ELDER ABUSE:

A HOLISTIC RESPONSE

BACKGROUND PAPER

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Background

The issue of abuse of older people, often called "elder abuse", was identified as a social phenomenon in developed nations in the 1970s and 1980s. It has subsequently been researched in the developing world (World Health Organization 2002). In Australia, the first substantial research on the issue took place in the late 1980s and the first policy responses occurred at state and national level in the early 1990s (McCallum 1993; Dunn & Sadler 1993).

A major focus at this time was on abuse in community settings, with patterns of family interactions a particular concern. Elder abuse became a topic of great media interest in this period (Commonwealth Office for the Aged 1994). Separately, there was a substantial focus on improving the quality of care in Australia's residential aged care services, with concerns about certain cases of very poor institutional practices providing an occasional burst of media attention.

Rarely, however, was the rubric of "elder abuse" applied to residential aged care. On 20 February 2006, ABC TV's Lateline program broke the story of an alleged sexual assault of up to 4 residents of a Victorian nursing home. Other allegations were aired regarding staff and management practices at another nursing home. A spokesperson for a relatively new group calling itself the Australian Elder Abuse Prevention Association claimed these incidents proved the need for mandatory reporting of elder abuse, in both residential aged care and community care settings.

The Federal Minister for Ageing, Santo Santoro, announced in response a "summit" of the Aged Care Advisory Committee to examine the options for responding to elder abuse and providing better protection to residents in aged care homes. He explicitly stated his preparedness "to discuss this proposal and any other measures that may improve the safety of older people, especially those in residential care" (Santoro 2006).

Purpose of Paper

This paper aims to assist Aged and Community Services Australia (ACSA) to develop a considered response to the issue of protection of vulnerable older people. Irrespective of the recent media attention, this is a serious issue that can affect many thousands of older people in Australia. As stated by Greg Mundy, ACSA CEO, "Abuse of residents in any of Australia's 3,000 residential care homes must not be tolerated. … Abuse, while rare, is very serious and we need to avoid grandstanding that would get in the way of real solutions" (Mundy 2006).

The paper reviews some of key aspects of the debate around elder abuse, including definitions, prevalence, intervention strategies and policy responses to date.

It discusses particular issues in residential aged care settings and community care, where people are living in their own homes.

Finally, the paper suggests some possible strategies for a holistic response to abuse; a response driven not by a crisis mentality but by an informed examination of shortcomings and strengths of our current systems.

Definition of Elder Abuse

> Elder abuse is any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. Abuse can include physical, sexual, financial, psychological and social abuse and/or neglect.
>
> *Australian Network for the Prevention of Elder Abuse definition cited in Victorian Elder Abuse Prevention Project, 2005*

Elder abuse, in this definition, occurs in the context of a relationship between the abused person and the abuser. It excludes self mistreatment and self neglect. The abuser may be a family member, friend, neighbour, care worker or other person in close contact with the victim. Crime or assault in the street or at home by strangers, and discrimination in the provision of goods and services, are excluded.

By grouping together abuse in the context of different styles of relationship, it is important to note that some very different dynamics are encompassed. For example, in residential aged care three possible categories of perpetrators of abuse are: other residents; family members/friends; and staff. Each category may need quite different responses.

Types of Abuse
The list of categories of abuse taken from the NSW Advisory Committee on Abuse of Older People (1997:10-11) summarises the standard scope of elder abuse:

- *Financial or material abuse:* the illegal or improper use of the older person's property or finances. This would include misappropriation of money, valuables or property, forced changes to a will or other legal document, and denial of the right of access to, or control over, personal funds.
- *Psychological abuse:* the infliction of mental anguish, involving actions that cause fear of violence, isolation or deprivation, and feelings of shame, indignity and powerlessness. Examples include verbal intimidation, humiliation and harassment, shouting, threats of physical harm or institutionalisation and the withholding of affection.
- *Physical abuse:* the infliction of physical pain or injury, or physical coercion. Examples include any form of assault such as hitting, slapping, pushing, burning. It includes physical restraint such as tying an older person in a chair or bed.
- *Sexual abuse:* sexually abusive or exploitative behaviour, ranging from violent rape to indecent assault and sexual harassment.
- *Neglect:* the failure of a caregiver to provide the necessities of life to an older person, ie, adequate food, shelter, clothing, medical care or dental care. Neglect may involve the refusal to permit other people to provide appropriate care. Examples include abandonment, non-provision of food, clothing or shelter, inappropriate use of medication, and poor hygiene or personal care.

The Victorian Elder Abuse Prevention Project (2005:28) notes that the standard definition of elder abuse encompasses "a broad range of harms, from subtle, social and emotional transgressions, to acts of criminality." Notably judging neglect and elements of psychological abuse (such as shouting and withholding of affection) as 'abusive' can be very subjective. For intervention purposes it can be more useful to separate out certain behaviours and respond differently. For example, severe physical or sexual assault is a crime and should be dealt with accordingly. However, assisting a stressed carer to manage without shouting at their elderly spouse may best be dealt with via means other than labels of abuse.

Prevalence

International prevalence studies suggest that between 4 and 6% of older people are victims of elder abuse when all types of abuse are considered. The more severe forms of abuse, such as physical and sexual assault are rare (World Health Organization 2002). An American longitudinal cohort study showed that 6.5% of community-dwelling older adults were investigated by protective services over a nine year period, with abuse or neglect corroborated in 1.6% of cases (Lachs et al. 1997). In 2003, Adult Protective Services in the United States received over 560,000 reports of suspected elder and vulnerable adult abuse, a rate of 8.3 reports for every 1,000 older Americans. Slightly less than half of elder abuse cases were substantiated, with substantiation rates varying from 7% to 72% in different states. 89% of cases were regarding alleged abuse in a domestic setting (National Center on Elder Abuse 2006a).

Boldy et al (2005) have estimated that 0.58% of West Australian seniors aged over 60 may be victims of abuse, with prevalence rising with age. Research on clients of Aged Care Assessment Teams (ACATs) found between 1 and 5% are victims of elder abuse (Kurrle et al 1992; 1997; Livermore et al 2001). Abuse has been identified in similar proportions among clients of other community care services.

Most victims of abuse are females, though a substantial number are males. Around 20% - 40% of victims are reported to be men, a much greater proportion than in cases of domestic violence among younger adults (Mears 1997). In most cases in the community family members are the abusers (mainly children and spouses) with a minority of reported cases involving paid workers (Elder Abuse Prevention Unit Queensland 2005).

In the ACAT studies, psychological abuse and physical abuse were the most commonly identified. However, many studies find financial abuse common (Tilse et al 2003; Age Concern New Zealand 2005; Elder Abuse Prevention Unit Queensland 2005). More than one form of abuse occurred in over half of ACAT study cases and this was also common in Western Australia (Boldy et al 2005). Men are more likely to be the abusers in cases of physical and psychological abuse while women are more likely in cases of financial abuse or neglect (Mears 1997).

Abuse in residential services is also commonly reported by the international literature. A report to the US Congress found one in three nursing homes had been reported to Long Term Care Ombudsmen or Adult Protective Services for at least one incident of abuse over the two years from 1999-2000. Included were cases of physical, sexual or verbal abuse or neglect by staff and resident-to-resident abuse (Committee on Government Reform 2001).

An analysis of calls to a British elder abuse helpline between 1997 and 1999 found a quarter of calls referred to alleged abuse in hospitals or nursing/residential homes. Physical abuse or neglect were the most common complaints with a handful of sexual assault cases. Nurses and care workers were the most common alleged abusers (Jenkins et al 2000).

There has been no similar research in Australia. The Commissioner for Complaints' Annual Report 2004-05 indicates that about 100 out of 1,004 complaints were about "abuse/restraint". Minister Santoro's (2006) media release indicated that only 1% of around 6,000 contacts with the Complaints Resolution Scheme referred directly to abuse.

Factors Contributing to Abuse

The literature identifies a range of factors which contribute to abuse (Sadler 1994; Australian Society for Geriatric Medicine 2004), including:

- *Dependency of the older person*, characterised by the abusive or neglectful behaviour beginning around or after the onset of the person's disability. Often linked to carer stress. People with dementia have been identified as at particular risk (Sadler et al 1995; Koch & Nay 2003).
- *Psychopathology in the abuser*, including psychiatric or drug and alcohol problems.
- *Family dynamics including domestic violence,* characterised by a history of violence (usually male to female) predating the onset of any disabilities.
- *Carer abuse*, where a person with dementia or another condition abuses their elderly carer.
- *Financial dependency of the abuser on the victim*. A key component in financial abuse but also linked to other types of abuse.

Interventions

Kurrle & Sadler (1994) point out each situation of abuse encountered is unique and must be considered individually. They recommend referring to the principles of beneficence and autonomy when making decisions about intervention. *Beneficence* is the principle of acting in a manner that will do good, and remove or prevent harm. This encompasses a worker's and organisation's duty of care. *Autonomy* is the principle of self determination. The rights of others to make their own decisions must be respected.

Older people are capable of making decisions for themselves unless severely impaired by dementia or other psychiatric illness. Where it appears that an older person lacks the capacity to make informed decisions, then assessment of mental competence is essential. Ethical dilemmas can occur where there are tensions between beneficence and autonomy, such as the case of the victim wishing to stay in an abusive situation.

Interventions can include (Kurrle & Sadler 1994):

- *Crisis care.* Options include admission to an acute hospital bed, emergency residential respite care, or women's refuge.
- *Provision of community support services*, including case management.
- *Provision of respite care* such as in-home respite, day-centre, or institutional respite to relieve carer stress.
- *Counselling.* This may involve individual counselling or family therapy to help victims cope with their situation, and assist them to find a way to be safe from their abusers. Carer support groups may also help.
- *Treatment of the abuser.* Psychological counselling could assist with some programs targeting abusers. In cases where abuser psychopathology is a major causative factor, acute or ambulatory care to address psychiatric illness or drug or alcohol problems could be required.
- *Alternative accommodation.* One Australian study found that 65% of cases of abuse resulted in the separation of the victim and abuser over a three-year period (Kurrle 1993). Most often this involved residential care for the victim of abuse, but in some situations where carer abuse had occurred, it was the abuser who moved to residential care.
- *Legal interventions.* These include criminal charges in cases of financial abuse or severe physical or sexual abuse, Powers of Attorney, guardianship orders or restraining orders such as an Apprehended Violence Order.

Fear of Retribution in Residential Care

A concern was raised in evidence to the Australian Senate Community Affairs References Committee in 2005 that abuse is under-reported because residents, families and staff members may fear retribution (whether that fear is well founded or not). In a literature review on retribution in residential care, the Commissioner for Complaints (2005) found the potential or actual barriers to reporting potential abuse most commonly cited include:

- the nature of the culture of institutional care, including the inherent and implicit disempowering language of institutional care;
- loss of power, and pre-existing or institutionally acquired loss of self esteem of the individual who fears or experiences retribution;
- the work environment, workload and stressors of caring for vulnerable, frail and/or dependent adults;
- inadequacy in skills, training, and understanding of the non-professional paid carers in institutional care environments.

Strategies to address fear of retribution identified include:

- promoting social support
- pro-active and continuous quality improvement with a particular focus on staff training, communication and involvement
- possible use of surveillance equipment
- multi-disciplinary, multi-agency cooperative models.

Systemic Responses

Elder abuse has been recognised legally in the United States via the *Older Americans Act Title VII Vulnerable Elder Rights Protection* provisions. All states in the USA have mandatory reporting legislation with Adult Protective Services established to investigate and intervene in cases of community-based elder abuse and long-term care ombudsman for investigation of abuse and other issues in residential care settings (National Center on Elder Abuse 2006b). Many provinces in Canada have also adopted mandatory reporting legislation, though the reports go to social services or health agencies rather than separate Adult Protection Services (Canadian Network for the Prevention of Elder Abuse 2005).

In the United Kingdom, the focus has been on development of multi-agency protocols to protect vulnerable adults from abuse (UK Department of Health 2000), introduction of a Protection of Vulnerable Adults scheme of pre-employment screening and more recently a decision to move to licensing for all residential and domiciliary care workers (UK Secretary of State for Health 2004).

In other nations in Europe, Asia, South America and Africa, policy responses tend to be at earlier stages, with a focus on research and training rather than legislation. It is notable that mandatory reporting is only in place in North America (World Health Organization 2002).

New Zealand, Australian Capital Territory, Queensland and South Australia have funded specialist statewide information and education services to provide telephone assistance and referral support in dealing with cases of abuse. The services also provide community education and a central point for dissemination of research and materials on good practice.

A number of Australian states have worked on guidelines or training packages for workers and model policies and procedures for service providers (eg Hughes 1995; NSW Advisory Committee on Abuse of Older People 1995a; Ageing & Disability Department 1995; ACT Health 2004).

Inter-agency protocols have also been a focus. For example, the NSW Advisory Committee on Abuse of Older People (1995b) produced an Inter-Agency Protocol covering identification, assessment, case management, other interventions and legal intervention. Notably it separated out financial abuse from other types of abuse.

Mandatory Reporting
To date, no Australian jurisdiction (including the Commonwealth – see Commonwealth Office for the Aged 1994) has supported mandatory reporting, with its inherent establishment of a new elder protection bureaucracy. The arguments for and against mandatory reporting are summarised in Appendix 1.

Professor Jan Mason (1997) undertook the most detailed Australian examination of the issue for the NSW Government. Her conclusions are worth quoting in full:

> *Some conclusions are drawn from the review and discussion of the literature to inform future policy directions. They are:*

1. *In terms of generating data for social policy development, there is no support for mandatory systems being any more effective than voluntary systems of reporting abuse of older persons.*
2. *Within the literature reviewed there is very little support for, and much criticism of, mandatory reporting laws as implemented.*
3. *It can be argued that where there is support for criminal proceedings to deal with elder abuse, there are laws already existing in the criminal justice system in Western societies, including the State of New South Wales. An option is to educate professionals in the use of this legislation.*
4. *Social policy responses to abuse of the elderly will most appropriately be placed in a context which recognises that many older persons and their carers are amongst the most disadvantaged in our society. Recognition of this context will provide impetus for social policies based on the rights of all citizens to services and an awareness of the inappropriateness of dichotomizing care as either "familial" or "institutional".*
5. *In the development of policies to counter abuse of the elderly, ageism is difficult to avoid. Strategies to counter ageism will include active involvement of older persons and their carers, both prior to the development of policies and in the process of implementation of these policies.*

Effectiveness of Current Australian Policy Responses

Recent reviews of elder abuse policies in the Australian Capital Territory and Victoria are instructive in assessing how effective responses currently are. In the ACT, the key issues identified included:

- The importance of a whole-of-government response and a need for effective inter-agency protocols
- Absence of a telephone support and information service and effective community education
- More effective service responses needed to social isolation, demand for respite care and emergency accommodation for older victims of domestic violence
- Mandatory police checks for residential aged care workers and better training on abuse detection and response for community care workers are required
- Improvements to legislation regarding Powers of Attorney needed.

The ACT Government responded by supporting all of the recommendations (Stanhope 2002).

Similarly, the Victorian Elder Abuse Prevention Project (2005) recommendations included:

- Identification of a lead agency responsible for coordinating a whole-of-government response
- Development of community education programs and a statewide telephone information service
- Support for development of local inter-agency protocols and networks
- Creation of age-friendly communities that value and include older people
- Consideration of specialised community legal services to improve access for older people to the justice system
- Further research on abuse.

ACSA believes these recommendations are a sound indication of the key issues that need to be addressed. Too often, Australian and State/Territory Governments have identified similar issues without retaining a consistent focus on implementing the processes required. For example, inconsistent policy directions from government agencies and too few resources hampered implementation of inter-agency protocols in New South Wales (Sadler & Sorensen 2000).

ACSA also agrees that better resourcing of residential and community care services is required. Demand for community care services, such as respite care, exceeds supply despite recent funding increases. Both residential and community care services have experienced tightening budgets in the face of inadequate indexation of recurrent funding. This in turn places pressure on providers to reduce levels of service in the community and means residential care staff find they have less time to spend on caring for residents' emotional and social needs.

ACSA is cautious about calls for tighter regulation of residential or community care services. As Greg Mundy (2006) points out, "Aged care is subject to elaborate systems of quality control by the Australian Government including regular visits from the Aged Care Standards and Accreditation Agency, and a complaints system operated by the Department of Health and Ageing." However, ACSA supports any changes that will streamline these processes and make them work more effectively for older people, families, staff and providers.

ACSA also believes responses to elder abuse need to be proportionate to the types of abuse concerned. Criminal acts should be responded to through the criminal justice system; more subtle forms of neglect or psychological abuse should not be placed into a reporting framework that treats them like criminal acts. Rather responding, for example, to harassment and bullying by staff, or to carer stress may be more appropriate.

Recommended Policy Options

On the basis of the above review of the literature, ACSA believes that elder abuse is a significant public policy issue, even if it affects a small proportion of older people in its more extreme forms.

Any response to elder abuse must start from a position of recognising the inherent dignity and worth of all older people, irrespective of disability or any other characteristic. Combating ageist stereotypes of older people will go a long way to setting a scene where older people are treated with the respect they deserve.

ACSA believes there are a range of policy options the Australian, State and Territory Governments and other stakeholders (including the aged and community care industry) should consider to strengthen our capacity to prevent abuse if possible and respond effectively if it occurs.

Generic Responses:

1. *Policies and Procedures.* Industry peak bodies including ACSA should identify and promote good practice policies and procedures for residential aged care and community care services for preventing and responding to elder abuse. Australian and State/Territory Governments should work with stakeholders to develop (or review) and implement effective inter-agency protocols relevant to each jurisdiction.

2. *Staff Training.* Australian and State Governments should fund development (where necessary) and implementation of training packages on preventing and responding to abuse for residential aged care, Aged Care Assessment Team and community care staff. Ideally recurrent funding should be made available for this. Inclusion of appropriate content on preventing and responding to abuse into Certificates III in Aged Care Work and Home and Community Care should be considered as part of the review of the Community Services Training Package. ACSA will update its resources for residential care and community care staff to include this issue where necessary.

3. *Elder Abuse Prevention Units.* Some States have established units providing telephone information and support and professional training on abuse and protection issues. The existing units do not provide case management but do provide limited individual advocacy.

This model should be considered for all jurisdictions. The Australian Government may wish to fund such units to cover residential aged care as well as community settings.

4. *Staff Screening.* ACSA believes there is a range of options that should be examined by an expert panel including representatives of law enforcement agencies, aged and community care employers and unions. These include mandatory criminal record checks, development of protection of vulnerable adult checks (as in place in the United Kingdom) and implementation of good practice in staff supervision. The examination should look closely at the practicality, timeliness, costs and benefits of any new systems.

5. *Strengthening Legal Protection.* ACSA supports residential care and community care staff being made aware of their existing legal obligations under State/Territory legislation to report crimes such as sexual assault and physical assault. ACSA does not support introduction of an expensive additional adult protection system and mandatory reporting. ACSA would support all jurisdictions reviewing the effectiveness of existing legislation and law enforcement processes for vulnerable older people.

6. *Complaints Resolution Scheme*. There is scope to improve the Aged Care Complaints Resolution Scheme, particularly its capacity to make a determination on whether an issue is substantiated or not. To reduce vexatious complaints, ACSA does not believe anonymous complaints should be accepted, but confidential complaints should continue to be accepted to provide protection to people who may be worried about the consequences of reporting concerns. The Australian Government should implement the recommendations of the National Aged Care Alliance's (2001) paper on *Resolving Aged Care Complaints*.

7. *Research and Data Collection*. A number of previous reports have suggested better research and data collection on abuse of older people, including inclusion of items in the ACAT Minimum Data Set. This should be examined as reporting requirements for residential and community care funding programs, accreditation and complaints bodies, law enforcement agencies and guardianship tribunals are reviewed.

Residential Care Responses:

8. *Accreditation.* Assessors from the Aged Care Standards & Accreditation Agency should be trained on how to identify and respond to possible abuse. Improvements to the Agency's practices, particularly regarding consistency of assessment should be pursued. The National Aged Care Alliance's (2004) paper on strengthening the focus on continuous improvement in the aged care accreditation scheme should be considered.

9. *Fear of Retribution.* The research conducted by the Commissioner for Complaints (2005) should form a basis for a considered response to reassuring people with genuine concerns that they can come forward. Implementation of the other policy options would largely address the issues raised.

Community Care Responses:

10. *Assessment Reforms.* As the assessment reforms under *The Way Forward* proceed, particularly those for comprehensive assessment, identification of and appropriate responses to abuse should be included in the scope of the new system.

    Consideration should be given to including an Elder Abuse Suspicion Index recently trialed in Victoria as part of an international study by the World Health Organization (Victorian Elder Abuse Prevention Project 2005).

References

ACT Health (2004) *Meeting the Challenge of Elder Mistreatment: a resource guide for Home and Community Care service providers in the ACT*. Canberra.

Age Concern New Zealand (2005) *Age Concern New Zealand releases report on elder abuse & neglect prevention service*. Media release at http://www.ageconcern.org.nz/?/article&id=0000000107.

Ageing and Disability Department (1996) *Dealing with abuse of clients and their carers – a training kit.* Sydney.

Australian Society of Geriatric Medicine (2004) ASGM Position Statement No.1 Elder Abuse. *Australasian Journal on Ageing*; 23(1):38-41.

Boldy D, Horner B, Crouchley K, Davey M, Boylen S (2005) Addressing elder abuse: West Australian case study. *Australasian Journal on Ageing*; 24(1):3-8.

Canadian Network for the Prevention of Elder Abuse (2005) *Canadian Laws on Abuse and Neglect*. At http://www.cnpea.ca/canadian_laws_on_abuse_and_negle.htm .

Committee on Government Reform (2001) *Abuse of Residents is a Major Problem in U.S. Nursing Homes*. US House of Representatives.

Commonwealth Office for the Aged (1994) *Working Party on the Protection of Frail Older People in the Community.* Aged & Community Care Service Development & Evaluation Report No. 14. Department of Human Services & Health, Canberra.

Dunn PF, Sadler PM (1993) Claim making about elder abuse in Australia. *Australian Journal on Ageing*; 12(4):42-46.

Elder Abuse Prevention Project (2005) *Strengthening Victoria's Response to Elder Abuse*. Office of Seniors Interests, Victorian Department of Human Services (at http://www.seniors.vic.gov.au/web19/osv/rwpgslib.nsf/Graphic+Files/ElderAbuseReportFINAL.pdf/$file/EldersAbuseReportFINAL.pdf).

Elder Abuse Prevention Unit Queensland (2005) *Annual Report 2005*. At http://www.eapu.com.au/DownLoads/46-Annual%20Report_2005.pdf

Hailstones A, Sadler P (1993) *Abuse of Older People in their Homes: final report and recommendations*. New South Wales Task Force on Abuse of Older People, Sydney.

Hughes M (1995) Abuse of older people: a network approach to service provider training. *Australian Social Work*; 48(4): 21-27.

Jenkins G, Asif Z, Bennett G (2000) *Listening Is Not Enough: an analysis of calls to Elder Abuse Response – Action on Elder Abuse's national helpline*. Action on Elder Abuse, London (at http://www.elderabuse.org.uk/documents/reportsetc/Listen.htm)

Koch S, Nay R (2003) Reducing abuse of older people with dementia and their carers. *Australasian Journal on Ageing*; 22(4):191-195.

Kurrle SE (1993) Responding to elder abuse – a follow-up study of interventions and outcomes. *Australian Journal on Ageing*;12 (4):5-9.

Kurrle S, Sadler P (1994) *Assessing and managing abuse of older people: a handbook for the helping professions*. Office on Ageing & Alpha Biomedical Communications, Sydney.

Kurrle SE, Sadler PM, Cameron ID (1992) Patterns of elder abuse. *Medical Journal of Australia*; 157(10): 673-676.

Kurrle SE, Sadler PM, Lockwood K, Cameron ID (1997) Elder abuse: prevalence, intervention and outcomes in patients referred to four Aged Care Assessment Teams. *Medical Journal of Australia*; 166(3): 119-122.

Lachs MS, Williams C, O'Brien S, Hurst L, Horwitz R (1997) Risk factors for reported elder abuse and neglect: a nine-year observational cohort study. *Gerontologist*; 37(4): 469-474.

Livermore P, Bunt R, Biscan K (2001) Elder abuse among clients and carers referred to the Central Coast ACAT: a descriptive analysis. *Australasian Journal on Ageing*; 20:41-47.

Mason J (1997) *Mandatory Reporting of Abuse of Older People*. Discussion Paper 4, NSW Advisory Committee on Abuse of Older People, Ageing & Disability Department, Sydney.

McCallum J (1993) Elder abuse: the new social problem? *Modern Medicine of Australia*; September: 74-83.

Mears J (1997) *Triple Jeopardy: Gender and abuse of older people*. Discussion Paper 5, NSW Advisory Committee on Abuse of Older People, Ageing & Disability Department, Sydney.

Mundy G (2006) *Elder abuse condemned by industry body*. Media release at http://www.agedcare.org.au/Publications/2006_Abuse_Condemmed_21_Feb.pdf

National Aged Care Alliance (2001) *Resolving Aged Care Complaints: A continuous improvement orientation for the aged care complaints mechanisms* (at www.naca.asn.au).

National Aged Care Alliance (2004) *Aged Care Accreditation. A continuous improvement orientation for the accreditation system applied to the aged care community throughout Australia* (at www.naca.asn.au).

National Center on Elder Abuse (2006a) *Abuse of Adults Aged 60+: 2004 Survey of Adult Protective Services*. Fact Sheet at http://www.elderabusecenter.org/pdf/2-14-06%2060FACT%20SHEET.pdf

National Center on Elder Abuse (2006b) *Elder Abuse Law Background Information*. At http://www.elderabusecenter.org/default.cfm?p=backgrounder.cfm

New South Wales Advisory Committee on Abuse of Older People (1995a) *Behind closed doors: the hidden problem of abuse of older people*. Video. Office on Ageing, Sydney.

New South Wales Advisory Committee on Abuse of Older People (1995b) *Abuse of older people: inter-agency protocol*. Ageing and Disability Department, Sydney.

New South Wales Advisory Committee on Abuse of Older People (1997) *Abuse of older people: the way forward*. Ageing and Disability Department, Sydney.

Sadler P (1994) What helps? Elder abuse interventions and research. *Australian Social Work*; 47(4): 27-36.

Sadler P, Kurrle S, Cameron I (1995) Dementia and elder abuse. *Australian Journal on Ageing*; 14(1):36-40.

Sadler P, Sorensen G (2000) Coordination and elder abuse: development of inter-agency protocols in New South Wales. *Australasian Journal on Ageing*; 19(3):118-124.

Santoro S (2006) *Government to convene summit on elder abuse*. Media release at http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2006-ss-san015.htm

Stanhope J (2002) *Government Response to Standing Committee on Health and Community Care Report No.11, August 2001: Elder Abuse in the ACT*. ACT Government, Canberra (at http://www.ageing.act.gov.au/elderabuse/)

The Commissioner for Complaints (2005) *Retribution in Residential Care: a literature review*. Department of Health & Ageing, Canberra (at http://www.cfc.health.gov.au/docreports/pdf/cfcrrf.pdf)

Tilse C, Wilson J, Setterlund D (2003) The mismanagement of the assets of older people: the concerns and actions of aged care practitioners in Queensland. *Australasian Journal on Ageing*; 22(1):9-14.

UK Department of Health (2000) *No Secrets: Guidance on developing and implementing multi-agency protocols and procedures to protect vulnerable adults from abuse*. London (at http://www.dh.gov.uk/assetRoot/04/07/45/44/04074544.pdf).

UK Secretary of State for Health (2004) *The Government's Response to the Conclusions of the Health Select Committee on Elder Abuse*. London (at http://www.dh.gov.uk/assetRoot/04/08/45/20/04084520.pdf)

World Health Organization (2002) Ch 5 Abuse of the elderly in *World Health Report on Violence and Health*. At http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap5.pdf

APPENDIX 1

SUMMARY OF ARGUMENTS FOR AND AGAINST MANDATORY REPORTING

Arguments in support of mandatory reporting

1. Mandatory reporting protects older people by ensuring that all cases of abuse are brought to public attention. In the USA up to 300 per cent increases in reporting were recorded.
2. Mandatory reporting puts the issue on the social agenda.
3. Mandatory reporting provides clear procedures.
4. A large number of reports may lead to allocation of additional funding to address the problem.

Arguments against mandatory reporting

1. Mandatory reporting prevents older people making their own decisions about reporting abuse, removes their control over their life and endangers their autonomy, dignity and self-esteem.
2. Most cases reported are already known to service providers.
3. Most cases come from non-mandated sources.
4. The problem is not in finding cases but in doing something about the issue when identified.
5. Mandatory reporting creates expectations that demands will be met.
6. If there are gaps between reporting and service delivery, agencies may be forced to resort to inappropriate institutionalisation.
7. Mandatory reporting represents an invasion of the older person's privacy.
8. Mandatory reporting can be seen as mere political window dressing.
9. Mandatory reporting may be administratively costly with resources required for training and management of the scheme.

Source: Hailstones & Sadler (1993:40-41)