services	**GCS** Government Community Services	**NGOCS** NGO Community Services	**GLFS** Government Legal and Financial Services	**NGOLFS** NGO Legal and Financial Services
Community Allied Health	St John's Private	Centrelink	Advocacy Tasmania	Guardianship and Administration Board/Office of the Public Guardian	Tasmanian Community Police
ACAT	RAC	Service Tasmania	EA Helpline	Public Trustees	Neighbourhood Houses Tasmania
Regional Assessment Services (CHSP)	District Nurses	Consumer Building and Occupational Services (CBOS)	Dementia Australia (Tasmania)	Australian Financial Complaints Association	Combined Pensioners and Superannuants Assoc.
Aged Care Complaints	Community Aged Care	Libraries Tasmania	COTA_Tas and Aged Care Navigators	Equal Opportunity Tasmania	Law Society of Tasmania- Elder and Succession Law Committee
RHH	Hobart Private		Salvation Army	Coroner's office	CPA Tasmania
LGH	Palliative Care Tasmania		Meals on Wheels	Ombudsman Tasmania	Australian Banking Association
Integrated Care Centres Primary Health	Hospice at Home		Relationships Australia	Magistrates	Politician's offices
GEM/Transition Care Units	Speak Out		Legal Aid/ Senior Assist	Official Visitors Programs Tasmania	Women's Legal Service Tasmania
Ambulance Services	Disability Support Australia		Bereavement Network	Department of Justice	Tasmanian Aboriginal Community Legal Service
NWRH	Tasmanian Aboriginal Health Services		Sexual Assault Support Service	Senior Assist	
Dementia Support Australia (DBMAS)	South East Tasmanian Aboriginal Corporation		Tasmanian Men's Shed Association	Legal Aid	
Department of Communities Tasmania			Migrant Resource centre		
Roy Fagan Centre			Family Violence Counselling and Support Service		
Older Persons Mental Health Services					
North = 2 South = 3	North = 1 South = 1	North = 1 South = 1	North = 3 South = 2	North = 2 South = 2	North = 2 South = 4

Recruitment

Tasmanian services, government, and non-government, that were approached to participate in this research are listed in Table 1 (above). These are services that have a direct service provision to older Tasmanians. The list was derived in consultation with SEAPAC[2] whose representatives fall within or advise the services listed in Table 1 (above). Services were emailed directly to invite participation, as well as arranging a day to run the on-line workshop, and to discuss any questions about the research.

[2] The Statewide Elder Abuse Prevention Advisory Committee was established according to *the Protecting Older Tasmanians from Abuse: Tasmania's Elder Abuse Strategy 2011*. Membership of this Committee comprises representatives from Department of Communities; Department of Health; Department of Justice; Tasmanian Police and Emergency Services; Office of the Public Guardian; Office of the Equal Opportunities Commissioner; COTA-Tasmania; University of Tasmania; TasCOSS; Relationships Australia; Public Trustee; Legal Aid; Advocacy Tasmania; and Aged and Community Services Australia.

Workshop Format

Participants were greeted and after confirming their consent and asking for any questions about the research, the facilitator started the workshop with guiding questions (sent to participants with the meeting confirmation).

The guiding questions discussed in the workshops were:

1. Are there any cases (deidentified) of elder abuse that you recall? (If not, the facilitator will describe an 'exemplar' case to stimulate discussion). Think about your understanding of elder abuse? Do you have any questions about elder abuse?

2. Describe what your service does in response to a 'case' of elder abuse

- Who does the service include (exclude?) in the response? Who would you call?
- What works, or does not work in this response? Can you identify any gaps, enablers and barriers to your service response to elder abuse? For example, has there been a situation where the response has led to a good outcome for your elderly client? Are there any external pressures on your service that may influence your response?

Using a diagram,[3] with you in the centre, describe what your service does in response to a 'case' of elder abuse. In your diagram, note who within your service is involved, and who outside your service may be involved or to whom the older person may be referred in your experience.

On your diagram, add notes about how well, or not, the people or services you include in your response resolve the problem to your satisfaction?

Indicate on your diagram where you think there are gaps; what needs to be added; what needs to stop happening for you and your service to respond better to a case of elder abuse.

3. Describe how you think your service should best respond to a case of elder abuse and what support you need? This may include:

- Type of staff
- Education
- Resources
- Communication
- Policy
- Funding
- Support from other services/community/government (any level)?

Data analysis

Fieldnotes (observations), notes of workshop discussion, on-line Chat text (typed discussion by participants) and screenshots recorded during workshops were transcribed and de-identified (data categorised according to participants' organisation type) then collated. The researchers conducted a thematic content analysis (Appendix 2), guided by the research question: what is the flow of recognition and responses to elder abuse in key relevant Tasmanian agencies and institutions?

Results

Of the forty organisations (Table 1) invited to participate in the research, eleven services in northern Tasmania (and 13 services in Southern Tasmania), agreed to participate. A 'pilot' workshop had been conducted to test the method and refine the workshop questions prior to commencement of southern workshops. All were comfortable using on-line meeting software (Zoom, Skype or MS Teams) with minimal technical difficulties encountered overall.

[3] The methodology was intended to be conducted in a face-to-face workshop. Because of the pandemic, the method was adapted to an on-line format. However, from the pilot study it was clear that 'workshopping' with diagrams did not work via on-line communication, so the method was reshaped accordingly - participants discussed these points and did not draw diagrams

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With agreement of participants, the workshops were recorded and then transcribed for analysis. A total of 470 minutes of recording were available for analysis.

Workshop data were reviewed by the senior researchers (SL,TH and SB) for content and grouped into key themes to answer the research question "what is the flow of recognition and responses to elder abuse in key relevant Tasmanian agencies and institutions?" The content analysis is tabulated in Appendix 1.

From the workshop-content analysis (Appendix 1) three key themes were identified, and a total of 32 factors relevant to each of those themes:

1. Recognition of elder abuse (ten factors)

2. Responses to elder abuse (six factors)

3. What are the barriers and enablers to service recognition and response to elder abuse (sixteen factors)

The responses proposed to the 32 factors identified by the workshop participants are listed at the conclusion of each discussion section, as summarised in Table 2 (p12).

Findings and Discussion

Introduction

The data from the workshops identified a number of settings in which elder abuse occurred or was reported. The participating services clarified the roles they hold within these settings. The settings ranged from the person's own home, residential care, acute care and public spaces. The structural and social contexts in which elder abuse occurs are important as they frame the lived experience of older Tasmanians as well as giving context to the factors that contribute to abuse. Clear identification of this context give services and government a starting point for change strategies and evaluation.

In the findings section of this report, the evidence provided by the participants is reported, framed by the code under which services have been grouped (Table 1). Regional variations are noted while maintaining anonymity (in accordance with the Ethics requirements of this research). The data findings are analysed and discussed to show how each service reports and shares information with other services in Tasmania or calls in support to their service as required.

This report seeks to allow the information provided in workshop discussions to speak for itself, to disclose the responses sought and recommended for the problems identified by the participants. Therefore, the findings and discussion contain numerous quotes from the participants. The discussion reported here is grouped around the quoted material according to the themes, and sub-themes, identified in the content analysis (Appendix 1). To further illustrate the findings, deidentified vignettes (case studies) are used. Except for Vignette 1, the death of Mrs Janet Macozdi that all participants were aware of, these vignettes were given by participants during the course of the workshops.

Table 2: Summary of Key Themes and Factors arising from workshop content analysis.

Key Theme	Factor	Sub-factor
1. Recognition of elder abuse	F1.1 Recognising elder abuse—a hidden crime	
	F1.2 What constitutes elder abuse	1.2i Elder abuse becomes 'normalised'
		1.2ii Using estate planning to prevent elder abuse
	1.3 Financial Abuse—why do people feel entitled to an older person's assets?	
	1.4 Institutional abuse	1.4i Institutional abuse—housing affordability
		1.4ii Institutional abuse—service availability
		1.4iii Institutional abuse- push to on-line services
		1.4iv Institutional abuse—policy/funding limitations on service
		1.4v Institutional Abuse—by financial and legal advisors, Guardian or Power of Attorney
	1.5 Family history of abuse	
2. Service responses to elder abuse	2.1 Referral pathways	2.1i Referral pathways—to Elder Abuse Helpline (EAH)
		2.1ii Referral pathways -Senior Assist
		2.1iii Referral pathways—hospital admissions
		2.1iv Referral pathways—outreach services
		2.1v Referral pathways—mediation & counselling services
		2.1vi Referral pathways—to the police
3. Service level barriers and enablers to recognising and responding to elder abuse in northern Tasmania	3.1 Awareness of service	
	3.2 Assessment of capacity	3.2i Assessment of capacity—getting the assessment done
		3.2ii Assessment of capacity—skills to do the assessment
		3.2iii Assessment of capacity—having capacity, but limited options
	3.3 The role of the Public Trustee	
	3.4 Legislation	3.4i Legislation—limited powers vs Safe at Home legislation
		3.4ii Legislation—third party referrals
	F3.5 Networking	3.5i Networking—central to elder abuse prevention
		3.5ii Networking—open doors everywhere
		3.5iii Networking—sharing information
	F3.6 Resourcing	3.6i Resourcing—as awareness grows, so will referrals …
		3.6iii Resourcing –funding restrictions on services
		3.6iii Resourcing—transport
		3.6iv Resourcing—community referrals take time
		3.6v Resourcing—meeting increasing demand for aged-care services
	3.7 Are there any North-South differences?	

Key Theme 1. Recognition of elder abuse

Most Tasmanians, and indeed all the participants in this research project, are aware of the case of Mrs Janet Mackozdi who in 2010 froze " *to death in a shipping container*"[4] while in the care of her daughter and son-in-law. This story (Vignette 1, below) illustrates the difficulties services face in recognising, and then responding to, elder abuse.

Vignette 1. Mrs Janet Mackozdi

Janet Mackozdi, 77, died of hypothermia in July 2010 while sleeping in a converted shipping container at her daughter and son-in-law's Mount Lloyd property. Five years later, Jassy Anglin and husband Michael Anglin were convicted of Ms Mackozdi's manslaughter. At the inquest conducted by Coroner Olivia McTaggart, we heard that Mrs Mackozdi was in the advanced stages of dementia, and was frail and underweight at the time she died, due to significant neglect by her family who were responsible for her care. This case is troubling because Mrs Mackozdi saw many different services over the three years prior to her death. The obvious question is why didn't any of these services identify that the family were not adequately caring for this increasingly frail woman and intervene on her behalf so she didn't spend the last moments of her life in a freezing shipping container.

Coroner McTaggart asked PEAT to address key questions to be included in her final report (Coroner McTaggart 2019). Given access to the available information surrounding Mrs Mackozdi's final years of life prior to the inquest, PEAT found a troubling trail of contacts with services that could potentially have intervened in her decline to death brought about by the actions (or inactions) of her family. Summarised in Figure 2 , Mrs Mackozdi's (MM) increasing dependence on her family starts in late 2007 when she sold her house in Sydney. At this point, MM sees her long-term financial planner who is concerned that MM is confused. The family reassure the planner they will be caring for MM, and that they are all moving to Tasmania. From here until her death in July 2010, there is a trail of interactions with aged care, GPs, pharmacies, allied health, banks and real estate agents (Figure 2). At some points along the timeline, concerns were raised, but the family, especially due to their health-care backgrounds, were able to convince the GPs they visited for example, that they could care for MM. Further insights from this complex case are included in parts of this report.

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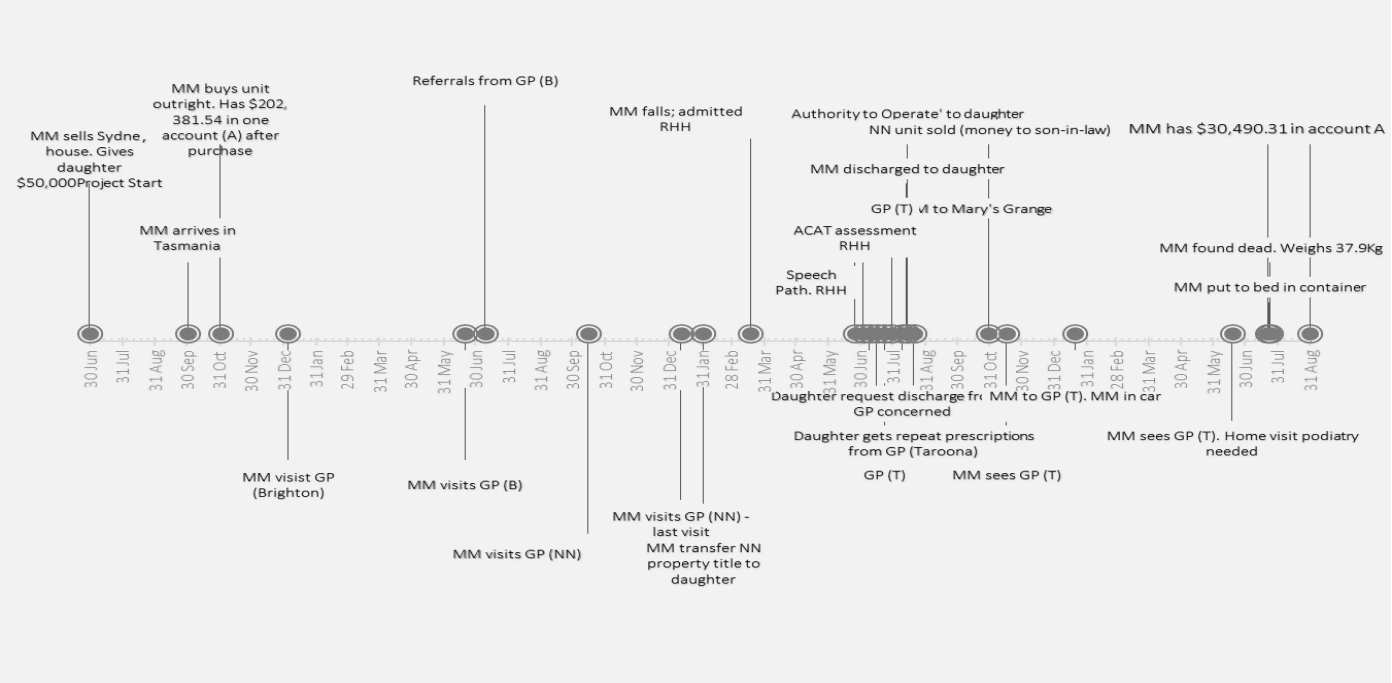
[4] ABC News https://www.abc.net.au/news/2015-04-13/queensland-couple-convicted-of-causing-death-of-elderly-woman/6389212#:~:text=A%20Queensland%20couple%20has%20been%20given%20two-year%20suspended,container%20at%20Mount%20Lloyd%20during%20mid-winter%20in%202010

Figure 2: The timeline of Mrs Janet Mackozdi's decline to death while in the 'care' of her family (Banks et al. 2017).



The story of Mrs Janet Mackozdi highlights the breadth of services involved in an older person's life. How these services recognise and respond to possible cases of elder abuse is the basis of the research for this report.

Elder abuse does not occur in a vacuum. As we see in the 'vignette' of Mrs Mackozdi above, a trail of circumstances and inaction of 'actors' led to her sad death in a cold shipping-container. When discussing their experience of elder abuse, participants were asked to think about the contexts and factors that may have 'allowed' the abuse to occur. If the factors are known, then services can use this knowledge to pre-empt situations in which they can see the potential for abuse occurring. These factors can be built into their assessments. Factors are not always obvious and may be overlooked in the 'busyness' of client assessment/care/interactions. One participant's comment sums up the view of the majority: *"when it comes to elder abuse, it's not the physical nature, it's more an emotional hang up or a property-based form of abuse, rather than what I would regard as physical or anything like that* (NGOLFS_N)."

The definition of elder abuse is itself contentious. While all participants expressed concern about managing (time, resources, emotional) the complexity of the elder abuse cases they described, a recurrent theme in the workshops was financial abuse—either as a single act, or as part of a more complex situation that included other acts of elder abuse.

Vignette 2. Abuse as being what the person determines to be abusive

An elderly woman, she lives with her son. The abuse has been along the lines of pressuring her to buy an object, for a large amount of money—she hasn't wanted to do that. There's also been an instance of physical abuse in the past—that she hasn't acted on. There appears to be some overseeing or restricting her ability to communicate with other persons—in my practice I tend to

look at abuse as being what the person determines to be abusive, rather than what I think is abusive. It comes from a perception of a trustful relationship (NGOLFS_N).

This complexity, and reality of elder abuse as described by the workshop participants is reflected in the number of definitions of elder abuse (Kaspiew, Carson & Rhoades 2016; ALRC 2017), with a new, but working, definition to be tested in the Elder Abuse National Research Program prevalence study (Kaspiew et al. 2019). For the purposes of this report, and in line with the Tasmanian Elder Abuse Prevention Strategy 2019-2022 (Tasmanian Government 2019) the WHO definition is used: *The World Health Organization (WHO) defines elder abuse as: "a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person* (WHO 2008, p1).

The 'acts' (or omissions) that define elder abuse include:

- *physical abuse (including pushing/shoving, hitting/slapping, punching and kicking)*
- *emotional/psychological abuse (including verbal abuse such as yelling insults and name calling; intimidation/bullying and harassment; damaging or destroying property; threatening to harm the older person or their family members/friends or pets; threatening to withdraw care and preventing or attempting to prevent access to funds, telecommunication or transport)*
- *financial/economic abuse (including misuse or theft of finances or other assets and abuse or misuse of powers of attorney)*
- *sexual abuse (including unwanted sexual contact and rape)*
- *social abuse (including preventing or attempting to prevent the older person from having contact with family, friends or community—social isolation)*
- *neglect (including the failure to provide access to essentials such as food and hydration, clean and appropriate shelter, adequate hygiene or medical care).*

(from Kaspiew et al. 2019)

Factor 1.1 Recognising elder abuse—a hidden crime

Vignette 3. Elder abuse is a 'hidden' crime

With our service, it is one of those things that we have in the back of our mind, when we get a referral about an older person—it's just one of those things that we will factor into our screening and our assessment, and having an understanding that elder abuse is a lot more than just physical abuse. More often than not it's very benign, it's hidden. People are very ashamed to talk about—it can be emotional, it can be around not giving the older person control over their decision making that impacts on them and things like that. So, I think, looking back at myself now (since receiving training) I've got a much better understanding of the extent of the problem, of the fact that it's hidden—people don't talk about it in the same way that they talk about other forms of abuse, and I also have an understanding of the complexity of the processes in place and the

lack of legal tools to actually support us. And even the lack of resources generally to support us, to actually provide the assessment and the follow-up and the care for the older person. (GACHS_N)

Throughout the discussions, the experience and 'people' skills of the participants were key to recognising and responding to the 'hidden' nature of elder abuse of their clients. Without the experience of 'seeing' elder abuse in their professional career or personal lives, service staff will not pick up on the cues that abuse is occurring. "*I've always had that interest in older people, but to be perfectly honest, I used to—not so much turn a blind eye—I was very naïve about the abuse that older people actually experience"* (GACHS_N). Another participant had concerns, but had never confirmed a case of elder abuse in their service: "*There's always cases, people are wondering about, but I've not actually come across something that's been confirmed, myself"* (NGOACHS_N).

One participant who had been in the service for a number of years commented that the language around elder abuse is "softened". For example, "*stealing money has become inheritance impatience. So instead of using the language of a criminal offence, it's turned into a social problem between the perpetrator and victim"* (GACHS_N).

Vignette 4. It's stealing

We hear from the families (more often than not being adult children), phrases like, "inheritance impatience" and things like this. And it's quite an astounding terminology, when really in any other format it would be called stealing. You can't just take anyone else's property off them for no reason. But as a person gets older, families seem to think it's okay to sell their houses. (GLFS_N)

Services that are able to go into a person's home are at an advantage to identify if 'something's not right'—no food in the fridge, heating not on, dirty clothes, prescriptions not filled. If the person comes into a clinic, a 'neutral space' then "*you're not seeing the dynamics, you're not seeing how they live, you're not noticing if there's food in their fridge or if the house is in a state of neglect. So, this is where we've got this advantage, we're in their homes. So, we're confronted with the reality of that person's life"* (GACHS_N). Other workshop participants noted that when a person is outside their environment, such as visiting the GP, then there is an element of 'performance' and they'll tell the doctor what they think the doctor wants to hear. Clients are also very aware of not wanting to 'waste' the doctor's time. Participants were sympathetic toward the limitations on a GP—not much can be achieved in a six-minute consultation. The other concern is when the person's carer, who may also be their abuser, accompanies the older person to the GP. "*A person's very restricted in what they can say. So, the GP often doesn't pick up on the cues. What I mean, the family they're policing what's said and sanitise to a certain degree"* (GACHS_N).The preference is to see the person on their own to avoid controlling behaviour.

1.1 Response Proposed:

1.1A Support Tasmanian services to develop/refine their elder abuse strategy/policy. 'Elder abuse is everyone's business'.

1.1B Recognise the range of skills, experience and turnover of staff of Tasmanian services when developing policy and training.

1.1C Develop a metric to measure the actual time taken by staff to manage a case of elder abuse—recognising that interviewing older people takes more time to communicate as well as develop trust.

1.1D Resist 'softening' the language around elder abuse as a way of avoiding agency and personal responsibility for acts that are violent, psychologically, emotionally, or financially abusive or neglectful towards older Tasmanians.

1.1E Evaluate implementation of mandatory elder abuse prevention training across government and NGO service organisations to promote a consistent, state-wide approach to elder abuse recognition and response.

1.1F State-wide monitoring of the use of ageist language in formal documentation.

Factor 1.2 What constitutes elder abuse?

It is important to understand what 'elder abuse' is in the eyes of the older person because this determines if the older person reports their concerns. It is also important to realise that older persons may have a different view of elder abuse to that of service providers (Roulet Schwab & Wangmo 2021). An Australian study by Dow and colleagues (2020) identified shame and stigma, especially around the reporting of abuse by family members as being key to the older person's decision to seek help (Dow et al. 2019). The research reported here gives only a brief 'snapshot' of older person perceptions of elder abuse, as understood by Tasmanian service providers. Without further study, including in minority populations, the 'voice' of the older person will not be heard, and policies will not align with the needs of the population they are intended to serve (Killick et al. 2015).

In the workshops, participants discussed what they believed to be a general lack of awareness of what constitutes elder abuse by their older clients, and even 'normalisation' of elder abuse in their client communities.

Vignette 5. What constitutes abuse?

And what constitutes abuse? If Grandma's biting you, giving her a smack may not feel like abuse to you. No, what do you call abuse? Is it if you're not showering Grandma more than once a week, or once a month, is that neglect? If she's losing weight because she's not eating enough because you haven't fixed her teeth, is that elder abuse? Well, probably it is, but people wouldn't necessarily see—they wouldn't call it that, they would just say, "Well, I'm just doing the best I can to look after Grandma, and there's no bloody services." So, I think people understand what abuse actually is, but I think the problem is that once you say, "This is what abuse is, this is neglect," then what do they do about it? If they go, "Well, you know what, I'm not doing the right thing by Mum, now what do I do?" You can't get a level four package, you can't get a nursing home thing, it costs $400,000 to get into a nursing home bed, and we don't have that sort of money, we don't own our house, you know. So, what do they do if they suddenly do realise there's some neglect going on in their family, when there is no way they can address it, or do something about it, or reach help? They can go to their GP, which is going to be the ad campaign's advice—go to your GP, and your GP goes, "What do I do about it? Stop hitting your mum." Yep, so it's complex, it's a social thing. It's at all levels from the grassroots up, education right through to government policy. That's why it's so hard to address. (NGOACHS_N)

Subfactor 1.2i Elder abuse becomes 'normalised'

While financial abuse is the most commonly reported act of elder abuse in Australia (Kaspiew , Carson & Rhoades 2016; Chesterman 2019) and worldwide (Pillemer et al. 2016; Yon et al. 2017), elder abuse overall often goes unreported, sometimes because the older person themself does not recognise they are being abused, or the abuse has become 'normalised' over the course of their life (Fulu et al. 2017; Weberman & Murphy 2020).

Vignette 6. Normalisation of abuse

Probably the most difficult thing in that case was the woman's own viewpoint and understanding what was happening. Yeah, is this a usual situation? Because it had become so normalised for her. But for me looking from the outside in, the physical, emotional abuse, the financial abuse that was happening was just so completely normal for her. It had been that way for however long and was something that she wasn't even thinking about. I think there needs to be more education in the community. We're talking about the issue of people not identifying that they are being subjected to elder abuse and that could be because it's been a process over time that becomes the normal, habitual, or it could be that culturally, they just think that that's okay or whatever (GCS_N).

This participant added that even if the person recognises they are being abused, they then have to know where to go for help.

Some participants were aware of the recent elder abuse awareness campaign but were ambivalent as to how it would help someone experiencing abuse. "When people are in these situations, that sense of powerlessness and loss of control—and a lot of these things that we're talking about, about making contact with someone or telling someone, that becomes beyond them to some extent or a really, really difficult thing to actually summon the courage—even the ability to be able to do that is compromised. They fear they would lose what little control they have and make their situation worse (GCS_N).

In another workshop participants were more positive about the Tasmanian Government elder abuse awareness campaign[5] and thought it would help 'perpetrators' recognise that what they were doing was abuse: "*some of the perpetrators are not aware that that's what they're doing. Particularly around financial things, they feel entitled and they may feel that it's not as bad as it looks from the outside"* (GACHS_N). or that the abuse is "*unintentional*" because of a lack of awareness.

Staff from cultures other than Australia are also not necessarily aware of elder abuse as it "*doesn't exist*" in their own communities.

Vignette 7. Elder abuse in other cultures

I was quite surprised, moving to Australia and learning about the way that older people are actually perceived in this culture, compared to where I'm from. I'm from culture Y, where older people are—the older you get, the more respected you become and your wisdom as an older person—whether you've got a little bit of memory, duration is never second guessed. So, we tend to put a lot of emphasis on looking after our older population. But when I first came here, for the first time in my life, I started hearing people actually having jokes about an older person or joke about when they have——it's a very different culture. (GACHS_N)

1.2i Response Proposed

1.2iA—The material raised so many issues about deficiencies in our system and its inability to meet older people's needs. Participants in the study were overwhelmed by the problems they were trying to deal with, to which there are no current solutions available because of the multiple failings of the system. This includes inadequate housing and care options. There is no emergency accommodation. Public Housing has long 'emergency' waiting lists. Nor is it

[5] Tasmanian Elder Abuse is Not OK TV Campaign https://www.communities.tas.gov.au/disability/projects/elder_abuse/elder_abuse_resources/elder_abuse_is_not_okay_tv_campaign

fair to remove the older person from their own home. Participants agreed that awareness alone was not a solution without actual interventions "*to help people get out of these situations*". Adult safeguarding legislation that protects and upholds the rights of the older person, with supporting services such as is available through Safe at Home would provide a clear action and referral pathway for services to act on behalf of older Tasmanians.

1.2iB—Build on the elder abuse awareness campaign to emphasise recognition by the 'perpetrator' and what other people think of what they are doing.

1.2iC—The language used toward the 'perpetrator' needs to focus on the rights of the older person. "I probably wouldn't say, "You're abusing your mum." I would say, "It's her right to do something" (GACHS_N).

1.2iD—Participants agreed that awareness campaigns are important but wondered how effective they are. Continue awareness programs with embedded evaluation to improve message 'targeting'.

Subfactor1.2ii Using estate planning to prevent financial abuse

Estate planning, or pre-planning, is an important step in ensuring an older person's wishes are fulfilled as they age and potentially lose capacity. Solicitors undertake the writing of powers-of-attorney, enduring guardianships, and wills which are the most common mechanisms for the future (Ries 2019). How accessible these mechanisms are to all Tasmanians and the costs involved in engaging a lawyer, plus the cost of lodging the documents with the Tasmanian Titles Office is unclear. But workshop discussions did indicate that both costs and levels of understanding of the various available instruments can create barriers to effective estate planning.

The accepted definition of elder abuse encompasses a wide range of acts or omissions that lead to almost a bewildered response of horror, and feelings of helplessness in the face of such complexity, to the cases described by participants. With the common theme of 'financial' abuse, it is possible to use instruments and services that are already in place to support older persons' financial decisions. For example, to develop an ongoing relationship of support for the older person around their finances is less judgemental/stigmatising/embarrassing for the older person to ask for help than other forms of elder abuse. These financial issues then become the basis of intervention/mediation with the 'perpetrator'. The 'perpetrator' is often a family member, who may have feelings of entitlement to the older person's money or lack understanding of the care needs of the older person. Making financial abuse the focus of future elder abuse prevention policy and services is not a complete solution for all types of abuse, but a clearer response pathway and a 'foot in the door' for services with older Tasmanians as clients (for example as listed in Table 1).

One of the workshops was held with a private practice financial service. During the course of the discussion, the participants were quite clear (blunt) that they have to operate on a 'time is money' basis and hence their clients must have the means to pay them for their service. "*Generally speaking, we don't do a lot without getting paid for it. Now, the idea of help can be in referral to somebody else during that process, but to get there in the first place, requires a level of financial resourcing"* (NGOLFS_N). The majority (80-90%) of clients of this financial service are over 65 years old and the participants agreed that estate planning for people without the resources to pay a private advisor was an unmet need. Being able to refer them to Legal Aid or the Elder Abuse Hotline (EAH) would be a start. "*Having a resource other than family, effectively, an independent third-party scenario to go to and get some advice"* (NGOLFS_N).

As one participant commented, Australians, unlike Americans, are not used to being open about setting up financial agreements before getting into debt with a partner or family. "(Australians) *go in with trust and emotions first, and we don't talk about money, it's almost like not a dirty word, but it's one of those things that as a society, we don't brag about it. We don't want to talk about it, and we don't even talk about it like wills, because people will go and write their will almost in privacy or maybe as a couple, but then not discuss it because, then it's about dying, which is another taboo topic. You don't want to talk about dying, because it'll upset someone"* (NGOCS_N).

In a different workshop, participants discussed the older person's lack of awareness around their own rights, and ways to protect themselves as they age by for example, implementing an enduring guardianship and power of attorney. "*Everyone knows about a will, but let's be honest, a will is not that important. Once you're dead, you're dead. What really matters is when you're alive, and I find, honestly, I'd say 90% of my clients have absolutely no understanding of those legal documents"* (GACHS_N).

1.2ii Response Proposed

1.2iiA Estate planning for people without the resources to pay a private advisor is an unmet need. Being able to refer people to Legal Aid or the EAH would be a start. "Having a resource other than family, effectively, an independent third-party scenario to go and get some advice from" (NGOLFS_N). Also, elderly people may need help with using technology to manage financial affairs.

1.2iiB Institute an awareness campaign to encourage older Tasmanians to engage and discuss long term personal protection regardless of their ability to pay for the advice and submission/registration of documents. For example, community education sessions might be instituted with Senior Assist.

1.2iiC Review what information is given when Tasmanians apply for carer or aged pension, and Seniors Card, to ensure Tasmanians are given information on how to access services that they may need as they get older, and also offered the opportunity to meet with a community legal person to help with, for example, estate planning and guardianship.

1.2iiD Identify places that are easily accessible, or routinely accessed by older Tasmanians that can provide free financial and legal advice in a safe environment. Service Tasmania may be an example, or at neighbourhood houses, local government offices and multipurpose centres.

1.2iiE Impose a duty on financial institutions to act on their suspicions of inappropriate access to accounts. A public investigatory and regulatory authority should be established by legislation for this purpose. Define financial institutions to include any body, whether incorporated or unincorporated, that has dealings with an elder person's finances.

Factor 1.3 Financial Abuse—why do people feel entitled to an older person's assets?

During the workshops, discussion about why people, usually family members, felt entitled to the older person's assets often arose. "*Why do they believe it's their asset and not the older person's asset? What changes—I can't understand—what has changed? And is it—I mean, you can understand people are under financial pressure, but you don't go and steal something from the shop"* (NGOLFS_N).

Even if the older person's only financial 'fortune' is the pension, there will be someone who wants it. "*What I've seen is where you've got a family member or a friend who might withhold the person's pension from them, or they say that they're going to manage the person's finances on their behalf"* (GACHS_N).Financial abuse is very common. "*It's always intertwined with other forms of abuse, but certainly it's the one that is often the most obvious. But then there's often emotional abuse attached to that, potentially some physical abuse as well, but financially—it's so common"* (GACHS_N). For example, using the grandchildren as blackmail: "*One of the worst cases I saw of elder abuse was the fact that it was literally told in front of me, "If you don't do this or sign this, we will withhold your grandchildren."* (NGOLFS_N).

Family members/carers are able to obtain the login of the older person's accounts—bank, Centrelink etc.—by offering to help them if they are having trouble with the technology. "*I have seen a lot of family members accessing their elder relatives' online services, changing passwords, changing bank accounts, taking their payments, getting*

advance payments and so forth in their name and taking their money from them" (GCS_N). The increasing loss of banks and post offices in small towns will increase the risk of financial abuse.[6]

Participants discussed how financial abuse puts the older person in an increasingly vulnerable position: "*they don't have enough money to go and buy groceries or to go out, it's exceptionally isolating … it's a really powerful way of cutting off people from others around them—whether it's home care services or being able to access a community or see their friends… it impacts on every part of their life"* (GACHS_N).

Vignette 8. Helping an older child with a loan

A woman approached us for help with what she saw as financial abuse. The situation was what the woman saw as being a loan of money to help her adult child establish a business. That business failed and went bankrupt, and the person had some mental health issues following that, some depression. Now the situation presenting to us was, "I lent this money to my child, they've never paid back a cent, and now we just don't talk about it because it upsets the family."

They skirted around the topic and that they avoided one another and would only in fact catchup at Christmas or a special occasion, and even then, would not talk about it. The woman came to us thinking that our service would make the person pay back the money. Our service agreed to assist. In the first meeting, the person thought that the money was a gift, and that his parent was ashamed of them, due to the failure of the business.

Even though the person argued that they thought it was a gift, it seemed very much as though it was a situation where one person was taking advantage of another, and the parent thought of it as abuse. The person viewed things differently. However, after some rethinking, they could see yes, this could be seen as elder financial abuse. So, but I suppose it was more the fact that they didn't see it as any form of abuse, it was just it was about the money, and it was about the business and the failure of the business from the person's point of view. From the parent's point of view, it was about the loan as opposed to the gift, and that he thought the son was using his relationship with his family as the only way to keep in touch and avoid repaying the loan.

For the parent, the most important thing was having acknowledgement that the money was given and basically, they wanted to hear the word sorry. They wanted to have an apology, they didn't really care about the money, although they would have liked to have had some paid back, but ultimately, they'd much rather be happy and have the family happy and so forth. The person wanted to be able to pay back what he could, and was quite genuine in that, or seemed to be genuine in what he was saying to that, and that the parent agreed to that. (NGOCS_N)

Getting formal financial advice and a written statement of intent would help prevent the scenario described above. However, the coercion can continue in other ways. The financial advice service participants recounted how a client had called them in distress after the client's adult child had spoken to the advisor: ""*What did you say?" And that's where you clearly know that there has been some level of verbal abuse, if not worse, by the way that they're reacting. They said they copped an absolute mouthful of anger from the adult child because of a decision that has been made, which I find intriguing because ultimately, the asset or situation isn't theirs"* (NGOLFS_N). In some circumstances you

[6] .https://www.federalreserve.gov/publications/november-2019-bank-branch-access-in-rural-communities.htm

don't have to lodge a tax return after retirement, so the likelihood of an older person going to their accountant at this stage of their lives lessens. They then may miss out on information and advice to keep them safe, and this puts the older person in a position where they are more easily exploited.

1.3 Response Proposed

1.3A Recognise and develop education/awareness around four key points:
(i) Some people think it is "reparation or compensation for what they perceive as historical ills or faults" by the parent.
(ii) Financial desperation in a climate of high debt and financial competition combined with an assumption that the older person's assets will be coming to them in future anyway.
(iii) Anger that the 'boomer' generation is holding onto a lot of wealth gained during a period of growth in Australia that younger generations have missed out on.
(iv) Regardless of the argument that the 'boomer' generation worked hard to create their wealth, younger generations have grown up with the experience and expectation of having discretionary spending. The majority of 'boomers' on the other hand were raised by parents who 'scrimped and saved' during the depression and war years. Hence, not only is the economic environment different between the generations, but also the experience of having money to spend, and with credit cards, whenever you want it.
1.3B Identify and evaluate existing financial safeguards in current use. Older Tasmanians with low IT literacy are, for example, particularly vulnerable to local bank and post office closures.
1.3C How to identify increasing isolation of an older person due to their finance decision making being taken from them? It's as though they are a drawing slowly being rubbed out. If someone cares enough to look, the imprint of their life remains.
1.3D Establish a checking system that requires Centrelink, Services Tasmania or another community agency to be available to check password changes. An alert system.
1.3E Implement mediation training for financial advisors, accountants and lawyers
1.3F Increase community awareness of value in seeing a financial advisor no matter the value of their assets.

1.4 Institutional abuse

When the term 'institutional abuse' is used most people, including workshop participants, immediately thought of the stories of abuse emerging from the Royal Commission into Aged Care Quality and Safety [7]. That is, abuse that occurs within the walls of an institution. However, the term is increasingly used more broadly to encompass abuse that occurs under the auspices of institutions—usually large public or private entities—that through their policies and practices, 'allow' abuse to occur because of a power imbalance (McDonald et al. 2012; Kamavarapu et al. 2017).

Subfactor 1.4i Institutional abuse—housing affordability

Some clients living in independent living units—private companies not associated with residential aged care—because of the cost of the units—have no spare cash. "*They're very expensive, and they don't even include utilities. Some include meals, but I've seen the meals … all they get served are things like baked beans, or sausages—not nutritional meals. And they're paying a lot of money to be in these places, and they're tiny*" (GACHS_N). The few subsided aged care independent units (associated with residential aged care companies) are very good and affordable, but are rarely available or not suitable for disabled elderly. They also don't allow pets.

Vignette 9. There was no option except a nursing home

I'll give you an example of institutional abuse. I don't know if you've heard, but in independent living units the rent is about to increase. It's already $800 a fortnight. So, I've got one lady at the moment who actually has no choice but to go into a nursing home. And that is not her wish. Her

[7] The Royal Commission into Aged Care Quality and Safety was established on 8 October 2018 and Final Report issued in March 2021 https://agedcare.royalcommission.gov.au/

wish is to stay independent. The problem is she can't access social housing because she's considered housed.

So, she's not considered a high priority, meaning she'll be waiting for years for public housing, and public housing for a lot of other people is not appropriate, because they're often mixed in with people of all different ages, where they're quite vulnerable and they're targeted. In terms of independent living units, for older people there aren't any affordable options. It is not affordable. $800 a fortnight is not affordable. One lady I'm helping at the moment, she's actually moving into care. And I don't want her to move into care. She doesn't want to move into care, but we actually don't have a choice. There is nowhere affordable for her to go. (GACHS_N)

1.4i Response Proposed

1.4Ai Provide support to Tasmanians considering entering contracts with 'retirement' village providers through Consumer Affairs and Fair Trading, or Consumer, Building and Occupational Services, or Senior Assist.

1.4Bii Review and evaluate existing 'independent living unit' businesses. Are they good value for older Tasmanians? Would you let your Mum buy into one of these contracts?

Subfactor 1.4ii Institutional abuse—service availability

The Australian Government has moved to a 'consumer' model of care provision in aged care and the NDIS. There are limitations to this model for example: oversight of costs and quality; management costs; availability; access to complaints. "*I have seen that shift significantly in the last seven to ten years, because of the change in the way that support services have been funded. Now there are NDIS providers—and there are good ones, don't get me wrong—but there's a lot of evidence in the community where older people have been charged for support services that they're not receiving. I think, when you've got an issue such as elder abuse, it's complicated. There are no easy solutions. In my experience, the more effective support services, and the more visible those services are in communities, then that becomes a protective factor against abuse. For example, an older person living in isolation, with the odd service visiting once every two weeks, versus somebody living in the community and you've got a lot of visiting services, visible services that they can actually engage with on a regular basis"* (GACHS_N).

The issue of 'institutional abuse' is broad and includes social and structural problems across a broad spectrum. The following comment was made by a health practitioner working in a rural area approximately 2-hour drive from Launceston:

Vignette 10 . It's grassroots

In the past we had only a few kids going through to grade 12, and that grudgingly. So, starting from the very bottom up, lack of education, lack of social structure, lack of activity for children, the kids move away so the elder—the older people, their children are often elsewhere, because there are no jobs here. So, their kids and grandkids are often not present. Their carers might be their neighbours. The neighbours, are not particularly beholden. They're often good people but busy or sick themselves. We have one psycho-geriatrician that I know of. I mean, I don't even bother referring to him, you can't get hold of him. There's an older person's mental health team that's in Hobart, which is actually quite good, but it's in Hobart. There's just lack of access, but even if we could get these people to the doctors, there just aren't enough people doing assessments. There are not enough psychologists, psychiatrists, there's not enough support in

any sort of aspect of mental health including geriatric mental health, etc. It's just this scarcity of pretty much everything, and it's grassroots.

Q: Sorry to interrupt, I was thinking aged care services, do you find that there are enough of those in the community?

A: Level four package is well, they say 18 months but probably will never happen. That's the highest level where people need the most desperate help, and forget it, it doesn't exist. So, that's why it's good to have the hospital, because we often look after these people in the hospital, but it's not very nice for them there.

Q: Do you have any long-term patients in the hospital because of that?

A: We do, we have people awaiting placement, but it's not like some units where they have them for years and years, we would have them six months, hopefully no longer for their own good. (NGOACHS_N)

This level of frustration will have an impact on practitioners' desire and ability to act on cases of suspected elder abuse. "*Everything is hard, and everything is complex, and multi-morbid and just as I've said, it's not well remunerated*"(NGOACHS_N). They simply do not have the time to respect all the nuances of a person's life in the context painted above to feel comfortable (or competent) to put in place any intervention that they feel won't make the situation worse.

Concerns about access to home care packages was raised in a separate workshop: "*I often get referrals for people who are, say, well into their 80s, that have probably been struggling at home for a very long time. They don't have any understanding around ACAT, any understanding around home care packages and services they can access. And when you try to start putting these services in place, as we know, home care packages, you're waiting for about 18 months to get one, leading them to a vulnerable position where they are either reliant on their family, which I think perpetuates the abuse, or they have to go into care, which is not always the outcome people want. Isn't it ironic? The greater your support needs, the longer the wait?"* (GACHS_N). This group argued that aged care support is "*a protective factor*" in relation to elder abuse, breaking down the isolation of the older person: "*When you start having more services coming in, keeping an eye on that person, helping that person be a bit more independent, helping them to get out to meet new friends, to access the community, I feel like that can be, in itself, enough to change the dynamics of the relationship between the person and their carer, or their family"* (GACHS_N). For example: "*If the person has a Level 3/4 package, which takes lots of work from the carer at home, from the family, the abuse might stop because the stress of caring for the person with dementia is lifted. The service can also help to educate the carer about dementia and how best to manage difficult behaviours. As well as encouraging them to care for themselves"* (GACHS_N).

Regarding government policy, participants made a number of suggestions, including improvements to community transport. They also expressed concern about the critical shortage of mental health workers in general, but also about the specific needs of older people. For example, without the support of an older person psychiatrist, nursing homes will resort to chemical restraint to manage distressed older residents. The health worker making this comment also said that they were in the process of trying to get a resident into Roy Fagan (in Hobart) because the nursing home (outside Launceston) was unable to continue 'specialling' this resident. However, the referral required review by a geriatric neuropsychiatrist to be considered ……

1.4ii Response Proposed

1.4iiA Tasmania has a state-wide network of multipurpose centres (MPC) (Table 3). This existing network can link to private providers to ensure older Tasmanians are protected through information sharing and provide continuity of care.

1.4iiB Identify and use the expertise of staff with long term experience in Tasmanian services. Their understanding of what works, and what programs have been a waste of time and money, is invaluable.

1.4iiC Review the requirement for extra time to manage the care of an older Tasmanian—living in the community or RAC—and remunerate the practitioner/service for their time and expertise. This would encourage provision of care in under-served areas and populations.

1.4iiD Tasmanian government to lobby the Commonwealth to improve access to home care for older Tasmanians.

Subfactor 1.4iii Institutional abuse—push to on-line services

In one workshop the participants raised concerns about the 'push' to have all services accessed on-line, for example through the MyAgedCare on-line portal[8]. This particular service works with a very vulnerable older cohort whose needs are not easily met by 'regular' aged care services, because meeting those needs would not be financially viable for most providers under the current funding model. Existing services have long-standing care-providing relationships with older Tasmanians, and it takes time to build trust with this cohort. When a special need is not met by the My Aged Care portal, ACAT has been known to refer clients directly to some services to save time and further pressure on the older person.

Closing banks and pushing other essential services such as Centrelink on-line, enables potential abusers to coerce older people who are unfamiliar with using computers, to trust them with their account details. Bank branch closures impact local residents and business leading to anxiety and concerns around safety and security. Banks justify these closures by citing the preference of customers to use on-line banking services. However, this preference has not been independently measured and also relies on a reliable and affordable internet service (TasCOSS 2019). Post-office agents have stepped in to provide a limited range of services in some towns (APH 2002). From the limited research available, staff in banks are able to recognise and intervene in cases of suspected financial abuse (Phelan et al. 2018).

The TasCOSS Digital Access report (2019) identified a number of barriers to use of on-line services in Tasmania such as banking, including geographic and socio-economic disadvantage; limited access to technology especially for older Tasmanians combined with low income and education; living in rental accommodation; as well as a preference for face-to-face communication to avoid social isolation. Some participants in the TasCoss survey preferred doing their banking in person out of 'wariness' when using on-line services (TasCOSS 2019, p 34).

Vignette 11. Online services enable elder abuse

(The family member had) broken into the older person's online accounts and changed passwords or applied for advances and things like that. We advised the older person to contact the police and put in a report. And there was one lady, her granddaughter, had done that and had taken quite a bit of money from her through her Centrelink account. She had also done it to a lot of other people and they were actually taking her to court and there were charges against her.

To be able to get the money back for that older person, we've got to be able to prove that it was fraud and that the older person hadn't given permission for the money to be taken out of the

[8] Australian Government MyAgedCare portal https://www.myagedcare.gov.au/

account. That's the hard part—getting the older person to go to the police, make the police report, bring the police report back to us so then we can then work to reverse the fraud. It's embarrassing for them to go down to the police station and say, "My daughter/my granddaughter/my son has done this to me" (GCS_N).

1.4iii Response Proposed

1.4iiiA Request Commonwealth evaluate the 'MyAgedCare' on-line portal for consumer (service and older client) satisfaction; what population groups are being adversely affected by lack of access to this on-line service; assess growth in 'consultants' to help older clients access/understand MyAgedCare.

1.4iiiB Tasmania conduct its own review into the impact of bank branch and Post Office closures on communities.

Subfactor 1.4iv Institutional abuse—policy/funding limitations on service

Some services have limiting definitions for client eligibility for home services. They can organise a carer to come and shower the older person who needs that assistance, but there is no funding for a person needing a welfare check: "*They need someone to check in and see how they're going. There's no service available. We can't do that. We just wait until disaster happens and this person is re-admitted to the hospital*" (GACHS_N). Not all services defined the eligibility criteria for clients to access their services. This may be another area of confusion for older people—they call a service only to be told they can't be helped because they don't meet certain criteria.

Services in Tasmania also adapt their work to accommodate cultural change and awareness which may precede funding or policy.

Vignette 12. Cultural awareness in service provision

Person 1: I think it's a cultural thing. I mainly deal with refugees. And those cultures have a totally different, greater respect for their elders and the family dynamic is completely different. They're also more reluctant to disclose anything like that. But we have a lot of trouble with family violence in general, and disclosure of that in these communities. It brings shame upon them and their family and the community if it's talked about. There are different cultural barriers involved. I think it's a combination of perhaps—and this is just from what I've known and I don't know if this is right via studies or data, but perhaps less incidences of elder abuse, in general, in those communities because of the great respect that they have for their elder relatives and the care that they tend to provide. They tend to all pitch in as a family and look after their elder relatives instead of shipping them off to nursing homes and whatever or getting other parties in to help care. I suspect a combination of that, as well as perhaps the stigma attached. I like to think that it just doesn't happen as much. But I don't know for sure. I worry that it's swept under the carpet. It's not spoken about. It's taboo. You have to really, really build rapport and gain trust with someone for them to disclose to you that that is happening in the family. So yeah, not sure.

I find it interesting that a lot of cultures outwardly express a greater respect for their elders, culture X, particularly, is one I'm looking at. We have so many culture X customers that are on a carer payment, carer allowance for caring for older relatives. It's standard what they do. But you're right, it's just what they do. So therefore, any potential elder abuse that comes along with that is just what happens. I've never done outreach about elder abuse, but I have about family violence and it is a really difficult subject to broach with these different cultures because you've got to get them to recognise it to start with. What is it? You see their eyes go oh when you start talking about different types of family violence and they went, "Mm." And you think: Mm,

something that they don't even realise. They don't recognise it as an issue. So yeah, I assume elder abuse is similar.

Person 2: I'm working in the Indigenous service space. I have been here less than a year, and none of it's been brought to my attention in that area. I'm not saying elder abuse doesn't happen. I'm sure that it does. But it's not something that's been broached or discussed with me. I'm new into the area, so I haven't gained the trust or the confidence of the community yet to probably discuss that with me. But then again, none of our longer-serving staff have spoken to me about it or mentioned any situations that are happening. When I was working front of house, I did deal with a person whose partner had severe dementia and was physically abusing them. The person would come in and used to come in on a regular basis to see me. And I think that was just about—to have someone to talk to because they were looking at convincing his family that they needed to put the partner into a home and all that kind of stuff. But the person was hiding the fact that the partner was physically abusing him, and the person would show me the marks and the bruises and everything up their arms and all over their body where the partner was attacking them. And that was really difficult to deal with, on a personal level, because I was—there was my line of what is my job and what isn't? And my job was, yes, I needed to make sure that the person was safe, refer the person off, make sure they were getting some assistance and counselling and all the rest of it and not wanting to do what I really wanted to do, just take him somewhere safe immediately. (GCS_N)

1.4iv Response Proposed

1.4iiiA This is 'institutional abuse' arising from government policy limiting the response of the service to a particular set of parameters that may be defined, for example, by funding from one government department *vs*. a whole of government approach. Writing such parameters into a policy means some people will be excluded from the service. A more wholistic 'no door is the wrong door' approach to government policy enables any service to 'triage' the person who has come to their door desperate for help, to the service that will help them best. Build on the success of the "No wrong door/The Right Place " program[2] to identify and strengthen current formal and informal connections between services and improve access to services for older Tasmanians.

Subfactor 1.4v Institutional Abuse—by financial and legal advisors, Guardian or Power of Attorney

Participants were discussing a mortgage fund set up by a prominent legal firm and concerns regarding the legality of using clients' funds in this way. The consensus was that with recent improvements to regulations, this abuse was not as easy to perpetrate as in the past: "*there's been a lot of regulation that's increased over the last 15 years. These mortgage funds, now they can only borrow up to 66% of the underlying asset, so there used to be a situation where the lawyers—yes, they abuse their position, yes, they got the money of the elderly. They were appointed executor or guardian and they ended up with Power of Attorney, putting it in their own fund, fund goes bust, right. But that doesn't often happen any more"* (NGOLFS_N). The sad reality is that clients trust their lawyer or accountant to manage their funds as they age because they don't have anyone else.

Vignette 13. Pressure by abuser to appoint them as Power of Attorney

There have been a couple of cases of more financial—taking advantage financially. So, someone with a power of attorney spending money on themselves. There was a case where they were taking the gentleman along to the bank and withdrawing his money and we didn't think they were using it for him. Another case where, as the man got more demented, one of his

granddaughters sort of started living with him, and convinced him to give her power of attorney, and we were wondering about her motives too, but there was nothing we could prove. Also, some neglect, not physically caring for them, showering them, that sort of stuff. (NGOACHS_N)

In another case, the participants were angry that an older person had to pay for getting rid of the abusive person holding their Power of Attorney. "*We had a case of a person in a nursing home who wanted to reallocate their power of attorney to another person—they couldn't pay online, and they couldn't pay over the phone, they had to go to the service centre, as the Government agency, and physically make a payment. And they're in a nursing home, and in their 90's!"* (GACHS_N).

Guardianships provide a crucial protective mechanism for the elderly and other vulnerable people in the community when they are utilised appropriately; that is, when they only come into effect when there has been a genuine loss of capacity, and stay in effect only as long as that incapacity exists (Guardianship and Administration Board 2019, p. 4). Whilst 'supported decision making' is preferable in protecting the autonomy and independence of the individual, it cannot replace complete guardianship and administration where complex financial transactions are required of a person who has lost capacity, where a vulnerable person is being neglected, exploited or abused, or there is an element of urgency to a decision regarding care and an immediate order of guardianship is required to protect them from harm (Guardianship and Administration Board 2019). The boundaries that should be imposed on guardians so as to limit their powers to the function they are intended and permitted to perform include: use only as a last resort when supported decision making is not an option; confinement in its scope and duration; accessible mechanisms for review; and operating in a way that is as consistent with the requests of the vulnerable person as is reasonably possible (Australian Law Reform Commission 2014).

A key difference between jurisdictions is the expectation of the guardian and the considerations they are required to make regarding the wishes of the vulnerable person. For example, in New South Wales, Western Australia and the Northern Territory, there is a duty of guardians and administrators to act in the 'best interest' of the person, without an explicit consideration of their requests. However, in Victoria and Tasmania, the 'best interest' of the person is a consideration of equal weight as the wishes of the person. In the ACT and Queensland, guardians are obliged to act in a way that least interferes with a person's right to make a decision and to give effect to a person's wishes, so far as they can be determined. South Australia's paramount consideration is the guardian's opinion of what the wishes of the person would have been if they were not mentally incapacitated (Australian Law Reform Commission 2014).

Given these inconsistencies, uniformity between Commonwealth, state and territory legislation would be preferable to the current 'patchwork' framework. National Disability Services claim that without 'nationally consistent definitions, processes and safeguards around legal capacity assessment and decision support' (ALRC 2014), the rights of people to make decisions, or to be supported to make their own decisions, will depend on which state they live in, creating an aspect of disadvantage and discrimination based on geographical location. Additionally, as people travel between jurisdictions or live in towns that straddle jurisdictional boundaries, a person's legal decision-making capacity can change from day to day; this invites a great deal of uncertainty for the person, their guardian and supporting services. Pre-emptive appointment of guardians can also be complicated if the vulnerable person loses capacity in a state other than the state they made their previous arrangements in. While the Victorian legislation attempts to mitigate this risk through provisions for the recognition of interstate guardianship and administration orders, other states have no similar laws (Australian Law Reform Commission 2014).

The relevant human rights considerations for guardianship of the elderly and other vulnerable people include the Human Rights Commission Act 1981 (Cth)'s incorporation, in Schedule 3, of the principles in the 1971 United Nations Declaration on the Rights of Mentally Retarded Persons. The declaration states that disabled people have the "right to a qualified guardian when this is required to protect his personal well-being and interests", but also have the right to "protection from exploitation, abuse and degrading treatment" (also protected under the ICCPR). These two rights are not always synonymous. For elderly people as well, there is often a battle between two competing goals;

maximising the freedom of the individual, and maximising the welfare of the individual (Carney and Singer 1986, p. 55).

1.4v Response Proposed

1.4vA Impose a duty on banks and other financial institutions (to include any incorporated or unincorporated person or body that has dealings with older persons' finances) to act on suspicions of financial elder abuse of their accounts. A public investigative and regulatory authority should be established by legislation for this purpose.

1.4vB Review costs and charges of government entities such as Public Guardian.

1.5 Family history of abuse

During one session a participant discussed how abuse is often more likely to be identified as part of the history of the relationship/s.

"*It's not necessarily just all of a sudden a person is now abusing their demented father or mother. It's that they've been caring for them the last seven years, that things slide and slip, and there's this little—you know? One small action leads to another action, and another action. And what I was hearing in that case sounded a lot like carer fatigue to me, and that person's own issues.*

Underlying these cases—there's this connection between abuse and trauma and all sorts of things that are long running, beyond what we see today. It could be that the elderly parent was the abuser of the child, and now there is a power shift in the relationship and the child is replicating the abuse they grew up with. There are all sorts of dynamics that can go on. It makes it very hard for the service to gather information because the older person does not see that there is anything wrong it's "just another day in the life of this person" (GCS_N).

Vignette 14. Older people are also re-experiencing abuse

Some time ago I did a placement in a nursing home, and I witnessed time and time again, older women in particular, being taken into bathrooms by male nurses and dysregulating[9] on the way there, being really—and it was always put down to a dementia episode. And what I was aware of, from speaking to my own grandmother, is that what I believed was happening in that instance, was they were reliving childhood adversity. I think it's not just that older people are experiencing abuse—older people are also re-experiencing abuse. (GACHS_N)

1.5 Response Proposed

1.5A Service staff need to receive trauma-response training to recognise and respond to an older-person's long-standing (or more recent) trauma. For some, the violence and abuse becomes 'normalised'.

1.5B Staff in nursing homes should also be trained to recognise the effects of historical abuse which manifest as fear of being bathed by a male carer, for example.

[9] In this vignette, 'dysregulating' is a term used in mental health care where a child or adult exhibits neuropsychiatric symptoms related to their health condition. These symptoms range from anxiety, irritability, verbal outbursts and other behavioural disturbances (Kales, Gitlin & Lyketsos 2015)

Key Theme 2. Service responses to elder abuse

The second key theme of the workshop discussions is the response of the service to elder abuse. While expressing frustration with the 'problems' of responding to elder abuse, overall participants were passionate about making a difference for their clients.

"We are kind of working out that this is the tip of the iceberg for elder abuse" (GLFS_N)

Factor 2.1 Referral Pathways

"*We've got a lot of agencies that we deal with, and we tend to do almost a triage, and initial assessment, and then—if there are issues that need to be addressed—we will do short term interventions. And those interventions would be about identifying suitable referrals outside of the organisation* (GLFS_N)."

Subfactor 2.1i Referral pathways—to Elder Abuse Helpline (EAH)

Overall, participants—if they knew about the EAH—relied on their own service or network, to manage a case of elder abuse. "*Sometimes it just stays with us. We get a lot of referrals around elder abuse, mostly from the self-referrals, from people in the community. Sometimes—a big part of our role is around helping people with their decision-making and letting them know what their options are"* (GACHS_N).

When asked if they had heard of or called the EAH, one service group responded with a flat "no". When the role the EAH was explained, and what they could offer the service's clients, one participant commented (dryly): "*it sounds very worthy*". This particular service needed to be convinced that a call to the EAH would be worth their time in a service that is paid by the minute. This same service had referred clients to a private counsellor, similar to Relationships Australia and had not heard of Senior Assist.

2.1i Response proposed:

2.1 EAH to consider how to encourage 'stand-alone' professions to refer clients to the Helpline. The pathway for information for stand-alone, private consultancies is via their professional bodies such as the Tasmanian Law Society, Australian Banking Association, CPA Australia, the College of General Practitioners, Pharmacy Guild, etc.

Subfactor 2.1ii Referral pathways -Senior Assist

Senior Assist had only recently started in the North (Launceston) when the workshops were held. Participants had been contacted and, in some cases, had had visits to advise of services available. Overall, the response to Senior Assist was very positive: "*we've only recently had them up to speak to us and I think I'd be more inclined to deal with or discuss complex cases with them in the future"* (GACHS_N).

In another workshop: "*the Senior Assist thing is a nice breath of fresh air, to be able to go and talk to them. I think Legal Aid are great. I've been to appointments before with clients and they've been very supportive with talking about their options. Sometimes they write support letters, or letters to the family. So, say if a person's not wanting to take action—take legal action, but they're wanting their family to understand what their rights are, a lawyer will sometimes outline, 'Okay, well, these are the person's rights, and we're asking that you leave the property by such-and-such a date'"* (GACHS_N).

2.1ii Response proposed:

2.1ii In both the North and South of Tasmania, Senior Assist has made a 'name' for itself with services already. It has set the right 'tone' across professional groups and, as such, been welcomed by health as well as non-health services. Senior Assist is currently a time-limited project and should be reviewed for permanent funding.

Subfactor 2.1iii Referral pathways—hospital admissions

This referral route was not mentioned much. In one example a referral came from a nurse while the person was in hospital; another example was from a GP who also consulted in a community hospital who would refer any concerns to the nursing staff for follow-up. Regardless of the referral route, consent from the older person is required to provide services. Otherwise, all that can be done is advice rather than action.

If the person is in hospital, services know they are safe, for the moment. Hospital admissions are an opportunity for staff to assess and respond to a suspected case of elder abuse. The time limitations, as well as the 'patient role', during a GP consultation is not conducive to resolving elder abuse. Access to services with a simple referral pathway for the older person should be made available to GPs state-wide and within their community. Community Health Centres (or similar, see Table 3) are a critical referral link for GPs in stand-alone practices. The role of the GP is integral to a multi-disciplinary response to elder abuse prevention (Ries & Mansfield 2018).

The Tasmanian Health Service (THS) provides and coordinates public sector health services and health support services through a range of inpatient, outpatient, community health, residential aged care and in-home settings.[10]

Table 3: Tasmanian health services (sourced from website[8] May 2021)

Region	North	Northwest	South
Hospitals	Launceston General Hospital St Helens District Hospital Deloraine District Hospital George Town District Hospital and Community Centre North East Soldiers Memorial Hospital and Community Centre	North West Regional Hospital Mersey Community Hospital Smithton District Hospital King Island District Hospital West Coast District Hospital	Royal Hobart Hospital New Norfolk District Hospital
Community Health Centres	Beaconsfield MPS Campbell Town MPS Flinders Island MPC St Marys CHC Cape Barren Island Nursing Centre John L Grove Rehabilitation Unit Mayne Street Day Centre Ravenswood CHC Westbury CHC Northern Integrated Care Service Kings Meadows CHC Toosey Inc (Longford) Longford CHC	Burnie CHC Central Coast CHC—Ulverstone Devonport CHC James Muir CHC—Wynyard Rosebery CHC	Swansea CHC Midlands MPHC Central Highlands CHC Triabunna / Spring Bay CHC Bridgewater / Brighton CHC Glenorchy CHC Clarence ICC Sorell CHC Clarence Plains / Rokeby CHC Kingston CHC Huon CHC Cygnet CHC Bruny Island CHC Hobart Repatriation Centre

As one group of participants commented, it is easier to get an assessment done if the person is in hospital, due to access to doctors. "*The main challenge for our inpatients to get assessed is that they resist the assessment sometimes. They don't want to be assessed. No matter how you try to explain or persuade them, they still resist, that's a sign of lack of capacity. If they just keep refusing, the assessor might just say, "Query lack of capacity""* (GACHS_N).

[10] The Tasmanian Health Service http://www.health.tas.gov.au/ths/area_health_services

2.1iii Response Proposed

2.1iiiA Review programs of in-hospital legal aid for implementation in Tasmania, for example, Health Justice Partnerships.[11]

2.1iiiB Evaluate assessments of capacity done for hospital inpatients compared with community living Tasmanians to identify barriers and enablers that may be transferable to different settings.

Subfactor 2.1iv Referral pathways—outreach services

Access to social workers in Tasmania is as close as the nearest multipurpose centre (Table 3). Outreach services, however, are limited but some participants mentioned doing home visits with the community nurse. "*It's easier for a nurse to get into a home visit, than it is for a social worker. Also, you can place the older person at further risk by visiting them. If all of a sudden you have a social worker going to a home, there's always suspicion around, why is a social worker here? In the case that I talked about earlier, in order for me to see her, we organised with the existing support person who used to take her out—I liaised with that worker and I saw the older person when she was out of the house, because to see her at home, her relative (the abuser) would have known that something was going on*" (GACHS_N).

2.1iv Response Proposed

2.1ivA It is not clear whether all MPC (or equivalent) have social workers. This should be reviewed, particularly in areas of the State with proportionally older populations.

Subfactor 2.1v Referral pathways—mediation and counselling

In the workshop discussions, participants were asked if they were aware of, or had used counselling services e.g., Relationships Australia. One service said they had when their service was under pressure, they did refer some cases to them. Another said they had, but not for elder abuse. "*I find, when people are in an abusive relationship, often it doesn't get to a mediation point because the other person doesn't want to mediate. They want to have control, and they don't want to be exposed and they won't engage with services, or they'll try and manipulate the situation to try and pretend that it's the other person that may not have all of their faculties, that they're vulnerable, that they're trying to assist them. I find that really difficult, because when we see people, it's already got to a point past mediation, where they've tried to mediate multiple times. They've tried to put in some boundaries with the person, they've tried to raise their concerns, and it falls on deaf ears*" (GACHS_N).

The majority of referrals for counselling come from the EAH, Legal Aid or Senior Assist but counselling takes place in all services and may consist of short, targeted sessions to address problems as they arise.

Vignette 15. Adapting to evolving situations

A woman who has two children, she chose to—she was living on her own, in her house. She sold her house to downsize, which made sense. She couldn't do the gardening any more, the maintenance and the upkeep of the house was too much. The children became quite abusive—these are adult children—they became quite abusive towards her, because they maybe felt that the house was something that they were hoping to get as part of their inheritance, perhaps, into the future. But she was looking after her own physical, and emotional, and financial wellbeing, by downsizing into a small unit that she could manage.

The abuse that then proceeded was quite nasty, but it wasn't like other cases where we would see financial abuse being used to get money. It just became quite nasty, so this person then

[11] Health Justice Partnerships NSW https://www.legalaid.nsw.gov.au/what-we-do/community-partnerships/health-justice-partnerships

considered having restraining orders against her children. And in the end, things sort of died down, she stood up to them. But we did a lot of ongoing short counselling with that person, and giving them options, and giving them their legal rights. So that was one case. We've had other cases where we have successfully applied for restraining orders, and we have evicted family members out of people's homes—in order to protect them and keep them safe. (NGOLFS_N)

2.1v Response Proposed

2.1vA Review use of mediation in cases of elder abuse in other jurisdictions and domestic violence in Tasmania.

2.1vB Reform the Family Violence legislation so that it covers cases of elder abuse within families.

Subfactor 2.1vi Referral pathways—to the police

The overall response was that this option was used 'rarely'. "*I find most of my clients don't want to, because most of the time it's family members. It could be their son that's committing the abuse, or their daughter, and they know that their family are struggling, and they don't want to see them homeless or they feel this sense of responsibility to be there as a mother or to be there as a father for them and have these really conflicting views around what to do"* (GACHS_N). On the occasions when the service has recommended the client take the matter to police, the outcomes were good. Other participants commented that if they had any concern that the person was in danger: "*if I had a sense of risk, any concern because the person's not answering the phone, I'm unable to get through to the person, and yet I know there's people living with them. That would be a great concern for me, and I would then contact the police. I wouldn't hesitate"* (GACHS_N).

While most participants were aware of police welfare checks, only one organisation said they used this on a regular basis. One of the main reasons was when a client threatened self-harm, regardless of their age. The option to get a restraining order is a complex and daunting process for anyone, let alone an older person. "*I have supported people to go through the Magistrate's Court to get restraining orders, but that's a real process and quite intimidating for people. They have to have evidence that there are concerns, and they have to initiate that themselves"* (GACHS_N).

Similar to what was reported in the South, police welfare checks are not formally reported/entered into the database. "*Unless that information's put into the system, there's no paper trail from the police and there's no requirement to record them. Unlike mandatory child abuse reporting—because even if you think it is minor, and then next week someone else makes a minor complaint, and records it, and someone else does—it becomes a whole litany of minor reporting, that starts to paint a picture that's not minor at all"* (GLFS_N). The picture emerging from all participants is that police have a different response to elder-abuse *vs.* child abuse. a response that is directed by legislation.

Vignette 16. Police response to elder vs child abuse

The case that I was talking to you about earlier, I can't tell you how many debriefs I had with carers who were crying because they saw her bruises, and she just wouldn't, didn't want anything to be done about it, and the doctor would not do it because he was the family doctor, and he didn't feel confident to do it. He hadn't seen the evidence himself, he said, he kept saying. So there needs to be, to get things to the next step, a professional who understands elder abuse. It's not just any old GP.

Q: Why weren't the police called in that case?

A: Because it would have been—the police don't want to do anything with it either—because the person is dependent on the carer, and the carer, in this instance, had his own issues—it wasn't about evilness, there was nothing evil happening—it was all about frustration and those kinds of things, and him not wanting to accept help. In the end he did. The police don't want to have to deal with that because they can make it worse for the person. So, the person was being bruised, but not broken, if you know what I mean. The physical abuse wasn't enough to hospitalise them, but it was enough for them to be miserable.

Q: But you realise if it was a child, there'd be a different response?

A: Absolutely. (GACHS_N)

2.1vi Response Proposed

2.1viA Tasmanian Police review their responses to cases of elder abuse for state-wide consistency and perhaps consider a 'single-desk' unit for internal and external referrals.

2.1viB Services to review their elder abuse policies to ensure staff give a consistent response to elders at risk.

Key Theme 3. Service level barriers and enablers to recognising and responding to elder abuse in Northern Tasmania

The third key theme from the workshops is the barriers, and enablers, to the recognition and response to elder abuse at the service level. As complex as the 'definition' of elder abuse, the barriers and enablers to services responding to a case of elder abuse are equally varied and individual. The following vignette is an example of how difficult it is for services to identify what they need to improve their responses to elder abuse in Tasmania.

Vignette 17. What's the solution?

I'd like there to be a specialist, multidisciplinary team that deals with elder abuse, that has social work, psychology, that is closely aligned with police, and that there's some recognition and some legislation around elder abuse, like Safe at Home, where police do have more authority to intervene. Because I think leaving it all up to the discretion of a person who's experiencing the abuse is sometimes a massive responsibility to be putting onto that person, and sometimes leaving them in a vulnerable position. Where they're working together, firstly trying to support the person's decision-making. But sometimes I think particularly with older people, you've got the added complication of people who have issues around their capacity. Elder abuse has this other added layer of complex health issues, cognitive and functional decline, where the person can't actually get out to access services, leaving older people particularly vulnerable. I think that there does need to be some sort of legislation in significant situations where there is police intervention. Yeah. Because otherwise, you feel very stuck, and some people are in these situations for so long.

Factor 3.1 Awareness of service

During one workshop, the question arose, 'how do they know you're there/what services you provide?' One participant said through friends who had used services in that centre, and also via their GP. " '*Have you thought about talking to the social worker?' So people seem to know of us, these services, and will often just ring in to have a talk in the beginning. They might come back in for further help, or they might decide to not proceed. We provide counselling support. We try and help them understand what might be happening for them, and then talk about some support options. Some people don't feel ready, and they go, "That's it. I just want to leave it there." And other people want further assistance"* (GACHS_N).

One participant mentioned how constant name changes to services confused clients, especially older folk. The example given was Centrelink, which now includes Medicare, so the name was changed to 'Services Australia' as part of the (Federal) Department of Human Services, before that 'Service Delivery Agency' and before that 'Social Security'.

3.1 Response proposed:

3.1A Review and evaluate community awareness of MPC in particular, and other services available to communities—physical and cultural.

Factor 3.2 Assessment of capacity

Assessment of capacity, along with legislation, emerged as a significant barrier to dealing with elder abuse throughout the discussions. So much so it became clear that services have two distinct response pathways based on whether the client had capacity, or not. Many participants raised concerns about the difficulties in obtaining assessments of capacity for older Tasmanians in this situation. There are also concerns that an assessment is being used to further abuse the older person.

Vignette 18. Assessment of capacity abuse

They also try to get people to be deemed as not having capacity. This is an ongoing thing. The case I gave you about the woman that sold her home. Her children had tried to have her committed through mental health services, as not being of sound mind. The service ignored them—well they met with the individual, and they assessed, and they determined that she was all right. This is what happens: "Oh, well mum's mad, mum's a bit nuts." Or "Dad's got dementia." Dad hasn't got dementia he just doesn't have any choice. (GLFS_N)

Inability to make decisions or consent—guardianship

a) A Singular Test?

The Tasmanian Law Reform Institute (TLRI 2018) Review of the Guardianship and Administration Act 1995 (Tas) (the 'Act') included a discussion on what should constitute an 'inability to make decisions or consent' in guardianship and administration orders. Under the Act, the characterisation of a person as an elderly person or a person with a disability is not sufficient, in itself, of establishing incapacity in decision-making. Rather, there must be adequate evidence that the disability affects the person's decision-making ability (TLRI 2018, p. 93). The considerations that support a judgement regarding this 'affect' include whether the person is 'unable to make reasonable judgements about their personal circumstances', 'all or any part of their estate', or are 'incapable of understanding' or consenting to any proposed treatment (TLRI 2018, p. 93).

However, a jurisdictional inconsistency arises where the relevant Australian Capital Territory, South Australian, Queensland, Northern Territory and Victorian acts do not include the 'reasonableness' requirement that features in other jurisdictions (TLRI 2018, p. 93). Furthermore, the reasonableness requirement features in the assessment of only select decision-making vulnerabilities (i.e. mental illness) and is not relevant in all relevant legislation. It is due to this inconsistency, and the difficulty for assessors to have to apply different tests in different jurisdictions, that a singular test is supported by OPG and the members if the Elder Law Committee. However, it is the institute's recommendation that, as decision-making capacity is context specific, time specific and support dependent, that it would be inappropriate to have a singular test across the legislation of different jurisdictions and subject areas (TLRI 2018, p. 94).

b) Rationality Requirement?

Advocacy Tasmania suggested that the Act should be amended so as not to require rationality of the person's decision in order to be held to be capable (TLRI 2018, p. 95). The reasons for this submission include that people without a disability or other vulnerability have the right to make an unwise, irrational, impulsive decision, without their legal capacity to make decisions being scrutinised, and vulnerable people should not be expected to show a higher standard of decision-making logic than the ordinary person (TLRI 2018, p. 95). The Institute supported this submission, recommending that the Act specifies a 'person's decision-making ability rather than capacity' and removes the rationality requirement of the test (TLRI 2018, p. 95).

c) With Support?

Similarly, the OPG submitted that the Act should explicitly state that the test of a person's ability to make a decision includes the ability to make a decision with support (TLRI 2018, p. 96). In response to this submission, the TLRI recommends that the Act specify that capability to make a decision includes capability to decide with support, and that a decision of incapability not be made until the person has received adequate support in their decision-making attempts (TLRI 2018, p. 97).

Statutory tests of capacity—legal instruments

Currently, there is no national statutory test for assessing decision-making capacity to make an instrument. However, the common law requires that the individual is able to understand the 'nature and effect of an instrument when it is explained to them' (TLRI 2018, p. 97).

On a state level, there are discrepancies in legislation on the test for capacity to make an instrument, with Victoria, Queensland and the Australian Capital Territory allowing a person to appoint an enduring guardian under the same capacity test as is applied when appointing an attorney. However, in the Northern Territory, the test of capacity is concerned with evidence of a person's ability to 'understand and retain information, weigh up that information, and communicate a decision' (TLRI 2018, p. 98). There are currently no legislative guidelines on a test for capacity to complete an instrument in New South Wales or Western Australia (TLRI 2018, p. 98).

Unlike capacity considerations in relation to guardianship, the Institute proposes that the Act implement a national test of decision-making capability when making a legal instrument. Included in this test, the Institute recommends specificity regarding which information should be 'relevant to a decision', possibly modelled off the current structure of the Powers of Attorney Act (TLRI 2018, p. 98). It is submitted that a uniform test would reduce the potential for abuse where third parties would use the state inconsistencies to make legal instruments which may financially, physically or psychologically harm the elderly person (TLRI 2018, p. 98).

A particular example of a legal instrument includes an advanced care directive (ACD). Currently, in South Australia and Victoria, the test for capacity in making an ACD has been developed in common law and has been codified in statute; requiring a person to 'understand the nature and effect of an ACD' (TLRI 2018, p. 99). Additionally, in Queensland, there must be an understanding that the document will be in effect only while the impaired capacity exists and that as soon as they have capacity, the person may revoke the document at any time (TLRI 2018, p. 99). Social Work Services at the Royal Hobart Hospital commented that, in Tasmania, the role of ACD is that even where a person is deemed incapable of making their own decisions, they may still have wishes and requests that should be

considered by their guardians or the support staff caring for them. An ACD allows these requests to be recorded and understood by all involved in that person's care (TLRI 2018, p. 99). Consistent with this role, the Institute recommends that the statutory test of capacity when making an ACD should require 'decision-making ability' in relation to each individual statement on the document, as is the current requirement in Victoria (TLRI 2018, p. 99).

Presumption and assumption of capacity

The Capacity Toolkit, which was implemented as a tool for people who are tasked with the responsibility of assessing a vulnerable person's decision-making capability, determines that an assessment of capacity must always begin with an assumption that of capacity (TLRI 2018, p. 100). This also reflects the presumption at common law. However, the Australian Law Reform Commission currently does not support statutes that include a presumption of capacity, as they argue that this may create too much separation between people with capacity, and those without (TLRI 2018, p. 100). Alternatively, the Institute is not against the Act codifying the common law presumption of capacity, but stops just short of making a formal recommendation to this effect on the grounds that it may 'unnecessarily lengthen the Act without adding any benefit', considering it is already a common law presumption (TLRI 2018, p. 101).

The Capacity Toolkit also specifies factors that should not, in themselves, constitute an assumption of incapacity, so as to prevent the influence of stereotypes on capacity assessments (TLRI 2018, p. 101). The Institute recommends that a similar list of exclusions be included in the Act, including considerations of:

- Whether a decision is, in the opinion of others, unwise;
- Whether a decision results, or may result, in an adverse outcome for the person;
- Whether a person has a particular level of literacy or education;
- Whether a person engages in particular cultural, political or religious practices; and
- Assumptions because of a person's age.

(TLRI 2018, p. 103).

Assessing decision making abilities

a) Environment of Assessment

It is the recommendation of the TLRI that the Act focuses on a person's abilities rather than incapacities, and supports these abilities by completing an assessment in the best environment for the maximum extent of the abilities to be demonstrated. This reflects the law reforms proposed in Victoria that 'reasonable steps' be taken to ensure that assessments are conducted at a time, and in an environment, where the assessment of a person's abilities would be most accurate (TLRI 2018, p. 103). Furthermore, the Institute does not recommend any statutory reform of who may assess decision-making abilities, but notes that medical practitioners should be excluded from making a report of the decision- making ability of a person in the presence of a close relative, in an attempt to mitigate a risk of family members obstructing the process to serve their own interests (TLRI 2018, p. 106). The Institute is particularly concerned that these third-party obstruction attempts 'might be intended to conceal potential abuse or neglect' (TLRI 2018, p. 112).

b) Requirement to Submit to Assessment?

Social Work Services at the Royal Hobart Hospital submitted that the Act should require a person to submit to an assessment of capacity 'where there is evidence that the person is suspected to be at risk' (TLRI 2018, p. 110). Additionally, the OPMHS suggested that there are circumstances where a person should be required to undergo an assessment, and that similar provisions are already outlined in the Mental Health Act in regard to an assessment of mental illness (TLRI 2018, p. 110). In Canada, the court is able to mandate an examination where a person refuses to voluntarily submit to a capacity assessment, and the court can even make a determination about capacity in the person's absence and without their consent, if it is satisfied on the evidence of incapacity (TLRI 2018, p. 108). However, the Institute has not made any formal recommendations for reform regarding requirements to submit, as they argue 'it would be contrary to a person's will and preference and this ought to be paramount', and the Board is still able make an emergency order, if necessary, without introducing a requirement to submit (TLRI 2018, p. 109).

Safeguards

There are currently no offences identified in the Act to be applied where there has been a failure in the assessment of a person's decision-making abilities (TLRI 2018, p. 113). In South Australia however, guardianship legislation makes it an offence for a medical practitioner to make an order without having examined the person, determine mental incapacity when they do not believe that to be true, or making a false or misleading statement, including purporting to be a medical practitioner (TLRI 2018, p. 113). The Institute makes no formal recommendation of the inclusion of offences in the Act on the grounds that existing regulatory schemes for inappropriate conduct by medical practitioners encompass conducting capacity assessments. However, they especially noted the OPG's suggestion that a medical practitioner should be required to record an assessment of decision- making capacity for accountability purposes. (TLRI 2018, p. 114).

The complexity of obtaining an assessment of capacity is reliant on the good graces of medical practitioners. There are two processes to guide services in Tasmania, one for the Office of the Public Guardian (OPG) and the Tasmanian health system (THS).

Subfactor 3.2i Assessment of capacity—getting the assessment done

During one of the workshops, discussion occurred about assessment of capacity and the difficulties in getting the assessment done. If the person has been assessed as lacking capacity, then it is easier for the service to step in and ensure the person's safety. However, the downside of this being that if there are no other options, the person ends up in a nursing home "*and they die—they die, because they don't want to be there*" (GACHS_N). Currently, for the Guardianship Board to step in, the assessment of capacity has to come from a medical professional. Participants discussed the difficulty a family GP has doing the assessment if the person (their patient) refuses.

Vignette 19. It shouldn't be this hard

The first thing that comes to mind always is a lady who everybody knew was being abused, and it took us three years to get her safe. And it was simply about formal processes. That's the one that comes to mind. We were notified one year that someone—that the carers of the particular person were convinced that the carer was abusing—physically abusing his wife. And nobody was taking responsibility, so there was a confusion about—initially—about who had the main responsibility for reporting and what needed to be reported. So, we went through a process of really educating some of the services that had the best relationship with that person, about what needed to happen. And the problem had been that because of the lack of understanding of the basic information around elder abuse, they had had lots of verbal concerns from different workers going in—so, this was a community-based service—going in, but they hadn't put anything in writing, and because there was nothing in writing, there was no paper trail and no evidence. And of course, the older person had dementia as well, so there was no way, really, to get into the house.

There was a lot of running around behind the scenes to try to organise with people who didn't really want to be involved on how to get access to this person. It actually took about a couple of months for us to get all the evidence that we needed, but then we actually needed to have the family GP, or someone from the medical profession to write a report to the Guardianship Board. And of course, the family GP didn't want to do that—in fact, didn't do that for another couple of years, despite us writing letters and advocating and doing all sorts of things. So, in the end, what we had to do was go back to all the services and say, "Every little thing, on every occasion needs to be reported, it needs to be sent through to us so that we can send it through to the GP". And

we had to inundate the GP with enough information to feel confident. And then we had to go in and work with that GP because they weren't sure how to write the report. (GACHS_N)

3.2i Response proposed:

3.2iA DoJ review current assessment processes of capacity across agencies to determine commonalities and potential for streamlining.

3.2iB Review national progress

3.2iC Can the process (documentation) be digitalised?

3.2iD Who else can determine capacity? For example, lawyers, nurse practitioners or police to improve the process while preventing perverse judgements (TLRI 2018).

Subfactor 3.2ii Assessment of capacity—skills to do the assessment

Restricting the definition of who can do capacity assessments has a flow on effect to services struggling to support and protect the older person while waiting for a determination of capacity. "*I find some of the GPs are quite hesitant to assess capacity, seeing that as a role of a geriatrician, or a neuropsychologist. Also, GPs may not have seen that person many times, and they want refer them to a specialist first. We've got to try and help protect that person as much as we can, until we establish what their capacity is"* (GACHS_N).

During another workshop, one of the participants expressed their concern with their own ability to undertake an assessment of capacity (despite the fact that they fitted the profession criteria). "*I don't do the assessment for capacity because I think that's nuanced and requires skills and is fraught —you know, you've got to get it right, it's really very important. We're talking about patients here with rights. So, I wouldn't do an assessment for capacity myself, unless it was someone who clearly didn't have capacity, that's OK, but it would have to be fairly clear. Most of them aren't that clear. They might have some capacity for some decisions and not for other decisions. I think if a legal determination of capacity is going to be made, it needs to be made by someone who—their credentials have to be recognised if it's challenged"* (NGOACHS_N). Their preference was to refer the person to a psycho-geriatrician. However, they also acknowledged the difficulties in not only getting an appointment in a reasonable time, but also ensuring that the person will keep the appointment. Ironically, this service would also refer any suspected cases of elder abuse for 'guardianship' without the understanding that an assessment of capacity was also required.

For community based rural GPs there is an added problem of everyone knowing each other's business, and the repercussions of doing something that negatively impacts another person's life. "*It's just like doing driving assessments. In a rural area, taking someone's licence away from them is a bit like chopping their legs off. It completely messes their life. They can't get anywhere, they can't do anything, they can't access medical care, and it makes you the bad person, when we're supposed to be the advocate. So, to deem someone, particularly those people who have no insight, to now say, "You don't have capacity, and we're going to force you to stay in hospital, or force you to go into a nursing home," it just seems like an absolute betrayal" (NGOACHS_N).*

The long-term relationships in rural health care practice can lead to a 'habituation' of the client's condition*: "I saw him every month for 18 years. At what point did he lose capacity? Like, someone who's seen him once every six months will say, "Whoa, he's heaps worse," whereas I might not notice, but there are disadvantages of having long term health practitioners who don't notice changes as much, as someone who hasn't seen them for a while"* (NGOACHS_N).

Another participant discussed how nurses are able to go into the person's home to do the assessment. For example: "*if a lady can't make a cup of tea in her kitchen of forty odd years, something is very wrong"* (GACHS_N). The overall support for specialist nurses, nurse practitioners in particular, to undertake assessments was very high amongst participants: "*All nurse practitioners I've worked with in the past, they've got very holistic training. They're across the*

board with an understanding of holistic care, mental health, and already have training in capacity type issues. I feel that the transition for them to go into elder abuse type areas is probably easier than say other health professionals. In the hierarchy of medical/health professionals, they are highly considered—they've got prescription authorities, that most health professionals don't have" (NGOACHS_N).

3.2ii Response Proposed

All the actions listed in 3.2i above apply here as well as:

3.2iiA Improve access to specialists. This includes the number of specialists (have numbers increased in line with the increasing age of Tasmania's population?); provide access via telehealth or mobile clinics; enable use of alternative professionals, e.g. nurse practitioners, to undertake assessments.

3.2iiB Evaluate the understanding of 'guardianship' amongst service providers.

3.2iiC Develop a Tasmanian Health Pathway for elder abuse.

Subfactor 3.2iii Assessment of capacity—having capacity, but limited options

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Vignette 20. The complexity of trying all options

An adult son had returned to live with his father on a farm. And, that theme of child returning to live with parent or become their carer is one that seems to be coming up time and time again. He also had some issues with drugs, anger, he was being verbally abusive towards his father, had made threats of violence, and he had also made requests for money. I'm not sure if they were requests or demands, but in the father's eyes, it was more like demands, he felt it was like that. The son was refusing to leave when asked, he'd become angry and verbally abusive, and he said, "No, I'm not going." At the same time, the father didn't want him to leave and become homeless. He didn't want to call the police—he just wanted the abuse to stop.

He called the Elder Abuse Helpline who referred him to our service, after hearing what his concerns were and checking out other options. What he decided on was he wanted counselling to help him make up his mind, just to sort of thrash it out. He came with a young relative, who was close enough to him to be involved and he trusted her. She didn't live on the farm or anything like that, but sort of kept an eye on things. He didn't want to take any legal action against the son, or have him evicted or charged, so that's why he wanted to seek counselling to make up his mind. It's a potential for elder mediation only if the son agreed, and the father didn't want to start that process, because that would make the son angry, in just receiving an invitation to come to elder mediation.

So, he was very much in the, "I'm fearful, but I don't want to go to the police, but I do want the abuse to stop" stage. I suppose if there was a good outcome, it was that the niece was remaining involved, and that she had stated to the father that she would call the police if any physical violence occurred, or if he asked her to. That was, if you like, his safety mechanism, at least having a person, he could just say, I'm going to call so-and-so, and she would take care of things. That's where it's at now, and at the end of the day, there's not a lot of legal options.

If the trusted person, wasn't there, the sad thing is there's not a heck of lot, available legally. Where he does have capacity to make his own decisions, so it's not a guardianship type situation. It's not that he needs a power of attorney, and it's not abuse of power of attorney. It's just

someone, as often happens, as most parents would, they'll say, yes, of course, "I've got a big home, come and stay here for as long as you like", is probably what they would say, thinking three or four months but without setting clear rules and expectations. (NGOCS_N)

A peculiar conundrum for health care services in particular is where a client has capacity but makes decisions that the service considers (knows are) risky either because the person is afraid of their family or they don't want to go into a nursing home. "*It's the issue of capacity that makes it a problem. And you find that some of the patients will want to return home, be concerned about returning home, because there might be an indication of abuse. But when you want to take it further with them, they then clam up, because they don't want issues with the family member when they return home. And they want to be able to remain at home and not go into a residential facility"* (GACHS_N).

One service in particular, that had been in operation for many years with older clients they know very well, sources information about changes to the client's situation from a network of other services that also work with that client. This is particularly useful when the client is, for example, developing dementia, pinpointing at what point they are starting to have problems with managing their money and spending, or to determine whether a suspicion is of abuse rather than an ongoing decline in capacity. This gradual approach to assessing capacity over time was discussed in a separate workshop with a community-based service: "*for us in the community we probably work with someone for, say, three or four months to see how things go over time, and to see if that's actually working. Sometimes that can be enough. Sometimes it's not enough"* (GACHS_N). The approach of this service was to add-on services, or interventions, as concerns over the person's capacity increased: "*We always try to look at, 'Okay, well, what sort of resources can we put in place to try our very best to help protect that person?' So, for example organising direct debits, helping to advocate on their behalf to, say, Aurora, or TasWater, or any outstanding bills they have, and look at sorting out payment plans for that person, and linking them in with services like financial counselling, in an attempt to try to help protect that person in some way.*

Sometimes looking at opening a different bank account or contacting Centrelink. Say if they've got a carer who's not fulfilling their obligations, to actually notify Centrelink and let them know, and play a bit of an advocacy role there as well. So even—yeah, so especially when there are concerns about capacity, about trying to pull those resources together to do as much as we can to protect that person" (GACHS_N). This service also applied for Guardianship and engaged with the Public Trustee on a "*frequent*" basis.

However, as pointed out by another group, the service needs clients' consent to engage with a person from the outset. It is not uncommon for concerned families, for example, to call the service "worried about mum's capacity to manage her finances". Without consent from the older person the service can't act, except perhaps to flag concerns with the person's GP if possible. If there is a known history of mental health issues, then the person may be compelled to attend a psychiatric assessment under the Tasmanian Mental Health Act (2013).[12]

An Assessment Order is a short-term order enabling a person to be assessed, without the person's informed consent, to determine the state of the person's mental health and to identify treatment options. Assessment Orders are made by medical practitioners and may only last for longer than 24 hours if a psychiatrist is satisfied that:

- The person has or appears to have a mental illness that requires or is likely to require treatment for the person's health or safety or the safety of others, and
- The person cannot be properly assessed with regard to the mental illness or the making of a Treatment Order except under the authority of the Assessment Order, and
- The person does not have decision making capacity.

[12] Mental Health Act 2013 https://www.legislation.tas.gov.au/view/html/inforce/current/act-2013-002

The maximum time for which an Assessment Order can stay in place is 96 hours. An Assessment Order may require the person who is being assessed to be detained in an approved facility for a short period of time, so that the assessment can occur.[13]

The material raised so many examples of what is missing if services are to meet older Tasmanians' needs. The participants themselves were overwhelmed by the problems they were trying to deal with because there are currently no solutions to the multi-sector problems and inadequacies across the spectrum of care—including housing options, social work, MyAgedCare, GPs, transport, and so on as articulated by participants in this research.

As a consequence of multisector neglect by governments and private service providers, inadequate funding of services causes staff member and carer (including family carer) burnout, leading to increased risk of abuse (Bonnie & Wallace 2003; CDC 2020, Aged Care Royal Commission Final Report 2021 p66).

3.2iii Response Proposed

3.2iiiA Government needs to take this seriously with a 'whole of government' response to prioritise older person rights and protections. There will be another Janet Macozdi. *"Yes, 'n' how many deaths will it take till he knows?"* (Bob Dylan 1962).

3.2iiiB Review service understanding of human rights. Why do health professionals struggle with, or see conflict, with client autonomy particularly in the acute health service sector?

3.2iiiC Research with older Tasmanians what they need to safe and supported in their own home.

Factor 3.3 The role of the Public Trustee

One participant discussed a case where the client was already known to the Public Trustee as their financial administrator, but they—the Public Trustee—were not aware of a coercive plan to change the client's will. The point being that just because the client is already on the Public Trustee 'books', does not mean that intervention to prevent financial abuse will happen if they (the Public Trustee) are informed, especially if the client lacks capacity.

Vignette 21. Keeping the Public Trustee informed

An elderly lady came to us and she doesn't have any of her own family. Her next of kin was identified as a health worker. It came to my attention when I visited her that the health worker was talking to her about changing her will because there'd be no money left over once she paid her aged care fees, etc. She was going to leave her estate to the children of three friends. I overheard this worker trying to convince the lady that there wouldn't be enough money left to divide up, etc., etc. The health worker expected that she was going to take her to the lawyer the following day and have her will changed, put into her name because she was doing all the caring for her, etc. So, I asked the lady directly what she wanted to do, did she want to change the will? She said, "No," she didn't want to change the will, she wanted to leave it as it was, but she felt coerced.

So, I approached the manager of the facility where she lived and told them what was going on. They contacted the GP. Meanwhile, the lady had an appointment with her psychiatrist the following day, so I informed him as well. So, the result of the plan was that the GP intervened immediately and contacted the Public Trustee and said, "No, this can't go ahead. There can't be,

[13] Tasmanian Department of Health, Statewide Mental Health Services, An overview of the Mental Health Act 2013 https://www.dhhs.tas.gov.au/mentalhealth/mental_health_act/mental_health_act_resources/an_overview_of_the_mental_health_act_2013

we can't have the will changed at such late notice." When I informed our psychiatrist, he spoke to the lady privately the next day and said, "Is this what you want to do?" She said, "No, I don't want to do it." So, he helped the lady become more assertive in saying no with what she wanted and what she didn't want.

The result of this combined approach between the aged care management, our service and our doctor and the GP was she didn't change her will. Yeah, so we had a good outcome because we did suspect a bit of foul play.

It was interesting, long after this happened, that particular health worker tried another tack and was trying to change over the guardianship to her, so she'd become her guardian. She couldn't get power of attorney because we'd gone through the system to get that set up through the public trustee. But yeah, I just said to the health worker, "Well, why does she need that? She's in care. She's taking her tablets. So, why does she actually need that?" So, I encouraged the lady, my client, not to sign those papers, because at this stage there was no need to have that in place for her to make her own decisions. She'd made the big one, which was to go into care, and that wasn't a problem. So, it's complicated. (GACHS_N)

The role of the Public Trustee is not clear to the general public and is "*not the financial 'catch-all' they are generally thought to be"* (NGOLFS_N).

Vignette 22. "But the Public Trustee is where you go if there is financial abuse?"

My view of the Public Trustee is that it is good to have a body that people could go to as what I would regard as a last resort. But it's still run like a corporation. My view of the Public Trustee is a lot of inefficiency, a lack of transparency around fees. It's like Industry Super Funds, they don't have to disclose their fees when every other super fund has to. It's the same as Public Trustee versus a lawyer, a legal office. A legal office has to tell you, "This is how much we're going to charge and this is what we're going to do." The Public Trustee doesn't.

The function it provides is that if you haven't done anything in your whole life to do a will, that's where it goes, and you need something like that because there is a heck of a lot of people out there that haven't done a will. It's conflicted, but there has to be somewhere that is basically the catch-all for these situations. But frankly it is a lottery up there. It's a lottery as to who you get on the day, who's looking after the file, will they get an outcome, will they get a result or will it sit there for years and years and years. There definitely needs to be a review of the Public Trustee functions—are they under-resourced, over-subscribed or just plain inefficient for the job they need to do. Also, unless you have the assets to pay the fees, the Public Trustee can't help you. So basically, they are not the financial 'catch-all' they are generally thought to be. (NGOLFS_N)

3.3 Response proposed

3.3A All this discussion leads back to the overarching, primary recommendation of this research, to establish an investigative and regulatory body with power to investigate, adjudicate, make a determination, and enforce the determination.

3.3B Evaluate the role of the Public Trustee in cases of elder abuse in Tasmania with a view to learning how the organisation can be strengthened to investigate and manage existing clients and develop understandable pathways for Tasmanians to access services.

3.3C Impose a duty on financial institutions to have a responsibility to act on their suspicions of inappropriate access to accounts. A public investigatory and regulatory authority should be established by legislation for this purpose. Define financial institutions to include any body, whether incorporated or unincorporated, that has dealings with an elder person's finances.

Factor 3.4 A lack of legislation

There is no specific 'elder abuse' crime in Tasmania, nor specific legislation addressing elder abuse in Tasmania. This has implications for dealing with elder abuse in terms of its recognition and responding to it. It also has an impact on data collection in services such as Tasmanian Police. With no data there is no ability to do a statistical analysis of the extent of elder abuse in Tasmania or measure the impact of any interventions. The concerns around legislation failure, and the impact this has on older Tasmanians is the same as discussed for the South of the State. It has emerged as an overwhelming barrier to services trying to act to protect older Tasmanians.

***"Would that be the anticipative hope from this research that you're doing, that there will be changes to the legislation? That would be good"* (GACHS_N).**

In November 2017, PEAT arranged a Tasmanian Symposium (Hasler et al. 2017) on elder abuse that brought together more than 60 representatives from the aged care sector, the legal profession, police, unions, clinicians, policy makers and academic researchers to examine the social, legal, and clinical dimensions of elder abuse and neglect in Tasmania. Based on the input of Symposium attendees in the theme discussions, the PEAT researchers, TLRI, EOT and COTA called on the Tasmanian Government and relevant agencies to:

1. Improve knowledge of elder abuse through research to improve understanding of the incidence, vulnerability factors and enabling culture.

2. Enhance strategies to address ageism including the development and use of guidelines promoting positive ageing language and images consistent with commitment under the Strong Liveable Communities Tasmanian Active Ageing Plan 2017-2022 to address ageism and combat age-related stereotypes.

3. Promote community understanding and shared responsibility for addressing elder abuse and neglect through awareness raising campaigns.

4. Embed a human rights culture within the Tasmanian community through the adoption of a Tasmanian Charter of Human Rights, containing a duty incumbent on all persons and public authorities to act consistently with human rights. The Charter must also contain mechanisms to allow individuals to seek remedy where protected human rights are violated.

5. Endorse and adopt the recommendations of the Australian Law Reform Commission's report into Elder Abuse—A National Legal Response including the adoption of state and territory adult safeguarding laws to give adult safeguarding agencies the role of safeguarding and supporting at risk adults.

6. Establish a transparent, independent and quick State-based complaints mechanism for taking, investigating and addressing elder abuse and neglect, including broad provisions for 3rd parties to make complaints.

7. Ensure that appropriate independent legal support, including access to mediation and family conferencing, is available to all adults including prior to signing residential aged care and related contracts.

To date, Recommendations 4,5 and 6 have not been addressed by the Tasmanian Government.

Vignette 23. It's all a paper tiger

I would say that the next step would be around legislative changes, and responses from Government in regard to protecting people's rights regardless of how old they are or whether they live at home or in a nursing home. I don't always go along the path of changing legislation, because I know that with the one-punch laws for example, often people would plea-bargain to the lower offence. And I think the difference is that if it's theft, it's theft. Do you know what I think we need? I think it's about re-education of the authorities to start using the offences that are there. "This is a case, in my opinion, where someone's finances were removed by a power of attorney, that there is no one to investigate it. Because the agencies that are maybe supposed to investigate it, aren't doing anything about it." And because it comes down to issues of authority, that they're given to me, and that I have to then talk to other agencies, such as the Public Trustee, and Public Guardian, there is no one that I can refer to, and say, "Look this is a definite theft—things have to happen."

Then you get scenarios where people with power of attorney have misused their power of attorney, and there is a Supreme Court action, that no one can afford, to rectify what's occurred. I just think that's madness. I mean, even if it went to something like VCAT, or an administrative tribunal in the first instance. How can you ask someone—like I'm 59, and I've got the experience, but if you asked me to go along and undertake the process at the local Magistrates Court to bring about a small claims, it'd still be stressful for me, and I know what I'm doing. But if you're 82, you know, you're blind in one eye and your hip's gone—where do you go, with the pressure of attacking your son or daughter, and having to fill in all the paperwork, because there's no one in existence that can do that for you—unless you pay them.

So, there are two things. There is who is going to do it for them, that they don't have to pay—and who's actually undertaking an active investigative response to issues, that the police really don't want to get involved with, because they see it as a civil matter. I think it's the Australian Law Commission's report on elder abuse, one of the issues that came up is there isn't an investigative body into elder abuse. And I think that's something that's really lacking, because we all dance around the edges, we all refer off to other people, we all want to do a good job—but there needs to be meat in the sandwich. And I think that there's no meat there. It's all paper tiger. (GLFS_N)

One of the recommendations arising from this research is a robust review of existing and missing legislation to support services that prevent elder abuse in Tasmania. As mentioned in Vignette 23 (above) Tasmania lacks a body to investigate suspected cases of elder abuse. Two Australian states have established authorities—South Australia Adult Safeguarding Unit[14] which is embedded in SA Health; and the NSW Ageing and Disability Commission[15] which as a commission, is able to operate independently of any particular government department. This model is recommended. From the Councils of Attorneys-General National Plan (2019, p.32)[16]: *NSW will establish an Ageing*

[14] Adult Safeguarding Unit, South Australia https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/department+for+health+and+wellbeing/office+for+ageing+well/adult+safeguarding+unit/adult+safeguarding+unit

[15] NSW Ageing and Disability Commission https://www.ageingdisabilitycommission.nsw.gov.au/

[16] https://www.ag.gov.au/sites/default/files/2020-03/National-plan-to-respond-to-the-abuse-of-older-australians-elder.pdf

and Disability Commissioner from 1 July 2019. The Commissioner will be a new, independent statutory appointee with an investigative function to respond to abuse, neglect and exploitation of people with disability and older people in home and community settings. It will have the power to initiate investigations, apply for and execute search warrants and share information with relevant agencies. The Commissioner will also report and make recommendations to Government on systemic issues related to the abuse, neglect and exploitation of adults with disability and older people.

Subfactor 3.4i Legislation—limited powers compared with Safe at Home legislation

Because many of the participants have experience across services, they were very aware of how the police are empowered by the Safe at Home legislation compared with dealing with elder abuse. "*I think police are quite limited in what they can do. Because again it comes down to consent. Under the eyes of the law, everyone has consent until proven otherwise. There have been occasions where I have called the police to help with welfare checks. But they can't remove, someone from the property, unless the person's insisting that they have to leave"* (GACHS_N). Another participant with years of experience in the family violence area explained, "*what we're hearing from our own clients is that it would upset my son, or my wife, or my—you know. I don't want to face it or deal with it, I just want it to stop*" (NGOCS_N).

Participants sympathised with the police, recognising that they have limited powers to act, unlike under Safe at Home legislation: "*With the Safe at Home legislation, it's entirely different. Where the police do have that power to put in a police family violence order and intervene, we don't have that with elder abuse"* (GACHS_N).

The 'gap' between the Safe at Home legislation and elder abuse boils down to the onus being on the older person to report. "*Whoever made the call, the police would respond. So the onus in on the police to assess and decide. That's the gap for me. It's on the record, and there's case management and all of those things are put in place* [under the Safe at Home legislative approach](NGOCS_N)." One participant was adamant that elder abuse, like child abuse, should have a mandatory reporting requirement: "*Like a mandatory line, not an option line, that has a discretionary component. Then if you had any suspicions that you must report, the same that you do for under 18. Then that can be a discussion with that particular body of the way to proceed. But at least it's being reported and it can be dealt with"* (GACHS_N).

As participants noted, unlike children deemed to be too young to make a decision, older people are able legally to make their own decisions but may be vulnerable to abuse. One participant noted, "*I have a work with children and vulnerable people card, and I'm so glad they put "and vulnerable people" on there because it's not just about children. There's already a mechanism to call if you're concerned about a child. I wonder if we could expand that to include disabled or senior people. Also include elder abuse in the training to get the card"* (NGOCS_N).

The other comparison made between the Family Violence response and elder abuse is the speed of the response, both legislatively and in practice. "*Colloquially, the legislative frameworks that are available for elder abuse, are about 10-15 years behind family violence. If we're advocating for legislation changes, we need to recognise that elder abuse needs to have a quicker response style available to it, that is similar to that which is available for intimate family violence vs trusted relationship violence"* (GLFS_N). Again, from the perspective of having worked in both areas, one participant described the differences in the experience of the support for victims of family violence compared with elder abuse: "*As soon as it's not intimate partner, even if it's within a family, you have to sue someone, you need to go through a different court, different mechanisms, different laws; much harder. That's the gap, the biggest gap that I can see is not only having a lack of laws, but also the supports in place that you require when you have these sorts of laws"* (NGOCS_N). This participant noted that from their experience these laws (Family Violence) changed the culture within the police force in how they respond to family violence.

3.4i Response proposed:

3.4i Start by redefining in the Family Violence Act, the definition which is currently limited to intimate partners to extend to other forms of family violence.

3.4i B A DoJ evaluation of current processes under Family Violence Legislation, to consider:

- Past five-year review of clients with breakdown of services used by age group.
- Cases where definition of 'family' has restricted access to services/protections by older Tasmanians.
- External review of equivalent State and Territory legislation with focus on older Australians and definition/s of 'family'.

3.4iC Use the already functioning and known Safe at Home service and reporting structure as a template for a Tasmanian framework for elder abuse and extend their application to elder abuse.

3.4iD Expansion of powers to the ombudsman to investigate elder abuse.

3.4iE Make the Public Guardians a public advocate (other States) to have strong powers of investigation and intervention.

3.4iF Need a Minister for Ageing or, establish a Commission (similar to NSW) to achieve a focus of attention and endeavour in building responses not otherwise achievable.

3.4iG Establish a complaints investigation body with power to: investigate; adjudicate; make a determination; and enforce the determination.

Subfactor 3.4ii Legislation—third party referrals

"*We're very hamstrung as a service, to deal with something where we can't access the client—because the older person is our client. So, we'll have concerned people write to us, or make a referral and say, "Look, we think this is happening to our father, but our sister won't let him talk to you, and he's too scared to say anything." Because of the way we operate, we don't have any legislative authority to go in there and say, "Hello, I'm so and so. I'm an authorised officer under whatever—I'd like to talk to your father please"* (GLFS_N).

The concern of the participant saying this was that if a report is made by someone else, it leaves the older person in a very vulnerable position if access to the older person is being blocked, or the older person denies any abuse is occurring from fear of the abuser. This is also true of access to residents of nursing homes. The service can't investigate the referral without the older person's consent out of respect for their autonomy, even if the service identifies significant indications of concern.

3.4ii Response proposed:

3.4iiA State Government to develop legislation, similar to 'Safe at Home', whereby any referral can be investigated while ensuring the older person is supported and protected by knowledgeable services.

Factor 3.5 Networking

Over the course of the research, it became evident that professional networks provided the strongest referral links across the State. Social workers, for example, conferred with other social workers in their networks including drug and alcohol services, prison support, family violence, Centrelink, community health, acute care or anywhere, in any

agency (state, NGO or C'wlth). By contrast, one participant mentioned his network of people came through his sport club. A recent systematic review by the National Ageing Research Institute (NARI) found that while the quality of evidence was low, interagency networking will reduce the risk of elder abuse (Owusu-Addo E, O'Halloran K, Birjnath B and Dow B. 2020, p46. Primary prevention interventions for elder abuse: A systematic review. Prepared for Respect Victoria on behalf of National Ageing Research Institute. https://www.careknowledge.com/media/48562/evidence-review-nari.pdf) .

An integrated, networked approach to elder abuse prevention has only limited evidence to support it (NARI 2020, p46)—a limitation due to a lack of research. However, in the workshops, all participants discussed how important it was to their services to engage with other agencies to coordinate responses to help their older Tasmanian clients. As an example of networking in practice, Canada (British Columbia) has developed 'community response networks'[17] initially with older people and health workers, but which has now extended to include police, victim support, legal aid, financial institutions, religious group representatives amongst others. Another program under consideration in Victoria is Eldercaring Coordination[18] where a measurable outcome is elder person wellbeing.

Subfactor 3.5i Networking—central to elder abuse prevention

Every service working with older Tasmanians should be required to network within Tasmania and nationally where-ever possible. This requirement can be written into job descriptions and reviews to ensure staff are allocated time to undertake network discussions and maintain relationships within existing networks and develop new network relationships as services change.

Vignette 24. Networking. A fashion that comes and goes

The risk with the idea of networking is, over the years—I've been at it a long time—so, over the years what happens is, people get on to that idea that, you know what, we do need networked services that can be quickly pulled together when a case comes up. And then what happens is changes within certain services happen, and the idea of networking becomes unfashionable, and you don't network anymore. We used to have these meetings for community, where the police would come and other people would come, but then less and less people came to those, as it was deemed to be just a chat fest. So, how it's framed up, how a network is framed up, I think, is really important. And I think if it's given a specific purpose, it can't so easily be discarded by managers who are looking for quicker turnover. (GACHS_N)

One workshop group expressed frustration with the tendency of other services to "pass the buck", if there was a suspicion of elder abuse. There was discussion about how these other organisations did not feel a responsibility in such cases, unlike a case of child-abuse: "*if it's a potential child abuse case, services who have the responsibility to report—and I guess it goes back to the fact that there are mandatory obligations related to child abuse—there is a much bigger tendency to actually do the reporting themselves"* (GACHS_N). Two reasons why this is a problem: (a) the requirements for the older person to then retell their story, for the service to gather the necessary background information, and to gain the person's trust is an added burden for the older person; and (b) the service itself is not resourced to take on referrals from similar services already responsible, and funded, for that person's care.

[17] Community Response Networks (Canada) https://bccrns.ca/#:~:text=A%20Community%20Response%20Network%20%28CRN%29%20is%20made%20up,to%20abuse%2C%20neglect%20and%20self-neglect%20in%20vulnerable%20adults.

[18] Eldercaring Coordination (US) https://www.eldercaringcoordination.com/

Another benefit of networking is to monitor changes in workload across services. This acts as a 'litmus' for changes in demand and ways in which services need to adapt practices to meet changes in demand.

3.5i Response proposed:

3.5iA Support service networking within Tasmania and nationally by writing networking into service-work and individual job descriptions.

3.5iB A service level referral flow-chart should indicate to staff that there are two referral pathways. Intra-service referrals to show how staff interact within the service to address elder abuse; interservice referral pathways—most commonly to the Elder Abuse Helpline. These two sets are embedded in the external networking context (there may be more than one) specific to the service. For example, the National Elder Abuse Policing Network plus SEAPAC.

3.5iC A centralised case-management model would ensure clients are directed to one service at a time, and it becomes the responsibility of the service to refer the client as well as informing the central case-management of changes.

3.5iD Consider the establishment of a Tasmanian Elder Abuse Commission, for example, which can sit outside the bureaucracy of everyday government business.

3.5iE Develop a very short elder abuse checklist with targeted referrals for GPs and other professionals.

Subfactor 3.5ii Networking—open doors everywhere

Arising from a discussion about EA awareness, one participant described how his service had been funded to provide a specific service targeted to older Tasmanians and their families. Up until then his experience of elder abuse was limited, but after attending an elder abuse conference, as he said "*my eyes were opened*" and at the conference he began talking to other Tasmanian services working in the State. From this a small group formed who meet informally to support each other's work: "*people realising that they're not in this alone, there are other services"* (NGOCS_N). This participant also noted that from his perspective, the most common frustration of the group is the ongoing lack of funding as well as not being able to protect the older people being abused.

In another workshop, participants were asked if they were aware of a 'north/south' difference (see also 3.4). They disagreed that there was less elder abuse in the north than the south, rather it was less reported and cases were less supported. "*I think the reason there's less reporting is we don't have the proper infrastructure for it. Whenever I have an elder abuse case, what I have to do is create a little team of all of the people working with this client. I have to replicate that work every time. There's no network. There's no elder abuse provider network. Every service that deals in any way with the elderly should have a liaison person and referral pathway for elder abuse that can be automatically triggered when a case comes through <u>any</u> door, <u>any</u> service. There should be no one-door policy—there should be open doors everywhere, and immediately, everybody should know who the elder abuse liaison is for any service"* (GACHS_N) (see also 3.6i). Sharing case experiences across services would not only bring different perspectives and ideas, but also more clearly identify specific gaps in service provision.

3.5ii Response proposed:

3.5iiA Encourage services to develop communication teams at a local level.

3.5iiB Develop centralised case management to ensure clients are either not 'falling through the gaps' or being seen across multiple services.

Subfactor 3.5iii Networking—sharing information

Due to restrictions on the service to act, services will adapt procedures in order to help and protect the older person from further abuse. A significant barrier to inter-service collaboration is information privacy. One service has a made an arrangement with their key community agencies around what sort of information can be shared. The client is included in these arrangements. As well as asking the client directly for permission to share information, there is also implied consent. For example, someone calls for help with a payment which involves the service contacting the biller on the person's behalf. A certain amount of information has to be shared to help that client out of their predicament.

Throughout discussions, participants appeared very confused and conflicted about what information they could and couldn't share. They sounded guilty if they used roundabout means to do it despite acting in the best interest of their clients. The confusion arises due to the different legislation that applies to each service sector. For example, in Tasmania, the Tasmanian Ombudsman[19] accepts complaints in relation to the Personal Information and Protection Act 2004 (Tas).20 This legislation covers the Tasmanian public sector, including public hospitals. The Privacy Act 1988 (Australian Gov't)[21] applies to all private sector health service providers anywhere in Australia. The Australian Government is currently conducting another review of the Privacy Act 1988. More information on this review is on the Office of the Australian Information Commissioner website.[22] The previous review by the Australian Law Reform Commission (2010) lists problems with the Privacy Act (1988) including submissions relating to situations where third parties were denied access to the personal information of another individual or experienced difficulty in communicating with an agency or organisation because of actual or perceived conflict with the Privacy Act.[22] The recommendation of this report includes developing a code whereby agencies develop documentation that addresses the sharing of information. For Tasmania this needs to include a common agreement between State, Commonwealth and private agencies to avoid an older person 'falling through the cracks' of Tasmania's fragmented social, legal, financial and health systems.

The Australian Government is in the process of developing a national 'Data Integration Partnership'.[23] The funding for this project concluded in June 2020 and it's not clear whether it is continuing or being continued by, for example, Tasmanian agencies.

Regardless of any perceived barriers to information sharing, the following quote shows how a service has, over time, developed a network to promote communication:

"*With our organisations, our relationships have been built up over time. By us doing our roles, getting out, being involved, spending time with them, e-mailing them, constantly phoning them, constantly—regular visiting services, getting to know all the staff and them getting to know our teams and all that kind of stuff—and that's how we've been able to build up that ability to talk to each other and communicate and know what's available, know what each service is doing. They know what we can do. They have our contact details, our e-mails, our phone numbers and all that kind of stuff. And we have always built that relationship in a very strong way here in Tassie, which has enabled us to be able to share information and share services and refer customers when needed"* (GCS_N) (see also 3.6i).

There is a strong sense of common purpose from participants and a great willingness to develop community-wide partnerships to help their older clients.

3.5iii Response proposed:

3.5iiiA What would a 'common-sense' approach to information sharing look like? Evaluate examples in Tasmanian practice to demonstrate how information sharing meets legislative [20,21] and community standards.[25] Determine the progress of any current developments in Tasmania with respect to the establishment of inter-agency data integration systems and programs.

[19] Ombudsman Tasmania "Acting independently in the public interest to resolve complaints and improve the standard of Tasmanian public administration" https://www.ombudsman.tas.gov.au/

[20] Personal Information and Protection Act 2004 (Tas) https://www.legislation.tas.gov.au/view/html/inforce/current/act-2004-046

[21] Privacy Act 1988 (Australian Gov't) https://www.legislation.gov.au/Series/C2004A03712

[22] LRC 2010 https://www.alrc.gov.au/publication/for-your-information-australian-privacy-law-and-practice-alrc-report-108/70-third-party-representatives/problems-with-the-privacy-act/

[23] Data Integration Partnership for Australia https://pmc.gov.au/public-data/data-integration-partnership-australia

3.5iiiB DoJ to evaluate recommendations of ALRC Report 108[22] and current review.[24] Conduct forums with service providers—government and nongovernment—to determine best practice and develop service level education[25] that promotes interservice communication that is in the best interests of clients.

3.5iiiC DPAC to report on progress with the national Data Integration Partnership and how it can be used to prevent elder abuse in Tasmania.

Factor 3.6 Resourcing

All participants wanted more resources to increase their capacity to help their older clients at risk of elder abuse. The cases are complex and talking to older people themselves takes time. Also, the response to the abuse is not simple. Making sure the wishes of the older person are respected is more complex than simply extracting them from the situation, for example.

Participants did not ask for increased resources specific to elder abuse per se, but services are experiencing an increasing complexity of cases due to the ageing of the population, as well as increasing community awareness that there is help available.

Released in 2019, the ACOSS report 'Demand for Community Services Snapshot' describes systematic, unmet need for community services nationally: "Data indicates significant unmet demand for community services during 2019. Only five per cent of survey respondents said the main service they were involved in was 'completely' able to meet demand, and a further 30 per cent said they were 'mostly' able to meet demand. While around two in five said their service was 'somewhat' able to meet demand (41%), 15 per cent were 'rarely' able to meet demand, and nine per cent were 'never' able to." The findings of the ACOSS report strongly agree with factors raised in the workshops.

Subfactor 3.6i Resourcing—as awareness grows, so will referrals …

Services are stretched to meet client needs. As awareness of elder abuse increases, demands on services will also increase. "*The more awareness there is, the more referrals there will be, the more staff we need to respond. We need staff who also have the time and drive and so forth too. We need that promotion, that awareness, that there are services here. It's a bit of a loop really*" (NGOCS_N). Some services expressed concern that not only will their service reach capacity, but also when their service is not appropriate for the case, that there will be nowhere to refer the older person to for help. "*If they say, "No, I'm not going to be in a room with that one*" (the abuser) *then we can't do anything, but that doesn't change the situation. I suppose it's more, who do we refer on to? That's the biggest concern for me at this point in time"* (NGOCS_N).

3.6i Response proposed:

3.6iA With input from key services, develop a monitoring system to alert government to increasing demand on services. For example, monitor the number and type of calls to the Elder Abuse Helpline.

3.6iB Evaluate national prevalence reporting.

3.6iC State Government to liaise with Commonwealth aged care services to establish processes for routine reporting of elder abuse in Tasmanian aged care (residential and community).

3.6iD Networking and communication, for example via the elder abuse prevention 'champions', to improve service level understanding of the role of government in elder abuse prevention.

Subfactor 3.6ii Resourcing——funding restrictions on service

Some services are restricted in providing a comprehensive service by their funding. This means they need to refer the client to another service rather than providing a continuum of care. This also results in the older Tasmanian

[24] Australian Government, Attorney-General's Department, Review of the Privacy Act 1988 https://www.ag.gov.au/integrity/consultations/review-privacy-act-1988

[25] Training resources on the Office of Australian Information Commissioner https://www.oaic.gov.au/privacy/training-resources/

having to repeat the trauma of their story over and over: "*elderly people that have to tell the same story to three different people, and then possibly still are told, "Well look, there's nothing we can do for you. You'll have to go and see someone else*" (GLFS_N). Staff need to take time because the stories can be "quite muddled and scattered" and traumatic: "*asking those questions is about trying to narrow down what's actually happening, with people that are struggling with some form of trauma, or traumatic event that's going on in their lives"* (GLFS_N).

Other services can be more flexible, mainly providing services to clients 65 years and but will also manage clients with younger onset geriatric conditions.

3.6ii Response proposed:

3.6iiA Establish a complaints investigation body with power to: investigate; adjudicate; make a determination; and enforce the determination.

3.6iiB Concurrent with any increases to staff, for example, efficiencies can be made if a cross-service, case-management model is adopted.

3.6iiC Government and NGO funding to services with older Tasmanians as clients needs routine evaluation with 'markers' of stress. E.g., COVID has increased and changed the workload of some services who are then too busy adapting to changes, to have time to call for help.

Subfactor 3.6iii Resourcing—transport

One participant wanted to see an increase in community transport options, especially for older people: "*Elderly people are not accessing health services, because they can't get there, it's as simple as that. There's one bus to Launceston, and one bus back from Launceston per day. There's a community car that may or may not happen, but the community car stacks people up and so take four or five people and they'll have to take them all to their appointments. So, mostly those people are sitting in the car all day and the taxi costs $240 because you have to pay for a return journey. So, if you don't drive, you're a bit stuffed"* (NGOACHS_N).

This is not just a problem in remote areas of the State. One participant in a regional centre commented "*the practical side of seeing clients outside the office is firstly being funded for a car, and the time it takes to get to outlying areas. Also, it means that I am out of the office most of the day, leaving us further short-staffed. Some clients are not mobile, and can't get to our office. While one of the 'benefits' of COVID was that we found we could do a lot more over the phone than we thought we could, many of our clients are not tech savvy, or they don't have access to a computer or smart phone"* (NGOCS_N). In another workshop the participants discussed how they did cover as much territory as possible, but they were not sure if they were contracted to cover those areas. Another group noted that their team based in Burnie/Devonport had a lot more travel time as they covered the entire NW.

How services determine the need and associated costs of managing an older person case-load as well as meeting the needs of a less mobile population will require a whole of government approach to ensure services are able to meet both community and funder expectations. Phone-in services may seem to be an option for remote clients, but it is important to remember that even if the client has access to a phone, they may also be unable to use the phone for physical or personal reasons. "*We have had cases where we've had to be very careful about times when we can call, particularly if the person's carer is present and the carer is the person that they're concerned about"* (NGLFS_N).

3.6iii Response proposed:

3.6iiiA Review existing services while acknowledging there is already a need to increase community transport for elderly people.

Subfactor 3.6iv Resourcing—community referrals take time

During one workshop the participants (community-based health) discussed the time difference between 'getting things done' in the acute sector compared with the community sector. "*In the community it's hard. I'm meeting a lot of people who aren't even engaged with their GP—we might be their only service they've accessed for a long time. It can take a number of months to start to build a bigger picture, to start getting services involved. But that can take a*

long time. In the community setting, that can take us a long time" (GACHS_N). Once a service has established a relationship, and is providing services to a person, then there is 'implied consent'. For example: "*if we've already been providing a service, and it becomes evident that there are some concerns around the capacity, we will try to talk to the person about some of our concerns. In that instance, I don't believe we need consent from the person to raise our concerns with the GP or the mental health helpline, because that's where duty of care steps in"* (GACHS_N).

Vignette 25. Multiple community service referrals

We were contacted by a community agency that was assisting an elderly lady that was living in a rural community and was also on our books. There was feedback from the community agency, and also the police and the healthcare workers involved with that case, that they did suspect elder abuse. It was a bit challenging for us working with the woman and also her family to sort out getting documentation that we required, getting confirmation of the circumstances and, yeah, I guess treading very, very carefully with how much notice we took of information coming in from various parties. While also making sure we supported that lady and how we made sure that she was in a safe place and got further assistance going forward. We did a lot of work with the community agencies, but from our service perspective we were more focussed on supporting the financial independence role than necessarily dealing with the family dynamics and things that were happening within the family. The police and the community agency took more of a lead with getting that sorted out. (GCS_N)

This is an example of how services use whatever ways and means they have at their disposal to help the older person in difficult circumstances. As emerged from the workshops, each case discussed required a different response. Unlike a hospital in-patient referral, there are multiple barriers for community services when helping an older person. In this quote, the service is acting on behalf of older Tasmanian's living in the community with a concern for their mental health: "*with community services we need a person's consent to provide support to them. And that's a challenge. Sometimes we do get referrals where there are concerns around capacity, or there are concerns that someone's very vulnerable, but we don't have any statutory powers to intervene without the person's consent. I often have to try and re-refer them back to the mental health service that have their crisis assessment plan"* (GACHS_N).

3.6iv Response proposed:

3.6ivA If community services can't act on referrals, then risk for the older person escalates. To interrupt the cycle of abuse, establish a complaints investigation body with power to investigate; adjudicate; make determinations; and enforce those determinations.

3.6ivB Support community services to promote awareness of service availability to older Tasmanians and other services.

3.6ivC Build on the success of the "No wrong door/The Right Place" program[2] to identify and strengthen current formal and informal connections between services and improve access to services for older Tasmanians. In this program the hairdresser, for example, can refer the person to a service that might help them more directly.

3.6ivD The extra time it takes to provide a service for older people living in the community requires formal recognition in community sector business cases/budget. The ACOSS (2019) report identifies a widening gap in increasing demand with static or decreasing service budget allocation.

Subfactor 3.6v Resourcing—meeting increasing demand for aged care services

As one participant pointed out, the more staff know about elder abuse, the more staff will be needed to respond to reports of elder abuse. "*There is increasing demand for aged services, but it only ever revolves around money, not about actual need*" (GACHS_N).

Some participants expressed frustration with the static response of government to Tasmania's changing population demographic: "*when are they going to take older people as seriously as they do younger people? New resources, younger people. New legislation, younger people every time"* (GACHS_N). One participant commented that their service had been running for over twenty years but the staffing has never been reviewed. When staff are spread 'a little thin', the temptation is not to engage in a suspected case of elder abuse: "*it sometimes takes an effort of will to make the leap to taking on another task that could be fairly complex"* (GACHS_N).

There is a public expectation (reflected in media coverage and politicians' statements), that the responsibility for the health of residents is managed by their GP. To what extent this is the reality is debatable. A point of discussion during the workshops was the time and associated cost borne by GPs to visit and care for older Tasmanians who also happen to live in residential aged care. "*The majority of GPs have nothing to do with nursing homes and the geriatric side of things—they will avoid it. It's not well paid, it's not well looked after, we're not trained to do it, we don't feel comfortable, it's uncomfortable and time consuming. You can't see an elderly patient in 10 minutes, you've barely got them sitting down before 10 minutes has passed, you've probably got them in the door, let alone look at their baby photos and you know, actually treat them like people. It's not just that they want more funding, it's just that there needs to be an understanding that talking to elderly people takes more time, and as well as the time it takes to drive to the facility, access health records, talk to staff and so on, the day is gone and I have less time to spend on activities, and patients that can physically come to my clinic, that are more realistically remunerated"* (NGOACHS_N).

Another service expressed gratitude that their MDT included a doctor which improved client outcomes if a case of elder abuse is suspected. This also saved time for the client needing assessments and referrals.

Having the right staff saves time and ensures older Tasmanians are not further traumatised by inexperienced questioning. "*A lot of what we do, we wouldn't necessarily name up on the day as what we're doing—but our staff have the use of empathy, reflection, all that sort of communication skills that we have, that's been part of our life for such a long time. We do it without even being aware of it"* (NGOCS_N). Another service workshop suggested that the best assessors are a team of social workers, occupational therapists, nurse practitioners, doctors and physiotherapists. "*Physio and social work—because there's often persistent pain related issues that are linked to the frustration that carers are feeling around their elders. So, under-medicating elders who've got persistent pain conditions, or over-medicating them, is a major form of elder abuse that we don't talk about. So, having physiotherapy and clinical social work—not welfare social work—clinical social work in a designated team"* (GACHS_N). This is stated from the health service perspective. The addition of a solicitor to the team would be beneficial, too.

3.6v Response proposed:

3.6vA Recognise and value staff experience in being able to interview older Tasmanians through subsidised training and job description.

3.6vB Develop, in collaboration with experienced staff/services, compulsory training modules for identifying and dealing with elder abuse targeted to specific services that work with older Tasmanians.

3.6vC State ministers take up with the federal Government remuneration for GPs so they are able to provide care for Tasmania's ageing population.

Factor 3.7 Are there any North-South differences?

The majority of participants in both the north and south of Tasmania did not think there are significant differences between the regions. Differences do arise, not because of the 'Boag's Border' but in regard to:

- Distance from major population centres and services
- Access to a MPC/Primary Health Care with allied health services on-site
- Transport
- Social and rural isolation

As an example of social isolation, one participant who had worked in both parts of the State, said that the worst elder abuse she had encountered was in an outer suburb of Hobart. "*I was very shocked …. when I moved to (outer suburb of Hobart) just how prevalent elder abuse and this sense of social isolation was for so many people who live so close to town. They feel very, very isolated. It doesn't matter if they live at X (rural town) or if they live at Y (urban suburb). If you can't get out, you can't get out. I had to take one lady to Hobart, to a guardianship hearing. She had not been to Hobart from (outer suburb) for eight years"* (GACHS_N). House boundness, it was noted, also occurs in younger clients with mental or physical disabilities.

One participant expressed concern that their service was not getting referrals from areas with large proportions of older Tasmanians: "*I'm really surprised 'Town X' hasn't been a really busy part of the role for us. Because 'Town X' has got a huge amount of elderly people. I think it probably has the largest amount of elderly people in Tasmania. Yeah, it's massive! Because—you know, I've worked in the Town X mental health services—and that was where we found that there was a lot of older persons mental health issues. And I don't think that they're—I don't know what the stats say, but I think if you've got a population of older persons that have mental health problems, you're probably going to find that all the risks of the problems that older people suffer from are going to be there as well"* (GLFS_N).

Overall, participants agreed that the type of agency tends to be the same regardless of region, however: "*like anywhere, we may have a slightly different relationship with the Salvation Army in Burnie than we might do in the Salvation Army in Launceston just because of the particular programs that each community agency runs. I can't really think of any obvious north/south type issues that really resonate"* (GCS_N).

3.7 Response proposed:

3.7A Tasmania to consider an elder abuse 'observatory' of referral patterns to ensure that elder abuse referrals, and access to available services, is population and needs based.

3.7B Establish a complaints investigation body with power to: investigate; adjudicate; make a determination; and enforce the determination.

Appendix 1: Workshop Content Analysis

Key theme	Factor [F]	Description/example	Response proposed
1. Recognition of elder abuse	1.1 Recognising elder abuse—a hidden crime	Elder abuse is multi-factorial and complex. Recognition can be hidden in the complexity of the older client's case. When discussing their experience of elder abuse, participants were asked to think about the contexts and factors that may have 'allowed' the abuse to occur. Factors are not always obvious and may be overlooked of in the 'busyness' of client assessment/care/interactions. "*when it comes to elder abuse, it's not the physical nature, it's more an emotional hang up or a property-based form of abuse, rather than what I would regard as physical or anything like that* (NGOLFS_N)." Throughout the discussions, the experience and 'people' skills of the participants were key to recognising and responding to the 'hidden' nature of elder abuse of their clients. "*With our service, it is one of those things that we have in the back of our mind, when we get a referral about an older person—it's just one of those things that we will factor into our screening and our assessment, and having an understanding that elder abuse is a lot more than just physical abuse. More often than not it's benign, but it's hidden. Something people are very ashamed to talk about—it can be emotional, it can be around not giving the older person control over their decision making that impacts on them* (GACHS_N)." Without the experience of 'seeing' elder abuse in their professional career or personal lives, service staff will not pick up on the cues that abuse is occurring. "*I've always had that interest in older people, but to be perfectly honest, I used to—not so much turn a blind eye—I was very naïve about the abuse that older people actually experience* (GACHS_N). Another participant had concerns, but had never confirmed a case of elder abuse in their service: "*There's always cases, people are wondering about, but I've not actually come across something that's been confirmed, myself* (NGOACHS_N)." One participant who had been in the service for a number of years commented that the language around elder abuse is "*softened*". For	1.1A-Support Tasmanian services to develop/refine their elder abuse strategy/policy. 'Elder abuse is everyone's business'. 1.1B Recognise the range of skills, experience and turnover of staff of Tasmanian services when developing policy and training. 1.1C Develop a metric to measure the actual time taken by staff to manage a case of elder abuse—recognising that interviewing older people takes more time to communicate as well as develop trust. 1.1D Resist 'softening' the language around elder abuse as a way of avoiding agency and personal responsibility for these acts that are violent, psychological, emotional, financial, neglectful towards older Tasmanians. 1.1E Evaluate implementation of mandatory elder abuse prevention training across government and NGO service organisations to promote a consistent, state-wide approach to elder abuse recognition and response. 1.1F State-wide monitoring of the use of ageist language in formal documentation.

		example, "*stealing money has become inheritance impatience. So instead of using the language of a criminal offence, it's turned into a social problem between the perpetrator and victim* (GACHS_N)." Services that are able to go into a person's home are at an advantage to identify if 'something's not right'. If the person comes into a clinic, a 'neutral space' then "*you're not seeing the dynamics, you're not seeing how they live, you're not noticing if there's food in their fridge or if the house is in a state or neglect. So, this is where we've got this advantage, we're in their homes. So, we're confronted with the reality of that person's life* (GACHS_N)." Other workshop participants noted that when a person is outside their environment, such as the GP, then there is an element of 'performance' and they'll tell the doctor what they think the doctor wants to hear. Clients are also very aware of not wanting to 'waste' the doctor's time. Participants were sympathetic toward the limitations on a GP—not much can be achieved in a six-minute consultation. The other concern is when the person's carer, who may also be their abuser, accompanies the older person to the GP. "*A person's very restricted in what they can say. So, the GP often doesn't pick up on the cues. What I mean, the family they're policing what's said and sanitise to a certain degree* (GACHS_N)." The preference is to see the person on their own to avoid controlling behaviour.	
	1.2 What constitutes elder abuse?	In the workshops, participants discussed what they believed to be a general lack of awareness of what constitutes elder abuse by their older clients, and even 'normalisation' of elder abuse in their client communities. "*And what constitutes abuse? If Grandma's biting you, giving her a smack may not feel like abuse to you. No, what do you call abuse? Is it if you're not showering Grandma more than once a week, or once a month, is that neglect? If she's losing weight because she's not eating enough because you haven't fixed her teeth, is that elder abuse*? (NGOACHS_N)."	
	1.2i Elder abuse becomes 'normalised'	"*I think there needs to be more education in the community. We're talking about the issue of people not identifying that they are being subjected to elder abuse and that could be because it's been a process overtime that becomes the normal, habitual, or it could be that culturally, they just think that that's okay or whatever* (GCS_N)." This participant added that even if the person recognises they are being abused, they then have to know where	1.2iA—The material raised so many issues about deficiencies in our system and its inability to meet older people's needs. Participants in the study were overwhelmed by the problems they were trying to deal with, to which there are no current solutions available because of the multiple failings of the

		to go for help. Some participants were aware of the recent elder abuse awareness campaign but were ambivalent as to how it would help someone experiencing abuse. "*When people are in these situations, that sense of powerlessness and loss of control—and a lot of these things that we're talking about, about making contact with someone or telling someone, that becomes beyond them to some extent or a really, really difficult thing to actually summon the courage—even the ability to be able to do that is compromised. They fear they would lose what little control they have and make their situation worse* (GCS_N)." In another workshop participants were more positive about the awareness campaign and thought it would help 'perpetrators' recognise that what they were doing was abuse: "*some of the perpetrators are not aware that that's what they're doing. Particularly around financial things, they feel entitled and they may feel that it's not as bad as it looks like from the outside* (GACHS_N)." or that the abuse is "*unintentional*" because of a lack of awareness.	system. This includes inadequate housing and care options. There is no emergency accommodation. Public Housing has long 'emergency' waiting lists. Nor is it fair to remove the older person from their own home. Participants agreed that that awareness alone was not a solution without actual interventions "to help people get out of these situations". Adult safeguarding legislation that protects and upholds the rights of the older person, with supporting services such as is available through Safe at Home would provide a clear action and referral pathway for services to act on behalf of older Tasmanians. 1.2iB—Build on the elder abuse awareness campaign to emphasise recognition by the 'perpetrator' and what other people think of what they are doing. 1.2iC—The language used toward the 'perpetrator' needs to focus on the rights of the older person. "I probably wouldn't say, "You're abusing your mum." I would say, "It's her right to do something" (GACHS_N)." 1.2iD—Participants agreed that awareness campaigns are important but wondered how effective they are. Continue awareness programs with embedded evaluation to improve message 'targeting'.
	1.2ii Using estate planning to support the right of older Tasmanians	One of the workshops was held with a private practice financial service. During the course of the discussion, the participants were quite clear (blunt) that they have to operate under a 'time is money' basis and hence their clients have the means to pay them for their service. "*Generally speaking, we don't do a lot without getting paid for it. Now, the idea of help can be in referral to somebody else during that process, but to get there in the first place,*	1.2iiA Estate planning for people without the resources to pay a private advisor is an unmet need. Being able to refer people to Legal Aid or the EAH would be a start. "*Having a resource other than family, effectively, an independent third-party scenario to go and get some advice from*

		requires a level of financial resourcing (NGOLFS_N)." The majority (80-90%) of clients to this financial service are over 65 years old and the participants agreed that estate planning for people without the resources to pay a private advisor was an unmet need. Being able to refer them to Legal Aid or the EAH would be a start. "*Having a resource other than family, effectively, an independent third-party scenario to go and get some advice from* (NGOLFS_N)." Also, to get help with the increasing need to use technology to manage financial affairs. As one participant commented, Australians, unlike Americans, are not used to being open about setting up financial agreements before getting into debt with a partner or family. *"(Australians) go in with trust and emotions first, and we don't talk about money, it's almost like not a dirty word, but it's one of those things that as a society, we don't brag about it. We don't want to talk about it, and we don't even talk about it like wills, because people will go and write their will almost in privacy or maybe as a couple, but then not discuss it Because, then it's about dying, which is another taboo topic, you don't want to talk about dying, because it'll upset someone* (NGOCS_N)". In a different workshop, participants discussed the older person's lack of awareness around their own rights, and ways to protect themselves as they age such as an enduring guardianship and power of attorney. "*Everyone knows about a will, but let's be honest, a will is not that important. Once you're dead, you're dead. What really matters is when you're alive, and I find, honestly, I'd say 90% of my clients have absolutely no understanding of those legal documents* (GACHS_N)".	(NGOLFS_N)." Also, elderly people may need help with in using technology to manage financial affairs. 1.2iiB Institute an awareness campaign to encourage older Tasmanians to engage and discuss long term personal protection regardless of their ability to pay for the advice and submission/registration of documents. For example, community education sessions might be instituted with Senior Assist. 1.2iiC Review what information is given when Tasmanians apply for Carer or aged pension, and Seniors Card, to ensure Tasmanians are given information on how to access services that they may need as they get older, and also offered the opportunity to meet with a community legal person to help with, for example, estate planning and guardianship. 1.2iiD Identify places that are easily accessible, or routinely accessed by older Tasmanians that can provide free financial and legal advice in a safe environment. Service Tasmania may be an example, or at local government offices and multipurpose centres. 1.2iiE Impose a duty on financial institutions have a responsibility to act on their suspicions of inappropriate access to accounts. A public investigatory and regulatory authority should be established by legislation for this purpose. Define financial institutions to include any body, whether incorporated or unincorporated, that has dealings with an elder person's finances.
	1.3 Financial Abuse—why do people	During the workshops, discussion about why people, usually family members, felt entitled to the older person's assets often arose. "*Why*	1.3A Recognise and develop education/awareness around four key points:

	feel entitled to an older person's assets?	*do they believe it's their asset and not the older person's asset? What changes—I can't understand—what has changed? And is it—I mean, you can understand people are under financial pressure, but you don't go and steal something from the shop* (NGOLFS_N)." Even if the older person's only financial 'fortune' is the pension, there will be someone who wants it. "*What I've seen is where you've got a family member or a friend who might withhold the person's pension from them, or they say that they're going to manage the person's finances on their behalf* (GACHS_N)." Financial abuse is very common. "*It's always intertwined with other forms of abuse, but certainly it's the one that is often the most obvious. But then there's often emotional abuse attached to that, potentially some physical abuse as well, but financially—it's so common* (GACHS_N)." Using the grandchildren as blackmail: "*One of the worst cases I saw of elder abuse was the fact that it was literally told in front of me, "If you don't do this or sign this, we will withhold your grandchildren."* (NGOLFS_N)." Family members/carers are able to garner the login of the older persons accounts—bank, Centrelink etc—by offering to help them if they are having trouble with the technology. "*I have seen a lot of family members accessing their elder relative's online services, changing passwords, changing bank accounts, taking their payments, getting advance payments and so forth in their name and taking their money from them* (GCS_N)." Participants discussed how financial abuse puts the older person in an increasingly vulnerable position: "*they don't have enough money to go and buy groceries or to go out, it's exceptionally isolating … it's a really powerful way of cutting off people from others around them—whether it's home care services or being able to access a community or see their friends… it impacts on every part of their life* (GACHS_N)." The financial advice service participants recounted how a client had called them in	(i) Some people think it is "reparation or compensation for what they perceive as historical ills or faults" by the parent. (ii) Financial desperation in a climate of high debt and financial competition combined with an assumption that the older person's assets will be coming to them in future anyway. (iii) Anger that the 'boomer' generation are holding onto a lot of wealth gained during a period of growth in Australia that younger generations have missed out on. (iv) Regardless of the argument that the 'boomer' generation worked hard to create their wealth, younger generations have grown up with the experience and expectation of having discretionary spending. The majority of 'boomers' on the other hand were raised by parents who 'scrimped and saved' during the depression and war years. Hence, not only is the economic environment different between the generations, but also the experience of having money to spend, and with credit cards, whenever you want it. 1.3B Identify and evaluate existing financial safeguards in current use. Older Tasmanians with low IT literacy are, for example, particularly vulnerable to local bank and post office closures. 1.3C How to identify increasing isolation of an older person due to their finance decision making being taken from them? It's as though they are a drawing slowly being rubbed out. If someone cares enough to look, the imprint of their life remains.

		distress after the client's adult child had spoken to the advisor: *""What did you say?" And that's where you clearly know that there has been some level of verbal abuse, if not worse, by the way that they're reacting. They said they copped an absolute mouthful of anger from the adult child because of a decision that has been made, which I find intriguing because ultimately, the asset or situation isn't theirs* (NGOLFS_N)." In some circumstances you don't have to lodge a tax return after retirement, so the likelihood of an older person going to their accountant at this stage of their lives lessens. They then may miss out on information and advice to keep them safe.	1.3D Establish a checking system that requires Centrelink, Services Tasmania or another community agency to be available to check password changes. An alert system. 1.3E Implement mediation training for financial advisors, accountants and lawyers 1.3F Increase community awareness of value in seeing a financial advisor no matter the value of their assets.
	1.4 Institutional abuse	When the term 'institutional abuse' is used most people, including workshop participants immediately thought of the stories of abuse emerging from the Royal Commission into Aged Care. That is, abuse that occurs within the walls of an institution. The term is used more broadly to encompass abuse that occurs under the auspices of institutions—usually large public or private entities—that through their policies and practices, 'allow' abuse to occur through a power imbalance.	
	1.4i Institutional abuse—housing affordability	Some clients living in independent living units—private companies not associated with residential aged care—because of the cost of the units—have no spare cash. "*They're very expensive, and they don't even include utilities. Some include meals, but I've seen the meals … all they get served are things like baked beans, or sausages—not nutritional meals. And they're paying a lot of money to be in these places, and they're tiny* (GACHS_N)." The few subsided aged care independent units (associated with residential aged care companies) are very good and affordable, but are rarely available or not suitable for disabled elderly. They also don't allow pets.	1.4Ai Provide support to Tasmanians considering entering contracts with 'retirement' village providers through Consumer Affairs and Fair Trading, or Consumer, Building and Occupational Services, or Senior Assist. 1.4Bii Review and evaluate existing 'independent living unit' businesses. Are they good value for older Tasmanians? Would you let your Mum buy into one of these contracts?
	1.4ii Institutional abuse—service availability	The Australian Government has moved to a 'consumer' model of care provision in aged care and the NDIS. There are limitations to this model for example oversight of costs and quality; management costs; availability; access to complaints. "*I have seen that shift significantly in the last seven to ten years, because of the change in the way that support services have been funded. Now there are NDIS providers—and there are good ones, don't get me wrong—but there's a lot of evidence in the community where older people have been charged for support services that they're not receiving. I think, when you've got an issue such as such as elder abuse, it's complicated,*	1.4iiA Tasmania has a state-wide network of Multipurpose Centres (MPC) (Table 3). This existing network can link to private providers to ensure older Tasmanians are protected through information sharing and provide continuity of care. 1.4iiB Identify and use the expertise of staff with long term experience in Tasmanian services. Their understanding of what works, and what programs have been a waste of time and money, is invaluable.

		there are no easy solutions. In my experience, the more effective support services, and the more visible those services are in communities, then that becomes a protective factor against abuse. For example, an older person living in isolation, with the odd service visiting once every two weeks, versus somebody living in the community and you've got a lot of visiting services, visible services that they can actually engage with on a regular basis (GACHS_N)." The issue of 'institutional abuse' is broad and includes social and structural problems across a broad spectrum. The following comment was made by a health practitioner working in a rural area approximately 2- hour drive from Launceston: "*In the past we had only a few kids going through to grade 12, and that grudgingly. So, starting from the very bottom up, lack of education, lack of social structure, lack of activity for children, the kids move away so the elder—the older people, their children are often elsewhere, because there's no jobs here. So, their kids and grandkids are often not present, their carers might be their neighbours. The neighbours, sort of not particularly beholden, they're often good people but busy or sick themselves. We have one psychogeriatrician that I know of. I mean, I don't even bother referring to him, you can't get hold of him. There's an older person's mental health team that's in Hobart, which they're actually quite good, but they're in Hobart. There's just lack of access, but even if we could get these people to the doctors, there just aren't enough people doing assessments. There's not enough psychologists, psychiatrists, there's not enough support in any sort of aspect of mental health including geriatric mental health et cetera. It's just this scarcity of pretty much everything, and it's grassroots*. Q: Sorry to interrupt, I was thinking aged care services, do you find that there's enough of those in the community? A: *Level four package is well, they say 18 months but probably will never happen. That's the highest level where people need the most desperate help, and forget it, it doesn't exist. So, that's why it's good to have the hospital, because we often look after these people in the hospital, but it's not very nice for them there.*	1.4iiC Review the requirement for extra time to manage the care of an older Tasmanian—living in the community or RAC—and remunerate the practitioner/service for their time and expertise. This would encourage provision of care in areas, and populations, already underserved by services. 1.4iiD Tasmanian government to lobby the Commonwealth to improve access to home care for older Tasmanians.

		Q: Do you have any long-term patients in the hospital because of that? A: *We do, we have people awaiting placement, but it's not like some units where they have them for years and years, we would have them six months, hopefully no longer for their own good* (NGOACHS_N)." This level of frustration will impact on practitioners' desire and ability to act on cases of suspected elder abuse. "*Everything is hard, and everything is complex, and multi-morbid and just as I've said, it's not well renumerated* (NGOACHS_N)."They simply do not have the time to respect all the nuances of a person's life in the context painted above to feel comfortable (or competent) to put in place any intervention that they feel won't make the situation worse. Concerns about access to home care packages was raised in a separate workshop: "*I often get referrals for people who are, say, well into their 80s, that have probably been struggling at home for a very long time. They don't have any understanding around ACAT, any understanding around home care packages and services they can access. And when you try and start putting these services in place, as we know, home care packages, you're waiting for about 18 months to get one, leading them to a vulnerable position where they are either reliant on their family, which I think perpetuates the abuse, or they have to go into care, which is not always the outcome people want.* *Isn't it ironic? The greater your support needs, the longer the wait?* (GACHS_N)." This group argued that aged care support is "a *protective factor*" of elder abuse, breaking down the isolation of the older person: "*When you start having more services coming in, keeping an eye on that person, helping that person be a bit more independent, helping them to get out to meet new friends, to access the community, I feel like that can be, in itself, be enough to change the dynamics of the relationship between the person and their carer, or their family* (GACHS_N)." For example: "*If the person has a Level 3/4 package, which takes lots of work from the carer at home, from the family, the abuse might stop because the stress of caring for the person with dementia is lifted. The service can also help to educate the*	

		carer about dementia and how best to manage difficult behaviours. As well as encouraging them to care for themselves (GACHS_N)."	
	1.4iii Institutional abuse- aged care portal	In one workshop the participants raised concerns with the 'push' to have all services to be accessed on-line through the MyAgedCare on-line portal. This particular service works with a very vulnerable older cohort whose needs are not easily met by 'regular' aged care services, not be financially viable to providers in the current funding model. This service also has long-standing care-providing relationships with this group, and it takes time to build trust with this cohort. This service has had referrals from ACAT when a special need, not met by the MyAgedCare portal, is recognised.	1.4iiiA Request Commonwealth to evaluate 'MyAgedCare' on-line portal for consumer (service and older client) satisfaction; what population groups are being adversely affected by lack of access to this on-line service; assess growth in 'consultants' to help older clients access/understand MyAgedCare. 1.4iiiB Tasmania conduct its own review into the impact of bank branch and Post Office closures on communities.
	1.4iv Institutional abuse—policy/funding limitations on service	Some services have limiting definitions for client eligibility for home services. They can organise a carer to come and shower the older person who needs that assistance, but there is no funding for a person needing a welfare check: "They need someone to check in and see how they're going. There's no service available. We can't do that. We just wait until disaster happens and this person is re-admitted to the hospital" (GACHS_N). Not all services defined the eligibility criteria for clients to access their services. This may be another area of confusion for older people—they call a service only to be told they can't be helped because they don't meet certain criteria.	1.4iiiA This is 'institutional abuse' arising from government policy limiting the response of the service to a particular set of parameters that may be defined, for example, by funding from one government department vs a whole of government approach. By writing such parameters into a policy means some people will be excluded from the service. A more wholistic 'no door is the wrong door' approach to government policy enables any service to 'triage' the person who has come to their door desperate for help, to the service that will help them best. Build on the success of the "No wrong door/The Right Place " program2 to identify and strengthen current formal and informal connections between services and improve access to services for older Tasmanians.
	1.4v Institutional Abuse—by financial and legal advisors, Guardian or	Participants were discussing a mortgage fund set up by a prominent legal firm and concerns regarding legality of using clients' funds in this way. The consensus was that with recent improvements to regulations, this abuse was not as easy to do as in the past: "*there's been a lot of regulation that's increased over the last 15 years. These mortgage funds, now they*	1.4vA Impose a duty on banks and other financial institutions (to include any incorporated or unincorporated person or body that has dealings with older persons' finances) to act on suspicions of financial elder abuse of their accounts. A

	Power of Attorney	*can only borrow up to 66% of the underlying asset, so there used to be a situation where the lawyers—yes, they abuse their position, yes, they got the money of the elderly. They were appointed executor or guardian and they ended up Power of Attorney, putting it in their own fund, fund goes bust, right. But that doesn't often happen anymore* (NGOLFS_N).". The sad reality is that clients trust their lawyer of accountant to manage their funds as they age because they don't have anyone else.	public investigative and regulatory authority should be established by legislation for this purpose. 1.4vB Review costs and charges of government entities such as Public Guardian.
	1.5 Family history of abuse	During one session a participant discussed how abuse is often more likely to be identified as part of the history of the relationship/s. "*It's not necessarily just all of a sudden a person is now abusing their demented father or mother. It's that they've been caring for them the last seven years, that things slide and slip, and there's this little—you know? One small action leads to another action, and another action. And what I was hearing in that case sounded a lot like carer fatigue to me, and that person's own issues.* *Underlying these cases—there's this connection between abuse and trauma and all sorts of things that are long running, beyond what we see today. It could be that the elderly parent was the abuser of the child, and now there is a power shift in the relationship and the child is replicating the abuse the grew up with. There's all sorts of dynamics that can go on. It makes it very hard for the service to gather information because the older person does not see that there is anything wrong it's "just another day in the life of this person*" (GCS_N)."	1.5A Service staff need to be trained to recognise and respond to an older-person's long-standing trauma. For some, the violence and abuse becomes 'normalised'. 1.5B Staff providing personal care should also be trained to recognise the effects historical abuse which may manifest as fear of being bathed by a male carer for example.
2. SERVICE RESPONSES TO ELDER ABUSE	"W*e are kind of working out this is the tip of the iceberg for elder abuse* (GLFS_N)."		
	2.1 Referral pathways	The second key theme of the workshop discussions is the response of the service to elder abuse. While expressing frustration with the 'problems' of responding to elder abuse, overall participants were passionate about making a difference for their clients. "*We've got a lot of agencies that we deal with, and we tend to do almost a triage, and initial assessment, and then—if there are issues that need to be addressed—we will do short term interventions. And those interventions would be about identifying suitable referrals outside of the organisation* (GLFS_N)."	
	2.1i Referral pathways—to Elder Abuse	Overall, participants—if they knew about the EAH—relied on their own service or network, to manage a case of elder abuse. "*Sometimes it just stays with us. We get a lot of referrals around elder abuse, mostly from the self-*	2.1iA EAH to consider how to encourage 'stand-alone' professions to refer clients to the Helpline. The pathway for information for stand-alone, private consultancies is via

Helpline (EAH)	*referrals, from people in the community. Sometimes—a big part of our role is around helping people with their decision-making and letting them know what their options are* (GACHS_N)." When asked if they had heard of or called the EAH, one service group responded with a flat "no". When the role the EAH was explained, and what they could offer the service's clients, one participant commented (dryly): "*it sounds very worthy*". This particular service needed to be convinced that a call to the EAH would be worth their time in a service that is paid by the minute. This same service had referred clients to a private counsellor, similar to Relationships Australia and had not heard of Senior Assist.	their professional bodies such as the Tasmanian Law Society, Australian Banking Association, CPA Australia, the College of General Practitioners, Pharmacy Guild etc.
2.1ii Referral pathways - Senior Assist	Senior Assist had only recently started in the North (Launceston) when the workshops were held. Participants had been contacted and, in some cases, had had visits to advise of services available. Overall, the response to Senior Assist was very positive "*we've only recently had them up to speak to us and I think I'd be more inclined to deal with or discuss complex cases with them in the future* (GACHS_N)." In another workshop: "*the Senior Assist thing is a nice breath of fresh air, to be able to go and talk to them. I think Legal Aid are great. I've been to appointments before with clients and they've been very supportive with talking about their options. Sometimes they write support letters, or letters to the family. So, say if a person's not wanting to action—take legal action, but they're wanting their family to understand what their rights are, a lawyer will sometimes outline, 'Okay, well, these are the person's rights, and we're asking that you leave the property by such-and-such a date'* (GACHS_N)."	2.1iiA In both the North and South of Tasmania, Senior Assist has made a 'name' for itself with services already. It has set the right 'tone' across professional groups and as such been welcomed by health as well as non-health services. This is currently a time-limited project and should be reviewed for permanent funding.
2.1iii Referral pathways—hospital admissions	This referral route was not mentioned much. In one example a referral came from a nurse while the person was in hospital; another example was from a GP who also consulted in a community hospital who would refer any concerns to the nursing staff for follow-up. Regardless of the referral route, consent from the older person is required to provide	2.1iiiA Review programs of in-hospital legal aid for implementation in Tasmania. For example, Health Justice Partnerships 2.1iiiB Evaluate assessments of capacity done for hospital inpatients compared with

	services. Otherwise, all that can be done is advice vs action. If the person is in hospital, services know they are safe, for the moment. Hospital admissions are an opportunity for staff to assess and respond to a suspected case of elder abuse. The time limitations, as well as the 'patient role', during a GP consultation is not conducive to resolving elder abuse. Access to services with a simple referral pathway for the older person should be made available to GPs state-wide and within their community. Community Health Centres (or similar, see Table 1) are a critical referral link for GPs in stand-alone practices. As one group of participants commented, it is easier to get an assessment done if the person is in hospital due to access to doctors. *"The main challenge for our inpatients to get assessed is that they resist the assessment sometimes. They don't want to be assessed. No matter how you try and explain or persuade them, they still resist, that's a sign of lack of capacity. If they just keep refusing, the assessor might just say "Query lack of capacity."* (GACHS_N)."	community living Tasmanians to identify barriers and enablers that may be transferable to different settings.
2.1iv Referral pathways—outreach services	Access to social workers in Tasmania is as close as the nearest Multi-Purpose Centre (MPC Table 3). Outreach services, however, are limited but some participants mentioned doing home visits with the community nurse. "*It's easier for a nurse to get into a home visit, than it is to a social worker. Also, you can place the older person at further risk by visiting them. If all of a sudden you have a social worker going to a home, there's always suspicion around, why is a social worker here? In the case that I talked about earlier, in order for me to see her, we organised with the existing support person who used to take her out—I liaised with that worker and I saw the older person when she was out of the house, because to see her at home, her relative (the abuser) would have known that something was going on* (GACHS_N)."	2.1ivA It is not clear whether all MPC (or equivalent) have social workers. Should be reviewed particularly in areas of the State with proportionally older populations.
2.1v Referral pathways—	In the workshop discussions, participants were asked if they were aware of, or had used	2.1vA Review use of mediation in cases of elder abuse in other

mediation and counselling services	counselling services eg. Relationships Australia. One service said they had when their service was so under pressure, they did refer some cases to them. Another said they had, but not for elder abuse. "*I find, when people are in an abusive relationship, often it doesn't get to a mediation point because the other person doesn't want to mediate. They want to have control, and they don't want to be exposed and they won't engage with services, or they'll try and manipulate the situation to try and pretend that it's the other person that may not have all of their faculties, that they're vulnerable, that they're trying to assist them. I find that really difficult, because when we see people, it's already got to a point past mediation, where they've tried to mediate multiple times. They've tried to put in some boundaries with the person, they've tried to raise their concerns, and it falls on deaf ears* (GACHS_N)." Majority of referrals for counselling come from the EAH, Legal Aid or Senior Assist.	jurisdictions and domestic violence in Tasmania. 2.1vB Reform the Family Violence legislation so that it covers cases of elder abuse within families.
2.1vi Referrals to the police	The overall response was 'rarely'. "*I find most of my clients don't want to, because most of the time it's family members. It could be their son that's committing the abuse, or their daughter, and they know that their family are struggling, and they don't want to see them homeless or they feel this sense of responsibility to be there as a mother or to be there as a father for them and have these really conflicting views around what to do* (GACHS_N)." On the occasions when the service has recommended the client take the matter to police, the outcomes were good. Other participants commented that if they had any concern that the person was in danger: "*if I had a sense of risk, any concern because the person's not answering the phone, I'm unable to get through to the person, and yet I know there's people living with them. That would be a great concern for me, and I would then contact the police. I wouldn't hesitate* (GACHS_N)."	2.1viA—Tasmanian Police review their responses to cases of elder abuse for state-wide consistency and perhaps consider a 'single-desk' unit for internal and external referrals. 2.1viB Services to review their elder abuse policies to ensure staff give a consistent response to elders at risk.

		While most participants were aware of police welfare checks, only one organisation said they used this on a regular basis. One of the main reasons was when a client threatened self-harm, regardless of their age. The option to get a restraining order is a complex and daunting process for anyone, let alone an older person. "*I have supported people to go through the Magistrate's Court to get restraining orders, but that's a real process and quite intimidating for people. They have to have evidence that there are concerns, and they have to initiate that themselves* (GACHS_N)." Similar to what was reported in the South, police welfare checks are not formally reported/entered into the database. "*Unless that information's put into the system, there's no paper trail from the police and there's no requirement to record them. Unlike mandatory child abuse reporting—because even if you think it is minor, and then next week someone else makes a minor complaint, and records it, and someone else does—it becomes a whole litany of minor reporting, that starts to paint a picture that's not minor at all* (GLFS_N)."	
3. SERVICE LEVEL BARRIERS AND ENABLERS IN RECOGNISING AND RESPONDING TO ELDER ABUSE IN NORTHERN TASMANIA	3.1 Awareness of service	During one workshop, the question arose, 'how do they know you're there/what services you provide?' One participant said through friends who had used services in that centre, and also via their GP. " '*Have you thought about talking to the social worker?' So people seem to know of us, these services, and will often just ring in to have a talk in the beginning. I find some people, it just stays there. They might come in. We provide counselling support. We try and help them understand what might be happening for them, and then talk about some support options. Some people don't feel ready, and they go, "That's it. I just want to leave it there." And other people want further assistance* (GACHS_N)."	3.1A Review and evaluate community awareness of MPC in particular, and other services available to communities—physical and cultural.

		One participant mentioned how constant name changes to services confused clients, especially older folk. The example given was Centrelink, which now includes Medicare, so the name was changed to 'Services Australia' as part of the (Federal) Department of Human Services, before that 'Service Delivery Agency' and before that 'Social Security'.	
	3.2 Assessment of capacity	In nearly every workshop, participants raised the issue of getting either an assessment of capacity done, or their unease with the assessment being too 'all or none'.	
	3.2i Assessment of capacity—getting the assessment done	During one of the workshops arose a discussion of assessment of capacity and the difficulties in getting the assessment done. If the person has been assessed as lacking capacity then it is easier for the service to step in and ensure the person's safety. However, the downside of this being that if there are no other options, the person ends up in a nursing home "*and they die—they die, because they don't want to be there*" (GACHS_N). Currently, for the Guardianship Board to step in, the assessment of capacity has to come from a medical professional. Participants discussed the difficulty a family GP has doing the assessment if the person (their patient) refuses; or for the GP to act if there has been a disclosure of financial abuse by a family member who is also their patient.	3.2iA DoJ review current assessment capacity of capacity across agencies to determine commonalities and potential for streamlining. 3.2iB Review national progress 3.2iC Can the process (documentation) be digitalised? 3.2iD Who else can determine capacity? Eg. Lawyers, nurse practitioners or police to improve the process while preventing perverse judgements.
	3.2ii Assessment of capacity—skills to do the assessment	Restricting the definition of who can do capacity assessments has a flow on effect to services struggling to support and protect the older person while waiting for a determination of capacity. "*I find some of the GPs are quite hesitant to assess capacity, seeing that as a role of a geriatrician, or a neuropsychologist. Also GP may not have seen that person that many times, and they want to try and refer them to a specialist first. We've got to try and help protect that person as much as we can, until we try and establish what their capacity is like* (GACHS_N)." During another workshop, one of the participants expressed their concern with their own ability to undertake an assessment of	All the actions listed in 3.2i above apply here as well as: 3.2iiA Access to specialists. This includes the number of specialists (have numbers increased in line with increasing age of Tasmania's population?); access via telehealth or mobile clinics; use of alternative professionals, eg nurse practitioners, to undertake assessments 3.2iiB Evaluate the understanding of 'guardianship' amongst service providers.

capacity (despite they fitted the profession criteria).

"*I don't do the assessment for capacity because I think that's nuanced and requires skills and fraught with—you know, you've got to get it right, it's really very important. We're talking about patients here with rights. So, I wouldn't do an assessment for capacity myself, unless it was someone who clearly didn't have capacity, that's OK, but it would have to be fairly clear. Most of them aren't that clear. They might have some for some decisions and not other decisions. I think if a legal determination of capacity's going to be made, it needs to be made by someone who—their credentials have to be recognised if it's challenged* (NGOACHS_N)"

Their preference was to refer the person to a psycho-geriatrician. However, they also acknowledged the difficulties in not only getting an appointment in a reasonable time, but also ensuring the person will keep the appointment. Ironically this service would also refer any suspected cases of elder abuse for guardianship without the understanding that an assessment of capacity was also required.

For community based rural GPs there is an added problem of everyone knowing each other's business, and the repercussions of doing something that negatively impacts that person's life.

"*It's just like doing driving assessments. In a rural area, taking someone's licence away from them is a bit like chopping their legs off, it completely messes their life. They can't get anywhere, they can't do anything, they can't access medical care, and it makes you the bad person, when we're supposed to be the advocate. So, to deem someone, particularly those people who have no insight, to now say, "You don't have capacity, and we're going to force you to stay in hospital, or force you to go into a nursing home," it just seems like an absolute betrayal* (NGOACHS_N)." The long-term relationships in rural health care practice

3.2iiC Develop a Tasmanian Health Pathway for elder abuse.

		can lead to a 'habituation' of the client's condition: "*I saw him every month for 18 years, at what point did he lose capacity? Like someone who's seen him once every six months will go, "Whoa, he's heaps worse," whereas I might not notice, but there are disadvantages of having long term health practitioners who don't notice changes so much, as someone who hasn't seen them for a while*. (NGOACHS_N). Another participant discussed how nurses are able to go into the person's home to do the assessment. For example: "*if a lady can't make a cup of tea in her kitchen of forty odd years, something is very wrong* (GACHS_N)." The overall support for specialist nurses, nurse practitioners in particular, to undertake assessments was very high amongst participants: "*All nurse practitioners I've worked with in the past, they've got very holistic training. They're across the board with an understanding of holistic care, mental health, and already have training in capacity type issues. I feel that the transition for them to go into elder abuse type areas is probably easier than say other health professionals. In the hierarchy of medical/health professionals, they are highly considered—they've got prescription authorities, that most health professionals don't have* (NGOACHS_N)."	
	3.2iii Assessment of capacity—having capacity, but limited options	A peculiar conundrum for health care services in particular, where a client has capacity but makes decisions that the service considers (knows are) risky either because the person is afraid of their family or they don't want to go into a nursing home. "*It's the issue of capacity that makes it a problem. And you find that some of the patients will want to return home, be concerned about returning home, because there might be an indication of abuse. But when you want to take it further with them, they then clam up, because they don't want issues with the family member when they return home. And they want to be able to remain at home and not go into a residential facility* (GACHS_N)."	3.2iiiA Government needs to take this seriously with a 'whole of government' response to prioritise older person rights and protections. There will be another Janet Macozdi. 3.2iiiB Review service understanding of human rights. Why do health professionals struggle with, or see conflict, with client autonomy particularly in the acute health service sector? 3.2iiiC Research with older Tasmanians what they need to safe and supported in their own home.

One service in particular, that had been in operation for many years with older clients they know very well, source information about changes to the client's situation from a network of other services that also work with that client. This is particularly useful when the client is, for example, developing dementia—at what point they are starting to have problems with managing their money and spending, or is the report a problem suspicious of abuse rather than an ongoing decline in capacity. This gradual approach to assessing capacity over time was discussed in a separate workshop of a community-based service: "*for us in the community we probably work with someone for, say, three or four months to see how things go over time, and to see if that's actually working. Sometimes that can be enough. Sometimes it's not enough* (GACHS_N)." The approach of this service was to add-on services, or interventions, as concerns over the person's capacity increased: "*We always try and look at, 'Okay, well, what sort of resources can we put in place to try our very best to help protect that person?' So, for example organising direct debits, helping to advocate on behalf to, say, Aurora, or TasWater, or any outstanding bills they have, and look at sorting out payment plans for that person, and linking them in with services like financial counselling, in an attempt to try and help protect that person some way.*

Sometimes looking at opening a different bank account or contacting Centrelink. Say if they've got a carer who's not fulfilling their obligations, to actually notify Centrelink and let them know, and play a bit of an advocacy role there as well. So even—yeah, so especially when there's concerns about capacity, about trying to pull those resources together to do as much as we can to protect that person (GACHS_N)." This service also applied for Guardianship and engaged the Public Trustee on a "frequent" basis.

However, as pointed out by another group, the service needs consent to engage with a person from the outset. It is not uncommon for concerned family, for example, to call the

		service "worried about mum's capacity to manage her finances". Without consent from the older person the service can't act, except perhaps to flag concerns with the person's GP if possible. If there is a known history of mental health issues, then the person may be compelled to attend a psychiatric assessment under the Mental Health Act.	
	3.3 The role of the Public Trustee	One participant discussed a case where the client was already known to the Public Trustee, placed as the administrator, but they—the Public Trustee—were not aware of a coercive plan to change the client's will. The point being that just because the client is already on the Public Trustee 'books', being able to intervene to prevent financial abuse is only going to happen if they (the Public Trustee) are informed, especially if the client lacks capacity. The role of the Public Trustee is not clear to the general public and is not the "*not the financial 'catch-all' they are generally thought to be* (NGOLFS_N)."	3.3A All this discussion leads back to the overarching, primary recommendation of this research, to establish an investigative and regulatory body with power to investigate, adjudicate, make a determination, and enforce the determination. 3.3B Evaluate the role of the Public Trustee in cases of elder abuse in Tasmania with a view to learning how the organisation can be strengthened to investigate and manage existing clients and develop understandable pathways for Tasmanians to access services. 3.3C Impose a duty on financial institutions to have a responsibility to act on their suspicions of inappropriate access to accounts. A public investigatory and regulatory authority should be established by legislation for this purpose. Define financial institutions to include any body, whether incorporated or unincorporated, that has dealings with an elder person's finances.
	3.4 A lack of Legislation	***"Would that be the anticipative hope from this research that you're doing, that there will be changes to the legislation? That would be good (GACHS_N)."*** There is no specific 'elder abuse' crime in Tasmania, nor specific legislation addressing elder abuse in Tasmania. This has implications for dealing with elder abuse in terms of its recognition and responding to it. It also has an impact on data collection in services such as Tasmanian Police. With no data there is no ability to do a statistical analysis of the extent of elder abuse in Tasmania or measure the impact of any interventions. The concerns around legislation failure,	

		and the impact this has on older Tasmanians is the same as discussed for the South of the State. It has emerged as an overwhelming barrier to services trying to act to protect older Tasmanians.	
	3.4i Legislation—limited powers vs Safe at Home legislation	Because many of the participants have experience across services, they were very aware of how the police are empowered by the Safe at Home legislation vs dealing with elder abuse. "*I think police are quite limited in what they can do. Because again it comes down to consent. Under the eyes of the law, everyone has consent until proven otherwise. There has been occasions where I have called the police to help with welfare checks. But they can't remove, someone from the property, unless the person's insisting that they have to leave* (GACHS_N)." From another participant with years of experience in the family violence area "*what we're hearing from our own clients is that it would upset my son, or my wife, or my—you know. I don't want to face it or deal with it, I just want it to stop. So, it's a tricky, tricky area, which the same sort of words would have been said in family violence* (NGOCS_N)." Participants sympathised with the police, recognising that they have limited powers to act, unlike under Safe at Home. "*With the Safe at Home legislation, it's entirely different. Where the police do have that power to put in a police family violence order and intervene, we don't have that with elder abuse* (GACHS_N)". The 'gap' between the Safe at Home legislation and elder abuse boils down to the onus being on the older person to report. "*Whoever made the call, that the police would respond, so the onus in on the police to assess and decide. That's the gap for me. It's on the record, and there's case management and all of those things are put in place* (NGOCS_N)." One participant was adamant that elder abuse, like child abuse, should have a mandatory reporting requirement: "*Like a mandatory line, not an option line, that has a discretionary component. Then if you had any suspicions that you must report, the same that you do for under 18. Then that can be a discussion with that particular body of the way*	3.4i Start by redefining in the Family Violence Act, the definition which is currently limited to intimate partners to extend to other forms of family violence. 3.4i B A DoJ evaluation of current processes under Family Violence Legislation, to consider: - Past five-year review of clients with breakdown of services used by age group. - Cases where definition of 'family' has restricted access to services/protections by older Tasmanians. - External review of equivalent State and Territory legislation with focus on older Australians and definition/s of 'family'. 3.4iC Use the already functioning and known Safe at Home service and reporting structure as a template for a Tasmanian framework for elder abuse and extend their application to elder abuse. 3.4iD Expansion of powers to the ombudsman to investigate elder abuse. 3.4iE Make the Public Guardians a public advocate (other States) to have strong powers of investigation and intervention. 3.4iF Need a Minister for Ageing (e.g. Victoria) or, establish a Commission (similar to NSW) to achieve a focus of attention and endeavour in building responses not otherwise achievable. 3.4iG Establish a complaints investigation body with power to investigate; adjudicate; make a determination; and enforce the determination.

		to proceed. But at least it's being reported and it can be dealt with (GACHS_N)." As participants noted, unlike children deemed to be too young to make a decision, family violence becomes "*everyone's responsibility*". For older people, they may be able to legally make their own decisions, but are vulnerable to abuse. One participant noted "*I have a work with children and vulnerable people's card, and I'm so glad they put "and vulnerable people" on there because it's not just about children. There's already a mechanism to call if you're concerned about a child. I wonder if we could expand on that to include disabled or senior. Also include elder abuse in the training to get the card* (NGOCS_N)." The other comparison made between the family Violence response and elder abuse is the speed of the response, both legislatively and in practice. "*Colloquially, the legislative frameworks that are available for elder abuse, are about 10-15 years behind family violence. If we're looking for advocating for legislation changes, we need to recognise that elder abuse needs to have a quicker response style available to it, that is similar to that which is available for intimate family violence vs trusted relationship violence* (GLFS_N)." Again, from the perspective of having worked in both areas, one participant described the differences in the experience of the support for victims of family violence compared with elder abuse: "*As soon as it's not intimate partner, even if it's within a family, you have to sue someone, you need to go through a different court, different mechanisms, different laws; much harder. That's the gap, the biggest gap that I can see is not only having a lack of laws, but also the supports in place that you require when you have these sorts of laws* (NGOCS_N)." This participant noted that from their experience these laws (Family Violence) changed the culture within the police force in how they respond to family violence.	
3.4ii Legislation—	"*We're very hamstrung as a service, to deal with something where we can't access the client—because the older person is our client.*	3.4iiA State Government to develop legislation, similar to 'Safe at Home', whereby any

	third party referrals	*So we'll have concerned people write to us, or make a referral and say, "Look, we think this is happening to our father, but our sister won't let him talk to you, and he's too scared to say anything." Because of the way we operate, we don't have any legislative authority to go in there and say, "Hello, I'm so and so, I'm an authorised officer under whatever—I'd like to talk to your father please"* (GLFS_N)." The concern of the participant saying this was that if a report is made by someone else, it leaves the older person in a very vulnerable position if access to the older person is being blocked, or the older person denies any abuse is occurring from fear of the abuser. This is also true of access to residents of nursing homes. The service can't investigate the referral without the older person's consent out of respect for their autonomy, even if the service identifies significant indications of concern.	referral can be investigated while ensuring the older person is supported and protected by knowledgeable services.
	3.5 Networking	Over the course of the research, it became evident that professional networks provided the strongest referral links across the state. In particular, social workers who, for example, conferred with other social workers in network including drug and alcohol services, prison support, family violence, Centrelink, community health, acute care or anywhere, in any agency (state, NGO or C'wlth). By contrast, one participant mentioned his network of people came through his sport club. Every service working with older Tasmanians should be required to network within Tasmania and nationally where-ever possible.	
	3.5i Networking —central to elder abuse prevention	One workshop group expressed frustration with the tendency of other services to "pass the buck", the client, if there was a suspicion of elder abuse. It was discussed how these other organisations did not feel obliged to that responsibility on, unlike a case of child-abuse: "*if it's a potential child abuse case, services who have the responsibility to report—and I guess it goes back to the fact that there are mandatory obligations related to child abuse—there is a much bigger tendency to actually do the reporting themselves* (GACHS_N)." Two reasons why this is a problem, (a) the requirements for the older person to then retell their story, for the service to gather the necessary background information, and to gain the person's trust is an added burden for the older person; and (b) the service itself is not resourced to take on a referrals from	3.5iA Support service networking within Tasmania and nationally by writing networking into service-work and individual job descriptions. 3.5iB A service level referral flow-chart should indicate to staff that there are two referral pathways. Intra-service referrals to show how staff interact within the service to address elder abuse; interservice referral pathways—most commonly to the Elder Abuse Helpline. These two sets are embedded in the external networking context (there may be more than one) specific to the service. E.g. the

		similar services already responsible, and funded, for that person's care.	National Elder Abuse Policing Network plus SEAPAC. 3.5iC A centralised case-management model would ensure clients are directed to one service at a time, and it becomes the responsibility of the service to refer the client as well as informing the central case-management of changes. 3.5iD—Consider the establishment of a Tasmanian Elder Abuse Commission, for example, which can sit outside the bureaucracy of everyday government business. 3.5iE—Develop a very short elder abuse checklist with targeted referrals
	3.5ii Networking—open doors everywhere	Arising from a discussion about EA awareness, one participant described how his service had been funded to provide a specific service targeted to older Tasmanians and their families. Up until then his experience of elder abuse was limited, but after attending an elder abuse conference, as he said "*my eyes were opened*" and at the conference he began talking to other Tasmanian services working in the State. From this began a small group who meet informally to support each other's work: "*people realising that they're not in this alone, there are other services* (NGOCS_N)." This participant also noted that from his perspective, the most common frustration of the group is the ongoing lack of funding as well as not being able to protect the older people being abused. In another workshop, participants were asked if they were aware of a 'north/south' difference (see also 3.4). They disagreed that there was less elder abuse in the north than the south, rather it was less reported and cases were less supported. "*I think the reason there's less reported is we don't have the proper infrastructure for it. Whenever I have an elder abuse case, what I have to do is create a little team of all of the people working with this client. I have to replicate that work every time. There's no network. There's no elder abuse provider network. Every service*	3.5iiA Encourage services to develop communication teams at a local level. 3.5iiB Centralised case management to ensure clients are either not 'falling through the gaps'; or being seen across multiple services.

		that deals in any way with the elderly should have a liaison person and referral pathway for elder abuse that can be automatically triggered when a case comes through <u>any</u> door, <u>any</u> service. There should be no one-door policy—there should be open doors everywhere, and immediately, everybody should know who the elder abuse liaison is for any service (GACHS_N)." (see also 3.6i)	
	3.5iii Networking —sharing information	A significant barrier to inter-service collaboration is information privacy. One service has a made an arrangement with their key community agencies around what sort of information can be shared. The client is included in these arrangements. There is also implied consent. For example someone calls for help with a payment which involves the service contacting the biller on the person's behalf. A certain amount of information has to be shared in order to help that client out of their predicament. A very common-sense approach. There is a strong sense of common-purpose from participants and a great willingness to develop community-wide partnerships to help their older clients. "*With our organisations, our relationships have been built up over time. By us doing our roles, getting out, being involved, spending time with them, e-mailing them, constantly phoning them, constantly—regular visiting services, getting to know all the staff and them getting to know our teams and all that kind of stuff—and that's how we've been able to build up that ability to talk to each other and communicate and know what's available, know what each service is doing. They know what we can do. They have our contact details, our e-mails, our phone numbers and all that kind of stuff. And we have always built that relationship in a very strong way here in Tassie, which has enabled us to be able to share information and share services and refer customers when needed* (GCS_N)." (see also 3.6i)	3.5iiiA What would a 'common-sense' approach to information sharing look like? Evaluate examples in Tasmanian practice to demonstrate how information sharing meets legislative 20,21 and community standards.25 Determine the progress of any current developments in Tasmania with respect to the establishment of inter-agency data integration systems and programs. 3.5iiiB DoJ to evaluate recommendations of ALRC Report 10822 and current review. Conduct forums with service providers—government and nongovernment—to determine best practice and develop service level education that promotes interservice communication that is in the best interests of clients. 3.5iiiC DPAC to report on progress with the national Data Integration Partnership and how it can be used to prevent elder abuse in Tasmania.
	3.6 Resourcing: monitoring demand	All participants wanted more resources to increase their capacity to help their older clients at risk of elder abuse. The cases are complex and talking to older people themselves takes time. Also, the response to the abuse is not simple.	

		Making sure the wishes of the older person are respected is more complex than simply extracting them from the situation, for example. Participants did not ask for increased resources specific to elder abuse per se, but services are experiencing an increasing complexity of cases due to the ageing of the population, as well as increasing community awareness that there is help available.	
	3.6i Resourcing—as awareness grows, so will referrals …	"*The more awareness there is, the more referrals there will be, the more staff we need to respond. We need staff who also have the time and drive and so forth too. We need that promotion, that awareness, that there are services here. It's a bit of a loop really*" (NGOCS_N)." Some services expressed concern that not only will their service reach capacity, but also when their service is not appropriate for the case, that there will be nowhere to refer the older person for help. "*If they say, "No, I'm not going to be in a room with that one*" (the abuser) *then we can't do anything, but that doesn't change the situation. I suppose it's more, who do we refer on to? That's the biggest concern for me at this point in time* (NGOCS_N)."	3.6iA With input from key services, develop a monitoring system to alert government to increasing demand on services. For example, monitor the number and type of calls to the Elder Abuse Helpline. 3.6iB Evaluate national prevalence reporting. 3.6iC State Government to liaise with Commonwealth aged care services to establish processes for routine reporting of elder abuse in Tasmanian aged care (residential and community). 3.6iD Networking and communication, for example via the elder abuse prevention 'champions', to improve service level understanding of the role of government in elder abuse prevention.
	3.6ii Resourcing—services are limited by funding restrictions	Some services are restricted from providing a comprehensive service by their funding. This means they need to refer the client to another service rather than providing a continuum of care. This also results in the older Tasmanian having to repeat the trauma of their story over and over: "*elderly people that have got to tell the same story to three different people, and then possibly still get told, "Well look, there's nothing we can do for you. You'll have to go and see someone else"* (GLFS_N)." Staff need to take time because the stories can be "*quite muddled and scattered*" and traumatic: "*asking those questions is about trying to narrow down what's actually happening, with people that are struggling in some form of trauma, or traumatic event that's going on in their life* (GLFS_N)." Other services are able to be more flexible, mainly providing services to clients 65 years and over (unless Indigenous clients) but will	3.6iiA Establish a complaints investigation body with power to investigate; adjudicate; make a determination; and enforce the determination. 3.6iiB Concurrent with any increases to staff, for example, efficiencies can be made if a cross-service, case-management model is adopted. 3.6iiC Government and NGO funding to services with older Tasmanians as clients needs routine evaluation with 'markers' of stress. E.g., COVID has increased and changed the workload of some services who are then too busy adapting to changes, to have time to call for help.

		also manage clients with younger onset geriatric conditions.	
	3.6iii Resourcing—transport	"*There's one bus to Launceston, and one bus back from Launceston per day. There's a community car that may or may not happen, but the community car stacks people up and so take four or five people and they'll have to take them all to their appointments. So, mostly those people are sitting in the car all day, or there's private car, and the taxi costs $240 because you have to pay for a return journey. So, if you don't drive, you're a bit stuffed (NGOACHS_N)*." This participant wanted to see an increase in community transport options, especially for older people: "*Elderly people are not accessing health services, because they can't get there, it's as simple as that* (NGOACHS_N)." Not just a problem in remote areas of the State: "A*lthough we are funded to cover all of Tasmania, the practical side of that is having a car, and potentially I'd say driving somewhere, having a practitioner, not out of the office for just a day sometimes, and even if it's a day and back, it's very hard. As well, as some potential clients that are not mobile, and not able to come to our office. But we did, something that we did find through COVID was that we could do a lot more over the phone than we thought we could. The other thing is that our clients are not always tech savvy, or they don't have access to a computer or smart phone, and even if they do, they still really want a face to face service* (NGOCS_N)*."* In another workshop the participants discussed how they did cover as much territory as possible, but they were not sure if they were contracted to cover those areas. Another group noted that their team based in Burnie/Devonport had a lot more travel time as they covered the entire NW.	3.6iiiA Review existing services but there is already a need increase community transport for elderly.
	3.6iv Resourcing—community referrals take time	During one workshop the participants (community based health) discussed the time difference between 'getting things done' in the acute sector vs the community. "*In the community it's hard. I'm meeting a lot of people who aren't even engaged with their GP—we might be their only service they've accessed for a long time. It can take a number*	3.6ivA If community services can't act on referrals, then risk for the older person escalates. To interrupt the cycle of abuse, establish a complaints investigation body with power to investigate; adjudicate; make determinations; and enforce those determinations.

		of months to start to build a bigger picture, to start getting services involved. But that can take a long time. In the community setting, that can take us a long time (GACHS_N)." Once a service has established a relationship, and is providing services to a person, then there is 'implied consent'. For example: "*if we've already been providing a service, and it becomes evident that there are some concerns around the capacity, we will try and talk to the person about some of our concerns. In that instance, I don't believe we need consent from the person to go and raise our concerns to the GP or the mental health helpline, because that's where duty of care steps in* (GACHS_N)." However, if there has not been contact with the service before, there is a barrier to helping an older person who may be refusing services getting a capacity assessment done in the community: "*with community social work we need a person's consent to provide support to them. And that's a challenge. Sometimes we do get referrals where there are concerns around capacity, or there are concerns that someone's very vulnerable, but we don't have any statutory powers to intervene without the person's consent. I often have to try and re-refer them back to the mental health service that have the crisis assessment plan* (GACHS_N)."	3.6ivB Support community services to promote awareness of service availability to older Tasmanians and other services. 3.6ivC Build on the success of the "No wrong door/The Right Place" program2 to identify and strengthen current formal and informal connections between services and improve access to services for older Tasmanians. In this program the hairdresser, for example, can refer the person to a service that might help them more directly. 3.6ivD The extra time it takes to provide a service for older people living in the community requires formal recognition in community sector business cases/budget. The ACOSS (2019) report identifies a widening gap in increasing demand with static or decreasing service budget allocation.
	3.6v Resourcing—meeting increased demand for aged-care services	As one participant pointed out, the more staff know about elder abuse, the more staff will be needed to respond to reports of elder abuse. "*There is increasing demand for aged services, but it only ever revolves around money, not about actual need*" (GACHS_N) Some participants expressed frustration with the static response of government to Tasmania's changing population demographic: "*when are they going to take older people as seriously as they do younger people? New resources, younger people. New legislation, younger people everytime* (GACHS_N)." One participant commented that their service had been running for over twenty-years but the staffing has never been reviewed. When staff	3.6vA Recognise and value staff experience in being able to interview older Tasmanians through subsidised training and job description. 3.6vB Develop, in collaboration with experienced staff/services, compulsory training modules for identifying and dealing with elder abuse targeted to specific services that work with older Tasmanians. 3.6vC State ministers take up with the federal Government remuneration for GPs so they are able to provide care for Tasmania's ageing population.

are spread 'a little thin', the temptation is to not engage in a suspected case of elder abuse: "*it sometimes takes an effort of will to make the leap to taking on another task that could be fairly complex* (GACHS_N)."

A lot is said in the media, politicians and public expectation, that the responsibility for the health of residents is managed by their GP. To what extent this is the reality is debatable. A point of discussion during the workshops was the time and associated cost borne by GPs to visit and care for older Tasmanians who also happen to live in residential aged care. "*The majority of GPs have nothing to do with nursing homes and the geriatric side of things—they will avoid it. It's not well paid, it's not well looked after, we're not trained to do it, we don't feel comfortable, it's uncomfortable and time consuming. You can't see an elderly patient in 10 minutes, you've barely got them sitting down before 10 minutes has passed, you've probably got them in the door, let alone look at their baby photos and you know, actually treat them like people. It's not just that they want more funding, it's just that there needs to be an understanding that talking to elderly people takes more time, and as well as the time it takes to drive to the facility, access health records, talk to staff and so on, the day is gone and I have less time to spend on activities, and patients that can physically come to my clinic, that are more realistically remunerated* (NGOACHS_N)."

Another service expressed gratitude that their MDT included a doctor which improved client outcomes if a case of elder abuse is suspected. This also saved time for the client needing assessments and referrals.

Having the right staff saves time and ensures older Tasmanians are not further traumatised by inexperienced questioning. "*A lot of what we do, we wouldn't necessarily name up on the day as what we're doing—but our staff have the use of empathy, reflection, all that*

		sort of communication skills that we have, that's been part of our life for such a long time. We do it without even being aware of it (NGOCS_N)." Another service workshop discussed the best assessors were a team of social work, occupational therapists, nurse practitioners, doctors and physiotherapists. "*Physio and social work—because there's often persistent pain related issues that are linked to the frustration that carers are feeling around their elders. So, under-medicating elders who've got persistent pain conditions, or over-medicating them, is a major form of elder abuse that we don't talk about. So, having physiotherapy and clinical social work—not welfare social work—clinical social work in a designated team* (GACHS_N)." This is stated from the health service perspective. The addition of a solicitor to the team would be beneficial too.	
	3.7 Are there any North-South differences?	The majority of participants in both north and south of Tasmania did not think there were significant differences between the regions. Differences do arise, not because of the 'Boag's Border' but in regard to: • Distance from major population centres and services • Access to a MPC/Primary Health Care with allied health services on-site • Transport • Social and rural isolation As an example of social isolation, one participant who had worked in both parts of the State, said that the worse elder abuse she encountered was in an outer suburb of Hobart. "*I was very shocked …. when I moved to (outer suburb of Hobart) just how prevalent elder abuse and this sense of social isolation was for so many people who live so close to town. They feel very, very isolated. It doesn't matter if they live at X (rural town) or if they live at Y (urban suburb). If you can't get out, you can't get out. I had to take one lady to Hobart, to a guardianship hearing. She had not been to Hobart from (outer suburb) for eight years* (GACHS_N)." House boundedness, it was	3.7A Tasmania to consider an elder abuse 'observatory' of referral patterns to ensure that elder abuse referrals, and access to available services, is population and needs based. 3.7B Establish a state-wide complaints investigation body with power to investigate; adjudicate; make a determination; and enforce the determination.

noted, also occurs in younger clients with mental or physical disabilities.

One participant expressed concern that their service was not getting referrals from areas with large proportions of older Tasmanians: "*I'm really surprised 'TownX' hasn't been a really busy part of the role for us. Because 'TownX' has got a huge amount of elderly people. I think it's probably got the largest amount of elderly people in Tasmania. Yeah, it's massive! Because—you know, I've worked in the TownX mental health services—and that was where we found that there was a lot of older persons mental health issues. And I don't think that they're—I don't know what the stats say, but I think if you've got a population of older persons that have got mental health problems, you're probably going to find that all the risks of the problems that older people suffer from are going to be there as well* (GLFS_N)."

Overall, participants agreed that the type of agency tends to be the same regardless, however: "*like anywhere, we may have a slightly different relationship with the Salvation Army in Burnie than we might do in the Salvation Army in Launceston just because of the particular programs that each community agency runs. I can't really think of any obvious north/south type issues that really resonate* (GCS_N)."

Appendix 2 Vignettes

Vignette 1. Mrs Janet Mackozdi

Janet Mackozdi, 77, died of hypothermia in July 2010 while sleeping in a converted shipping container at her daughter and son-in-law's Mount Lloyd property. Five years later, Jassy Anglin and husband Michael Anglin were convicted of Ms Mackozdi's manslaughter. At the inquest conducted by Coroner Olivia McTaggart, we heard that Mrs Mackozdi was in the advanced stages of dementia, and was frail and underweight at the time she died, due to significant neglect by her family who were responsible for her care. This case is troubling because Mrs Mackozdi saw many different services over the three years prior to her death. The obvious question is why didn't any of these services identify that the family were not adequately caring for this increasingly frail woman and intervene on her behalf so she didn't spend the last moments of her life in a freezing shipping container.

Coroner McTaggart asked PEAT to address key questions to be included in her final report (Coroner McTaggart 2019). Given access to the available information surrounding Mrs Mackozdi's final years of life prior to the inquest, PEAT found a troubling trail of contacts with services that could potentially have intervened in her decline to death brought about by the actions (or inactions) of her family. Summarised in Figure 2 , Mrs Mackozdi's (MM) increasing dependence on her family starts in late 2007 when she sold her house in Sydney. At this point, MM sees her long-term financial planner who is concerned that MM is confused. The family reassure the planner they will be caring for MM, and that they are all moving to Tasmania. From here until her death in July 2010, there is a trail of interactions with aged care, GPs, pharmacies, allied health, banks and real estate agents (Figure 2). At some points along the timeline, concerns were raised, but the family, especially due to their health-care backgrounds, were able to convince the GPs they visited for example, that they could care for MM. Further insights from this complex case are included in parts of this report.

Vignette 2. Abuse as being what the person determines to be abusive

An elderly woman, she lives with her son. The abuse has been along the lines of pressuring her to buy an object, for a large amount of money—she hasn't wanted to do that. There's also been an instance of physical abuse in the past—that she hasn't acted on. There appears to be some overseeing or restricting her ability to communicate with other persons –in my practice I tend to look at abuse as being what the person determines to be abusive, rather than what I think is abusive. It comes from a perception of a trustful relationship (NGOLFS_N).

Vignette 3. Elder abuse is a 'hidden' crime

With our service, it is one of those things that we have in the back of our mind, when we get a referral about an older person—it's just one of those things that we will factor into our screening and our assessment, and having an understanding that elder abuse is a lot more than just physical abuse. More often than not it's very benign, it's hidden. People are very ashamed to talk about—it can be emotional, it can be around not giving the older person control over their decision making that impacts on them and things like that. So, I think, looking back at myself now (since receiving training) I've got a much better understanding of the extent of the problem, of the fact that it's hidden—people don't talk about it in the same way that they talk about other forms of abuse, and I also have an understanding of the complexity of the processes in place and the lack of legal tools to actually support us. And even the lack of resources generally to support us, to actually provide the assessment and the follow-up and the care for the older person. (GACHS_N)

Vignette 4. It's stealing

We hear from the families (more often than not being adult children), phrases like, "inheritance impatience" and things like this. And it's quite an astounding terminology, when really in any other format it would be called stealing. You can't just take anyone else's property off them for no reason. But as a person gets older, families seem to think it's okay to sell their houses. (GLFS_N)

Vignette 5. What constitutes abuse?

And what constitutes abuse? If Grandma's biting you, giving her a smack may not feel like abuse to you. No, what do you call abuse? Is it if you're not showering Grandma more than once a week, or once a month, is that neglect? If she's losing weight because she's not eating enough because you haven't fixed her teeth, is that elder abuse? Well, probably it is, but people wouldn't necessarily see—they wouldn't call it that, they would just say, "Well, I'm just doing the best I can to look after Grandma, and there's no bloody services." So, I think people understand what abuse actually is, but I think the problem is that once you say, "This is what abuse is, this is neglect," then what do they do about it? If they go, "Well, you know what, I'm not doing the right thing by Mum, now what do I do?" You can't get a level four package, you can't get a nursing home thing, it costs $400,000 to get into a nursing home bed, and we don't have that sort of money, we don't own our house, you know. So, what do they do if they suddenly do realise there's some neglect going on in their family, when there is no way they can address it, or do something about it, or reach help? They can go to their GP, which is going to be the ad campaign's advice—go to your GP, and your GP goes, "What do I do about it? Stop hitting your mum." Yep, so it's complex, it's a social thing. It's at all levels from the grassroots up, education right through to government policy. That's why it's so hard to address. (NGOACHS_N)

Vignette 6. Normalisation of abuse

Probably the most difficult thing in that case was the woman's own viewpoint and understanding what was happening. Yeah, is this a usual situation? Because it had become so normalised for her. But for me looking from the outside in, the physical, emotional abuse, the financial abuse that was happening was just so completely normal for her. It had been that way for however long and was something that she wasn't even thinking about. I think there needs to be more education in the community. We're talking about the issue of people not identifying that they are being subjected to elder abuse and that could be because it's been a process overtime that becomes the normal, habitual, or it could be that culturally, they just think that that's okay or whatever (GCS_N)." This participant added that even if the person recognises they are being abused, they then have to know where to go for help.

Some participants were aware of the recent elder abuse awareness campaign but were ambivalent as to how it would help someone experiencing abuse. "When people are in these situations, that sense of powerlessness and loss of control—and a lot of these things that we're talking about, about making contact with someone or telling someone, that becomes beyond them to some extent or a really, really difficult thing to actually summon the courage—even the ability to be able to do that is compromised. They fear they would lose what little control they have and make their situation worse (GCS_N).

Vignette 7. Elder abuse in other cultures

I was quite surprised, moving to Australia and learning about the way that older people are actually perceived in this culture, compared to where I'm from. I'm from cultureY, where older people are—the older you get, the more respected you become and your wisdom as an older person—whether you've got a little bit of memory, duration is never second guessed. So, we tend to put a lot of emphasis on looking after our older population. But when I first came here, for the first time in my life, I started hearing people actually having jokes about an older person or joke about when they have—it's a very different culture. (GACHS_N)

Vignette 8. Helping an older child with a loan

A woman approached us for help with what she saw as financial abuse. The situation was what the woman saw as being a loan of money to help her adult child establish a business. That business failed and went bankrupt, and the person had some mental health issues following that, some depression. Now the situation presenting to us was, "I lent this money to my child, they've never paid back a cent, and now we just don't talk about it because it upsets the family."

They skirted around the topic and that they avoided one another and would only in fact catchup at Christmas or a special occasion, and even then, would not talk about it. The woman came to us thinking that our service would

make the person pay back the money. Our service agreed to assist. In the first meeting, the person thought that the money was a gift, and that his parent was ashamed of them, due to the failure of the business.

Even though the person argued that they thought it was a gift, it seemed very much as though it was a situation where one person was taking advantage of another, and the parent thought of it as abuse. The person viewed things differently. However, after some rethinking, they could see yes, this could be seen as elder financial abuse. So, but I suppose it was more the fact that they didn't see it as any form of abuse, it was just it was about the money, and it was about the business and the failure of the business from the person's point of view. From the parent's point of view, it was about the loan as opposed to the gift, and that he thought the son was using his relationship with his family as the only way to keep in touch and avoid repaying the loan.

For the parent, the most important thing was having acknowledgement that there was money given and basically, they wanted to hear the word sorry. They wanted to have an apology, they didn't really care about the money, although they would have liked to have had some paid back, but ultimately, they'd much rather be happy and have the family happy and so forth. The person wanted to be able to pay back what he could, and was quite genuine in that, or seemed to be genuine in what he was saying to that, and that the parent agreed to that. (NGOCS_N)

Vignette 9. There was no option except a nursing home

I'll give you an example of institutional abuse. I don't know if you've heard, but in independent living units the rent is about to increase. It's already $800 a fortnight. So, I've got one lady at the moment who actually has no choice but to go into a nursing home. And that is not her wish. Her wish is to stay independent. The problem is she can't access social housing because she's considered housed.

So, she's not considered a high priority, meaning she'll be waiting for years for public housing, and public housing for a lot of other people is not appropriate, because they're often mixed in with people of all different ages, where they're quite vulnerable and they're targeted. In terms of independent living units, for older people there aren't any affordable options. It is not affordable. $800 a fortnight is not affordable. One lady I'm helping at the moment, she's actually moving into care. And I don't want her to move into care. She doesn't want to move into care, but we actually don't have a choice. There is nowhere affordable for her to go. (GACHS_N)

Vignette 10. It's grassroots

In the past we had only a few kids going through to grade 12, and that grudgingly. So, starting from the very bottom up, lack of education, lack of social structure, lack of activity for children, the kids move away so the elder—the older people, their children are often elsewhere, because there are no jobs here. So, their kids and grandkids are often not present. Their carers might be their neighbours. The neighbours, are not particularly beholden. They're often good people but busy or sick themselves. We have one psychogeriatrician that I know of. I mean, I don't even bother referring to him, you can't get hold of him. There's an older person's mental health team that's in Hobart, which is actually quite good, but its in Hobart. There's just lack of access, but even if we could get these people to the doctors, there just aren't enough people doing assessments. There are not enough psychologists, psychiatrists, there's not enough support in any sort of aspect of mental health including geriatric mental health etc. It's just this scarcity of pretty much everything, and it's grassroots.

Q: Sorry to interrupt, I was thinking aged care services, do you find that there are enough of those in the community?

A: Level four package is well, they say 18 months but probably will never happen. That's the highest level where people need the most desperate help, and forget it, it doesn't exist. So, that's why it's good to have the hospital, because we often look after these people in the hospital, but it's not very nice for them there.

Q: Do you have any long-term patients in the hospital because of that?

A: We do, we have people awaiting placement, but it's not like some units where they have them for years and years, we would have them six months, hopefully no longer for their own good (NGOACHS_N)."

Vignette 11. Online services enable elder abuse

(The family member had) broken into the older person's online accounts and changed passwords or applied for advances and things like that. We advised the older person to contact the police and put in a report. And there was one lady, her granddaughter, had done that and had taken quite a bit of money from her through her Centrelink account. She had also done it to a lot of other people and they were actually taking her to court and there were charges against her.

To be able to get the money back for that older person, we've got to be able to prove that it was fraud and that the older person hadn't given permission for the money to be taken out of the account. That's the hard part—getting the older person to go to the police, make the police report, bring the police report back to us so then we can then work to reverse the fraud. It's embarrassing for them to go down to the police station and say, "My daughter/my granddaughter/my son has done this to me (GCS_N)."

Vignette 12. Cultural awareness in service provision

Person 1: I think it's a cultural thing. I mainly deal with refugees. And those cultures have a totally different, greater respect for their elders and the family dynamic is completely different. They're also more reluctant to disclose anything like that. But we have a lot of trouble with family violence in general, and disclosure of that in these communities. It brings shame upon them and their family and the community if it's talked about. There are different cultural barriers involved. I think it's a combination of perhaps—and this is just from what I've known and I don't know if this is right via studies or data, but perhaps less incidences of elder abuse, in general, in those communities because of the great respect that they have for their elder relatives and the care that they tend to provide. They tend to all pitch in as a family and look after their elder relatives instead of shipping them off to nursing homes and whatever or getting other parties in to help care. I suspect a combination of that, as well as perhaps the stigma attached. I like to think that it just doesn't happen as much. But I don't know for sure. I worry that it's swept under the carpet. It's not spoken about. It's taboo. You have to really, really build rapport and gain trust with someone for them to disclose to you that that is happening in the family. So yeah, not sure.

I find it interesting that a lot of cultures outwardly express a greater respect for their elders, cultureX, particularly, is one I'm looking at. We have so many cultureX customers that are on a carer payment, carer allowance for caring for older relatives. It's standard what they do. But you're right, it's just what they do. So therefore, any potential elder abuse that comes along with that is just what happens. I've never done outreach about elder abuse, but I have about family violence and it is a really difficult subject to broach with these different cultures because you've got to get them to recognise it to start with. What is it? You see their eyes go oh when you start talking about different types of family violence and they went, "Mm." And you think: Mm, something that they don't even realise. They don't recognise it as an issue. So yeah, I assume elder abuse is similar.

Person 2: I'm working in the indigenous service space. I have been here less than a year, and none of it's been brought to my attention in that area. I'm not saying elder abuse doesn't happen. I'm sure that it does. But it's not something that's been broached or discussed with me. I'm new into the area, so I haven't gained the trust or the confidence of the community yet to probably discuss that with me. But then again, none of our longer-serving staff have spoken to me about it or mentioned any situations that are happening. When I was working front of house, I did deal with a person whose partner had severe dementia and was physically abusing them. The person would come in and used to come in on a regular basis to see me. And I think that was just about—to have someone to talk to because they were looking at convincing his family that they needed to put the partner into a home and all that kind of stuff. But the person was hiding the fact that the partner was physically abusing him, and the person would show me the marks and the bruises and everything up their arms and all over their body where the partner was attacking them. And that was really difficult to deal with, on a personal level, because I was—there was my line of what is my job and what isn't? And my job was, yes, I needed to make sure that the person was safe, refer the person off, make sure they were getting some assistance and counselling and all the rest of it and not wanting to do what I really wanted to do, just take him somewhere safe immediately. (GCS_N)

Vignette 13. Pressure by abuser to appoint them as Power of Attorney

There have been a couple of cases of more financial—taking advantage financially. So, someone with a power of attorney spending money on themselves. There was a case where they were taking the gentleman along to the bank and withdrawing his money and we didn't think they were using it for him. Another case where, as the man got more demented, one of his granddaughters sort of started living with him, and convinced him to give her power of attorney, and we were wondering about her motives too, but there was nothing we could prove. Also, some neglect, not physically caring for them, showering them, that sort of stuff. (NGOACHS_N)

Vignette 14. Older people are also re-experiencing abuse

Some time ago I did a placement in a nursing home, and I witnessed time and time again, older women in particular, being taken into bathrooms by male nurses and dysregulating on the way there, being really—and it was always put down to a dementia episode. And what I was aware of, from speaking to my own grandmother, is that what I believed was happening in that instance, was they were reliving childhood adversity. I think it's not just that older people are experiencing abuse—older people are also re-experiencing abuse. (GACHS_N)

Vignette 15. Adapting to evolving situations

A woman who has two children, she chose to—she was living on her own, in her house. She sold her house to downsize, which made sense. She couldn't do the gardening anymore, the maintenance and the upkeep of the house was too much. The children became quite abusive—these are adult children—they became quite abusive towards her, because they maybe felt that the house was something that they were hoping to get as part of their inheritance, perhaps, into the future. But she was looking after her own physical, and emotional, and financial wellbeing, by downsizing into a small unit that she could manage.

The abuse that then proceeded was quite nasty, but it wasn't like other cases where we would see financial abuse being used to get money. It just became quite nasty, so this person then considered having restraining orders against her children. And in the end, things sort of died down, she stood up to them. But we did a lot of ongoing short counselling with that person, and giving them options, and giving them their legal rights. So that was one case. We've had other cases where we have successfully applied for restraining orders, and we have evicted family members out of people's homes—in order to protect them and keep them safe. (NGOLFS_N)

Vignette 16. Police response to elder vs child abuse

The case that I was talking to you about earlier, I can't tell you how many debriefs I had with carers who were crying because they saw her bruises, and she just wouldn't, didn't want anything to be done about it, and the doctor would not do it because he was the family doctor, and he didn't feel confident to do it. He hadn't seen the evidence himself, he said, he kept saying. So there needs to be, to get things to the next step, a professional who understands elder abuse. It's not just any old GP.

Q: Why weren't the police called in that case?

A: Because it would have been—the police don't want to do anything with it either—because the person is dependent on the carer, and the carer, in this instance, had his own issues—it wasn't about evilness, there was nothing evil happening—it was all about frustration and those kinds of things, and him not wanting to accept help. In the end he did. The police don't want to have to deal with that because they can make it worse for the person. So, the person was being bruised, but not broken, if you know what I mean. The physical abuse wasn't enough to hospitalise them, but it was enough for them to be miserable.

Q: But you realise if it was a child, there'd be a different response?

A: Absolutely. (GACHS_N)

Vignette 17. What's the solution?

I'd like there to be a specialist, multidisciplinary team that deals with elder abuse, that has social work, psychology, that is closely aligned with police, and that there's some recognition and some legislation around elder abuse, like

Safe at Home, where police do have more authority to intervene. Because I think leaving it all up to the discretion of a person who's experiencing the abuse is sometimes a massive responsibility to be putting onto that person, and sometimes leaving them in a vulnerable position. Where they're working together, firstly trying to support the person's decision-making. But sometimes I think particularly with older people, you've got the added complication of people who have issues around their capacity. Elder abuse has this other added layer of complex health issues, cognitive and functional decline, where the person can't actually get out to access services, leaving older people particularly vulnerable. I think that there does need to be some sort of legislation in significant situations where there is police intervention. Yeah. Because otherwise, you feel very stuck, and some people are in these situations for so long.

Vignette 18. Assessment of capacity abuse

They also try and get people to be deemed as not having capacity. This is an ongoing thing, the case I gave you about the woman that sold her home. Her children had tried to have her committed through mental health services, as not being of sound mind. The service ignored them—well they met with the individual, and they assessed, and they determined that she was all right. This is what happens: "Oh, well mum's mad, mum's a bit nuts." Or "Dad's got dementia." Dad hasn't got dementia he just doesn't have any choice. (GLFS_N)

Vignette 19. It shouldn't be this hard

The first thing that comes to mind always is a lady who everybody knew was being abused, and it took us three years to get her safe. And it was simply about formal processes. That's the one that comes to mind. We were notified one year that someone—that the carers of the particular person were convinced that the carer was abusing—physically abusing his wife. And nobody was taking responsibility, so there was a confusion about—initially—about who had the main responsibility for reporting and what needed to be reported. So, we went through a process of really educating some of the services that had the best relationship with that person, about what needed to happen. And the problem had been that because of the lack of understanding of the basic information around elder abuse, they had had lots of verbal concerns from different workers going in—so, this was a community-based service—going in, but they hadn't put anything in writing, and because there was nothing in writing, there was no paper trail and no evidence. And of course, the older person had dementia as well, so there was no way, really, to get into the house.

There was a lot of running around behind the scenes to try to organise with people who didn't really want to be involved on how to get access to this person. It actually took about a couple of months for us to get all the evidence that we needed, but then we actually needed to have the family GP, or someone from the medical profession to write a report to the Guardianship Board. And of course, the family GP didn't want to do that—in fact, didn't do that for another couple of years, despite us writing letters and advocating and doing all sorts of things. So, in the end, what we had to do was go back to all the services and say, "Every little thing, on every occasion needs to be reported, it needs to be sent through to us so that we can send it through to the GP". And we had to inundate the GP with enough information to feel confident. And then we had to go in and work with that GP because they weren't sure how to write the report. (GACHS_N)

Vignette 20. The complexity of trying all options

An adult son had returned to live with his father on a farm. And, that theme of child returning to live with parent or become their carer is one that seems to be coming up time and time again. He also had some issues with drugs, anger, he was being verbally abusive towards his father, had made threats of violence, and he had also made requests for money. I'm not sure if they were requests or demands, but in the father's eyes, it was more like demands, he felt it was like that. The son was refusing to leave when asked, he'd become angry and verbally abusive, and he said, "No, I'm not going." At the same time, the father didn't want him to leave and become homeless. He didn't want to call the police—he just wanted the abuse to stop.

He called the Elder Abuse Helpline who referred him to our service, after hearing what his concerns were and checking out other options. What he decided on was he wanted counselling to help him make up his mind, just to sort of thrash it out. He came with a young relative, who was close enough to him to be involved and he trusted her.

She didn't live on the farm or anything like that, but sort of kept an eye on things. He didn't want to take any legal action against the son, or have him evicted or charged, so that's why he wanted to seek counselling to make up his mind. It's a potential for elder mediation only if the son agreed, and the father didn't want to start that process, because that would make the son angry, in just receiving an invitation to come to elder mediation.

So, he was very much in the, “I'm fearful, but I don't want to go to the police, but I do want the abuse to stop” stage. I suppose if there was a good outcome, it was that the niece was remaining involved, and that she had stated to the father that she would call the police if any physical violence occurred, or if he asked her to. That was, if you like, his safety mechanism, at least having a person, he could just say, I'm going to call so-and-so, and she would take care of things. That's where it's at now, and at the end of the day, there's not a lot of legal options.

If the trusted person, wasn't there, the sad thing is there's not a heck of lot, available legally. Where he does have capacity to make his own decisions, so it's not a guardianship type situation. It's not that he needs a power of attorney, and it's not abuse of power of attorney. It's just someone, as often happens, as most parents would, they'll say, yes, of course, "I've got a big home, come and stay here for as long as you like,"is probably what they would say, thinking three or four months but without setting clear rules and expectations. (NGOCS_N)

Vignette 21. Keeping the Public Trustee informed

An elderly lady came to us and she doesn’t have any of her own family. Her next of kin was identified as a health worker. It came to my attention when I visited her that the health worker was talking to her about changing her will because there’d be no money left over once she paid her aged care fees, etc. She was going to leave her estate to the children of three friends. I overheard this worker trying to convince the lady that there wouldn’t be enough money left to divide up etc etc. The health worker expected that she was going to take her to the lawyer the following day and have her will changed, put into her name because she was doing all the caring for her, etc. So, I asked the lady directly what she wanted to do, did she want to change the will? She said, “No,” she didn’t want to change the will, she wanted to leave it as it was, but she felt coerced.

So, I approached the manager of the facility where she lived and told them what was going on. They contacted the GP. Meanwhile, the lady had an appointment with her psychiatrist the following day, so I informed him as well. So, the result of the plan was that the GP intervened immediately and contacted the Public Trustee and said, “No, this can’t go ahead. There can’t be, we can’t have the will changed at such late notice.” When I informed our psychiatrist, he spoke to the lady privately the next day and said, “Is this what you want to do?” She said, “No, I don’t want to do it.” So, he helped the lady become more assertive in saying no with what she wanted and what she didn’t want.

The result of this combined approach between the aged care management, our service and our doctor and the GP was she didn’t change her will. Yeah, so we had a good outcome because we did suspect a bit of foul play.

It was interesting, long after this happened, that particular health worker tried another tack and was trying to change over the guardianship to her, so she’d become her guardian. She couldn’t get power of attorney because we’d gone through the system to get that set up through the public trustee. But yeah, I just said to the health worker, “Well, why does she need that? She’s in care. She’s taking her tablets. So, why does she actually need that?” So, I encouraged the lady, my client, not to sign those papers, because at this stage there was no need to have that in place for her to make her own decisions. She’d made the big one, which was to go into care, and that wasn’t a problem. So, it’s complicated. (GACHS_N)

Vignette 22. “But the Public Trustee is where you go if there is financial abuse?”

My view of the Public Trustee is that it is good to have a body that people could go to as what I would regard as a last resort. But it’s still run like a corporation. My view of the Public Trustee is a lot of inefficiency, a lack of transparency around fees. It’s like Industry Super Funds, they don’t have to disclose their fees when every other super fund has to. It’s the same as Public Trustee versus a lawyer, a legal office. A legal office has to tell you, “This is how much we’re going to charge and this is what we’re going to do.” The Public Trustee doesn’t.

The function it provides is that if you haven't done anything in your whole life to do a will, that's where it goes, and you need something like that because there is a heck of a lot of people out there that haven't done a will. It's conflicted, but there has to be somewhere that is basically the catch-all for these situations. But frankly it is a lottery up there. It's a lottery as to who you get on the day, who's looking after the file, will they get an outcome, will they get a result or will it sit there for years and years and years. There definitely needs to be a review of the Public Trustee functions—are they under-resourced, over-subscribed or just plain inefficient for the job they need to do. Also, unless you have the assets to pay the fees, the Public Trustee can't help you. So basically, they are not the financial 'catch-all' they are generally thought to be. (NGOLFS_N)

Vignette 23. It's all a paper tiger

I would say that the next step would be around legislative changes, and responses from Government in regard to protecting people's rights regardless of how old they are or whether they live at home or in a nursing home. I don't always go along the path of changing legislation, because I know that with the one-punch laws for example, often people would plea-bargain to the lower offence. And I think the difference is that if it's theft, it's theft. Do you know what I think we need? I think it's about re-education of the authorities to start using the offences that are there. "This is a case, in my opinion, where someone's finances were removed by a power of attorney, that there is no one to investigate it. Because the agencies that are maybe supposed to investigate it, aren't doing anything about it." And because it comes down to issues of authority, that they're given to me, and that I have to then talk to other agencies, such as the Public Trustee, and Public Guardian, there is no one that I can refer to, and say, "Look this is a definite theft—things have to happen."

Then you get scenarios where people with power of attorney have misused their power of attorney, and there is a Supreme Court action, that no one can afford, to rectify what's occurred. I just think that's madness. I mean, even if it went to something like VCAT, or an administrative tribunal in the first instance. How can you ask someone—like I'm 59, and I've got the experience, but if you asked me to go along and undertake the process at the local Magistrates Court to bring about a small claims, it'd still be stressful for me, and I know what I'm doing. But if you're 82, you know, you're blind in one eye and your hip's gone—where do you go, with the pressure of attacking your son or daughter, and having to fill in all the paperwork, because there's no one in existence that can do that for you—unless you pay them.

So, there are two things. There is who is going to do it for them, that they don't have to pay—and who's actually undertaking an active investigative response to issues, that the police really don't want to get involved with, because they see it as a civil matter. I think it's the Australian Law Commission's report on elder abuse, one of the issues that came up is there isn't an investigative body into elder abuse. And I think that's something that's really lacking, because we all dance around the edges, we all refer off to other people, we all want to do a good job—but there needs to be meat in the sandwich. And I think that there's no meat there. It's all paper tiger (GLFS_N).

Vignette 24. Networking. A fashion that comes and goes

The risk with the idea of networking is, over the years—I've been at it a long time—so, over the years what happens is, people get on to that idea that, you know what, we do need networked services that can be quickly pulled together when a case comes up. And then what happens is changes within certain services happen, and the idea of networking becomes unfashionable, and you don't network anymore. We used to have these meetings for community, where the police would come and other people would come, but then less and less people came to those, as it was deemed to be just a chat fest. So, how it's framed up, how a network is framed up, I think, is really important. And I think if it's given a specific purpose, it can't so easily be discarded by managers who are looking for quicker turnover. (GACHS_N)

Vignette 25. Multiple community service referrals

We were contacted by a community agency that was assisting an elderly lady that was living in a rural community and was also on our books. There was feedback from the community agency, and also the police and the healthcare workers involved with that case, that they did suspect elder abuse. It was a bit challenging for us working with the

woman and also her family to sort out getting documentation that we required, getting confirmation of the circumstances and, yeah, I guess treading very, very carefully with how much notice we took of information coming in from various parties. While also making sure we supported that lady and how we made sure that she was in a safe place and got further assistance going forward. We did a lot of work with the community agencies, but from our service perspective we were more focussed on supporting the financial independence role than necessarily dealing with the family dynamics and things that were happening within the family. The police and the community agency took more of a lead with getting that sorted out. (GCS_N)

Appendix 3: Literature Review

Tasmania is an 'ageing' state. With the highest proportion of people over 65 in Australia, Tasmania is the 'ageing' state. This trend will continue with increasing life-expectancy, and an on-going loss of younger Tasmanians to the mainland for work, coupled with an increasing influx of sea and tree changers in the older age groups. Tasmania already has a population with significant, known risk factors for elder abuse (Tasmanian Government 2012; Jervis et al 2016). These concerns have prompted the State Government to seek to respond comprehensively to the increasing risk of elder abuse, in hand with the National reforms (Australian Government 2019) already underway.

Elder abuse is multi-sectorial. Along with international trends, the National review has recognised that elder abuse is multi-sectorial and not the sole responsibility of, for example, health or justice agencies. All sectors need to respond in a co-ordinated way because elder abuse is not 'just' financial or physical. Often all forms of abuse are present in the same case. Cases can be difficult to identify, investigate and prosecute. Agencies that might have responsibility for handling such cases may fail to do so which results in victims 'falling through the cracks' much like the initial responses to child abuse.

Individual services are not referring to Tasmanian policy in their response to elder abuse. Multi-sector research conducted by the Preventing Elder Abuse Tasmania (PEAT) research group (H0016164), has established that while individual services (State, Commonwealth and NGO) have elder abuse policies and procedures with respect to cases of elder abuse, these policies and procedures have largely arisen independently of existing State policy (Tasmanian Government 2019) directions. The service level responses have been moulded by the context of the service including access to other services and community supports. The PEAT research identified that while at the service level there is expertise and a passion to resolve issues recognised as elder abuse, there is also frustration with the lack of support or coordination by State Government and its slowness in developing response pathways. It was also found that several services have, or are, developing their own policies and protocols for responding to elder abuse without any reference to State policy (Lawrence, Henning, Banks 2016).

The conceptualisation of elder abuse has changed over time. One of the complexities of elder abuse is the need for multi-sector, interdisciplinary interventions ranging across adult protection services (e.g., guardianship), home health care agencies and personnel, community NGO older-person services, police, legal services, courts, housing authorities, health professionals, hospital personnel, nursing homes, as well as banking and financial services (Lachs & Pillemer 2015). The conceptualisation of elder abuse has ranged from 'older adults in need of protection' (1950s), to 'elder abuse as caregiver stress' in the 1970s, 'elder abuse as a crime' to a blended concept calling on all the above agencies to act together, recognising that sometimes elder abuse is a medical issue, sometimes a crime, sometimes a social issue and often a combination of all these elements (Johannesen & LoGiudice 2013). There is no simple, single response that is the responsibility of just one agency (Jackson 2016) and front-line agencies need to be supported in the development and evaluation of their services (Baker et al. 2016). However, there is also a realisation of the need for a co-ordinated response involving all relevant agencies.

What services are best placed to respond to elder abuse? Using the expertise of front-line staff, a key study by DuMont and colleagues (2015) conducted a scoping review and then deployed a Delphi methodology to determine whom they would recommend taking responsibility for responses to cases of elder abuse. The (Canadian) expert respondents recommended 22 (out of 33 from the scoping study) professionals should be involved. These were (in order of highest to lowest ranking): the public guardian and trustee, a geriatrician, a senior police officer, a GEM (geriatric emergency management) nurse, a GEM social worker, a community health worker, a social worker/counsellor, a family physician, a paramedic, a financial worker, a lawyer, a pharmacist, a hospital physician, a Crown prosecutor, a neuropsychologist, a bioethicist, a caregiver advocate, a victim support worker, and a respite care worker (DuMont et al. 2015). This, and the Campion (2015) research will inform the inclusion/exclusion criteria for the current research.

Barriers to service-level response to elder abuse. The influence and knowledge of personnel across the range of relevant agencies is key to their response to elder abuse (Lachs & Pillemer 2015; Garma 2017). Identified barriers to

elder abuse recognition and response by personnel are: lack of training; lack of confidence in screening tools; lack of awareness about the association between abuse and mortality; poor past experiences with referral pathways; disbelief that detection will lead to a solution; fear of confrontation; fear of compromising provider-patient relationships; abuse signs may mimic ageing changes and go unnoticed (Baker & Kim 2019). Procedures and protocols may guide personnel responses to elder abuse, however they need to include training of front-line personnel, information specific to diverse and vulnerable elders, as well as being responsive to a changing service context (Schmeidel et al. 2012; Blundell, Warren and Moir 2020). While there are some intervention studies into institutional elder abuse and neglect, there is a scarcity of known, community-based interventions for older adults and their carers (Fearing et al 2017) which leaves agencies struggling to know how to respond to suspected cases of abuse of their older clients. As well as the Office of the Public Guardian, Tasmania has an 'elder-abuse hotline' and has recently increased the capacity of legal aid to provide services specific to older Tasmanians. Other identified referral services include Community Police, Relationships Tasmania and Advocacy Tasmania. Abuse that occurs in RAC is referred to Aged Care Complaints (Commonwealth Government), or the police if a crime has occurred. However, the links between these agencies and 'front-line' services (e.g., Community Allied Health) is largely undocumented and problematic (Cairns & Vreugdenhil 2014).

Appendix 4: RECOMMENDATIONS of Coroner Olivia McTaggart following the holding of an inquest under the Coroners Act 1995 into the death of: Janet Lois Mackozdi

Recommendations from Coroners McTaggart's 2018 Report (pp43-44):

197. I recommend that the Tasmanian government undertakes a review of legislation to determine whether current components of legislation effectively and efficiently prevent or respond to abuse, neglect or exploitation of older persons; and in the event that they do not, commence a program of legislative reform to achieve that purpose.

198. I recommend that the Tasmanian government develop, as a matter of priority, a renewed Elder Abuse Prevention Action Plan, such Plan to include: 1. A strategy to ascertain the prevalence of elder abuse in the Tasmanian community; 2. A strategy for responding to and preventing elder abuse in the Tasmanian community; and 3. Establishment of a steering committee or other mechanism to ensure efficient implementation of the Plan.

199. I recommend that, in developing the Plan, the government undertakes an analysis of the applicability of the recommendations for preventing elder abuse contained in Elder Abuse – A National Legal Response (ALRC Report 131) and the Legislative Council General Purpose Standing Committee No.2 – Enquiry into Elder Abuse in New South Wales.

200. I recommend that the Tasmanian government give consideration to the establishment of an independent body with specific responsibility for elder abuse by, inter alia, investigating complaints, researching and responding to the ill-treatment of older people, developing community education programs and by overseeing cases where there is a risk of elder abuse.

201. I recommend, alternatively, that the Tasmanian government give consideration to enhancing the powers of, and appropriately resourcing, the Office of the Public Guardian so that the above functions can be effectively performed.

202. I recommend that the government give consideration to resourcing and utilising Preventing Elder Abuse Tasmania (PEAT) as an appropriately qualified advisory group in respect of both law reform considerations and other prevention strategies.

FINDINGS and RECOMMENDATIONS of Coroner Olivia McTaggart following the holding of an inquest under the Coroners Act 1995 into the death of: Janet Lois Mackozdi
https://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0018/440280/Mackozdi,-Janet-Lois-latest-version.pdf

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