THE LAW AND HEALTHY AGEING:

LEGAL STRATEGIES FOR THE PREVENTION OF

ELDER ABUSE

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SYNOPSIS

Elder abuse is one of the most significant violations of the human rights and dignity of older persons in both Australian society and in the global community. Elder abuse is defined as the physical, sexual, psychological, financial and social abuse and or neglect of older people, by a person or persons with whom the victim of abuse maintains a relationship of trust and confidence.

This thesis acknowledges and expands upon the role of the international and Australian legal systems in the prevention of elder abuse. To this end, the law has a role in the promotion of healthy and active ageing and the protection and promotion of the human rights of the aged.

Through an understanding of the historical recognition of elder abuse as a phenomenon and the nature of the global cultural, social and economic issues that face older people, a framework is identified to assist in combating elder abuse.

The discussion draws widely upon the various disciplines, theoretical perspectives and practical responses that have developed historically to combat the challenges of ageing, celebrate the contributions of older people to society and empower older people to retain their autonomy and dignity. Social, primary health, public health and epidemiological

perspectives on ageing and elder abuse, in both a global and domestic setting, are essential to effectively develop a valuable framework for the analysis of the law and a pathway for future legal reforms to address elder abuse. Human rights principles underscore this analysis.

This thesis focuses upon the legal strategies that currently operate internationally and that exist in Australia for the prevention, detection and remedy of the abuse of older people, and draws upon the experiences and lessons learned in other jurisdictions such as the United States of America and the United Kingdom. Building upon existing legal frameworks, acknowledging the theoretical and practical challenges confronting professionals working in the aged care arena, and by recognising community perceptions and expectations about the care of older members of our society, this thesis proposes future directions for legal policy and reform in Australia. It is argued that the law constitutes a critical tool for promoting healthy and active ageing.

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I affirm that to the best of my knowledge the thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Parts of Chapter 1 of this thesis have been published in the *Journal of Law and Medicine*, (2010) 18 *JLM* 19.

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My professional interest in investigating ways to improve the opportunities for older people to enjoy active and healthy ageing was forged during my time working as a doctor in geriatric medicine at the Western and Sunshine Hospitals in Melbourne, prior to undertaking legal studies. I was impressed and inspired by the dedication and professionalism of the staff who provide care to older people in those institutions, and I am grateful for the guidance and mentorship of Dr Michael Brignell during that time.

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LIST OF ABBREVIATIONS

ABS	Australian Bureau of Statistics
ADL	Activities of Daily Living
AHRC	Australian Human Rights Commission
AIHW	Australian Institute of Health and Welfare
APS	Adult Protective Services
CALD	Culturally and Linguistically Diverse
CAT	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CEDAW	Committee on the Elimination of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CRPD	Convention on the Rights of Persons with Disabilities
DALY	Disease Adjusted Life Years
HRC	Human Rights Committee
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
MDGs	Millennium Development Goals
UDHR	Universal Declaration of Human Rights
VLRC	Victorian Law Reform Commission
WHO	World Health Organization
YLL	Years of Life Lost

Chapter 1

INTRODUCTION

As the 2015 deadline for the attainment of the United Nations Millennium Development Goals[1] approaches, the need to respond to the challenges confronting the world's community of older persons is an urgent one. The world's population is ageing rapidly.[2] Global development strategies must take account of the dramatic demographic shifts that are underway this century, if significant progress is to be achieved in reducing poverty and in enhancing the health and development of all the world's communities. Significant achievements have been made over the last few decades in the improvement of the health and life expectancy of the world population. As a result of increased life expectancy combined with lower levels of fertility, the number and proportion of aged persons across the world is growing faster than any other group.

Yet marked global disparities and inequalities in the enjoyment of health, security, development and many other human rights of older people persist and compromise these

[1] *United Nations Millennium Declaration*, GA Res 55/2, 55th sess, UN Doc A/Res/52/2 (2000).
[2] United Nations, Department of Economic and Social Affairs, Population Division, *The Ageing of the World's Population* (2007) http://www.un.org/esa/socdev/ageing

successes. The World Health Organization points out that '[p]opulation ageing is one of humanity's greatest triumphs. It is also one of our greatest challenges.'[3] The moral and practical imperative of attending to these inequalities is stark: the global population of older persons is estimated to rise 223 per cent between 1970 and 2025, with 1.2 billion people aged over 60 years by 2025, and 2 billion people aged over 60 by 2050. Furthermore by the middle of this century, 80 per cent of the world's aged persons will reside in developing countries.[4]

Global population trends are mirrored in Australia, ensuring that ageing issues will be integral to national health, social and economic policy and programme developments well into this century. In Australia, the population aged 65 years or over has risen from 12.2 per cent to 13.2 per cent in the last two decades, but more startling is the projected rise to 22.3 per cent by 2051.[5] The exponential rise of the 'very old' (people aged 85 years or over) from 1.2 to 1.7 per cent in the last two decades to a projected level of 4.6 per cent by 2051[6] is worthy of particular attention.

In Australia, the majority of people aspire to and look forward to the prospect of health, security and contentment in older age, yet many are uneasy about the loss of physical independence and decision making capacity that may accompany ageing. Despite this, the challenges that confront aged citizens attract relatively little political will or broader community attention. Nationally, the urgency of action on climate change and global and domestic economic crises have been the focus of much discussion and debate. However,

[3] World Health Organization, *Active Ageing: A Policy Framework*, WHO/NMH/NPH/02.8 (2002) 6. http://www.who.int/ageing/publications/active_ageing/en/
[4] Ibid.
[5] Australian Bureau of Statistics, 4102.0, *Australian Social Trends 2009, Data Cube- Population* http://www.abs.gov.au
[6] Ibid.

these important challenges are not often viewed specifically through the prism of an ageing population.

Rarely are the opportunities of an ageing society celebrated. The beginning of the twenty first century provides an urgency to acknowledge the world's aged population greater than has been experienced at any other time in history. While unquestionably, responsible policy and law making demands careful analysis, prediction and planning for the increased health, social and economic demands of an ageing population, this period also provides an outstanding opportunity to celebrate, empower and utilise the skills, experience and wisdom of older persons.

Elder abuse is one of the significant challenges to and violations of the human rights and dignity of older persons in both Australian society and in the global community. Elder abuse is widely understood to be the physical, sexual, psychological, financial and social abuse and or neglect of older people, by a person or persons with whom the victim of abuse maintains a relationship of trust and confidence.[7] As will be explored in detail in Chapter 4, consensus among professionals working in the area of ageing on the nature, causes and extent of elder abuse has been slow to evolve. This has in turn contributed to the delay in development of clear strategies to prevent, identify and combat elder abuse. Across health, allied health, criminological, legal and academic disciplines, answers remain elusive and controversial. The advancement of health and well-being into old age and the provision of health services dedicated to this are integral elements of such strategies. Equally however, measures aimed at poverty reduction, improvement of social integration and the provision of supportive and empowering environments for older persons are critical to addressing elder mistreatment and neglect. Comprehensive,

[7] Action on Elder Abuse, *What is Elder Abuse?* http://www.elderabuse.org.uk/Mainpages/Abuse/abuse.html

manageable and cohesive legal structures must aim to ensure that older people and their advocates are aware of the rights of older people.

A. A Law Reform Framework for Elder Abuse Prevention

Several key themes emerge and recur in the discussions throughout this thesis and provide a framework for reviewing the law in relation to elder abuse through contemporary perspectives.

The first theme is that global cultural, policy and human rights perspectives on ageing, together with a clear understanding of the impact of demographic changes in the world's population, fundamentally inform Australian directions in confronting elder abuse. While the emphasis may vary around the globe, several common concerns arise in relation to supporting autonomy, dignity, health, security and social inclusion as well as reducing poverty.

The second theme recognises that discrete, elder focussed legal, economic and social measures must operate in concert with the 'mainstreaming' of the specific issues confronting older persons into broader legislative, policy and programme development. Internationally this approach has attracted broad support in the last decade. 'Mainstreaming' in respect of the concerns of older people encompasses 'paying attention to their particular needs when conceiving, implementing and evaluating development policies'.[8] The same mainstreaming principles can be applied in the legal context by viewing all relevant legislative reform in the context of the needs of an aged population.

[8] Robert Venne, *Mainstreaming the Concerns of Older Persons into the Social Development Agenda* (United Nations Programme on Ageing, Department of Economic and Social Affairs, United Nations, New York, 2003) http: www.un/org/esa/socdev/ageing.

The third theme proposes that in order to plan and implement legal strategies to combat elder abuse, professionals and the broader community must have a clear understanding of the nature of elder abuse. An understanding of the dynamics of the relationships that may exist between a victim of abuse and the perpetrator(s) of that abuse, and the vulnerability of the older person that may heighten the risk of abuse, is integral to broad primary prevention programmes. Equally, education of legal, health, allied health professionals and the general community will assist in the intervention in cases of abuse.

The fourth theme emphasises that the legal solutions to elder abuse are not simply about the protection of older persons; they are dependent upon a celebration of the opportunities of an ageing population and empowerment of older people. It is essential to produce legal and social strategies which do not lead to unwanted and inappropriate institutionalisation caused by stereotyped views about the capacity of older people to remain autonomous. Regulation should recognise that ageing in itself does not equate to physical or cognitive impairment. Laws must be crafted to accommodate the heterogeneity of the population of older people, in particular recognising that the majority of older people are not impaired in their decision making capacity. Furthermore, a diagnosis of dementia should not necessarily be equated with an absolute incapacity to make decisions; dementia related illnesses produce a spectrum of clinical manifestations and rates of progression vary from individual to individual and from one disease type to another. The beneficial aspects of recent advances in improved awareness and early diagnosis and treatment of dementia type illnesses by health professionals should not be undermined by an overzealous and automatic equation of a diagnosis of a dementia type illness with a profound lack of decision making capacity.

The fifth theme embraces the assumption that acts or omissions that constitute elder abuse fundamentally violate the human rights and dignity of older persons. Viewing elder abuse

from a human rights perspective provides a platform for strengthening responses which build upon the opportunities of ageing, rather than focussing solely on the burden of disease and disability which may accompany ageing.

The sixth theme acknowledges that Australia, through Commonwealth and State legislation, has an existing framework of legal instruments which protect and promote the freedoms and entitlements of those in the community who are disadvantaged or vulnerable. However this system has evolved to a large extent without particular regard to the needs of a growing older population. It is timely to review structures through 21st century understandings of health, ageing, and population and human rights considerations. Legal reforms must comprehensively address elder abuse in the domains of primary prevention and early intervention, while recognising an obligation to promote the empowerment of older people, protect rights, combat restriction of freedoms, and allow for supported decision making of those with impaired cognitive capacity.

A final theme requires that successful prevention programs and responses to elder abuse must be multidisciplinary and multifaceted. The law, through both domestic legislation and obligations under international legal instruments, provides part of the solution. From the outset, the voices of older Australians must be heard in any future planning and the engagement of aged care workers, carers, law enforcement officers and the broader community is necessary in order to strengthen the overall resolve and effectiveness of confronting elder abuse.

B. Older Persons

On first response to the question ‘who are older persons?’ many may respond in terms of chronological age, while others may mark age by physical or cognitive dependence. That this question can elicit different responses, reflects the dilemma that confronts society in discussion of ageing issues and responses to elder abuse. Ageing is integral to the notion of elder abuse, yet defining who is old in the context of elder abuse poses particular challenges. Legal measures must be sufficiently targeted to reach the population at risk of elder abuse, but avoid being over-restrictive or prescriptive simply on the basis of chronological age alone. While a detailed discussion of the theoretical constructs of ageing is beyond the scope of this thesis, some understanding of theoretical perspectives needs to inform discussions regarding the nature of elder abuse and how specific legal measures should be crafted.

Chronological age reflects simply the number of years a person has been alive. The simplicity of this conceptualisation of age ensures that chronological age forms the core of statutory accounts of age, as exemplified by definitions in employment and social welfare statutes. Similarly the disaggregation and analysis of statistical data is necessarily conducted on the basis of chronological age. In Australia, chronological age has been most broadly applied to recognise people aged 65 years or over as ‘the elderly’, but chronological age does not guarantee consistency in statutory instruments or policy and programme planning. This is illustrated in the United States of America where variation exists in the age at which a person is considered an elder for the purposes of Adult Protective Services (60 or 65 years and older), domestic violence and sexual assault programs (50 years or older) and additional criminal penalties where the victim is an elder (65 years or older). At a federal level in the United States, the *Older Americans Act (1965)*

defines an elder as a person aged 60 years or older.[9] Thus, even based on chronological age, there is no broadly accepted definition of older persons.

A person's physiological or biological age reflects his or her health status. Certain physiological changes are associated with ageing such as changes to eyesight, hearing, cardiac, respiratory, bladder and bowel function — yet none of them is inevitable. Physical and cognitive changes and impairments resulting from disease may also accompany ageing. Together these changes can result in impaired functioning and increasing dependency on others. Statistically, overall dependency on others does increase with age, with the prevalence of profound or severe core-activity limitation (always or sometimes needing help with self-care, mobility or communication) increasing dramatically from 10 per cent of those aged 65–69 years to 74 per cent of those aged 90 years or over.[10] Furthermore, increased rates of institutionalisation and prevalence of cognitive impairment due to dementia related illnesses are associated with ageing. However, broad statistical rates of disability do not predict the consequences of the genetic, social, cultural, economic and environmental factors which contribute to an individual's experience of ageing. The law must be sufficiently sophisticated to accommodate practical responses which recognise that each individual's state of physical and mental health is the product of the actual life experiences of that person. As will be discussed further in Chapter 9, legislative provisions dictating the mandatory reporting of elder abuse, regardless of the wishes and decision making capacity of older people, fail to acknowledge the diversity of the experience and effects of ageing.[11]

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[9] *Older Americans Act of 1965* 42 USC § 3001, Pub L No100-175, 101 Stat 926 (1987). Note further detailed discussion of the United States system for the legal protection of older persons will be undertaken in Chapter 9 in the discussion of mandatory reporting systems.

[10] Australian Bureau of Statistics, *4430.0 –Disability, Ageing and Carers Australia: Summary of Findings, 2003*
http://www.abs.gov/ausstats at 8 March 2010.

[11] Such as *Aged Care Amendment (Security and Protection Act) 2007* (Cth), Section 63-1AA(2).

Finally, ageing perspectives can be constructed through society's view of ageing. Questions such as;

- how does society perceive older people?
- what behaviours does society expect of them?
- to what extent does society recognise the influence of older people in community life?
- what responsibilities does society accept the community has towards the aged population?

form the framework for a societal view of ageing. As Rachel Pain suggests, 'the socially and economically constructed aspects of old age are far more influential on the condition of older people's lives, and the problems they face, than chronological or physiological age'.[12]

The truth is that none of these theoretical constructs of ageing alone is sufficient or satisfactory in providing practical guidance for legal professionals seeking to improve the support, safeguards and empowerment of older people in order to combat elder abuse. While chronological age may provide a starting point for particular legislative measures and primary prevention programs, these systems must be adaptable and flexible enough to accommodate the dynamics of the other aspects of ageing. Guided by the themes identified earlier in this chapter, this thesis will explore theoretical and practical legal primary prevention, intervention and remedies, which are minimally restrictive of rights and freedoms and which promote the autonomy and dignity of older people, while acknowledging and incorporating the complexities of ageing.

[12] Rachel Pain, *Theorising Age in Criminology: The Case for Home Abuse* (British Society of Criminology Conferences: Selected Proceedings, Volume 2, London, 1999).

C. Elder Abuse

While there is now a growing body of academic literature and clinical reporting of elder abuse, the 1990s were marked by significant discourse dedicated to the view that elder abuse should not be considered a specific phenomenon, but rather as one aspect of domestic abuse. Attributed to a 'flurry' of activity in the early 1980s in the United States, when elder abuse in non-institutional settings emerged as a 'newly discovered' form of intra-familial violence, some United States commentators suggested that 'premature legislative responses have been exacerbated by the interventions designed without empirical support.'[13] Much of this criticism apparently stemmed from the impact of mandatory reporting provisions within the United States Adult Protection legislation. While valuable insights are to be gained from a study of theoretical models of domestic violence, in order to guide practical responses to the abuse of older people, strict adherence to a 'domestic violence' view of elder abuse fails to reflect the evolution in our understanding of the types and causes of abuse against older people, in particular the aspect of neglect.[14]

Ruthann Macolini criticises the concept of elder abuse on the basis of 'ageism' whereby 'the alleged need for heightened societal attention is based on age rather than physical or cognitive limitations'.[15] There is some validity in the concerns that elder abuse strengthens the 'view of old age as a second childhood. It is the assumption that most elderly people are feeble-minded, vulnerable, a burden on long-suffering caregivers, and therefore at risk

[13] Ruthann Macolini, 'Elder Abuse Policy: Considerations in Research and Legislation' (1995) 113 *Behavioural Sciences and the Law* 349, 350.
[14] Further discussion of the impact of domestic violence, child violence theory and practice will be made in Chapter 4 of this thesis in relation to the aetiology of elder abuse.
[15] Ruthann Macolini, above n 13, 350.

of home abuse'.[16] Undeniably ageing is at the heart of the concept of elder abuse — it involves a recognition that certain physical and cognitive issues are statistically associated with ageing on a broad population basis. However, ageism whereby discriminatory laws and practices are applied on the basis of age alone need not be a corollary. Nothing is to be achieved through the denial of the existence of particular violations of the human rights of some people as they experience the physical and cognitive changes that may be associated with ageing. Ageism is best avoided through the development of solutions and responses to abuse which are not applied on the basis of age alone. In contemporary Australia, there is an opportunity to review and develop legislation based on the recognition of elder abuse as a phenomenon, which will raise community and professional awareness of the problem and provide clear practical legal strategies to prevent and combat abuse.

D. Ageing and Abuse Terminology

References to 'the aged', 'older persons', 'the elderly' and 'elders' have variously found favour throughout different jurisdictions in academic discussion, policy and programme development. Cultural differences in the use of the word 'elder' have led some commentators to prefer the term 'older persons'. Within this thesis, the phrases 'older persons', 'aged persons' and 'elders' are used interchangeably unless otherwise noted.

The vast majority of the literature adopts the terminology of 'elder abuse', which will be the preferred term adopted throughout this thesis. 'Elder abuse' will be used to include intentional actions that cause harm to an older person, by a person providing care or in

[16] Justin McDermott, 'Elder Abuse; Eight Scenarios in Search of a Construct, Crime and Older People' (Paper presented at the Australian Institute of Criminology Conference on Crime and Older People, Adelaide, 23 February 1993) 5.

whom the older person is in a relationship of trust. It can occur by act or omission and will be taken to include cases of neglect. Another common term used within the literature is 'elder mistreatment' and this term, except where otherwise specified, is adopted interchangeably with 'elder abuse'.

According to the definition of elder abuse identified earlier in this introduction, self-neglect (that is, the failure of an older person to attend to his or her own needs) is excluded from the discussion throughout this thesis. Similarly, harm caused to older people by strangers is not within the ambit of this discussion as it does not contend with the intrinsic element of trust and confidence that is central to elder abuse.

Future policy, programmes and intervention require a cohesive set of definitions in relation to elder abuse. Without this, the benefits and protections afforded by any new developments will be diluted and undermined.

E. Outline of Thesis

The aim of this thesis is to acknowledge and expand upon the role of the legal system internationally and in Australia in the prevention of elder abuse. To this end, it is argued that the law has a role in the promotion of healthy and active ageing and the protection and promotion of the human rights of the aged.

Through an understanding of the historical recognition of elder abuse as a phenomenon and the nature of the global cultural, social and economic issues that face older people, a legal framework will be identified to contribute to elder abuse prevention.[17]

[17] The financial aspect of elder abuse will not be considered in detail. The elements of physical, sexual, psychological social abuse and neglect which directly impact on the health of older people will be the focus

The aim of this thesis is to draw widely upon the various disciplines, theoretical perspectives and practical responses that have developed historically to combat the challenges of ageing, celebrate the contributions of older people to society and empower older people to retain their autonomy and dignity throughout life. Social, primary health, public health and epidemiological perspectives on ageing and elder abuse, in both a global and domestic setting, are essential to develop an effective framework for the analysis of the law and a pathway for future legal reforms to combat elder abuse. Human rights principles underscore this analysis.

This thesis focuses upon the legal strategies that currently operate internationally and which exist in Australia for the prevention, detection and remedy of the abuse of older people. It draws upon the experiences and lessons learned in other jurisdictions such as the United States of America and the United Kingdom. Building upon existing legal frameworks, acknowledging the theoretical and practical challenges confronting professionals working in the aged care arena, and by recognising community perceptions and expectations about the care of our older members of society, this thesis will recommend future directions for legal policy and reform in Australia. It is argued that the law constitutes a critical tool for promoting healthy and active ageing.

Chapter 2 provides a global perspective on ageing issues through an examination of the historical evolution of the ageing agenda in the latter part of the 20th century. It will be argued that the *Vienna International Plan of Action on Ageing*,[18] the *United Nations*

of this thesis. While acknowledging that the impact of financial abuse of the elder can affect the health and well-being of older persons, the nature and remedies for financial crimes require separate and detailed consideration.

[18] *Report of the World Assembly on Ageing, Vienna (1982), Vienna International Plan of Action on Ageing*, GA Res 37/51, UN Doc A/CONF.113/31 (1982).

Principles for Older Persons[19] and the *Madrid Declaration and International Plan of Action on Ageing 2002*,[20] provide the international platform for further developments.

Chapter 3 expands upon the challenges facing older people and outlines the health issues related to ageing that may have an impact upon older people's ability to maintain physical independence and decision making capacity. The relationship between these health issues and the occurrence of elder abuse is explored. This chapter examines system responses to elder abuse, and critically evaluates the current legal framework for elder abuse prevention and intervention in Australia. The discussion draws on the public health model of primary, secondary and tertiary prevention in order to analyse current legal responses to elder abuse prevention. It is noted that current Australian legislative instruments have evolved often without specific regard to older people as a target population.

Chapter 4 outlines theoretical and practical conceptions of elder abuse. The disparity in definitions of elder abuse across jurisdictions and professional disciplines, which have hindered practical responses to elder abuse in the past, is explored. Comparisons with domestic and family violence models and child abuse theory are examined in order to recommend legal reforms. The incidence and prevalence of elder abuse is identified and methodological difficulties in establishing accurate estimates are noted.

Chapters 5, 6, 7 and 8 examine the application of human rights principles to the phenomenon of elder abuse and evaluate the utility of viewing law reform in the area of elder abuse through a human rights lens. The increasing trend to human rights discourse in the context of ageing at an international level, as well as national human rights advances over the last decade are noteworthy. A critical analysis of the practical benefit of a human

[19] *United Nations Principles for Older Persons*, GA Res 49/91, UN Doc A/Res/46/111 (1991).
[20] United Nations Second World Assembly on Ageing, *Political Declaration and Madrid International Plan of Action 2002*, UN Doc A/CONF.197/9 (2002).

rights approach to elder abuse is undertaken, concluding that rights protection and promotion are essential components of future legal strategies to combat elder abuse.

Chapter 5 analyses the historical background and current human rights framework in relation to older people. In the absence of a unified human rights document for the specific benefit of older people, this chapter addresses the application of international, regional and domestic human rights systems in order to facilitate the prevention of elder abuse and neglect. States that are signatories to binding international documents have obligations to respect, protect and fulfil the rights of older people. Normative gaps in the rights embodied in international, regional and domestic human rights documents are identified, specifically as they relate to the challenges that face older people.

Chapter 6 expands upon the practical implementation of the right to the highest attainable standard of physical and mental health, as enunciated in Article 12 of the *International Covenant on Economic, Social and Cultural Rights*[21] as it provides for the availability, accessibility, acceptability and quality of the right to health of older people. It is argued that content of the right to health must be enunciated with the specific needs of older people clearly identified.

Chapter 7 focuses on older people with impaired decision making capacity due to dementia. There is a positive association between the risk of an older person experiencing abuse and neglect and the incidence of dementia. This chapter examines how human rights frameworks and principles, at international and domestic levels, can apply to the primary, secondary and tertiary prevention of elder abuse and neglect among older people with impaired decision making capacity. For example, the various state Guardianship and

[21] *International Covenant on Economic, Social and Cultural Rights*, opened for signature 19 December 1966, 993 UNTS 3 (entered into force 3 January 1976).

Administration statutes together constitute the primary tool assisting in the care of cognitively impaired older people. It is critical to note that cases before the guardianship tribunals are increasingly related to issues arising from older people whose decision making capacity is affected by dementia. The Office of the Public Advocate in Victoria reported that in 2008 to 2009, 66 per cent of guardianship cases involved people over the age of 65, and furthermore, 34 per cent of all guardianship cases involved people with dementia (16 per cent having acquired brain injury and 17 per cent mental health issues).[22] In particular, this chapter will explore the shift in policy perspectives on substituted decision making towards supported decision making within the context of guardianship legislation, and examine the specific abuse encountered by some older people with dementia who have unlawful restrictions placed on their liberty.

Chapter 8 takes a gender perspective approach to elder abuse, by examining the current normative gaps that exist in the protection and promotion of the rights of older women. In the last decade, increased attention has been directed to the rights of women in the context of maternal and reproductive health and the rights of girls. The Millennium Development Goals[23] are a significant example of this encouraging development. However, the rights of older women have not received the same degree of international attention. This chapter examines some of the discriminatory health, social and cultural practices encountered by many older women across the globe, and argues that the combined discrimination of age and gender can have devastating effects of the ability of older women to enjoy active and healthy ageing.

Chapter 9 expands upon regulatory aspects of current law and future reform in the area of elder abuse. This chapter focuses on the *Aged Care Act 1997* (Cth) and the impact of

[22] Office of the Public Advocate (Victoria), *Annual Report 2008-2009* http://www.publicadvocate.vic.gov.au
[23] *United Nations Millennium Declaration*, GA Res 55/2, 55th sess, UN Doc A/Res/52/2 (2000).

mandatory reporting provisions enacted by the *Aged Care Amendments (Security and Protection) Act 2007* (Cth). The scope of the Commonwealth provisions extends only to residents of Commonwealth supported aged care facilities, thereby limiting protection to only those older people potentially vulnerable to institutional abuse.[24] The merit and effectiveness of mandatory reporting will be critically evaluated, particularly in light of the consistent rejection of mandatory reporting by several States and Territories in Australia over the last decade. Comparative analysis of other jurisdictions will guide discussion about the relative emphasis that should be placed on regulation in the area of elder abuse. Insight is drawn from the experiences in the United States of America where Adult /Elder Protection Services have been in operation since the 1980s across most States, and the United Kingdom where focus has developed on 'safeguarding adults' in the context of the human rights framework which influences legislative developments in that jurisdiction.

Chapter 10 will draw together the analysis of global trends and the relative merits of the different (although not necessarily conflicting) approaches to elder abuse prevention. Four main future strategies are advocated. These are:

1. To pursue the 'mainstreaming' of ageing issues broadly and elder abuse prevention through the incorporation of targeted elder justice principles in all new law and policy at both an international and domestic level;
2. To support and contribute to the development of an international Convention on the rights of older people. This would be guided by the dual aims of (a) strengthening universal human rights as they have particular relevance to the lives of older people; and (b) addressing the normative gaps that exist in contemporary human rights instruments which create a barrier to active ageing;

[24] Note further discussion of the distinction between 'institutional' and 'domestic' or 'community' elder abuse will be undertaken in Chapter 4.

3. To formulate domestic elder policies and legislative programs, including a national strategy on elder abuse incorporating legal, social, economic and cultural perspectives. The lengthy timeline for the development of an international Convention for older persons mandates that Australia adopt a national response in advance of the ratification and imposition of international legal responsibilities; and
4. The introduction of domestic legislation at a state and territory level, in the form of an Older Persons Act. Such an Act should draw together human rights principles such as non-discrimination, autonomy and dignity, with protection principles that take account of the specific challenges of elder abuse. Building upon legal protections such as those provided by guardianship legislation for people with impaired decision making and in light of recent investigations into the reform of such legislation, an Older Persons Act would fulfil many of the key aims and themes outlined above that are critical to the prevention of elder abuse and neglect.

Chapter 10 acknowledges a role for each of these strategies and explores further and advocates for a new direction in Australia's legal response to elder abuse.

Chapter 2

GLOBAL POLICY PERSPECTIVES ON AGEING AND ELDER ABUSE

Elder abuse must be acknowledged and confronted within the context of the contemporary health, social and economic challenges that have an impact upon older people globally and within Australian society. Part 1 of this Chapter will begin with an examination of the historical evolution of ageing as an issue on the global agenda; it is argued that current responses to elder abuse prevention are the legacy of significant shifts in emphasis within international ageing policy and programming through recent decades. Regional and cultural differences with the potential to have an impact upon the nature, incidence and remedies for elder abuse are taken into account, while emphasising the common themes of autonomy, dignity and empowerment that are applicable to all people.

International bodies such as the United Nations and World Health Organization have been critical in highlighting the challenges of and promoting developments in ageing policy and practice. Acknowledging that regional and cultural differences have an impact upon the specific challenges confronting older people in different parts of the globe, the focus of the

United Nations has been to develop principles to guide policy and practice which can be applied and adapted to the specific circumstances of a region or nation.

Internationally, the development of strategies to address the challenges of ageing for both populations and individual members of a community is a dynamic process. While adherence to the principles of autonomy, dignity, security, poverty reduction and social inclusion constitute the non-negotiable core of international strategies, any practical responses must take account of regional issues. An appreciation of global attitudes to elder abuse is contingent upon an understanding of the progression of policy and practical responses over recent decades to the matters of concern to ageing people.

A. The Vienna International Plan of Action on Ageing

Upon the background of the *Universal Declaration of Human Rights* (UDHR),[1] the *International Covenant on Civil and Political Rights*[2] (ICCPR) and *International Covenant on Economic, Social and Cultural Rights*[3] (ICESCR), the attention of the United Nations General Assembly throughout the 1970s was increasingly directed towards the demographic changes underway internationally and the implications for both communities and individuals of an ageing world. Culminating in Resolution 33/52 made on 14 December 1978 [4] in which the General Assembly undertook to convene a World Assembly on the Elderly in 1982,[5] the *Vienna International Plan of Action on Ageing*[6] (the '*Vienna*

[1] *Universal Declaration of Human Rights*, GA Res 217A, UN Doc A/810 (1948).
[2] *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976), ('ICCPR').
[3] *International Covenant on Economic, Social and Cultural Rights*, opened for signature 19 December 1966, 993 UNTS 3 (entered into force 3 January 1976), ('ICESCR').
[4] *World Assembly on the Elderly*, GA 33rd sess, 84th plen mtg, UN Doc A/RES/33/52 (14 December 1978)
[5] In UN GA Res 35/129 (1980), the General Assembly decided to change the name to the World Assembly on Aging' in 'view of the interrelatedness of the issues of aging individuals and the aging populations.'
[6] *Report of the World Assembly on Ageing, Vienna (1982), Vienna International Plan of Action on Ageing*, GA Res 37/51, UN Doc A/CONF.113/31 (1982) [17].

Plan of Action') adopted in 1982 by the first World Assembly on Ageing was a critical milestone in the development of international awareness of the specific issues confronting an ageing population. Acknowledging the existence of challenges for both communities and individuals, the *Vienna Plan of Action* emphasised both humanitarian and developmental issues. Humanitarian considerations encompassed matters such as health, housing, social welfare, income security, employment and education within the context of 'the special concerns and needs' of older persons as a group.[7] Developmental concerns highlighted social and economic issues of productivity and consumption.[8] Emphasis was placed on the central role of governments at a national level in the effective implementation of the 62 recommendations of the *Vienna Plan of Action.*

While the *Vienna Plan of Action* was praised for raising awareness of the issues confronting the community in relation to the ageing population and the barriers to active ageing for individuals, there was a perceived lack of practical responses in the subsequent decade. In the Report of the United Nations Secretary General in 1986 on the progress of the implementation of the *Vienna Plan of Action,* reflection upon the lack of progress was evident.

> The articulation of the problem was a necessary, but by no means sufficient pre-condition to solving it. New programmes and policies for the aging required substantial resources. In the face of prevailing budgetary stringency, perhaps the only possibility for initiating these policies and programmes was to generate a wider acceptance of the fact, by decision-makers at large, that investments in social development were not uneconomic as sometimes believed, but had, on the contrary, a considerable impact on the process of economic development.[9]

[7] Ibid [2].
[8] Ibid [18].
[9] *Report of the Secretary General, 'Question of Aging*, UN GAOR, 41st sess, Agenda Item 85, UN Doc A/41/631 (1 October 1986).

Furthermore in the *Second Review and Appraisal of the Implementation of the Vienna International Plan*, it was acknowledged that while

> considerable awareness of issues of aging of populations has been created in many parts of the world, concrete policies and programs (are) however, severely limited...responsive policies and programs have grown little. Far from anticipating the process of aging, they have not even kept pace with it.[10]

It was noted that progress on the implementation of the *Vienna Plan of Action* was particularly lacking in developing countries, where economic constraints were greatest but conversely, where the rate of ageing demographic changes were (and continue to be) the most pronounced. While the world-wide recession of the 1980s and the unforseen devastation of the emerging HIV/AIDS epidemic undoubtedly contributed to the lack of progress, commentators noted that a lack of co-ordination between national and international bodies concerned with ageing was also a significant factor.[11]

The *United Nations Principles for Older Persons*[12] were adopted by the General Assembly in 1991. These principles are grouped under the headings of independence, participation, care, self-fulfilment and dignity. As will be discussed further in Chapter 5, in the continued absence of an international covenant related specifically to the rights of older people, and the lack of specific reference to the rights of older people in the ICESCR, these principles still constitute the core statement of the rights of older persons. It was noted by the Committee on Economic, Social and Cultural Rights in its General Comment No 6 that

> [u]nlike the case of other population groups such as women and children, no comprehensive international covenant yet exists in relation to the rights of older persons

[10] *Second Review and Appraisal of the Vienna International Plan of Action on Ageing*, UN Doc E/1989/13 (1989).
[11] See for example, H Sokalski, 'Global Targets, Local Implications', (1992) 19(4) *Ageing International* 17.
[12] *United Nations Principles for Older Persons*, GA Res 49/91, UN Doc A/Res/46/111 (1991).

> and no binding supervisory arrangements attach to the various sets of United Nations principles in this area.[13]

It is worth pausing here to reflect upon the extent to which the phenomenon of elder abuse gained attention within these core international documents of the 1980s and 1990s. The development of the international awareness of ageing issues created by these international documents and policies was occurring at the same time as an evolving recognition of elder abuse as a discrete form of violence. In the early stages, the concept of elder abuse was evolving in a different arena: from the late 1970s onwards, theoretical and practical responses to elder abuse were a focus of particular attention in the United States of America, gaining momentum concurrent with the development of state systems of adult protective services developed in response to professional and community concern.[14]

During these two decades, the language of the international ageing policies and programmes regarding the health, security and social inclusion factors that have an impact upon the incidence of elder abuse was framed in general terms. Perhaps as a result of the early parallel development of professional and community understandings of the notion of elder abuse, the *Vienna Plan of Action* makes no specific reference to elder abuse or the abuse of older persons. Certainly, prohibition of elder abuse is implicit in the multiple objectives and recommendations of the document.

B. Madrid International Plan of Action on Ageing

Concerns over the lack of progress on implementing the *Vienna Plan of Action* recommendations were compounded by criticisms that it had been framed with too great a

[13] Committee on Economic, Social and Cultural Rights, *The Economic, Social and Cultural Rights of Older Persons; General Comment No 6,* UN Doc/CESCR GC 6 (1995) [13].
[14] See further Lisa Nerenberg, *Elder Abuse Prevention, Emerging Trends and Promising Strategies* (Springer Publishing Company, 2008) 36-40.

focus on social welfare strategies. In response, at the tenth anniversary of the *Vienna Plan of Action*, the General Assembly adopted a set of global targets on ageing for the year 2001. These targets were intended to 'provide a pragmatic focus for the broad and ideal goals of the International Plan of Action on Ageing, and accelerate its implementation into the next millennium'.[15] The 'pragmatism' of the eight enunciated goals was evident in the emphasis on a 'more effective use of existing structures, procedures and resources'. This perhaps represents an acknowledgement that if the ambitious objectives and principles of the documents of the preceding decade were to be realised, a shift in approach was imperative. In light of the economic, political and social realities of the time, a requirement to focus less on small scale specific projects for individual groups of older people, and more on the broader developmental aspects of ageing was perceived to be the path forward.

In 2002 the Second World Assembly on Ageing in Madrid adopted the *Madrid International Plan of Action on Ageing* (the '*Madrid Plan*').[16] Reflecting upon the previous two decades of progress on ageing, the *Madrid Plan* had a clear change of emphasis from its predecessor by emphasising 'including older persons in policies rather than designing policies for older persons.'[17] Three 'priority directions' were identified in the *Madrid Plan*. Within the first priority direction, ageing issues were firmly entrenched within the developmental framework, with the emphasis on active participation in society and development, work force participation, the consequences of urbanisation, access to education, intergenerational solidarity, poverty eradication, social security and protection,

[15] *Global Targets on Ageing for the Year 2001; A Practical Strategy. Report of the Secretary General*, UN Doc A/47/339 [1] (1992).
[16] United Nations Second World Assembly on Ageing, *Political Declaration and Madrid International Plan of Action 2002*, UN Doc A/CONF.197/9 (2002).
[17] United Nations Department of Economic and Social Affairs, *Mainstreaming Ageing into National Policy Frameworks – an Introduction* (2003) http://www.un.org/esa/socdev/ageing/documents/workshops/Vienna/issues.pdf

and vulnerability of older persons in emergencies.[18] The second priority direction identified the advancement of health and well-being into old age through health promotion, access to adequate food, nutrition, health care services, recognition of the impact of HIV/AIDS, mental health concerns and attention to the needs of older persons with disabilities. As will be discussed in Chapter 6, in view of the fundamental contribution ill-health makes to the risk of elder abuse, the recognition and promotion of the right to the highest attainable standard of physical and mental health provides a key platform on which to address the occurrence of elder abuse.

Clearly the elements of both of these 'priority directions' have the potential to have an impact upon the incidence and prevention of elder abuse. By contrast to the earlier international documents, the language of the report of the Madrid Second World Assembly makes closer reference to the specific issue of elder abuse. Article 5 of the *Madrid Political Declaration* adopted by the General Assembly following the Madrid World Assembly is of particular note:

> We reaffirm the commitment to spare no effort to promote democracy, strengthen the rule of law and promote gender equality, as well as to promote and protect human rights and fundamental freedoms, including the right to development. We commit ourselves to eliminating all forms of discrimination, including age discrimination. We also recognise that persons, as they age, should enjoy a life of fulfilment, health, security and active participation in the economic, social, cultural and political life of their societies. We are determined to enhance the recognition of the dignity of older persons and to eliminate all forms of neglect, abuse and violence. [19]

Many of the aetiological factors contributing to the occurrence of elder abuse were addressed by the other articles of the *Madrid Political Declaration*. For example, Article 14 recognises 'the right to the enjoyment of the highest attainable standard of physical and

[18] United Nations Second World Assembly on Ageing, *Political Declaration and Madrid International Plan of Action 2002*, 'Older Persons and Development,' UN Doc A/CONF.197/9 (2002) [16].
[19] Ibid art 5.

mental health', and Article 16 acknowledges the need to 'encourage mutually responsive relationships between generations'.[20]

The third priority direction 'ensuring enabling and supportive environments' was a significant advance in formalising the recognition of violence against older people. With an emphasis on ensuring adequate physical environments and attention given to caregiver policies, the *Madrid Plan* here directs attention to the specific types and settings of violence and abuse against older people.

> Neglect, abuse and violence against older persons takes many forms – physical, psychological, emotional, financial – and occurs in every social, economic, ethnic and geographic sphere....Communities must work together to prevent abuse, consumer fraud and crimes against older persons. Professionals need to recognise the risk of potential neglect, abuse or violence by formal or informal caregivers both in the home and in the community and institutional settings.[21]

Elder abuse is a complex phenomenon, the causes of which stem from both broad social and economic developmental conditions, but also from the particular circumstances of the individual, a phenomenon which cannot solely be addressed by policies focussing on wider concerns of ageing. The dilemma in the development of future strategies is evident from this analysis. On the one hand, the mainstreaming approach of the *Madrid Plan* is at once both necessary and desirable. Poverty, conflict, social and cultural changes cause and compound elder abuse and strategies aimed at these broad concerns must take specific account of older persons.

On the other hand, caution must be exercised to avoid the impact of strategies to address elder abuse being diluted by the issue being 'thinned out' throughout broad and diverse development of human rights recommendations and plans. Elder abuse statements need to

[20] Ibid art 16.
[21] Ibid [107].

be cohesive and emphatic. The difficulty in mainstreaming ageing issues is evident though the following outline of the United Nations *Millennium Development Goals*. There is a need to maintain a balance between targeted programmes and integration and mainstreaming of ageing and elder abuse into wider forums.

C. United Nations Millennium Development Goals

Despite the international recognition during the 1980s and 1990s of the imperative of including ageing issues within the development agenda, both the United Nations *Millennium Declaration*[22] and the *Millennium Developments Goals* (MDGs) are devoid of specific reference to older persons. This absence of any specific attention within these documents to the actual and potential vulnerabilities of older people is bewildering; the successful attainment of those goals by 2015 deadline (or any time in the foreseeable future) is dependent on specific attention being given to the state of the world's older people. Of the eight Millennium Development Goals, several have the potential to have an impact upon older people's lives. Furthermore, the broader success of those goals for populations other than older people is unlikely to be met unless the concerns of older people are taken into account.

Millennium Goal No 1 aims to eradicate extreme poverty and hunger and is perhaps the most crucial of all the goals to the situation of older persons. The specific targets of that goal include; between 1990 and 2015 to halve the proportion of population whose income is less than a dollar a day; to achieve full and productive employment and decent work for all including young people and women; and to halve between 1990 and 2015 the proportion of people who suffer from hunger. There are no specific targets aimed at older

[22] *United Nations Millennium Declaration*, GA Res 55/2, 55th sess, 8th plen mtg, UN Doc A/Res/55/2 (2000).

persons, exposing a lack of acknowledgement of the varying intergenerational causes and effects of chronic poverty. Unless significant disaggregation of data relating to poverty and hunger is undertaken, and specific targets are developed which recognise the intergenerational issues, progress in achieving the goal will be compromised. Factors which contribute to poverty in older age include the increasing responsibility of older people to care for adult children suffering from HIV/AIDS, or orphaned grandchildren, or grandchildren unable to be cared for by their parents due to ill health or the need to seek work away in urban areas, increased difficulty of older people in rural areas to access services, and age-related physical and cognitive disabilities.

By contrast, the *Madrid Plan* is clear that the eradication of poverty among older persons is a 'fundamental aim'.

> Although global attention has recently been focussed more actively on poverty eradication targets and policies, older persons in many countries still tend to be excluded from these policies and programmes. Where poverty is endemic, persons who survive a lifetime of poverty often face an old age of deepening poverty.[23]

Furthermore it is noted that gender inequalities contribute to a 'feminisation of poverty' particularly among older women. The *Madrid Plan* does set out concrete objectives and targets for the reduction of poverty among older people including, inter alia, the aim to reduce by one half the proportion of persons living in extreme poverty, and inclusion of the particular needs of older women, the very old, older persons with disabilities, and older persons living alone in strategies and programmes.[24] It is evident that the progress of the overall outcome of reducing global poverty and poverty of older people will be dependent on the effective implementation of both of these two vital strategies.

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[23] United Nations Second World Assembly on Ageing, *Political Declaration and Madrid International Plan of Action 2002*, 'Older Persons and Development,' UN Doc A/CONF.197/9 (2002) [45].
[24] Ibid [48].

The success of Millennium Goal No 2, to achieve universal primary education for boys and girls by 2015, will also be dependent upon an acknowledgement of the role older people play in the lives of children. In developing nations where the HIV/AIDS epidemic has resulted in large numbers of older people (particularly women) being the primary care givers for their grandchildren who may have been orphaned by HIV/AIDS, the social and economic conditions of those older person's lives will have a direct impact on the likelihood of achieving that goal. For example, an elderly grandparent may not only adopt the role of care giver but become the provider of informal education and the provider of access to formal education services and often be a financial contributor to the education of his or her grandchildren. Programmes which address poverty reduction, income security, social security, access to health care of older persons will undoubtedly have an impact upon the likelihood of achieving educational outcomes for the children in their care. By contrast to the MDGs' emphasis on child education, the *Madrid Plan* stresses the education rights of older people. It refers to life-long access to knowledge, education and training, specific targets such as achieving adult literacy rates by 50 per cent by 2015, and measures to ensure access to the benefits of new technologies are available to older persons.[25]

Gender equality and the empowerment of women is addressed by Millennium Goal 3 which sets targets to reduce gender inequality in education by 2015. This goal will have beneficial effects on the intergenerational impacts of poverty if achieved. However the current targets are focussed on girls and young women, and do not set any specific goals for gender equality among older people.

The role of older persons in the successful fulfilment of the other MDGs is evident. Millennium Development Goal 4 to reduce by two thirds, under 5 child mortality between

[25] Ibid [40].

1990 and 2015, and Millennium Goal 5 to reduce by three quarters the maternal mortality ratio will be assisted by an understanding of the role older people may undertake in many cultures in the care of young children and in providing perinatal support to women within their immediate and extended families.

The goal to reduce HIV/AIDS, malaria and other diseases has the potential to have a direct impact upon the incidence of those diseases among older populations. Public health strategies must take into account older people as a specific target population for education programmes designed at primary and secondary prevention, access to preventive interventions such as the provision of immunisation, and the provision of health care and services to combat disease and illness. Recognition of older persons as a particular population group within programmes aimed at achieving these goals will ensure appropriate consideration is given to rates of literacy, access to and familiarity with information technology, as well as access to services due to isolation in rural communities, or due to physical and cognitive disability.

The Millennium Development Goals set some ambitious and desirable targets for many key development indicators. However, without specific acknowledgement of the issues confronting the world population of older people, and the role of older persons in the eight goals aspired to, the MDGs are incomplete and those that are enunciated will be only variably achieved.

D. The World Health Organization

Extensive public health measures and programmes are essential for the fulfilment of the Millennium Development Goals. Effective solutions to large scale health dilemmas require co-operation between the traditional public health and human rights measures. Adopted by

the World Health Organization in 1999 during the International Year of Older Persons, the concept of 'Active Ageing' was promoted as the framework for its public health strategies: 'Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age.'[26] The 'Active Ageing' policy is a marriage between the traditional analytical tools of public health disciplines and the language of international strategies which focus on rights and responsibilities. The result is the World Health Organization's 'life course' approach to the promotion of the well-being of older persons. By maintaining and promoting every individual's functional capacity through his or her lifetime, the rate and age of onset of disability can be prevented and delayed. For example, if attention is directed to aetiological factors such as smoking, alcohol consumption, physical activity and diet which are important for non-communicable diseases, then primary prevention and secondary intervention programmes can be effective in maintaining independence and preventing disability in older age.[27]

Upon entering the new millennium, policy developments of the World Health Organization echoed the shifts from welfare provision to the inclusion of older people in developmental policy that were evident in the evolution from the *Vienna Plan of Action* to the *Madrid Plan*. The World Health Organization acknowledges that appropriate responses to ageing demographic changes are guided by the *United Nation Principles for Older People* — action on health, participation and security is set firmly within a human rights paradigm.

Elder abuse prevention will be aided by all levels of activity within this model. Decreasing the rate of decline in functional capacity over an individual's lifetime may delay the onset of physical or cognitive disability which may threaten independence and 'active ageing'.

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[26] World Health Organization, *Active Ageing: A Policy Framework*, WHO/NMH/NPH/02.8 (2002) 6. http://www.who.int/ageing/publications/active_ageing/en/

[27] Ibid 14 (Figure 4).

As well as through the indirect benefits gained by attention to many of the risk factors for the occurrence of elder abuse, the World Health Organization's Active Ageing Policy Framework has specifically addressed the issue of elder abuse. A stated policy response is to 'ensure the protection, safety and dignity of older people by addressing the social, financial and physical security rights and needs of people as they age' and to 'increase awareness of the injustice of elder abuse through public information and awareness campaigns.'[28]

E. Active and Healthy Ageing – Public Health Considerations

Elder abuse is both a cause and a consequence of the inequality and discrimination that many older people around the globe experience and poses a significant threat to healthy ageing. Under the Constitution of the World Health Organization adopted in 1946,[29] health is defined in broad aspirational terms as 'a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity'. In more recent times, the World Health Organization's emphasis on the core of 'active ageing' encompasses the multidimensional elements of physical health, mental health and social inclusion and participation as reflecting the definition set out in its Constitution. A deliberate move was made from earlier references to 'healthy ageing' to use of the term 'active ageing' in order to 'convey a more inclusive message than healthy ageing and to recognise the factors in addition to health care that affect how individuals and populations age.'[30]

[28] Ibid 53.
[29] *Constitution of the World Health Organization*, opened for signature 22 July 1946, 14 UNTS 186, preamble (entered into force 7 April 1948).
[30] World Health Organization, above n 26, 13.

Alan Walker and Tony Maltby note that the emergence of a common definition of 'active ageing' has been problematic:

> The problem with active ageing, like many scientific ideas that are transported into policy arenas, is that it lacks a precise, universally accepted definition. As a result it has quickly become common currency globally and, basically, all things to all people. [31]

Walker and Maltby advocate for a paradigm of active ageing that moves away from models that have predominated in Europe in the past which have been based on prolonged workforce participation, to a model that incorporates other elements such as family, leisure and community.[32]

Physical and mental illnesses contribute to rates of disability in old age, particularly in very old age, and are significant aetiological factors in the occurrence of elder abuse and neglect. It is essential when developing public health, legal or social strategies that the specific health concerns facing the current cohort of older persons are clearly articulated. This will necessarily be a dynamic process — the environmental and lifestyle factors that determine the health of individuals and populations will change with time.

This section analyses the important health concerns that have an impact upon the lives of older people in the developed and developing world in the 21st century. It also examines how those health concerns may have an impact in incidence of elder abuse and outlines the preventive and remedial strategies which are discussed throughout this thesis. A discussion of the 'right to health' in international law will be undertaken in Chapter 6 in the context of a human rights approach to elder abuse prevention.

[31] Alan Walker and Tony Maltby, 'Active Ageing: A Strategic Policy Solution to Demographic Ageing in the European Union' (2012) 21 *International Journal of Social Welfare* S117, S119
[32] Ibid S127

The 2010 World Health Statistics Report[33] of the World Health Organization reports that in low income countries, communicable diseases, maternal and perinatal diseases and nutritional deficiencies contribute overall to the majority of Years of Life Lost (YLL).[34] As these types of illness disproportionally affect younger people, they impact on the overall life expectancy of the population. But as life expectancy increases in these countries, with improved access to primary prevention and health care services, there is an 'epidemiological transition' with a shift overall towards an increased burden of disease and mortality arising from non-communicable diseases (NCDs).

In populations aged over 60 years in low, middle and high income countries, non-communicable diseases are responsible for the majority of mortality and morbidity. Cardiovascular disease, hypertension, stroke, diabetes, cancer, chronic obstructive pulmonary disease (COPD), musculoskeletal conditions such as arthritis and osteoporosis, mental health conditions such as dementia and depression, and visual impairment are the major causes of chronic disability among older people.

Specific risk factors contributing to the incidence of all disease types, but in particular NCDs, can have an impact on the potential vulnerability of older persons to elder abuse. By slowing the rate of decline in functional capacity of people as they age, through rigorous attendance to prevention and risk reduction programmes, the 'healthy life expectancy'[35] of individuals and populations can be extended. Demographic data on the increasing overall life expectancy of populations can have a dramatic impact in highlighting the broader economic and social implications of an ageing population. Disaggregated data that addresses life course strategies for delaying or preventing the onset

[33] World Health Organization, *World Health Statistics Report 2010* at www.who.int
[34] Years of Life Lost (YLL) refers to the years of life lost due to premature mortality.
[35] World Health Organization, above n 26, 13. Note 'healthy life expectancy is equated with 'disability free life expectancy.'

of disability is necessary to address the potential public health and individual health implications of overall improvements in life expectancy. A greater 'healthy life expectancy' will clearly enhance the likelihood of individuals retaining autonomy and independence generally and will also contribute specifically to the reduction of risk in relation to elder abuse.

Broadly grouped, there are several core determinants of active ageing:[36]

i. Behavioural and lifestyle factors such as smoking, alcohol consumption, diet, and physical activity;
ii. Individual factors related to genetic predisposition to disease affecting physical and cognitive capacity;
iii. Physical environmental factors such as access to exposure to environmental hazards, access to safe housing, water and food;
iv. Social factors such as the provision of education, social inclusion and security;
v. Economic determinants such as employment opportunities, income provision and social security; and
vi. Health determinants including access to primary care services, acute hospital services, pharmaceutical provision, disease prevention programmes, access to health education, provision of and access to rehabilitation, residential and mental health care facilities.

Evidently, each of these determinants of active ageing is highly dependent upon the others and, as will be identified in the ensuing discussion on the regional challenges, is permeated by cultural and gender perspectives. Success in promoting 'healthy' ageing, encompassing both physical and mental health, is contingent upon attention being directed to all aspects

[36] See especially, World Health Organization, above n 26.

of the active ageing framework. Conversely, overall achievement in promoting active ageing will be limited if the pervasive influence of health on the economic and social aspects of people's lives is underestimated.

F. Regional and Cultural Ageing Challenges

The conceptualisation of ageing demographic change as a 'challenge' has come under some criticism in recent times. By viewing demographic change as a challenge, it is suggested that the corollary is that it is a 'problem' that 'the international community would have to 'face', giving policy responses to a phenomenon of decreased productivity and increased demand for social services, particularly health care and income security.'[37]

There is merit in these concerns that the notion of a 'problem' perpetuates the negative stereotypes that historically have pervaded policy and community perspectives on ageing. A better view is that ageing itself is not a problem or a challenge, but an achievement; the challenges arise out of some but not all of the variable associations with and consequences of ageing.

It is imprudent however, to remove altogether the notion of 'challenge' from the dialogue on ageing — the language provides the international community with a cogent reminder that in order for individuals and communities to benefit fully from the achievements of ageing, opportunities must be celebrated and challenges must be recognised and met. Elder abuse is one such challenge: society can celebrate the health and social improvements that

[37] Alejandra Ayuso, 'Mainstreaming Ageing: Forging Links between the Madrid Plan of Action and the Millennium Development Goals' (Speech delivered at the Proceedings of the 13th Annual Observance of the International Day of Older Persons, United Nations, New York, 2 October 2003) http://www.globalaging.org/elderrights/world/2004/idop.pdf .

have contributed to increased longevity but be alert to the threat that elder abuse poses to some members of society.

Global and regional variation exists in the particular barriers experienced by both older individuals and population groups, to fulfilment of active ageing. The discussion below will highlight some global and regional issues which have the potential to have an impact upon the incidence and prevalence of elder abuse.

i) Urbanisation

Urbanisation is a phenomenon common to both developed and developing countries which poses a challenge to active ageing and the ability of societies to provide a supportive and enabling environment for older citizens. For those older people who are living within urban areas there is a need to have access to employment, adequate housing and, if necessary, supportive residential care. While urbanisation in some areas has improved access to resources for older people, in others competition for employment and resources is intense. For example, cities in developing countries are often densely populated with large numbers of people living in temporary or improvised housing.

For older people who remain in rural areas, the effects of urbanisation can be felt through the loss of traditional social structures that may have provided support to individuals with physical or cognitive disability. Economic constraints often result in resources being directed away from rural areas to population centres in the cities, further exacerbating the social isolation of older people. In addition, health care, transport infrastructure and access to food supplies may all be compromised.

ii) Societal attitudes

Changes in societal attitudes to older people are interconnected with the effects of urbanisation and industrialisation upon older people in many countries. As access to

information technological advances has expanded, the central role of older people within family structures in many cultural groups has altered. Evidence indicates that respect for and reliance upon the experience and knowledge of older people within families and communities is changing. For example, in a recent study conducted by Agewell in India, it was noted that:

> Today's generation may completely ignore or sidestep an elderly person in their own homes, either deliberately or unknowingly, due to various factors but would bend backwards to show respect to the elderly in the neighborhood. While respect for the elderly is engrained in our system, the vagaries of daily life and pressures make us ignorant towards it in a way that is blatant for the elderly but unnoticeable to us. Almost a fourth of the respondents agreed that respect for the elderly is missing at home.[38]

And yet, too often there is an unfortunate disregard for the reality of the lives of many older people who, particularly as a result of the HIV/AIDS epidemic, remain a fundamental source of income and practical support for many families. So too, is there a broad failure to acknowledge that many technological, health and other advances are the direct result of the efforts of earlier generations who now are disconnected from the benefits of those advances.

'Intergenerational Interdependence' is the term adopted by the *Madrid Plan* of Action aimed at removing the perception of older people as a burden to both communities and governments at both the level of policy and programme development, and through reshaping societal views on ageing.

> Solidarity between generations at all levels – in families, communities and nations – is fundamental for the achievement of a society for all ages. Solidarity is also a major prerequisite for social cohesion and a foundation of formal public welfare and informal care systems[39]

[38] Agewell Foundation, *Study on Perceptions towards Human Rights of Older Persons* (July 2013)14.
[39] United Nations Second World Assembly on Ageing, *Political Declaration and Madrid International Plan of Action 2002*, 'Older Persons and Development,' UN Doc A/CONF.197/9 (2002) [42].

The terminology of 'intergenerational interdependence' is somewhat cumbersome. Perhaps it is more usefully perceived as a shift from dependence to a process of 'exchange'. If communities can be encouraged to view the relationships that exist between generations not in terms of hierarchy or burden of care, but rather those of reciprocity and exchange, it may assist in promoting the positive aspects and benefits of the inclusion of older people with the active life of the community.

iii) Gender disparity

Older women comprise an increasing proportion of the global population living in extreme poverty, and represent a greater proportion of the 'very old'.[40] A gender perspective on ageing necessarily embraces a life course approach because the gender norms of many societies impact on women as they enter old age. Greater amounts of time involved in unpaid work, lower incomes for women, social security systems which fail to recognise engagement in informal work, discriminatory laws and cultural practices in relation to access to education and women's property rights are the foundation of the health, economic and social conditions of older women. Gender perspectives will be explored in Chapter 8 in the context of realisation of the rights of older women.

iv) Older people in emergencies

Older people may be particularly vulnerable when affected by emergencies such as natural disasters. They may also be caught in the path of conflict, or be part of the world's growing populations of internally displaced persons and refugees. It has been observed by HelpAge International, a global network of not-for-profit organisations focussing on the situation of older people across the globe, that:

[40] World Health Organization, *Women, Ageing and Health: A Framework for Action* (2007) 3.

> Although the humanitarian community does include older people in its current definition of vulnerability, it is often as an afterthought....and the elderly always at the end of the sentence, and almost always at the end of the list of priorities.[41]

Practical challenges arise in accessing food and clean water, shelter, medical assistance and other emergency relief for older people with physical or cognitive disability during humanitarian crises or other emergency situations. This can be exacerbated by separation from family due to both displacement, and increasingly by abandonment.[42] An under-recognised problem for older people also arises when camps are closed and displaced populations are repatriated. When older people are left behind their situation can become increasingly dire, or when they are repatriated they may face uncertainty with regard to access to land, shelter and means to provide food and income.

In addition to the challenges of competing for and accessing resources in humanitarian situations, the specific risk of elder abuse is heightened, not only through neglect and abandonment, but by violence. For example it has been reported by HelpAge that in the conflict in Darfur, older women took responsibility for collecting food, water and firewood from outside protected areas in order to protect the younger women, and as a consequence were increasingly exposed to sexual violence.[43]

v) Access to legal rights

Normative gaps exist in the legal protection of human rights as they relate to the actual experiences of older people. Of equal significance is the implementation gap that exists in respect of those rights. Access to justice persists as a significant impediment to older people asserting their legal rights. Promoting awareness of their rights among older people

[41] Will Day, Antoinette Pirie and Chris Roys, 'Strong and Fragile: Learning from Older People in Emergencies' (Report, HelpAge International, 2007) 1.
[42] Ibid 6.
[43] Ibid 18.

and the communities that may facilitate older people accessing those rights, remains a key element of improving access to and implementation of legal rights. For example, the 2013 study conducted by the Agewell Foundation in India identified that only 5.5 per cent of the 32 100 respondents to the survey on *Perceptions Towards the Human Rights of the Elderly* reported that they were aware to a great extent of the legal provisions for older persons in India. Only a further 7.2 per cent of respondents had some knowledge of those provisions.[44] The report noted that

> in a traditional society like India, most cases pertaining to the elderly go unreported and never reach a formal legal space for resolution. The social stigma attached to anything related to the police or courts is too deeply entrenched especially within the earlier generations to take any proactive steps for resolution.[45]

The study concluded that improvement is being made in the low levels of awareness of the community of the legal provisions for older persons that have existed historically in India. That community members find it 'practically impossible to translate their awareness into actual help/assistance to older persons',[46] remains the ongoing impediment to the realisation of those legal rights.

G. Conclusion

While elder abuse is not a modern phenomenon, the emphasis of this chapter has been upon the contemporary conditions that influence the lives of older people around the globe. It is a modern phenomenon that the absolute and relative numbers of older people in the world are dramatically rising. On the international stage, the last three decades have

[44] Agewell Foundation, above n 36, 23
[45] Ibid.
[46] Ibid 40.

heralded significant progress in the promotion and protection of the rights of older persons, chiefly through the mainstreaming of ageing within the development agenda, and the gradual translation of principles and policies into definitive goals and practical programmes. To this end, the *Madrid International Plan of Action on Ageing* remains pivotal.

Solutions must take account of past mistakes and successes, recognise the current social, economic and humanitarian conditions that may increase older people's vulnerability to abuse and neglect, and attempt to anticipate the challenges for future cohorts of older people. The next chapter turns from the global context of policies on ageing to Australian perspectives on elder abuse.

Chapter 3

AUSTRALIAN PERSPECTIVES ON ELDER ABUSE

The relative economic prosperity and stability that Australia has enjoyed and maintains, may appear to shelter older Australians from many of the challenges that are being considered in the international arena and that have been raised throughout the preceding chapter. Reflecting upon the determinants of active ageing, however, it is clear that as Australian society is economically, socially, culturally and linguistically diverse, the myriad of life experiences of Australians as they age needs to be taken into account in policy formation. For example, the impact of ongoing disadvantage for many Indigenous Australians must also been seen through the eyes and through hearing the voices of the older members of Australia's Indigenous community.

Concerns with the economic implications of increased demand for residential aged care services and the potential burden on health care resources dominate wider ageing discussions in Australia. The economic consequences of the ageing population cannot be denied; highlighting these issues can galvanise political and community awareness of the ageing demographic change. A disturbing consequence of a preoccupation with the question, perhaps best framed as 'what are our elderly people going to cost us?', is that this

has perpetuated the pervasive negative view of ageing held by large sections of the community.

A 2013 research report conducted by the Australian Human Rights Commission entitled *Fact or Fiction? Stereotypes of Older Australians*, evaluated the prevalence and depth of stereotypes and attitudes towards older Australians.[1] The report identified that 71 per cent of all Australians feel that age discrimination in Australia is common, and furthermore, 43 per cent of Australians aged 65 years or over have experienced discrimination because of their age.[2] The report also examined the role and influence of the media in the portrayal of older people, identifying that older Australians are poorly represented and portrayed.[3]

It is necessary to reiterate a theme identified in the introduction to this thesis: that success in promoting active ageing is dependent upon both the recognition of challenges and the celebration of opportunities. Reframing the question then as 'what can society gain by the empowerment and support of older people?' allows the community to recognise and attend to challenges such as the health issues outlined below.

There is a marked disparity between attention given over the last two decades at a political, professional and societal level to violence against Australia's older citizens and the attention given to violence against women and children. Dramatic changes in community and professional awareness, as well as political and legal responses have been evident in addressing family violence against women and children. By contrast, momentum has been slower in addressing violence towards and the neglect of older people within the Australian community. Periodic media reporting of distressing allegations of elder abuse often cause a corresponding flurry of media and community responses for a few days, and then interest

[1] Australian Human Rights Commission, 'Fact of Fiction? Stereotypes of Older Australians,' (Research Report, 2013).
[2] Ibid 4-5.
[3] Ibid 9.

and impetus dies away. This cycle has been repeated several times in recent decades. The media reporting of elder abuse is a vexed issue. Undoubtedly, community consciousness is raised by such reporting of what are often the most severe occurrences of abuse, but it is unclear that this leads to a sustained or co-ordinated contribution to elder abuse awareness. The nature and spectrum of acts that constitute elder abuse are rarely explored in these contexts, and the news cycle should not be relied upon to create community momentum to support and respond to elder abuse. For example, recent reports of the alleged inappropriate use of anti-psychotic medication in residential care as a form of restraint upon people with the behavioural and psychological symptoms of dementia, prompted brief community outrage.[4] The media reporting of elder abuse in this manner can prompt reactionary strategies from governments which continue to add to a piecemeal approach to elder abuse prevention. Sustained, considered responses are required.

This chapter will examine the government policy responses to ageing broadly and to elder abuse which have evolved in Australia in recent decades, and how they have and will have an impact upon the phenomenon of elder abuse.

A. 'Ageing in Place' within Australia

'Ageing in place' encapsulates the notion that individuals, as they age, should be given the opportunity to maintain as great a degree of independence and autonomy in their living circumstances as possible, and unwanted or unnecessary institutionalisation should be avoided. Choice is integral to what has been termed 'ageing in place' which is explained below. An examination of the social and practical consequences of government policies in

[4] Australian Broadcasting Corporation Television, 'Families Count Cost of Dementia Drugs Prescriptions', *Lateline*, 16 August 2012, (Margot O'Neill) http://www.abc.net.au/lateline/content/2012/s3569736.htm.

relation to ageing and community and professional attitudes to the care of older Australians both in domestic and residential care settings is integral to understanding and developing responses to elder abuse and neglect. Ageing in place was a key objective of the reforms to the aged care system that were introduced by the *Aged Care Act 1997* (Cth).[5]

In its broadest interpretation, ageing in place represents the national implementation of international ageing policies and responses. For example, ageing in place is one manifestation of the *United Nations Principles for Older Persons*[6]. Principles 5 and 6 which are set out within the broad aim to promote independence, are clear expressions of the policy of ageing in place. Principle 5 states that 'older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities'. Principle 6 states that 'older persons should be able to reside at home for as long as possible.'[7] Ageing in place also promotes the principle of participation [8] by promoting the ability of older persons to remain active within the social and intergenerational networks they have developed over a lifetime. A corollary of the policy of ageing in place has been the need to provide flexible health care, personal care and other supportive services and the necessity to acknowledge and respond to the impact such a policy has upon informal care givers. Individually tailored care programmes are at the heart of providing quality care and assistance to older people with physical and cognitive illness and disability.

Contrary to widely held community perceptions that large proportions of older people live in 'nursing homes', in Australia 94 per cent of older people aged 65 years or over live in private dwellings, and only 6 per cent live in non-private residences (including hotels, motels, guesthouses and care accommodation such as public hospitals, residential care

[5] Australian Institute of Health and Welfare, 'Ageing in Place: Before and after the 1997 Aged Care Reforms' (*Bulletin*, Issue 1 June 2002).
[6] *United Nations Principles for Older Persons*, GA Res 49/91, UN Doc A/Res/46/111 (1991) Annex.
[7] Ibid.
[8] Ibid 7-9.

facilities).[9] Of these people living in private dwellings, the majority live with their partner, although this falls to only 26 per cent in the group over age 85 years. Older people living alone represent 29 per cent of those in private dwellings, rising to 39 per cent of those aged over 85 years.[10]

A detailed discussion of the structure of community aged care services is not within the scope of this thesis. However it is valuable to provide a brief outline here, insofar as such services have an impact on the likelihood of care providers within those organisations to be active participants in the prevention and detection of elder abuse and neglect. Care to older persons within the community can be provided by informal or formal caregivers. Informal caregivers such as spouses, partners, family members, neighbours and friends, are the primary providers of care, predominantly unpaid, in the community to older Australians who require assistance. Formal care services are provided by joint arrangements between the Commonwealth, State and Territory governments, with funding and regulation provided by the Commonwealth Government under the provisions of the *Aged Care Act 1997* (Cth) and the *Aged Care Principles.*

Incremental care provision forms the basic structure of community care services within recent models for the provision of aged care. Previous structures were implemented in 2005 as part of what were then new initiatives and broader aged care reforms of 'The National Framework for Action on Dementia 2006-2010'.[11] At the time of writing in 2013, the structure and funding arrangements for the provision of home care services in Australia is undergoing revision. The model that has operated for the last several years involved several strategies, including community care initiatives for people with dementia, funding

[9] Australian Institute of Health and Welfare, *Older Persons at a Glance* (2007) 13.
[10] Ibid.
[11] 'The National Framework for Action on Dementia 2006 – 2010' (Australian Health Ministers' Conference, May 2006) http://www.health.gov.au

for early intervention and prevention strategies and research, and funding for training of professionals involved in the care of older people. Three main streams of care provision operated under this model; community care, residential care and flexible care. Services began with the provision of assistance with domestic matters such as shopping and meal preparation, house cleaning and maintenance ('activities of daily living' or ADLs) and low level assistance with personal care, via Home and Community Care (HACC). If required, more complex Community Aged Care Packages (CACPs) were available for older individuals who would otherwise be eligible for low level residential care due to, for example, requirements for assistance with personal care such as dressing, eating, toileting and showering ('personal activities of daily living', PADLs), or health care needs (including for example ongoing requirements for nursing, physiotherapy or other health and allied health services). At the higher end of care requirements, Extended Aged Care at Home (EACH) services provided for higher levels of nursing care, and care for people who experience behavioural and psychological symptoms of dementia. An important component of these packages was the provision of respite services to dependent older people and informal care givers which could operate in the home or in residential care.

The Intergenerational Report 2010 highlighted the pace of demographic change in relation to the ageing of Australia's population.[12] The Report focussed on the economic impact of the ageing population and analysed the consequences of increased demand on aged care services in the forthcoming decades.[13] It subsequently prompted the federal government to instigate an inquiry into the impact of that demographic change upon Australia's aged care services sector. The Productivity Commission's 2011 report noted that improvements have been made in the range and quality of aged care available and the monitoring of standards

[12] Australian Government, *Australia 2050:Future Challenges*, (The Intergenerational Report, 2010), http://archive.treasury.gov.au/igr/igr2010/Overview/pdf/IGR_2010_Overview.pdf
[13] The impact of climate change was the other major focus of the Intergenerational Report 2010.

and safeguards have also evolved.[14] However, the Productivity Commission also identified weaknesses in the aged care system, including a projected relative shortfall in the aged care workforce in coming years with the demographic changes producing an anticipated increase in demand for aged care services. In addition, the Report identified complexities in the current system, variable quality and workforce training issues as requiring re-evaluation and reform.[15]

In April 2012, in response to the Productivity Commission findings, the federal government announced reforms in aged care policy entitled 'Living Longer, Living Better.'[16] In June 2013, five Bills forming the 'Living Longer, Living Better' reforms were passed by the federal Parliament, which included the introduction of a new structure of four levels of 'Home Care Packages.'[17] The four levels correspond to basic, low, intermediate and high care needs of individuals and replace the CACP and EACH care packages described above. One element of the reforms is to provide additional dementia care support through all levels of the proposed 'Home Care' system, as distinct from the previous system whereby dementia support was available through the EACH-D arrangements for high level care recipients. Consumer Directed Care (CDC) is a welcome component of the 'Living Longer Living Better' reforms.[18] CDC allows for greater choice

[14] Productivity Commission, Australian Government, *Caring for Older Australians*, Productivity Commission Inquiry Report No 5 (2011) xxi http://www.pc.gov.au/publications
[15] Ibid.
[16] Press release. 'More Choice, Easier Access and Better Care for Older Australians' 20 April 2012, Mark Butler, Julia Gillard, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr12-mb-mb032.htm
[17] See: Australian Government, *Living Longer Living Better* (2013) http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/Proposed-Legislative-Changes
[18] Department of Health and Ageing, 'Living Longer, Living Better' http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/Consumer-Directed-Care-Home-Care-Packages

by older people receiving home care packages in relation to the types and delivery of services and facilitates older people exercising greater authority to meet their care needs.[19]

On a second level 'ageing in place' represents a specific Commonwealth Government policy in relation to the provision of residential aged care services. The changing needs of people can be accommodated within residential institutions avoiding the need for people to be relocated in order to meet their care needs. 'Low level care' encompasses the provisions of accommodation, assistance with ADLs, and some PADLs, while 'high level care' allows for the provision of complex nursing and other care needs. 'Ageing in place' policy in the context of residential care was created in response to the practical challenges occurring for many individuals in aged care facilities. Many people living within low care facilities, such as hostel or special accommodation houses, were increasingly having their rising care needs attended to in those facilities that were designed for residents with less significant individual care needs. These people were effectively ageing in place, and yet the system was not designed, resourced, or funded to deal with this. As a consequence, one of the objectives of the *Aged Care Act 1997* (Cth) is 'to promote ageing in place through the linking of care and support services to the places where older people prefer to live'.[20] This Act allows for the funding and provision of different levels of care within a particular residential facility. While not available within all facilities, processes which support ageing in place, can avoid repeated and often unsettling and distressing changes in care settings for people at times when they may be suffering physical and emotional stress.

Dementia is the leading cause of disability burden in older Australians, and is rapidly becoming one of the major overall sources of burden of disease in Australia.[21] In

[19] See generally, Carmel Laragy and Gerry Naughtin, *Increasing Consumer Choice in Aged Care Services: A Position Paper* (Brotherhood of St Laurence, 2009)
[20] *Aged Care Act 1997* (Cth), s 2-1(1)(j).
[21] Access Economics, *Keeping Dementia Front of Mind: Incidence and Prevalence 2009- 2050* (Report for Alzheimer's Australia, 2009) 84.

recognition of the major contribution that dementia will make to the increased prevalence of disability in older age with the demographic changes of the next few decades, recent successive governments have targeted dementia as a health priority, fearing the economic impact of the increasing prevalence and incidence of dementia. In 2012 the then federal government proposed reforms to address the impact of dementia over coming decades under the banner of 'Tackling Dementia.' These reforms incorporate increased resources directed to dementia support at all levels of home care, increase funding for better care of older people with behavioural and psychological symptoms of dementia, and improved hospital acute care services for people with dementia and better support for people with early onset dementia.[22]

Policy developments at a national level in response to the growing awareness of dementia as a major health and social concern of coming decades are most welcome. The improved recognition of dementia as a key priority in health care in broader healthcare policy has enormous potential to provide a forum for the increased awareness of elder abuse, as the association between dementia and elder abuse is supported by epidemiological evidence.[23] Investment in resources directed to dementia care is fraught with the uncertainties of the political and economic environment.

However, issues of resourcing, accessibility and funding aside, it is evident from this brief outline that the aged care system in Australia has developed a structure that in principle, can facilitate the participation and independence of older people within community settings and provide for the ongoing and evolving care needs of people living in residential care.

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[22] Australian Government, 'Living Longer, Living Better: Tackling Dementia' (2012). http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-aged-care-reform-measures-toc~ageing-aged-care-reform-measures-chapter9.htm

[23] Further discussion of the risk factors and epidemiological data on elder abuse is made in Chapter 4 and further discussion of the complex and important relationship between dementia and elder abuse will be undertaken in Chapter 7.

The system is supported by a range of existing legal tools and can be enhanced in the future through thoughtful and targeted law reform to benefit the needs and prevent abuse of as well as promote the rights of older persons. These future reforms will need to take account of the range of social, economic and health influences upon the lives of older Australians.

B. The Health and Disability Status of Older Australians

This thesis contends that the law has a role in the promotion of healthy and active ageing and the prevention of elder abuse and neglect. One component of healthy and active ageing is health status. Given the aetiological role that physical and cognitive disability exerts in elder abuse and the historical emphasis upon health care and allied health care models of elder abuse prevention, prior to identifying specific legal strategies, it is valuable to first make a closer assessment of the health impacts upon ageing Australians. Delaying the onset of physical and cognitive illness and disability and thereby increasing the healthy life span of individuals, is essential for reducing the vulnerability of people to abuse. This section will examine the main factors that contribute to illness and disability in older Australians.

As discussed in the context of international public health considerations of ageing, a thorough understanding of how a person's health has an impact upon his or her vulnerability to abuse requires a 'life course' approach to health and ageing. Importantly, the health, disability and vulnerability issues that confront today's cohort of older people may not (and most likely will not) reflect those of future generations. So as health challenges evolve, so must the nature and emphasis of future strategies to combat them. While elder abuse results from the complex interaction of economic, social, health and

other factors, elder abuse strategies, including legal strategies, must take account of the current cohort of older persons but also anticipate the health impacts of behaviour of people today upon the cohorts of the future.

In 2011, 14 per cent of the population were aged 65 years or over and by 2031 they will comprise approximately 20 per cent of the population.[24] Overall life expectancy for Australian males is 83.1 years, and for females is 86.4 years, with coronary heart disease and cerebrovascular disease as the leading causes of death for both males and females.[25] The cumulative effects of behavioural factors that contribute to ill-health and disability in older age arise from such factors as smoking, physical inactivity, poor diet and alcohol consumption. These behaviours can lead to obesity, hypertension, hypercholesterolaemia and impaired glucose tolerance, which in turn pose the major risk factors for coronary artery disease, stroke and diabetes.

The Australian Institute of Health and Welfare reports that the gains in overall life expectancy achieved in recent decades have been made with gains both in years with disability and years without disability. In 2009,

- Females at the age of 65 years, could expect to live a further 21.8 years, with 16.1 of those years lived without severe or profound core activity limitation; and
- Males at age 65 years, could expect to live a further 18.7 years, of those, 15.2 years without requiring assistance with core activities of living.[26]

Severe or profound core activity limitation is defined as always or often needing personal assistance or supervision with at least one of the activities of self-care, mobility or

[24] Australian Institute of Health and Welfare, *Australia's Health 2012* (2012) 82.
[25] Australian Institute of Health and Welfare, *Australia's Health 2010* (2010) 286.
[26] Australian Institute of Health and Welfare, above n 24, 82.

communication.[27] As disability does not necessarily equate with a need for assistance, the statistics on core activity limitation are important for evaluating those individuals who are more likely to require assistance. Previously, age specific rates of disability have remained fairly stable, but the increased years of life gained have been associated with disability or severe or profound core activity limitation. However, currently there is some early evidence that increases of years of life are being gained without severe or profound core activity limitation.[28] The overall rate of severe or profound core activity limitation fell 0.5 per cent between 2003 and 2009, mainly due to a decline in physical conditions including asthma and heart disease.[29] The main implication for the assessment of vulnerability to elder abuse, is in regard to those added years of life which are (in population terms) spent with increased disability and higher levels of dependence in personal activities of daily living.

C. Elder Abuse Awareness in Australia

In Australia, elder abuse first emerged as an issue of concern in the 1980s, with discussions arising from the clinical experiences and perspectives of professionals working in services having regular contact with older people. For example, those working in primary health care, community social work, specialist gerontology and geriatrics disciplines as well as law enforcement officers provided early clinical perspectives and the first epidemiological data on the problem of elder abuse in Australia.[30]

[27] Ibid 84.
[28] Ibid 83.
[29] Ibid 111.
[30] See for example, Susan Kurrle, Paul Sadler, Ian Cameron, 'Elder Abuse – An Australian Case Series' (1991) 155 *Medical Journal of Australia* 150 and Susan Kurrle, Paul Sadler and Ian Cameron, 'Patterns of Elder Abuse' (1992) 157 *Medical Journal of Australia* 673.

The earlier phases of elder abuse awareness in the United States of America, had resulted in rapid responses to the identification of abuse of older people at the core of which was the creation of Adult Protective Services (APS) regimes across many state jurisdictions. Australia did not follow suit in this regard. From the outset, the Australian response benefited from and was informed by the broader evolution of discussion about elder abuse at an international level. This conversation had been characterised by a shift away from the emphasis on older people as frail, incapacitated and vulnerable people who require the protection of the state, an emphasis which has also characterised the response adopted to the abuse of children. Increasing criticism emerged at an international level of this paradigm of elder protection, as one which perpetuated ageism and paternalism in relation to aged members of society.[31]

Australia lacks a unified and cohesive response to address elder abuse at a national level. Nonetheless, there are promising developments. Australia has benefited from commentary and analysis of the theoretical perspectives and practical responses taking place over the subsequent decades since the first recognition of elder abuse as a phenomenon in the late 1970s. The result has been focus on practical measures that incorporate principles of empowerment and autonomy, heavily influenced by the developments at an international level. Human rights perspectives are being integrated into the development of new laws and proposed reforms and these will be discussed in subsequent chapters of this thesis. The development of elder abuse prevention policies and programmes is increasingly influenced by broader legal change such as reforms to guardianship legislation recently undertaken in Victoria[32] and the obligations and accountability generated by specific human rights

[31] See, eg, Ruthann Macolini, 'Elder Abuse Policy: Considerations in Research and Legislation' (1995) 113 *Behavioural Sciences and the Law* 349 and see generally Lisa Nerenberg, *Elder Abuse Prevention, Emerging Trends and Promising Strategies* (Springer Publishing Company, 2008) 4.
[32] Victorian Law Reform Commission *Guardianship Final Report 24*, (2012).

legislation such as the *Charter of Human Rights and Responsibilities Act 2006* (Vic) and the *Human Rights Act 2004* (ACT). The influence of the *Convention on the Rights of Persons with Disabilities*[33] upon national and international guardianship law and practice has recently been the subject of closer attention.[34]

In 2010 the House of Representatives Standing Committee into Legal and Constitutional Affairs conducted an inquiry into *Older People and the Law*.[35] The terms of reference of the inquiry were limited to the investigation of fraud, financial abuse, power of attorney provisions, family agreements, barriers to accessing justice and discrimination.[36] Regrettably, the terms of reference did not include an inquiry into older people's experience of other forms of abuse and neglect. Perhaps as a reflection of broader community concern on the problem of physical, sexual and psychological abuse, the Committee noted in the Report that it nonetheless received submissions that contained discussions relating to these types of abuse.[37]

While there has been growing acknowledgement of the importance of human rights principles in the legal responses to the challenges of ageing and elder abuse, the implementation of these principles has generally lacked consistency. For example, the amendments to the *Aged Care Act 1997* (Cth) which implement mandatory reporting obligations for suspected or alleged abuse against residents of Commonwealth funded aged care facilities can be viewed as breaching certain human rights. While the objective of these amendments to prevent violations of the rights of older people in residential care to

[33] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).
[34] For example, these issues were the focus of the 'Second World Congress on Adult Guardianship' held in Melbourne in October 2012. http://agac2012.conorg.com.au/index.html
[35] House of Representatives Standing Committee into Legal and Constitutional Affairs, Australian Parliament, *Older People and the Law* (Report, Inquiry into Older People and the Law, 20 September 2007).
[36] Ibid xi.
[37] Ibid 7.

live free from violence, abuse and neglect is admirable, it has come at the expense of respect for and fulfilment of the right to autonomy through consent to the reporting of the abuse older people who have no impairment of their decision making capacity.

Ad hoc legal responses to particular challenges facing older people should be abandoned in favour of a comprehensive national policy response that builds upon the existing legal protections available through international and domestic law and that closes the normative gaps that exist in the content of the law in relation to older persons. Furthermore, effective access, implementation and education in respect of those legal rights must be facilitated for older people themselves, professionals and the community as a whole in order to give full effect to these legal measures. Policy, practical and financial support is essential for the valuable and effective contributions being made at a community level through advocacy and education, and at a professional level through improved access to services and support and through national advocacy and lobby groups such as COTA Australia (Council on the Ageing) and the Australian Network for the Prevention of Elder Abuse (ANPEA). The policy response must not be confined to the aged care system. A broader view of ageing policy that incorporates responses and practical measures that attend to the needs of older people in residential care, home-based aged care, or independent, domestic living arrangements will be facilitated by a framework that acknowledges the rights and challenges of older people who may be vulnerable to abuse and neglect.

It is contended that there is a need and an obligation for these human rights considerations to be incorporated in the language, dialogue, theory and practice of *all* disciplines responding to the challenges facing older people, both broadly in respect of their opportunity to enjoy active and healthy ageing, but also in the context of specific preventive measures against the occurrence of elder abuse and neglect. A human rights perspective underpins all the themes of this thesis. Primary health care and public health

disciplines are critical contributors to this response. The World Health Organization and other international public health programmes have incorporated human rights principles into their objectives and processes. Similarly, the principles of primary prevention and models of abuse can be drawn upon to ensure a multifaceted and multidisciplinary response to ageing issues and the phenomenon of elder abuse and neglect in Australia. There has been some progress in this regard in the States and Territories of Australia which will be discussed below.

Elder Abuse Prevention - Policy and Practice in Australia

Over the last two decades all States and the Australian Capital Territory have developed a range of elder abuse responses. A brief overview is given below.

The Victorian Government's response to elder abuse in the last two decades has placed a central role upon primary health services and community agencies. In 1995, the Victorian Department of Human Services published '*With Respect to Age'*.[38] This guide resulted in the promotion of elder abuse awareness and the early establishment of protocols and resources for those dealing with older people in the health and aged care sectors. In 2005, the Victorian Elder Abuse Prevention Project published a report entitled 'Strengthening Victoria's Response to Elder Abuse.'[39] This report outlined 11 recommendations focussing on improved community education, cooperation and collaboration of response services, promoting participation of older Victorians and the establishment of specialised community legal services. Seniors Rights Victoria was then established to provide a Helpline, specialist legal service, advocacy and community education for older people.

[38] Department of Human Services (Vic) *With Respect to Age – A Guide for Health Services and Community Agencies Dealing with Elder Abuse* (2005).
[39] Office of Senior Victorians (Vic), *Strengthening Victoria's Response to Elder Abuse*, (Report of the Elder Abuse Prevention Project, 2005).

With Respect to Age – 2009[40] was developed by the Victorian Government Elder Abuse Prevention Strategy to revise the practice guidelines for primary health care and community service agencies to develop interagency policies and procedures to combat elder abuse. The revised guidelines acknowledge the aims based on 'empowering older people, consistent with the human right to live free from violence and abuse,' and the obligations that arise from the *Charter of Human Rights and Responsibilities Act 2006* (Vic) and reflect developments in elder abuse research and practice that have taken place since 1995. The most recent policy statement in respect of elder abuse prevention and response by the Victorian Government is contained in the *Elder Abuse Prevention and Response Guidelines for Action 2012–14.*[41] Four strategic directions are identified in this document focussing on:

i) Increased community awareness;

ii) Empowerment of older people;

iii) Active engagement by professionals; and

iv) Co-ordinated multiagency support.

Throughout the series of policy responses to elder abuse in Victoria over the last two decades, culminating in the 2012–2014 action statement, there has been an increasing recognition that a multidisciplinary response is required and that the response must be co-ordinated and cohesive. Legal measures in the range of policy documents in Victoria have gained increasing prominence with an emphasis on informing and empowering older people to access their legal entitlements, and professional education of the law

[40] Department of Human Services (Vic), *With Respect to Age – 2009, Victorian Government Practice Guidelines for Health and Community Agencies for the Prevention of Elder Abuse* (2009).
[41] Department of Health (Vic), Ageing and Aged Care Branch, *Elder Abuse Prevention and Response Guidelines for Action 2012-14* (2012).

enforcement sector and legal practitioners of the nature and legal responses to the problem of elder abuse.

New South Wales established a Task Force and subsequent Advisory Committee on the Abuse of Older People in their Homes in the early 1990s to investigate the issue of elder abuse[42] and the first Interagency Protocol was published in 1995. Since revised, the Interagency Protocol[43] provides a practical framework for the response to elder abuse by government and non-government organisations.

In Queensland, the first major government response to elder abuse came in 1994 with the report commissioned by the then Department of Family Services and Aboriginal and Islander Affairs. The Elder Abuse Prevention Unit (EAPU) was founded in 1997 in response and over the subsequent two and a half decades, EAPU has developed a leading role in community education, advocacy and older persons support services, including the establishment of a Helpline information, support and referral service for people who suspect or experience abuse.[44]

South Australia also provided an early response to elder abuse with the Aged Rights Advocacy Service (ARAS) in operation since 1990. ARAS engages in advocacy in a range of programs focussed on residential care, home and community care, an Aboriginal Advocacy Service in conjunction with the Council of Aboriginal Elders, and an Abuse Prevention Program.[45] The Alliance for the Prevention of Elder Abuse (APEA) is a collaborative association between several South Australian organisations including the Legal Services Commissioner, the Office of the Public Advocate, the Public Trustees and

[42] New South Wales Advisory Committee on the Abuse of Older People in Their Homes, Ageing and Disability Department, *Abuse of Older People: The Way Forward, Final Report* (1997).
[43] New South Wales Department of Ageing, Disability and Home Care, *Interagency Protocol for Responding to the Abuse of Older People* (2007). http://www.adhc.nsw.gov.au/
[44] See Elder Abuse Prevention Unit, 'EAPU – Promoting the Right of Older People to Live Free from Abuse' http://www.eapu.com.au/Welcome.aspx
[45] See Aged Rights Advocacy Service, 'Abuse Prevention' http://www.sa.agedrights.asn.au/abuse_prevention

the South Australian Police. The South Australian Government policy and strategic response to elder abuse is outlined in 'Our Actions to Prevent the Abuse of Older South Australians 2007'.[46] This plan outlines priority directions centred on safety and security issues, education and training, community awareness, multidisciplinary co-ordination and prevention, with underlying themes of self-determination and human rights promotion.[47]

Tasmania is the most recent State to adopt a formal elder abuse prevention policy. In 2012 the Tasmanian government produced a policy document entitled 'Protecting Older Tasmanians from Abuse'. This document outlines government strategy to combat elder abuse in that state.[48] Modelled on the Victorian response, the core principles incorporate the empowerment of older people, community awareness campaign, legal support services, informed decision making and availability of choice for older people. An elder abuse Helpline has also been established in Tasmania to provide, information, advice and referral for individuals, families and the community.[49]

In Western Australia, an Older Person's Rights Service provides specialist legal advice to older people. The Western Australian Alliance for the Prevention of Elder Abuse (APEA: WA) has produced an elder abuse protocol for use by agencies in that state in responding to elder abuse.[50] There has been recent attention given to the assessment of elder abuse policy, service responses and data collection in Western Australia in a joint study by the

[46] Office for the Ageing, Department for Families and Communities (SA), *Our Actions to Prevent the Abuse of Older People in South Australia* (2007).
[47] Ibid 6, 9.
[48] Department of Health and Human Services (Tas), *Protecting Older Tasmanians from Abuse* (2010).
[49] Advocacy Tasmania, Elder Abuse Helpline, http://www.advocacytasmania.org.au/elderabusehelpline.htm
[50] Alliance for the Prevention of Elder Abuse: Western Australia, *Elder Abuse Protocol: Guidelines for Action* (2006)

University of Western Australia and Advocare.[51] Prevalence data identified by this study will be discussed in the following chapter.

The ACT revised its policy responses to elder abuse in 2012[52] as an element of the ACT Strategic Plan for Positive Ageing 2010–2014.[53] The policy emphasises a multidisciplinary approach to elder abuse prevention, and strengthens measures for community awareness, data collection and referral and response processes. There is at present no Northern Territory government strategic or policy framework to respond to elder abuse. The police service is the first point of referral for cases of abuse.

This overview indicates that there has been a growth in the awareness of elder abuse and neglect. The development of professional education programmes and the formation of interagency protocols to facilitate multidisciplinary responses to abuse have been the hallmark of elder abuse responses in the majority of states and territories in the last decade. The establishment of helpline services to assist with information, reporting and legal support to victims of abuse and family and community members has been an important step to enhance the availability and accessibility of support and legal interventions for the victims of abuse who reside in the community.

A common feature of the interagency protocols and broad government elder abuse policy is the overwhelming focus upon elder abuse occurring in the home. While it is acknowledged that the abuse of older people in their homes is a significant challenge that requires co-ordinated and multidisciplinary responses, attention should be directed at a policy level to address all types of abuse, in both residential and non-residential settings.

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[51] Mike Clare, Barbara Black Blundell and Joseph Clare, *Examination of the Extent of Elder Abuse in Western Australia: A Qualitative and Quantitative Investigation of Existing Agency Policy, Service Responses and Recorded Data* (2011).
[52] ACT Government, *ACT Elder Abuse Prevention Program Policy* (2012).
[53] Department of Community Services (ACT), *ACT Strategic Plan for Positive Ageing – Action Plan 2012-2014* (2010).

The justification for the exclusion of abuse perpetrated against older people in residential care from government policy documents and interagency policy documents is most often attributed to either:

i) The existence of mandatory reporting legislation in the *Aged Care Act 1997* (Cth) to deal with residential care abuse; or

ii) The exclusion of abuse against people in residential care from the actual definition of elder abuse on the basis that the abuse is perpetrated by paid caring staff in a 'commercial' arrangement.[54]

It is argued that this approach is misguided. First, reliance upon the *Aged Care Act 1997* (Cth) mandatory reporting provisions places too great an emphasis of reporting of abuse after the fact. The ideal of primary prevention is not sufficiently supported.

Second, the idea that older people may be differentiated simply on the basis of their place of residence does not accord with the fundamental principles of non-discrimination that underpin a human rights approach to addressing elder abuse.

It is agreed that the specific measures may differ for primary, secondary and tertiary prevention of elder abuse in different settings. However, in accordance with international obligations to respect, protect and fulfil the rights of older persons, it is argued that the distinction as to whether the same act perpetrated by a person upon a vulnerable older victim is abuse or not, is not justified on these grounds. National and State ageing and elder abuse prevention policy must acknowledge elder abuse in both community and residential settings and be inclusive of mechanisms to address professional and community awareness, social, legal, health and other preventive interventions in all settings.

[54] See for example, ACT Government, *ACT Elder Abuse Prevention Program Policy* (2012).

D. The Current Law in Relation to Older Persons in Australia

No single law in Australia comprehensively or specifically addresses the prevention of, protection against or intervention in elder abuse. In recent decades, much of the legal progress in the protection and promotion of the rights of older persons in Australia has been made within the context of broader developments in relation to family violence prevention, the rights of people with disabilities, and the focus of some of the states and territories on the formal legal recognition of human rights. The advances in the promotion of the rights of older people are, of course, welcome. The demographic changes of the current century dictate, however, that future developments must be purposeful, comprehensive and strategic.

To this end it is proposed that there are two essential and complementary components of an effective legal response to elder abuse and neglect. Both are dependent upon a thorough and detailed understanding of the nature of elder abuse. An effective legal response thus

1. involves the evaluation of Australia's existing legal obligations at international law and in domestic federal and state law to assess how such obligations are or can be applied to combat elder abuse and neglect; and
2. involves the development of ideas and strategies for law reform including de novo legal strategies that may derive from the responses to elder abuse employed in other disciplines.

In regard to the first of these components, Alison Brammer, in an early evaluation of legal responses to elder abuse in the United Kingdom, suggested that 'three levels of intervention may be utilised in cases of elder abuse: preventive measures, private law

initiatives, and state intervention.'[55] This framework to some extent reflects the outline of Australian law that will be discussed below. In context of this model, the 'levels of intervention' refer to the possible levels of legal intervention. This approach begins with an assessment of the legal tools available within a particular legal system, and then analyses the ways that those sources of law can be applied to the problem of elder abuse. Recently in Australia, the advent of elder focussed legal services has provided complementary practical support to older people who need a broad range of legal services, including those individuals who have suffered abuse and neglect. In particular, these services have provided an avenue for assistance in cases of financial abuse. With the development of these services, it is timely to examine the specific legal tools available to professionals working with older people and evaluate the effectiveness of these tools in response to physical, sexual and psychological abuse and neglect.

The model suggested by Brammer is guided by the current structure of the law, rather than being guided primarily by the nature of the problem. It may be argued that this method involves starting with the solutions (the laws) and determining how they might be applied in any particular circumstance or problem (elder abuse and neglect). This can be problematic if relied upon alone, as the majority of the applicable laws have not been developed or drafted with the specific needs of older people in mind. An analytical model of preventive, private law and state intervention can certainly be a useful first step in evaluating the status of exiting law in relation to elder abuse. However, it is suggested, that this model is insufficient for evaluating new directions for the legal intervention in elder abuse and neglect.

[55] Alison Brammer, 'Elder Abuse in the UK: A New Jurisdiction?' (1996) 8(2) *Journal of Elder Abuse and Neglect* 33.

Consequently, this section will outline current Australian law in relation to older people and abuse, and follow with an analysis of how public health principles can inform a comprehensive legal approach to elder abuse and neglect. A complementary approach can be derived through the incorporation of public health principles of primary, secondary and tertiary prevention and health promotion. These public health principles begin by defining the nature of the underlying problem, analysing the risks and contributing factors, and then assessing the stages at which intervention may be called upon or required. These principles can be adapted for a legal framework that follows these steps, thus ensuring that aspects of elder abuse will not be overlooked and the existing normative gaps in the law will be closed through reform and de novo legislation addressing the spectrum of elder abuse.

The specific elements of this legal framework will be expanded upon in subsequent chapters in light of an analysis of the nature and types of elder abuse and in the context of the particular challenges of elder abuse poses to the active and healthy ageing of our older population. The major contemporary legal tools available to legal practitioners, older people and their advocates to combat elder abuse will be identified below. Further attention will be directed in subsequent chapters to how effectively these legal strategies operate individually, and in concert, at the various levels of elder abuse prevention.

1. Civil Law and Criminal Law

Civil law offers some avenues for redress for individuals subjected to elder abuse. Contract law provides remedies for unconscionable conduct and undue influence and while not the focus of this thesis, provides remedies for financial abuse of older people. The law of torts offers a limited platform for redress in cases of physical, sexual, psychological abuse of older persons through an action in trespass, including the torts of battery, assault and false

imprisonment.[56] The tort of negligence may be applicable where a breach of a duty of care can be established by the plaintiff.[57] In respect of acts of elder abuse, this cause of action is most obviously applicable to duties imposed upon health professionals or professional care-givers who provide care to older persons.[58] Following the 2002 national 'Review of the Law of Negligence' conducted by the Negligence Review Panel, chaired by Justice David Ipp,[59] various statutory reforms have been introduced across Australian jurisdictions governing the law of negligence.[60] A common element of the reforms has been the inclusion of higher thresholds of physical or psychological impairment for personal injury[61] than were previously required for an award of damages for negligence. Furthermore, caps on damages have been set that may limit the compensation available.[62] It may be envisaged that the statutory reforms to negligence law will exclude many of the people who suffer personal injury as a result of acts that constitute elder abuse from seeking a remedy in negligence, as they may not meet the statutory threshold for having incurred a significant injury. As will be discussed below and in Chapter 10, a range of barriers exist to older people successfully accessing legal assistance and remedies.

Many of the acts that constitute elder abuse are offences under the various criminal statutes in Australia. For example, the *Crimes Act 1958* (Vic) and the *Summary Offences Act 1966* (Vic) provide the police and Director of Public Prosecutions with the power to investigate

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[56] See generally, Danuta Mendelson, *The New Law of Torts* (Oxford University Press, 2nd ed, 2010) Chapter 4.
[57] Ibid 281.
[58] See, for example, a discussion of trespass to persons and negligence applied to the principle of consent to medical treatment in; Danuta Mendelson and Anne Saunders, 'Operation of Guardianship Laws in the Emergency Ward' (2011) 19 *Journal of Law and Medicine* 13.
[59] Negligence Review Panel, *Review of the Law of Negligence* (2002)
[60] *Civil Law (Wrongs Act) 2002* (ACT), *Civil Liability Act 2002 (*NSW), *Personal Injuries (Liabilities and Damages) Act* (NT), *Civil Liability Act (2003*) QLD, *Personal Injuries Proceedings Act (2002)* QLD, *Civil Liability Act 1936* (SA*), Civil Liability Act 2002* (Tas), *Wrongs Act 1958* (Vic) *Civil Liability Act 2002* (WA)
[61] For example, *Wrongs Act 1958* (Vic) s 28LE, s 28 LF.
[62] See for example, *Wrongs Act 1958* (Vic) s 28G. Note: in May 2013, the Victorian Government commissioned an inquiry into the operation of the *Wrongs Act 1958* in respect of personal injuries. The final report is due in February 2014. See, Victorian Competition and Efficiency Commission, *Issues Paper: Inquiry into Aspects of the Wrongs Act 1958* (July 2013).

and prosecute assault, intentional, reckless and negligent serious injury, sexual offences and theft. The presence of existing criminal and civil sanctions for some acts that constitute elder abuse has been used to refute the need to legislate to protect against elder abuse. However, this view of the utility of current remedies is founded on too narrow a construction of the nature and types of abuse that constitute elder abuse. Neither civil nor criminal law alone or in combination accommodate the various circumstances of violence that constitute elder abuse and in particular psychological abuse, social abuse and neglect. Furthermore, access to the criminal justice system can be difficult for older people and the time delay in criminal proceedings can be problematic for very elderly persons, particularly if their physical or cognitive abilities decline over that time. Older people are often directed to bring complaints via the health care system and the offences are not pursued. If the criminal law is to be effectively harnessed as a mechanism to intervene in elder abuse, law enforcement, community and legal services must receive adequate professional training on the specific needs of older victims.

2. Family Violence Statutes

While not specifically targeted at violence against older people, family violence legislation such as the *Family Violence Protection Act 2008* (Vic) provides protection and remedies for older people in respect of violence perpetrated by a family member. Under s 5 of the Act 'family violence' is defined as:

> (a) behaviour by a person towards a family member of that person if that behaviour—
>
> (i) is physically or sexually abusive; or
>
> (ii) is emotionally or psychologically abusive; or
>
> (iii) is economically abusive; or
>
> (iv) is threatening; or

(v) is coercive; or

(vi) in any other way controls or dominates the family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person[63]

Importantly in the context of elder abuse s 8 (3) of the *Family Violence Protection Act 2008* (Vic) defines a family member as a person who is reasonably regarded as being like a family member having regard to the circumstances of the relationship including:

(g) any other form of dependence or interdependence between the relevant person and the other person;

(h) the provision of any responsibility or care, whether paid or unpaid, between the relevant person and the other person;

(i) the provision of sustenance or support between the relevant person and the other person.[64]

In the setting of elder abuse, the scope of this provision may, depending on the circumstances incorporate acts of abuse perpetrated by a carer with whom the older person has developed a relationship of trust and confidence.

The utilisation of family violence law in the context of the abuse of older people by family members has only recently gained attention and has some limitations in this context. For example, the definition of family violence in the Victorian Act accords with the types of violence that may constitute elder abuse with the significant exception of acts of neglect. Economic, psychological and emotional abuse are also defined in the Act.

However, a significant limitation of the legislation is the focus on acute and crisis intervention, which may not allow for adequate consideration of the complex situations

[63] *Family Violence Protection Act 2008* (Vic) s 5(a).
[64] *Family Violence Protection Act 2008* (Vic) s 8 (3).

that may result in an older person's vulnerability to abuse. Early intervention and primary prevention of elder abuse are less well accommodated through these statutes. Furthermore, adequate training of professionals working with older people is necessary to ensure that they are able to recognise and utilise family violence protection for the benefit of older persons experiencing violence, abuse and neglect by family members.

3. Guardianship legislation – review and reform

Adult guardianship legislation exists in all jurisdictions in Australia. Legislation variously provides for the appointment of a guardian as a substitute decision maker to make personal and lifestyle decisions for a person who no longer has capacity.[65] Again, guardianship legislation is not elder specific, however it operates as a major legal mechanism in the protection of the rights of older people with impaired decision making capacity.

Under current Victorian guardianship law, for example, a person has the ability to appoint a guardian under an enduring power of guardianship to make decisions about personal matters in the event that the person no longer has decision making capacity.[66] Alternatively, an application can be made for guardianship to the Victorian Civil and Administrative Tribunal (VCAT) to hear and make a decision upon the appointment of a guardian. The types of decisions that the guardian has the authority to make on behalf of the represented person will be specified by the order. A person may also specify that the guardian has the power to make decisions in respect of medical treatment including consent or withholding consent to medical treatment. Under the *Medical Treatment Act 1988* (Vic) a person can also appoint an agent as an enduring Power of Attorney (Medical

[65] *Guardianship and Management of Property Act 1991* (ACT), *Guardianship Act 1987* (NSW), *Adult Guardianship Act* (NT), *Guardianship and Administration Act 2000* (QLD), *Guardianship and Administration Act 1993* (SA), *Guardianship and Administration Act 1995* (Tas), *Guardianship and Administration Act 1986* (Vic), *Guardianship and Administration Act 1990* (WA).
[66] *Guardianship and Administration Act 1986* (Vic).

Treatment) who can make decisions about medical treatment on behalf of the person if they no longer are able.[67] In all instances the guardian or agent must make decisions in the 'best interests' of the represented person. Only an agent or guardian appointed by VCAT can refuse medical treatment on behalf of a person on the grounds specified in the Act.[68]

A major review of guardianship laws in Victoria was recently undertaken with the final report of the Victorian Law Reform Commission (VLRC) published in 2012.[69] The VLRC identified the need to simplify the current law of guardianship which is contained in a number of statutory instruments as well as the common law in order to improve community understanding and effective utilisation of the law.[70] Several factors prompted the review of the *Guardianship and Administration Act 1986* (Vic). The Act was primarily introduced to address the need of people with intellectual disabilities. The annual report of the Office of the Public Advocate in Victoria reported that in 2011–12 people with dementia comprised 34 per cent of new clients and made up the largest group by disability.[71] The recent review of guardianship laws acknowledged the need to 'reflect the changing profile of the people using guardianship laws.'[72]

The VLRC review of guardianship legislation also reinforces a stated theme of this thesis: legal reforms which address abuse and neglect of older persons must incorporate human rights principles which promote autonomy and dignity, and to which Australia has obligations in international law. A recommendation of particular significance in this

[67] *Medical Treatment Act 1988* (Vic), s 5A.
[68] *Medical Treatment Act 1988* (Vic) s 5 B (2).
[69] Victorian Law Reform Commission, *Guardianship: Final Report 24* (2012).
[70] Ibid.
[71] Office of the Public Advocate, *Working to Eliminate Abuse, Neglect and Exploitation: Annual Report 2011-12* (2012), 11.
[72] Victorian Law Reform Commission, above n 69, xx.

context relates to the incorporation of new measures to improve accountability for substitute decision makers.[73]

The VLRC recommends the creation of 'new public wrong' for which civil penalties would apply for substitute decision makers who fail to carry out the authority vested in them in the best interests of the person and who inflict abuse upon the person on whose behalf they make decisions.[74] The Commission has proposed it should be 'unlawful for a person with responsibility to care for a person with impaired decision making ability to abuse, neglect or exploit a person.'[75] This proposal extends obligations beyond substitute decision makers, to the co-decision makers and informal decision makers proposed in the report. With overlap between the civil wrongs and criminal offences such as trespass and assault, the VLRC states that the 'recommendation effectively crystallises these legal duties in a public wrong and places enforcement in the hands of public authorities.'[76] The reforms proposed would incorporate new extended investigatory powers of the Public Advocate, in combination with a new statutory officer to take civil proceedings on the basis of alleged public wrong of abuse, neglect or exploitation.[77]

The reforms identified and outlined above represent a small proportion of the wide-ranging recommendations of the VLRC report into guardianship law. Further discussions will be made of the proposals in relation to the use of restrictive interventions and unlawful deprivation of liberty of people with dementia in Chapter 7. If the recommendations in the VLRC report are implemented, they may have a significant impact upon the incidence of abuse of older people with impaired decision making capacity. They must, however be seen as a component of broader legislative recognition of the rights of older people in all

[73] Ibid xxviii.
[74] Ibid 417.
[75] Ibid 419.
[76] Ibid.
[77] Ibid 421.

contexts, including older people who may retain their decision making capacity but who nonetheless may be vulnerable to abuse or neglect.

The following chapters of this thesis will seek to demonstrate that a broader lens is required to direct legal responses than guardianship alone. A recognition of the complex determinants of health and active ageing, the fulfilment of which will reduce the risk of elder abuse, will be most effectively achieved through a response at a national level. This will be the subject of the final chapters of this thesis.

4. Aged Care Legislation

Key elements of the *Aged Care Act 1997* (Cth) (the Act) and the associated *Aged Care Act Principles*, provide for the accreditation, funding and regulation of standards of aged care. The Act regulates care that is administered to over 1 million Australians.[78] In 2012, 10 per cent of people aged over 70 years received permanent residential care under the Act and a further 3.6 per cent received community care support under the Act.[79] The Act provides for the Aged Care Complaints Scheme[80], and the Aged Care Commissioner who is authorised to review decisions and investigate complaints against the scheme.[81]

The *User's Rights Principles 1997* are made under s 96-1(1) of the Act and Schedule 1 contains a *Charter of Residents' Rights and Responsibilities* and a *Charter of Rights and Responsibilities for Community Care*. The *Aged Care Act* also contains provisions[82] which mandate the reporting of some forms of abuse in relation to Commonwealth funded

[78] Department of Health and Ageing (Cth) *2011-12 Report on the Operation of the Aged Care Act* (2012), 6.
[79] Ibid.
[80] The Aged Care Complaints Scheme and accompanying *Complaints Principles* replaced the former Aged Care Complaints Investigation Scheme with the aim of improving complaints resolution, conciliation and investigation.
[81] *Aged Care Act 1997* (Cth) s 95A-1.
[82] *Aged Care Act 1997* (Cth) s 63(1)AA.

residential aged care. These controversial provisions will be discussed in detail in Chapter 9.

5. Anti-discrimination and Human Rights Legislation.

Commonwealth anti-discrimination law provides a framework for the implementation of Australia's obligations created through the ratification of the major international human rights treaties. The Commonwealth anti-discrimination legislation includes the

i) *Racial Discrimination Act 1975* (Cth)

ii) *Disability Discrimination Act 1992* (Cth)

iii) *Sex Discrimination Act 1984* (Cth)

iv) *Age Discrimination Act 2004* (Cth)

The Australian Human Rights Commission is a statutory body that has the authority to investigate and conciliate complaints of discrimination and breaches of human rights under these acts.[83] Australian legislation is scrutinised for its compatibility with obligations under international law by the Joint Parliamentary Committee on Human Rights. This Committee was established by the *Human Rights (Parliamentary Scrutiny) Act 2011* (Cth).

Older people are subject to the rights embodied in international treaties without discrimination. However, none of these statutes were designed to address the specific rights of older people. The *Age Discrimination Act 2004* (Cth) provides protections against discrimination on the basis of age including in respect to employment, education, and access to goods, services and accommodation.[84] However, significant exemptions are provided for in the *Age Discrimination Act*, including exemptions for religious organisations, charities, voluntary bodies and in the areas of superannuation and taxation.[85]

[83] *Australian Human Rights Commission Act 1986* (Cth).
[84] *Age Discrimination Act 2004* (Cth) Part 4, Divisions 1-3.
[85] *Age Discrimination Act 2004* (Cth) Division 5.

Amendments were introduced in 2010 creating a statutory office of a full time Age Discrimination Commissioner, which aligned the *Age Discrimination Act* with the other human rights statutes. Victoria and the Australian Capital Territory have legislation that provides human rights protections. The Charter of *Human Rights and Responsibilities Act 2006* (Vic) and the *Human Rights Act 2004* (ACT) will be discussed in greater detail in chapter 7.

Availability and accessibility are major hurdles in respect of older people accessing their legal rights in Australia. Existing laws were rarely drafted with the particular needs or interests of older people in mind. Even less consideration has been given to providing preventive frameworks against the abuse and neglect of older people. The remainder of this chapter will analyse how future legal reforms can be made in a structured manner in order to attend to every level of prevention in respect to elder abuse and neglect. In this regard, an elder specific lens will maximize the breadth and effectiveness of future legal responses that promote healthy and active ageing, free from abuse and violations of the human rights of the aged.

E. The Interplay between Public and Primary Health and Legal Responses to Elder Abuse

There are two dimensions to the relationship between the principles and practice of public health, primary health and the prevention of elder abuse and neglect. The first dimension is concerned with the way in which direct and specific public health measures can be implemented to combat elder abuse. A second, less obvious dimension, is the possibility that public health principles may be drawn upon in the development of structured, multidimensional legal strategies and responses to elder abuse.

How might the principles of prevention applied within primary health care and public health inform a structured legal response to elder abuse? This section will outline the current public health approach to combating elder abuse, and will critically examine which principles can be drawn from public health models of elder abuse prevention to inform legal responses to protecting the rights and freedoms of older people in order to ensure active and healthy ageing.

An historical emphasis on primary health and community service systems has existed at all levels of elder abuse prevention globally and in Australia. As elucidated in the Alma Ata Declaration of the World Health Organization in 1978, 'primary health care' refers to the equitable provision of essential health care, which is accessible, ongoing, and comprehensive and which operates at an individual and population level.[86] The actual providers of this primary health contact will vary widely depending on the international and regional setting. However, a common feature is that primary health care centres and providers, when available, provide up to 80 per cent of health care.[87] A narrow view of primary health care that focuses on acute management of episodes of illness or injury, is inadequate to deal with the chronic and often complex health needs of older people. In Australia, primary health care professionals have provided an accessible avenue for the detection of elder abuse and the provision of practical support, advice and intervention, including general practitioners, nursing services and social work services. Further assessment and intervention is facilitated by community and hospital based geriatric assessment teams.

Public health principles can make a useful contribution to the way in which legal systems are analysed in the context of elder abuse. In particular, the tiered approach to preventive

[86] World Health Organization, *Alma Ata Declaration (1978*).
[87] World Health Organization, *Active Ageing: Towards Age-Friendly Primary Health Care* (2004).

health can be applied in order to assess the distribution of existing Australian law across the spectrum of the phenomenon of elder abuse. Through this analogy with the principles of primary, secondary and tertiary disease prevention, the aim is to demonstrate the practical scope of the law in relation to elder abuse.

In light of the significant historical and contemporary reliance upon health models for intervention in elder abuse, the principles of primary health care and public health and preventive medicine provide a constructive framework which is useful for examining current and potential legal interventions. As discussed in Chapter 2, the broad objectives of public health promoted by institutions such as the World Health Organization have been integral to the development of global and national perspectives on ageing policy and health practice generally.

Public health is 'a social and political concept aimed at improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention.'[88] A wider view of public health encompasses the recognition of a need to invest in 'policies, programmes and services which create, maintain and protect health by supporting healthy lifestyles and creating supportive environments for health'.[89]

Elder abuse prevention operates upon all the objectives enunciated within this definition of public health: an individual subjected to physical, sexual or emotional abuse and or neglect suffers compromised health, quality of life and in some cases this may impact on life expectancy. Elimination of all forms of abuse through implementation of a range of legal interventions and remedies is a fundamental element of the creation and maintenance of healthy lifestyles and supportive environments. The components of 'health promotion' and

[88] World Health Organization, *Health Promotion Glossary*, WHO/HPR/HEP/98.1 (1998).
[89] Ibid.

'disease prevention' warrant closer analysis, to the extent that they inform discussions of the role of the legal system in the support of healthy ageing.

1. Health Promotion

Legal processes for elder abuse prevention can make a valuable contribution to health promotion within the community of older Australians. 'Health promotion' refers to the 'process of enabling people to increase control over, and to improve their health.'[90] Significantly, the *Ottawa Charter for Health Promotion* (the '*Ottawa Charter'*) acknowledges that:

> Health is a positive concept emphasizing personal and social resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.[91]

As discussed in Chapter 3, health promotion necessarily (and critically, in respect of the actual and potential role of the legal system) incorporates activities directed towards the determinants of health. Following from the principles set out in the *Ottawa Charter*, the *Jakarta Declaration on Leading Health Promotion into the 21st century* (the '*Jakarta Declaration*')[92] emphasises that the promotion of health within the community requires a broadening of strategies beyond the traditional methods of the health sector. The *Jakarta Declaration* states that '[t]he challenge for the coming years will be to unlock the potential for health promotion inherent in many sectors of society, among local communities and within families.'[93] The *Jakarta Declaration* identifies five priorities for health promotion, all with relevance to, and some with direct reference to, the law and older persons. For example, priority three to 'consolidate and expand partnerships for health', requires

[90] World Health Organization, *Ottawa Charter for Health Promotion* (First International Conference on Health Promotion, 21 November 1986).
[91] Ibid.
[92] World Health Organization, *Jakarta Declaration on Leading Health Promotion into the 21st Century* (Fourth International Conference on Health Promotion, July 1997).
[93] Ibid.

strengthening and expanding partnerships 'for health and development between different sectors and at all levels of governance and society.'[94] More specifically, priority five, to 'secure an intra-structure for health promotion', identifies that:

> All countries should develop the appropriate political, legal, educational, social and economic environments required to support health promotion.[95]

In embracing this interpretation and these objectives of health promotion, it is possible to envisage the potential contribution of the legal system in elder abuse prevention. In pursuit of the objectives of health promotion, a multifaceted legal regime built upon the provision of elder specific legal services, the strengthening and reform of existing legal protections against elder abuse, and the development of community and professional education programmes, the activities of the health, legal and other sectors can act in concert to address elder abuse and neglect.

2. Prevention

'Prevention' is directed towards eliminating or reducing the likelihood that an undesirable or harmful event or disease will occur, and furthermore limiting the effects of that event or disease if it does occur.[96] Although less intuitive than in relation to health promotion, 'primary', 'secondary' and 'tertiary' disease prevention strategies provide a tiered approach which can help to ensure legal strategies operate at all points in the continuum of the phenomenon of elder abuse at both an individual and population level. Primary preventive strategies which operate before exposure to risk factors for abuse or the experience of abuse are clearly the most desirable interventions. However, acknowledging the existence of a spectrum of risk and abuse in the community, concurrent attention to all

[94] Ibid.
[95] Ibid.
[96] National Public Health Partnership (Aus), *The Language of Prevention* (2006), 2

levels of prevention is necessary in order to effectively address elder abuse within the whole population.

(a) Primary Prevention

Primary prevention in biomedical terms refers to the activities directed towards avoiding the onset of a disease and towards positive health promotion.[97] Examples include large population based vaccination programmes for diseases such as measles and poliomyelitis and public health programmes aimed at ensuring safe, potable drinking water to reduce the incidence of waterborne infectious diseases such as cholera and amoebic dysentery. Primary prevention can also be directed towards particular groups and healthy individuals.[98] Legislation can operate at the level of primary prevention such as through the regulation of alcohol and safe driving to prevent the consequences of road trauma.

In the context of elder abuse and neglect, primary prevention encapsulates the prevention of the exposure of older people to the risk factors for elder abuse. Primary prevention is targeted at actions before abuse occurs and before risk factors develop. Avenues of primary prevention of elder abuse might include broad public health measures directed to the promotion of healthy lifestyles through diet, exercise and avoidance of behavioural factors such as tobacco, and alcohol abuse which contribute to the primary prevention of diseases and which are responsible for increased physical dependency and impaired cognitive ability — both risk factors for elder abuse. For example, on the basis of the projected fourfold increase in dementia prevalence from 2009 to 2050, the 'Access Economics' report for Alzheimer's Australia estimates that if levels of physical inactivity among older people could be reduced from 70 to 50 per cent from 2009 to 2050, there would be an

[97] Ibid 3.
[98] Ibid 4.

estimated reduction in cases of dementia by 5.7 per cent.[99] Furthermore, the report identifies that a failure to maintain rates of hypertension control over the same period could result in a 5.6 per cent increase in the prevalence of dementia.[100]

Primary preventive activities may also target the avoidance of social isolation and ageism that contributes to the risk of elder abuse for older people. In this regard, access to legal services, as well as legal protections against discriminatory, ageist practices in employment, social services and housing can contribute to strengthening the determinants of health, and empowering people into old age. Human rights law can be instrumental in this regard. International human rights obligations and the domestic embodiment of those rights as reflected in *International Convention on Civil and Political Rights,*[101] the *International Convention on Economic, Social and Cultural Rights,*[102] the *Convention on the Rights of Persons with Disabilities,*[103] the *Convention on the Elimination of All Forms of Discrimination against Women*[104] and the *Charter of Human Rights and Responsibilities Act 2006* (Vic) have a role to play in promoting the determinants of health.

The assessment services, case management and care support packages that currently exist can prevent the development of factors such as social isolation and carer stress. The education of legal professionals on the nature of elder abuse is essential for practitioners to enable them to play an effective role in primary prevention.

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[99] Access Economics, *Keeping Dementia Front of Mind: Incidence and Prevalence 2009- 2050* (Report for Alzheimer's Australia, 2009), 82.
[100] Ibid.
[101] *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976).
[102] *International Covenant on Economic, Social and Cultural Rights*, opened for signature 19 December 1966, 993 UNTS 3 (entered into force 3 January 1976).
[103] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).
[104] *Convention on the Elimination of All Forms of Discrimination against Women*, opened for signature 1 March 1980, 1249 UNTS 13 (entered into force 3 September 1981) ('CEDAW').

(b) Secondary Prevention

Secondary prevention within a public health model encapsulates the strategies directed towards early disease detection in order to reduce the progression of disease, prevent the onset of clinical symptoms and signs and limit dysfunction. In respect of elder abuse, secondary prevention can be seen as the early detection of the existence of risk factors or behaviours that may lead to abuse or neglect, such as carer stress or drug and substance abuse, onset of cognitive impairment due to dementia, or physical dependency on others. Intervention strategies are thus directed at controlling exposure to, or halting the progression of risk factors to the signs and symptoms of elder abuse.

Examples of secondary prevention include screening programmes for breast and cervical cancer in women. These are large population based programmes directed to whole populations that are potentially at risk. Screening can also be used at an individual level for 'case finding' or 'diagnostic evaluation'.[105] This form of screening is of particular importance in elder abuse detection. Screening practices are an integral component of secondary prevention strategies. The World Health Organization has directed the core of its 'Global Response to Elder Abuse and Neglect'[106] towards improving the capacity of primary health care providers to respond to elder abuse. To this end the WHO has stressed 'it is central to understand the nature and value of increased and more refined medical and social surveillance and screening practices.'[107]

Screening practices should form a part of professional education on elder abuse. Some attempts at screening tools have been developed. Whether through interaction with older

[105] Silvia Perel-Levin, 'Discussing Screening for Elder Abuse at Primary Health Care Level' (Discussion Paper World Health Organization, 2008).
[106] World Health Organization, *A Global Response to Elder Abuse and Neglect: Building Primary Health Care Capacity to Deal with the Problem Worldwide: Main Report* (2008) http://www.who.int/ageing/publications/elder_abuse2008/en/index.html.
[107] Ibid 4.

people in relation to non-elder abuse related legal matters, through referral from assessment services or via elder specific legal services, legal professionals may have the opportunity to respond to situations of increased risk.

The provision of legal measures to regulate service provision to older persons at risk of abuse is an example of secondary prevention measures. In this regard, the accreditation standards of the *Aged Care Act 1997* (Cth), have the potential to prevent the abuse and neglect of vulnerable older residents of aged care facilities by setting standards of care for people living in Commonwealth supported residential care facilities.

A key area of potential law reform which would operate at the level of secondary prevention would be the introduction of legislative safeguards to prevent the unlawful and inappropriate use of physical, chemical and environmental restraints upon older people with behavioural disturbances due to dementia who live in residential care. Furthermore, the contemporary review of guardianship legislation that has been undertaken in Victoria offers further opportunity to strengthen legal responses to elder abuse at an early secondary prevention stage. The review proposes the creation of supported decision making systems that give effect to the rights of older people to 'equal recognition before the law'[108] and to empower older persons with impaired decision making ability to continue to exercise autonomy over decisions such as health and residential care decisions. An important example of preventive benefit would be the opportunity to avoid the informal admission of a person to residential care without their consent which constitutes a violation of their right to liberty.

[108] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008), art 12.

Secondary prevention measures to combat restrictive interventions and deprivation of liberty will be discussed in detail in Chapter 7 in relation to elder abuse and dementia.

(c) Tertiary Prevention

Tertiary prevention within public health medical models is aimed at reducing the negative impact of a disease and restoring functioning and health. When elder abuse has occurred within a relationship of trust held by an older person, tertiary prevention addresses the removal of the triggers of that abuse and the provision of remedies and solutions to improve the quality of life of that person and to promote healthy and active ageing. Interagency protocols that are designed to give guidance to organisations on the response to elder abuse operate largely at the level of tertiary prevention. Once elder abuse has occurred, such protocols give advice on service response frameworks in order to mitigate the effects of that abuse, prevent further complications and provide remedies to sufferers of abuse. These protocols however, tend to focus on the abuse of people in community settings. In a legal context, the operation of 'private legal remedies,' such as tort and contract law, occurs within the scope of tertiary prevention. Statutory remedies that are found in family violence legislation and criminal law sanctions all operate at the level of tertiary prevention, after established abuse has occurred.

The only significant and recent legislative development at a federal level that is targeted specifically at elder abuse has operated at the level of tertiary prevention. The mandatory reporting provisions of the *Aged Care Act 1997* (Cth)[109] require the reporting of suspected or alleged abuse of residents of residential aged care facilities. It may be argued that the existence of this statutory requirement may act as a deterrent to potential perpetrators of abuse, and therefore this process operates at an earlier stage in the continuum. However, it

[109] *Aged Care Act 1997* (Cth) s 63-1AA

is impossible to quantify the actual deterrent effect of the legislation. Under mandatory reporting legislation, rates of reporting have increased steadily since the introduction of the mandatory provisions. It is not clearly evident whether this is due to actual increases in the rates of abuse occurring, or due to an increased awareness of and compliance with the reporting obligations of those mandated to report abuse under the *Aged Care Act*.

International and regional human rights frameworks also have the capacity to provide legal remedies to victims of abuse. The operation of this framework in relation to older person will be discussed at length in the subsequent chapters of this thesis.

G. Conclusion

It is not proposed that legal strategies for elder abuse prevention necessarily should, or can, be *directly* translated into public health frameworks for disease prevention, nor health strategies into legal frameworks. The analogy of the phenomenon of elder abuse to the disease model of public health is an imperfect one and should not be over-emphasised.

First, elder abuse is not a disease but rather a phenomenon which is the consequence of a wide range of aetiological factors, some health related, but others related to the social and economic conditions of an individual. Preventive medicine, however, does provide some valuable perspectives upon the manner in which elder abuse can be viewed as a result of a progression of contributing risk factors and events. All aspects of the continuum must be addressed by legal preventive and remedial measures.

Second, population health strategies must be combined with a concurrent dedication of resources and attention to modification of individual risk and exposure to elder abuse and neglect. Some commentators have suggested also that caution needs to be exercised in the

adoption of medical terms which have the potential to simply strengthen the dominance of the medical model in public health.[110] Silvia Perel-Levin writes:

> In order to advance interdisciplinary cooperation in line with the ecological model, communication and language are key elements that need to be clarified so that all the professionals involved understand what is at stake and can work together towards solutions.[111]

The objective of public health promotion documents such as the *Ottawa Charter* and *Jakarta Declaration* to broaden involvement across government, professional and community sectors has obvious merit. Certainly, care must be taken that with such broad scope of involvement, practical responses operate in a co-ordinated and constructive manner, and this is dependent on a common understanding of language and terminology.

This chapter proposes that while acknowledging the limitations outlined above, the tiered approach of public health and disease prevention and the objectives in respect of health promotion can provide a useful contribution to establishing consistency in the objectives and implementation of strategies within the scope of practice of any particular group.

This chapter has explored the historical national influences upon ageing and the phenomenon of elder abuse. Given the significant contribution that physical and cognitive illness and disability make to overall incidence and individual risk of elder abuse and neglect, it is not surprising that medical models of prevention have formed the core of Australia's response to elder abuse in the past. These primary health care models based on early intervention by general practitioners, community nursing and allied health professionals, assessment and co-ordination by Aged Care Assessment Teams are valuable

[110] Silvia Perel-Levin, above n 105, 13.
[111] Ibid.

strategies for identifying health risks to individuals and implementing preventive measures against elder abuse.

A health model is integral to elder abuse prevention, but alone, it is an insufficient response. In order to fully comprehend and attend to the economic, social and cultural influences upon older people, multidisciplinary and multifaceted action is required. Subsequent chapters of this thesis are devoted to the examination of legal strategies to prevent elder abuse. These strategies will be strengthened and enlivened by an understanding of the array of empowering and challenging influences upon older people's lives, as individuals and as members of a community.

Chapter 4

ELDER ABUSE: CONCEPTS AND CONTENT

An intuitive understanding of what may constitute elder abuse does exist within the contemporary Australian community. Media reports in recent years of cases of physical, sexual, psychological, social and financial abuse of older persons have generated a level of community awareness of the challenges that face many older Australians.[1] The community perception of elder abuse as a 'social-ill' (in the same way that child and family violence had been perceived before it), an awareness of a rapidly ageing population demographic, and a general awakening among the baby-boomer generation of their own imminent 'old age', has ensured a level of attention from community, professional and government agencies and policy makers.

Fortunately, elder abuse dialogue has moved beyond the emotive and unhelpful language of 'granny battering' that characterised early discussions on the issue.[2] Regardless, a concrete consensus on the definitions, aetiology and prevalence of elder abuse has eluded professionals, academics and legal and social policy developers over the last three decades.

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[1] See for example, Australian Broadcasting Corporation, 'Claims of Sexual Abuse at Vic Nursing Home', *Lateline* (28 February 2006) http://www.abc.net.au/lateline/content/2006/s1574384.htm
Australian Broadcasting Corporation Television, 'Families Count Cost of Dementia Drugs Prescriptions', *Lateline* (16 August 2012) http://www.abc.net.au/lateline/content/2012/s3569736.htm
[2] G R Burston, 'Granny Battering' (1975) 3 *British Medical Journal* 592, 592.

This can in part be attributed to both differing theoretical understandings of the complex web of factors resulting in the abuse of older persons, and to the historical development of practical responses to cases of abuse in Australia and abroad. Similarly, while the community may be more familiar with the terminology of elder abuse than it was a decade ago, efforts need to be made to ensure that it is reinforced by a real recognition of the rights of and obligations to older members of our society. Attending to elder abuse is a social imperative.

This chapter begins by briefly exploring the evolution of the differing definitions of elder abuse, settling on the widely accepted definition that has emerged internationally. The chapter then examines the estimated incidence and prevalence of elder abuse in Australia and other jurisdictions, noting in particular the difficulties that exist in obtaining accurate representative data, and the general lack of large scale studies in this country.

The chapter discusses many of the aetiological factors that may contribute to the occurrence of elder abuse, and outlines evidence in support of such factors. A detailed understanding of these aetiological factors is important for effective policy, programme and legislative responses in the future. The utility of analogies between elder abuse, child abuse and domestic violence will be critically evaluated. Cultural perspectives influencing attitudes and understandings of abuse and access to services for victims of abuse from diverse cultural backgrounds will be considered.

This chapter concludes by examining the theoretical content of the phenomenon of elder abuse. A proposed theoretical framework will form the foundation for further analysis throughout this thesis of the current and potential future legal responses to elder abuse encompassing public health perspectives, international human rights paradigms and Australian domestic legal frameworks.

A. Defining Elder Abuse and Neglect

After four decades of increasing community awareness, academic discussion and epidemiological research a clear statement of the definition of elder abuse is of paramount importance. The definition stated in the introduction to this thesis is repeated for clarity and each element of the definition will be discussed below.

> Elder abuse is 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. [3]

This definition was developed in 1993 by the Action on Elder Abuse organisation in the United Kingdom and has been widely adopted by the international community, including the International Network on the Prevention of Elder Abuse and the World Health Organization in the *Toronto Declaration on the Global Prevention of Elder Abuse*.[4]

The acknowledgement of elder abuse as phenomenon has not been universal. For example, in a 1993 paper for the Conference of the Australian Institute of Criminology, Justin McDermott argued that

> [E]lder abuse is not a sufficiently coherent construct to act as a guide for policy makers or people working in aged care or adult protective services. It might have been better if the term had not been developed in the first place... The various forms of behaviour encompassed by elder abuse are best understood as other things – for example, as domestic violence, embezzlement, medical malpractice or caregiver stress. Elder abuse *is not something different* from all of these.[5] (Emphasis in original)

[3] Action on Elder Abuse, *What is Elder Abuse?* http://www.elderabuse.org.uk/Mainpages/Abuse/abuse.html
[4] World Health Organization, *Toronto Declaration on the Global Prevention of Elder Abuse* (2002) http://www.who.int/ageing/publications/toronto_declaration/en/
[5] Justin McDermott, 'Elder Abuse: Eight Scenarios in Search of a Construct' (Paper presented at Australian Institute of Criminology Conference, Crime and Older People, Adelaide, 25 February 1993).

However, this view is a minority one. While discussion frequently draws upon perspectives from the models of domestic/family violence, a broader acknowledgement has evolved of the complex influences on the occurrence of abuse that are specific to older people.

Central to the definition of elder abuse is the relationship that exists between the perpetrator of abuse and the victim of abuse. A position or expectation of trust can be held or created by a family relationship, a friendship or a paid caring role.[6] In view of this, the approach adopted in many jurisdictions which excludes abuse occurring within residential care facilities is perplexing.

For example, the Victorian Government Practice Guidelines for Health Services and Community Agencies for the Prevention of Elder Abuse specifically excludes institutional abuse from elder abuse definitions. The Guidelines define abuse as:

> Any act occurring within a relationship where there is an implication of trust which results in harm to an older person.[7]

The Guidelines then proceed to state:

> This definition is consistent with Australian and international agreement about what constitutes abuse of older people and defines a relationship where trust is the sole connection.[8]

Consequently, the Guidelines define abuse perpetrated against older people who are in residential care as 'abusive relationships other than those based on trust.'

> [A]buse that occurs in a residential aged care setting might better be characterised as a 'failure of care' on the part of the provider, who has the responsibility to ensure that residents are protected from abuse.[9]

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[6] Action on Elder Abuse, *What is Elder Abuse?* http://www.elderabuse.org.uk/Mainpages/Abuse/abuse.html
[7] Department of Human Services (Vic), *With Respect to Age – 2009. Victorian Government Practice Guidelines for Health Services and Community Agencies for the Prevention of Elder Abuse* (2009) 4.
[8] Ibid.
[9] Ibid 6.

This approach has also been adopted by the Tasmanian Government in 'Protecting Older Tasmanians from Abuse'.[10] It can be criticised on the basis that it fails to properly acknowledge that residential care provides a home, the social and cultural enjoyment and the personal relationships that may be of great importance to older people.

By contrast, in the *Family Violence Intervention Guidelines: Elder Abuse and Neglect* produced by the New Zealand Ministry for Health, elder abuse is clearly taken to encompass acts of abuse perpetrated upon older persons in residential care and well as private homes, by either paid or unpaid carers.[11]

The exclusion of abuse perpetrated against older people in residential care from the definition of elder abuse is flawed. The distinction can only be viewed as one of administrative convenience. Distinguishing whether an act constitutes abuse or not simply on the basis of the place of residence of the victim cannot be justified on human rights grounds and constitutes a serious obstacle to the realisation of the human rights of older people in residential care.

Clearly the reality of life for many older persons in residential care is that paid carers and professional staff provide the most significant and trusting relationships that exist for those people at that time in their life. On a daily basis older people are reliant upon and place their trust in the staff of residential care facilities to assist with the activities of daily living. The Action on Elder Abuse states clearly:

> Both older men and women can be at risk of being abused, and this can potentially happen wherever they live or visit. This may include: someone's own home, in a carer's home, in a day centre, in a residential home, in a nursing home, or in a hospital.

[10] Department of Health and Human Services (Tas), *Protecting Older Tasmanians from Abuse*, 2010.
[11] Kathy Glasgow and Janet Fanslow, *Family Violence Intervention Guidelines: Elder Abuse and Neglect* (New Zealand Ministry of Health, 2006).

> The key issue is not about where someone lives or visits, but about whether or not the opportunity exists for another to abuse the relationship of trust and exploit or harm them.[12]

While the practical details of particular strategies, programmes and intervention measures that must be implemented to combat elder abuse may vary depending on the setting, the underlying principles for primary and secondary prevention are common to abuse in all types of settings. Elder abuse must be addressed comprehensively and logically by a multifaceted approach for all older people regardless of their place of residence. Simply excluding acts of abuse against vulnerable older people living in residential care from the definition of elder abuse is as illogical as it would be to claim that abuse of people in corrective detention does not amount to assault.

B. Types of Abuse

Elder abuse may encompass acts of physical, sexual, psychological, social, financial abuse or neglect. Abuse may occur by act or omission. Abuse may be intentional or unintentional. This section will outline acts and behaviours that may constitute elder abuse.[13] The list is intended to be illustrative not exhaustive. Further detailed discussion of the nature of acts of violence and abuse against older people will be made in subsequent chapters in discussions of elder abuse within the human rights framework and in relation to the abuse of older women and older people with dementia.

a) **Physical abuse** involves acts carried out with the intention of causing physical pain or injury or coercion. Physical assault constitutes a criminal offence. Such acts may include:

[12] Action on Elder Abuse, 'Abuse Can Occur Anywhere,' http://www.elderabuse.org.uk/Mainpages/Abuse/abuse.html

[13] See for further discussion of the nature of acts that may constitute abuse, Victorian Government, above n 7, 12-16.

- Hitting, slapping, punching, pushing, shaking, burning, pinching or biting a person;
- Physical restraint of a person using ropes or ties;
- Imprisonment of a person in a room, building or other space;
- Chemical restraint of a person using medications, alcohol or illegal substances; or
- Force-feeding.

The consequences of such abuse may include bruises, abrasions laceration, sprains, fractures, burns or other serious injury.

b) **Sexual abuse** involves the perpetration of acts or threats of forced, coercive or exploitive behaviour of a sexual nature. Sexual abuse encompasses (but is not limited to) acts perpetrated upon older persons unable to give consent, or without the cognitive capacity to give consent. Such acts may include:
    - Non-consensual sexual contact including inappropriate touching;
    - Rape;
    - Unwanted use of sexual language; or
    - Inappropriate contact of genital area of older person during washing and cleaning.

Clinical evidence of sexual abuse may include traumatic injuries to the genitals, mouth, rectum and also include sexually transmitted diseases.

c) **Psychological (or emotional abuse)** refers to any acts or behaviours that may cause distress, fear or anguish, shame or powerlessness for older persons. Psychologically abusive behaviour may include both verbal and non-verbal acts such as:

- Verbal or physical abuse including intimidation;
- Threats to harm the older person or their property, family members or pets;
- Threats to withdraw assistance, services or other care or affection;
- Threats of institutionalisation; or
- Degrading treatment including name calling.

The clinical signs and manifestations of psychological abuse may include anxiety and or depression evidenced by sadness, tearfulness, paranoia, excessive fear, confusion, insomnia, excessive weight loss or excessive weight gain.

d) **Social abuse** encompasses the removal or isolation of older people from social interaction. It includes:
    - The restriction/removal of access to electronic communication such as a telephone or computer;
    - Withholding mail; or
    - Preventing participation in cultural and religious practices and celebrations.

e) **Financial abuse** involves the illegal or improper use or mismanagement of a person's money, property or financial resources.[14]

f) **Neglect** is the failure by a person in whom an older person has placed their trust as either a formal or informal caregiver to meet the physical and emotional needs of that older person.[15] This involves a failure to provide the necessities of life such as:
    - Adequate food and nutrition;

[14] Victorian Government, above n 7, 12.
[15] Lynn McDonald and April Collins, *Abuse and Neglect of Older Adults: A Discussion Paper* (Family Violence Prevention Unit, Health Canada, 2000) iv.

- Access to clothing, housing and shelter;
- Access to medical and dental care and services;
- Failure to attend adequately to personal activities of daily living of a person in their care such as the provision of hygiene assistance, dental, optical and hearing aids, gait aids or assistance with pressure care for immobilised persons;
- Failure to ensure safe living conditions, including the provision of appropriate supervision; or
- Abandonment involving desertion of an older person whose care has been undertaken to be provided by the perpetrator. Abandonment may occur in a hospital, institution, or public place such as a shopping centre.

As will be discussed further in Chapter 8, abandonment has received increasing attention as a form of abuse of older women in developing countries in particular, exacerbated by the movement of younger people from rural to urban areas, who may traditionally provide care for older relatives.

C. The Incidence and Prevalence of Elder Abuse

The lack of widespread and detailed epidemiological data on elder abuse is not only a matter of academic interest. It has continued to hinder elder abuse prevention strategies for the last four decades. Without a significant body of reliable data sourced from well designed, reproducible studies, it is impossible to ascertain whether the policies, programmes and strategies implemented to combat elder abuse are effective.

Lynn McDonald and April Collins in a discussion paper on elder abuse in the Canadian context, emphasise that it is essential to have information on the magnitude of the problem

in order to manage the magnitude of the response, and to understand the aetiology of elder abuse in order to implement preventive strategies.[16] Furthermore, those studies that have been conducted have been within developed countries. No systematic collection of data on the incidence and prevalence of elder abuse has taken place in developing countries.

The lack of epidemiological data is, in part, a manifestation of:

- The relative lack of attention that elder abuse has achieved in comparison to other issues of violence such as violence against women and children;
- The practical difficulties associated with accurate data collection in particular due to under-reporting;
- The lack of a cohesive definition of elder abuse within academic discourse and policy, health and social responses in Australia and across international jurisdictions; and
- Wide variation in the methodological approaches to prevalence data collection. These include data collected by single agencies such as Aged Care Assessment Teams, or law enforcement agencies, to population surveys involving direct questioning of older people via telephone or in person survey.

Methodological issues aside, inaccuracy in elder abuse data is in part due to under-reporting. Older people may not consider the acts or omissions of a perpetrator of abuse as warranting intervention or redress because of generational or cultural perspectives. Alternatively the shame and fear of reprisal or other consequences may prevent them from reporting abuse to an outsider.

Case reports comprised the earliest reports in the literature of elder abuse and neglect. As will be discussed below, data obtained in the early studies was predominantly collected

[16] Ibid.

from case samples arising within particular social, health or law enforcement agencies. The range of agencies sampled in agency based surveys has become more comprehensive as study design has evolved over recent decades. However, it is clear that significant disparities exist in the prevalence rates detected between agency based and population based surveys. The following discussion will review briefly the major epidemiological studies in the United States, Canada, the United Kingdom and Australia to illustrate the complexity of research in this area and the way study design has developed over the last four decades in order to overcome the obstacles in data collection.

1. United States of America

In keeping with the early recognition of elder abuse and neglect as a phenomenon, the earliest reported attempts to identify the incidence and prevalence of elder abuse arose in the United States of America. Noting that 'these are highly selective samples and that there is a large reservoir of unreported and undetected cases', Karl Pillemer and David Finkelhor conducted the first large scale random population sample survey in 1988.[17] In this landmark study, over 2000 older (aged 65 years or older) community dwelling residents of Boston, Massachusetts were randomly sampled and interviewed by telephone or in person. A two stage interview process was undertaken: the first interview stage involved identifying abuse victims and the second stage involved a follow-up interview with those identified as abuse victims during the initial phase. In the second interview (conducted either in person or by telephone) further detail of the context and consequence of abuse were sought. The study incorporated physical abuse, psychological abuse and neglect. Self-neglect and financial abuse were not within the definition of abuse adopted in this study.

[17] Karl Pillemer and David Finkelhor, 'The Prevalence of Elder Abuse: A Random Sample Survey' (1988) 28 *The Gerontologist* 51.

Pillemer and Finkelhor reported a prevalence of all types of abuse of 32 per 1000, with physical violence identified most commonly (20 per 1000) followed by psychological abuse (11 per 1000) and neglect (4 per 1000).[18] Spousal abuse was the most common form of abuse identified with 58 per cent of all types of abuse perpetrated by a spouse.[19]

The National Elder Abuse Incidence Study ('NEAIS') in 1996 in the United States found that almost 450 000 older persons (aged 60 years or over) in domestic residential settings were abused or neglected during 1996.[20] Data was collected via Adult Protective Service records and reports from 'sentinels'. Sentinels are described as 'specially trained individuals in a variety of community agencies having frequent contact with the elderly.'[21] This method is aimed at mitigating the underestimation when APS reports are relied upon alone, although commentators have noted that it remains very likely that the incidence is underestimated as 'a large majority of cases are unreported and undetected by monitoring agents.'[22] The study has also been criticised by Bonnie Brandl and colleagues on the basis of a) the small sample size; b) the study design which was 'not designed to determine how much elder abuse exists, but rather to look at the proportion of cases reported to APS versus the proportion of cases that actually exist'; and c) the exclusion of older people in residential or other institutional care.[23]

The recent National Elder Mistreatment Study in the United States was aimed at assessing the one year prevalence of physical, sexual, emotional or financial mistreatment or neglect. The survey population was a national sample of randomly selected community dwelling

[18] Ibid 54.
[19] Ibid.
[20] National Centre on Elder Abuse, *The National Elder Abuse Incidence Study* (1998), 1.
[21] Ibid 3.
[22] Ron Acierno et al, 'Prevalence Correlates of Emotional, Physical, Sexual and Financial Abuse and Potential Neglect in United States: The National Elder Mistreatment Study' (2010) 100 *American Journal of Public Health*, 292, 292.
[23] Bonnie Brandl et al, *Elder Abuse Detection and Intervention: A Collaborative Approach* (Springer Publishing Company, 2007) xiii.

residents aged 60 years or over. The 5777 participants were interviewed by telephone. The study authors stated the study design was intended to 'build on existing research and address the limitations of previous studies.'[24] Sexual abuse and neglect were included in the study parameters, and questions were designed to adequately identify abuse and assault in order to overcome the limited single question only approach to questioning on each type of abuse in some earlier studies. Study design also included questions to identify correlates of the various forms of abuse.

The National Elder Mistreatment Study identified that overall 11.4 per cent of respondents reported experiencing at least one of the forms of mistreatment surveyed in the past year (physical, sexual, emotional, neglect and financial abuse). The study found that:

- Emotional abuse was reported by 4.6 per cent of respondents in past year although only 7.9 per cent of those incidents had been reported to the police;
- Physical abuse prevalence in the previous year was reported at 1.6 per cent with a higher rate of reporting to police of 31 per cent;
- Sexual abuse past-year prevalence was reported at 0.6 per cent with 16 per cent reporting to police; and
- Neglect was reported by 5.9 per cent of respondents.

A comprehensive effort to quantify the extent of elder abuse has been recently undertaken in the State of New York in 2011. The New York State Elder Abuse Prevalence Study[25] combined data on the prevalence and incidence of all forms of abuse from a large representative population over people aged 60 years or older from across New York State. While not investigating abuse in residential care facilities, the definitions of abuse adopted

[24] Ibid 292-293.
[25] Mark Lachs and Jaquelin Berman, *Under the Radar: New York State Elder Abuse Prevalence Study, Self-Reported Prevalence and Documented Case Surveys: Final Report* (2011).

for this study correlate well with the definitions of abuse adopted most broadly in Australia. In contrast to a majority of United States studies on elder abuse prevalence and incidence of the past, self-neglect was not included within the study terms of the New York Study. This correlates with the widespread Australian consensus on the exclusion of self-neglect from elder abuse definitions. While Australia lacks an equivalent of the Adult Protective Services system of the United States, the findings of the New York study may be well suited to extrapolation to the Australian context.

Crucially, the study data was collected via (i) self-reported incidents of abuse obtained through direct interview; and (ii) through collection of data on reports to all agencies and programmes responsible for the care and support of older persons who experience abuse. An agency response rate to the survey of 78 per cent was recorded.[26]

The benefit of this two streamed data collection process is that it enables more accurate assessment of the total extent and magnitude of the problem of elder abuse. Through a comparison of 'known' versus 'hidden' reports the study authors' objective was to identify the extent of under-reporting.[27] Direct interviews were conducted with 4156 older persons and data from reports to 292 agencies were collected on episodes of physical, sexual, emotional, financial abuse and neglect.

The New York Study identified among the respondents directly interviewed, a self-reported one-year incidence rate of 76 per 1000 residents of all forms of abuse measured.[28] An overall prevalence rate of 141.2 per 1000 was detected (elder abuse event since turning 60 years of age). In respect to non-financial forms of abuse, the one-year incidence rate was 46.2 per 1000 persons. Financial abuse was the most reported form of abuse. The

[26] Ibid 36.
[27] Ibid 1.
[28] Ibid 3.

results from the documented case study revealed a rate of 3.24 per 1000 in the one-year period, with emotional abuse the most commonly reported form of abuse.[29]

A glaring disparity is present between the rates identified in this study through self-reporting and those identified through document agency case reports. There was a greater than 23 times reporting of all forms of abuse via self-reporting than through document cases within agencies.[30] The disparity was greatest in the reporting of financial abuse and neglect. Neglect was more than 57 times more frequently detected through self-reporting than via documented cases. While the study authors attribute some of that gap to methods of documentation of reports with the services surveyed, the study concluded that it had 'uncovered a large number of older adults for whom elder abuse is a reality but who remain "under the radar" of the community response system set up to assist them.'[31]

The United States provides the greatest range and extent of investigation into the incidence and prevalence of elder abuse to date of any country. This is a legacy of the longstanding presence of Adult Protective Services (APS) across all states of America. How that data is interpreted and extrapolated to the Australian context (or any other country) remains complex. Two main factors continue to complicate evaluating the Australian situation. First, the selection of United States studies discussed briefly above illustrates that while successive attempts at gathering epidemiological and statistical data have addressed some of the flaws in previous studies, there remains a persistent dilemma of varying definitions, sample populations and methods. For example, the exclusion of older people in residential care facilities from these major studies remains problematic. In addition, the existence of APS in America is a significant point of difference with Australia. The New York study

[29] Ibid 28.
[30] Ibid 50.
[31] Ibid 57.

indicates that law enforcement agencies and APS were able to provide significantly more data in relation to the types of abuse occurring than community based agencies. It is unclear how the absence of APS in Australia translates into the overall rates of reporting that would be measured if similar documented cases survey were to be conducted within Australia.

2. Canada

In 1992 a national Canadian survey was conducted by Elizabeth Podnieks utilising random telephone interviews of over 2000 community dwelling persons aged 65 or over. The study found that four per cent of Canadian older persons experienced either material (financial), physical, verbal abuse or neglect.[32] Material abuse was the most commonly reported type of abuse (2.5 per cent of the sample) followed by chronic verbal abuse (1.4 percent) and physical violence (0.5 per cent).[33]

3. United Kingdom

In the United Kingdom, the 2006 'UK Study of Abuse and Neglect of Older People Prevalence Survey Report' analysed data from over 2100 people aged 66 years or over living in private dwellings, from England, Scotland, Wales and Ireland.[34] The study collected data on physical, sexual, psychological and financial abuse. The prevalence rates identified that 2.6 per cent of those surveyed reported mistreatment involving a family member, close friend or care worker in the past year, and 4 per cent when incidents of mistreatment by neighbours and acquaintances were taken into account. Neglect was identified as having the highest prevalence (1.1 per cent), followed by financial abuse (0.7

[32] Elizabeth Podnieks, 'National Survey on the Abuse of the Elderly in Canada' (1992) 4 (1-2) *Journal of Elder Abuse and Neglect* 5, 48.
[33] Ibid 41. See generally Elizabeth Podnieks 'Elder Abuse: The Canadian Experience' (2008) 20 (2) *Journal of Elder Abuse and Neglect* 126.
[34] Madeleine O'Keefe et al, *UK Study of Abuse and Neglect of Older People Prevalence Survey Report* (2007) 4.

per cent), psychological abuse (0.4 per cent), physical abuse (0.4 per cent) and sexual abuse (0.2 per cent).[35] The study authors noted that the prevalence data are likely to under-estimate the actual prevalence due to the conservative definitions of mistreatment and the absence of survey data from older persons living in residential care or older persons with severe dementia.[36]

4. Australia

Initial Australian policy, social and medical responses relied to a significant extent on these overseas estimates of around 4–6 per cent. Subsequently, an Australian retrospective case series reported in the Medical Journal of Australia in 1991, conducted by Susan Kurrle, Paul Sadler and Ian Cameron, identified the issue of elder abuse in the Australian context.[37] This was followed by the first Australian study, conducted by the same authors, which examined the rate of occurrence of elder abuse in Australia, through a retrospective review of referrals to a NSW geriatric and rehabilitation service in a 12 month period between July 1990 and June 1991. [38] The findings indicated that among older people living in the community, 4.6 per cent reported abuse with psychological and physical abuse accounting for the majority of cases of abuse followed by neglect.

A 1997 study of elder abuse prevalence was conducted among the patients of four Aged Care Assessment Teams which included both a retrospective and prospective component in the study design.[39] The study identified a lower overall prevalence of elder abuse of 1.2 per

[35] Ibid.
[36] Ibid 5.
[37] Susan Kurrle, Paul Sadler, Ian Cameron, 'Elder Abuse – An Australian Case Series' (1991) 155 *Medical Journal of Australia* 150.
[38] Susan Kurrle, Paul Sadler and Ian Cameron, 'Patterns of Elder Abuse' (1992) 157 *Medical Journal of Australia* 673.
[39] Susan Kurrle, Paul Sadler, Keri Lockwood, Ian Cameron, 'Elder Abuse: Prevalence, Intervention and Outcomes in Patients Referred to Four Aged Care Assessment Teams' (1997*) 166 Medical Journal of Australia* 119.

cent, with abuse identified retrospectively at a rate of 1.9 per cent as compared to that identified prospectively at a rate of 0.98 per cent.

A further study of agency documented cases was conducted by Patrick Livermore and colleagues in 2001. This study collected data through referrals to a NSW Central Coast Aged Care Service. Similar overall prevalence rates were identified.[40] The study, which was conducted over a total of 12 months, involved a three month retrospective component and a longer nine month prospective component. Significant differences in the rates of abuse were identified within the two periods. In the retrospective period, Livermore and colleagues report an incidence of 2.7 per cent in contrast to an incidence of 6.3 per cent in the prospective component. Livermore and colleagues suggest that this difference may be attributable to the absence of a documentation protocol during the period of the retrospective study and that documented information in relation to elder abuse was 'often inconsistent and unclear.'[41] By contrast, an education programme was delivered to assessors in the prospective phase of data collection. These differential findings appear to provide support for the benefits of improved education and awareness as well as the need to formalise reporting protocols for cases/ suspected cases of elder abuse.

A 2002 study to establish prevalence data of elder abuse in Western Australia followed the design of agency documented cases.[42] A survey response rate of 30 per cent was received of the 1017 organisations surveyed identified as having contact with older people. Twenty four per cent of responding organisations reported known or suspected cases of abuse in

[40] Patrick Livermore, Robert Bunt and Katrina Biscan, 'Elder Abuse Among Clients and Carers Referred to the Central Coast ACAT: A Descriptive Analysis' (2001) 20 *Australasian Journal on Ageing* 41.
[41] Ibid 44.
[42] Duncan Boldy et al, *Elder Abuse in Western Australia: Report of a Survey Conducted for the Department for Community Development – Seniors' Interests*, (Report, Curtain University of Technology: Division of Health Sciences. Freemasons Centre for Research into Aged Care Services 2002)

the previous six months. The overall prevalence estimate was 0.58 per cent in Western Australia.[43]

Population data on the incidence and prevalence of episodes of abuse of older people in residential care is difficult to isolate. Data collection on this group of older persons is frequently absent because either:

1. within a particular jurisdiction, the abuse of older people in residential care is not considered elder abuse; or
2. older persons in residential care are excluded from sample populations in population surveys because of the difficulty accessing respondents, or because of the higher populations of people in residential care with cognitive impairment who are excluded from study.

An estimate of annual reporting numbers will be discussed further in in Chapter 9 in the context of Australia's federal mandatory reporting legislation for the abuse of older people in residential care.

It is worth noting here that in the 2010–11 reporting year there were a total of 1815 reports of alleged or suspected abuse within Commonwealth funded residential aged care facilities.[44] Of that number, 1499 were reports of alleged 'unreasonable use of force'; 284 were reports of alleged or suspected sexual assault and 32 were both. The Annual Report of the Operation of the Aged Care Act does not present the data as a rate based on the total population of older persons in residential care.

[43] Ibid 17.
[44] Department of Health and Ageing (Cth) *Report on the Operation of the Aged Care Act 1997: Annual Report 2010-2011* (2011).

However, based on data from the Australian Institute of Health and Welfare, in June 2011 there were approximately 169 000 people in residential care in Australia.[45] This equates to a rate of 10.74 reports of alleged or suspected abuse per 100 000 persons in residential aged care.

5. Summary of prevalence and incidence study review.

There were a number of differences in study design and methodology evident from the discussion above, including difference in the:

- Range of behaviours classified as abusive (for example, exclusion of sexual abuse and neglect);
- Classification of abuse according to the identity of the perpetrator (for example, paid carer);
- Methodology of data collection (for example, agency based versus population sampling);
- Mode of collection (for example, telephone versus mailing);
- Differences in the question design; and
- Ages of those studied.

Several general observations can be made. Overall, population surveys resulted in higher reported prevalence rates than agency-based, documented case surveys. Direct interviews using multiple questioning resulted in higher prevalence rates than mailing or single question interview. More recent surveys have been generally more inclusive in the types of abuse incorporated into survey definitions of abuse.

[45] Australian Institute of Health and Welfare, *Residential Aged Care in Australia 2010-2011: A Statistical Overview*, Aged Care Statistics Series No.36.Cat No AGE 68 (2012) vii.

No large scale national population based survey of elder abuse prevalence has been conducted in Australia or any of the states or territories. In the future, a study with large sample size, incorporating direct interviews with persons aged 60 years or older in both community and residential care within both urban and rural communities would be beneficial. The successful development of policies, programmes, law enforcement responses, legislation, advocacy support services are dependent on an accurate knowledge of the nature and magnitude of the problem of elder abuse.

D. Risk Factors for Elder Abuse

Understanding the aetiological factors for the occurrence of elder abuse is necessary for the design and implementation of effective primary and secondary prevention strategies. The need for further data collection on prevalence and incidence is mirrored by a need for more elaborate data on the aetiological factors contributing to elder abuse. Interpretation of such data is complex due to the inter-relatedness of the factors contributing to the occurrence of elder abuse.

The majority of discussion on the risk factors contributing to elder abuse distinguishes between factors attributable to characteristics of the victim of abuse, and factors attributable to the perpetrator of the abuse. This division is artificial as interactions between multiple complex factors, unique to the circumstances of an individual older person, are manifest in the occurrence of elder abuse. Furthermore, caution is urged with this approach on the grounds that it can be seen to attribute ‘blame’ for the abuse to the victim of the abuse because of particular characteristics or behaviours of the older person.

The World Health Organization cautions against too great an individualistic focus on the characteristics of the victims and perpetrators and interfamilial relationship dynamics.

Nonetheless, the distinction can be useful as the contributing aetiological factors in elder abuse raise particular obstacles and demand different responses in primary and secondary prevention strategies. Several of these factors will be outlined below.

1. Risk Factors Relating to the Victims of Abuse

(a) Gender of victim

Overall women are more likely to experience abuse than men. Kurrle, Sadler and Cameron report a gender ratio of 2:1.[46] A higher incidence by a factor of more than three times amongst women was also identified in the 2002 Western Australian Study.[47] The United Kingdom Prevalence Study reported 3.8 per cent of women and 1.1 per cent of men reported abuse in the past year.[48]

(b) Age of victim

Age has been identified as a risk factor in elder abuse. Multiple studies demonstrate the greatest vulnerability for persons over 85 years. For example, the United Kingdom Prevalence Study reported 4.1 per cent of people over 85 years reported abuse compared with 2.8 per cent of people aged 66–74 and 2.1 per cent of people age 75–84.[49] The high prevalence among the very old is largely attributable to the higher incidence of neglect.

(c) Cognitive impairment

Kurrle, Sadler and Cameron found that 46.3 per cent of older persons identified in the study who were abused had significant dementia.[50] The role of dementia as a risk factor in

[46] Kurrle, Sadler and Cameron, above n 38, 675.
[47] Boldy et al, above n 42, 15.
[48] O'Keefe et al, above n 34, 4.
[49] Ibid 40.
[50] Kurrle, Sadler and Cameron, above n 38, 675.

elder abuse and the broader issues for policy, public health and legal frameworks directed at elder abuse prevention will be discussed in Chapter 7.

(d) Poor health and disability leading to physical dependency

Evidence of an association between ill-health and the risk of elder abuse has been varied. The Australian study conducted by Kurrle, Sadler and Cameron indicated that 65 per cent of victims of abuse identified had physical disabilities. Furthermore in 42.6 per cent of cases of abuse, dependency on others was found to be the primary factor leading to abuse.[51] The authors suggest the high rates of disability amongst victims of abuse may be attributable to the sample population of clients for geriatric services having higher levels of physical and cognitive disability than the older population more generally. The 2002 Western Australian study conducted by Duncan Boldy and colleagues identified a rate of 43 per cent of known cases of abuse where the older person had a significant physical disability.[52]

The 2007 United Kingdom Study of Abuse and Neglect of Older People also indicated an increased prevalence of abuse with declining health status, although to a lesser degree than the Australia study. Rates of reported abuse varied from 9.2 per cent of those with self-reported bad or very bad health to 3.7 per cent of those with fair health and 1.2 per cent of those with good or very good health.[53] Neglect was highest (5.1 per cent) among the group with bad or very bad health, compared with people who reported being in good or very good health (0.4 per cent). Furthermore, the report identified people with a 'limiting long-term illness' having a higher rate (4.5 per cent) of reporting of neglect.

[51] Ibid.
[52] Boldy et al, above n 42, 18.
[53] O'Keefe et al, above n 34, 5.

The nature of the relationship between health status and the occurrence of elder abuse will be explored further in Chapter 6 in the context of the application of a right to health framework to elder abuse prevention. An important aspect of these statistics to note is that ill health and disability may be both a cause and a consequence of elder abuse and neglect.

(e) Social isolation

A lack of family, financial and community support is positively associated with an increased risk of elder abuse. The United States National Elder Mistreatment Study identified that low social support significantly increased (more than tripled) the risk of virtually all forms of mistreatment. As low social support may be both a cause and a consequence of elder abuse, the study authors indicate the association should be integral to 'predicting negative outcomes in older adults but also for developing preventive interventions addressing both interpersonal violence and psychopathology.'[54]

2. Risk Factors Relating to the Perpetrators of Abuse

(a) Gender of perpetrator

Adult Protective Services data identifies an overall roughly equivalent distribution of male and female perpetrators of abuse. This may be attributable to the fact that women are more often the caregivers of older people than men and that neglect by women accounted for the majority of the reported incidents of violence. In other categories of abuse, men were the perpetrators of violence at a ratio of 3:2.[55]

[54] Acierno et al, above n 22, 292.
[55] Manitoba Law Reform Commission, *Adult Protection and Elder Abuse* (1999)11.

(b) Relationship to victim.

Evidence suggests the majority of abuse is perpetrated by either spouses or relatives. Studies are approximately equally divided in reporting abuse by spouses as predominant versus abuse by adult children, or the reverse. The 2002 Western Australian study found that children of the older person were the most frequently identified perpetrators of abuse (43 per cent). Abuse by a spouse or de facto accounted for 18 per cent of reports and other relative 17 per cent.[56] Karl Pillemer and David Finkelhor found that 58 per cent of perpetrators of abuse were spouses and 24 per cent of the perpetrators were the children of the victim of abuse.[57]

The increased rate of abuse by spouses might in part be accounted for by the further association of risk of elder abuse with the shared living arrangements of the perpetrator and the victim. There is a higher incidence of abuse among older people who reside with the perpetrator of the violence.

(c) Prior history of violence in the relationship

The majority of older people live in domestic settings.[58] In light of this, the early approaches to elder abuse focussed on the view that elder abuse constitutes the continuation of pre-existing patterns of spousal/family violence into older age.[59] These pre-existing patterns of spousal violence may be exacerbated by the cognitive or physical decline of either or both the victim or perpetrator of the abuse. Alternatively, the patterns

[56] Boldy et al, above n 42,19.
[57] Pillemer and Finkelhor, above n 17, 55.
[58] Australian Bureau of Statistics report on the 2011 census data identified that 94% of people aged over 65 years live in private dwellings. See Australian Bureau of Statistics, *2071.0 - Reflecting a Nation: Stories from the 2011 Census, 2012–2013* http://www.abs.gov.au/ausstats/abs
[59] See, Bridget Penhale, 'The Abuse of Elderly People: Considerations for Practice' (1993) 23 *British Journal of Social Work* 95, 95-112

of spousal abuse may be reversed with the development of physical and cognitive disabilities of the past abuser placing them at risk of the abuse themselves.

Other forms of family violence may involve the children of older people who have been abused themselves in childhood, becoming the perpetrators of violence and the dynamics of the relationship are reversed with the ageing of their parents.

(d) Caregiver stress

The nature and extent of the contribution that carer stress makes to the incidence of elder abuse remains controversial. The notion encompasses a recognition that caring for frail and dependent older people can be emotionally, physically, financially and socially demanding for the caregiver. Caregivers may have adopted the role reluctantly, out of a sense of responsibility or under pressure from other family members. They may lack the skills or a clear understanding of the physical and emotional requirements of the person in their care. Caregivers may lack the support they require to deal with the demands of the care.

The Western Australian study by Boldy and colleagues surveyed respondents on what they thought were the main causes of abuse. Responses highlighted the lack of support services for carers and the stress of caring for an older person.[60] However, other commentators caution about the evidence for carer stress as a primary cause of elder abuse. Bonnie Brandl and colleagues state that carer stress is identified in only a limited number of cases.[61] There are a number of problems associated with an over emphasis upon caregiver stress because:

- In a proportion of cases the caregiver may be the victim of the abuse;

[60] Boldy et al, above n 42, 20.
[61] Brandl et al, above n 23, 38.

- Attention of professional and community responses is diverted away from the needs of the victim to the needs of the carer/perpetrator;
- Attention may be diverted away from the fact that the acts of abuse may constitute crimes which justify a criminal justice response; and
- An emphasis is placed on the 'burden' created by the older person and hence appears to attribute blame to the victim for the occurrence of the violence.

It is most likely that the most significant contribution made by caregiver stress is in the manner in which it interacts in an intricate way with other factors such as the financial and other dependence of the carer on the older persons that may exist or develop in the relationship.

(e) Mental illness, substance and alcohol abuse

The majority of studies have identified a strong correlation between both substance and alcohol abuse and/or the existence of a mental illness among the perpetrators of violence against older people.[62]

(f) Dynamics between the individuals

Evidence exists that violent responses by carers may be precipitated by violent behaviour from the dementia sufferer. In a study directed at examining the links between violent feelings and violent behaviours in caregivers to dementia sufferers, Karl Pillemer and Jill Suitor found that 57 per cent of respondent caregivers who reported violent feelings toward the care recipient had experienced violence from the care recipient.[63] By contrast only 17 per cent of those who did not fear becoming violent had actually experienced violent

[62] Gregory Paveza et al, 'Severe Family Violence and Alzheimer's Disease: Prevalence and Risk Factors' (1992) 32 *The Gerontologist* 4, 493, 496
[63] Karl Pillemer and Jill Suitor, 'Violence and Violent Feelings: What Causes Them among Family Caregivers?'(1992) 47 *Journal of Gerontology* 4, S165, S168.

behaviour from the care recipient.[64] This study also examined whether a fear of violence towards the care recipient actually transferred to an increased incidence of actual violence. Pillemer and Suitor found that 'violence by the care recipient is not only a risk factor for fear of violence, but also appears to move persons who are fearful of becoming violent to actually commit violent acts.[65]

(g) Conclusion

An analysis of elder abuse of the type undertaken above with a victim/perpetrator divide and an emphasis on familial factors, is valuable but insufficient for a clear understanding of the aetiological factors contributing to elder abuse. The risk of this approach, WHO states, is that elder abuse remains a family problem, 'rather than being viewed as a larger societal concern.'[66] There are also risks in the reverse. If too broad a lens is taken on the issues of abuse, then the risk arises that professionals and all members of society will not be sufficiently alert to the factors that may contribute to the individual stories of older people who experience abuse. This too, can lead to 'missing voices'.

This thesis identifies both global perspectives on elder abuse and a thorough analysis of risk factors at an individual level as key themes for discussion. The contributing aetiological factors in elder abuse raise particular challenges, obstacles and demand different responses in primary and secondary prevention strategies and certainly warrant attention. Likewise, throughout this thesis, attention will be directed to the international efforts to encompass cultural, gender-based and right-based societal responses to elder abuse prevention.

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[64] Ibid.
[65] Ibid S170.
[66] World Health Organization, *Missing Voices: Views of Older Persons on Elder Abuse* (2002), 8.

E. Domestic Violence and Child Abuse Analogies

Frequently, theoretical models have been formulated that liken elder abuse to child abuse and domestic abuse. While a detailed analysis of the nature of child abuse and family violence theory is beyond the scope of this thesis, a few valuable observations have been made by researchers in these fields that inform an understanding of how elder abuse responses have evolved in the past, and must continue to evolve. The first observation is that theoretical models matter: models adopted and relied upon dictate the nature of government, professional and community responses to the problem of elder abuse. Understanding elder abuse within the family violence model helps to highlight the problems that may be encountered with its detection and reporting. Bridget Penhale identifies a number of features of family violence which illustrate this:

- Domestic violence is often considered a 'private affair' occurring within the family domain;
- Family relationships while inherently intimate, are also prone to conflict;
- Older people are often isolated from support networks and detection mechanism due to their reduced contact with education, employment and social networks;
- Older persons may not report violence within the home for fear of retaliation, fear that they may be removed to residential care, particularly if the perpetrator of the abuse is also the primary carer for the victim; and
- Abuse may not be reported by older persons in the family setting because of shame that they have raised an abusive child or because they blame themselves for the situation of violence.[67]

[67] Penhale, above n 59, 95-112.

Marianne James and Adam Graycar propose that a family violence model would emphasise responses that focus on the immediate safety of the victim of the abuse, the removal of the perpetrator and emphasis on the criminality of the behaviour.[68] The focus on empowerment of individuals within domestic violence prevention models is more favourable than models which reinforce 'protection' such as child abuse models. While undoubtedly many situations of elder abuse do occur within the context of family relationships, pre-existing patterns of spousal or family violence account for only some of the complex factors that influence the occurrence of elder abuse. It is therefore a necessary but insufficient component of models for elder abuse.

Child abuse models have contributed to both the theoretical analysis of elder abuse and the design and implementation of prevention and intervention strategies for elder abuse in the past. The historical explanation for this is that the early phase of recognition of elder abuse in the late 1970s and early 1980s followed the attention directed towards other forms of family violence, including child abuse.[69] First reports of 'granny-battering' framed elder abuse in terms of family violence by stressed carers of dependent people[70] — a component of theoretical approaches to child abuse. It is unsurprising therefore, that academics and professionals working with older people, sought to draw on the experiences and the theoretical perspectives which aimed to identify the various categories of abuse, victim and perpetrator characteristics as well as the range of practical intervention and prevention solutions, that had been adopted within the area of child protection.

Another view of the origins of this analogy is more confronting and challenges society to address the way it views older members of society. That older people are readily and

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[68] Marianne James and Adam Graycar, *Preventing Crime against Older Australians* (Australian Institute of Criminology Research and Public Policy Series No 32, 2000), 63.
[69] See also Ruthann Macolini, 'Elder Abuse Policy: Considerations in Research and Legislation' (1995) 113 *Behavioural Sciences and the Law* 349, 349-350.
[70] See also Brandl et al, above n 23, 5-7.

commonly viewed from a perspective that is marked by frailty, physical and emotional dependence as well as cognitive incapacity, is perhaps the real bias that underpins the analogy of elder abuse and child abuse. This view stresses a perceived 'burden' that older people generate either as a group upon society as a whole, and as individuals upon families and carers.

Ageist stereotypes are difficult to overcome. Indeed, in a discussion that focuses on the risk and aetiological factors for abuse, it is very easy to create a picture that all these factors are applicable to all older people who are all the victims of all types of elder abuse. Clearly this is not the case. The vast majority of older people live free from any form of abuse and live independent, fulfilled and productive lives. However, the child abuse analogy has been remarkably persistent in discussions on elder abuse, most often in the context of the analysis of the merits of mandatory reporting systems for elder abuse through adult protective service systems modelled on child protective services. With this caveat in mind and to the extent that it is necessary to discuss the analogy in order to conclude that it is an inappropriate one, the following section will analyse what, if any, justifications there may be for the likening of elder and child abuse.

On first inspection, an obvious similarity between elder abuse and child is that in broad terms, both encompass acts of physical violence, sexual violence, emotional abuse and neglect. Both encompass notions of abuse by either act or omission.

Other common features identified in the literature include:[71]

(i) The perpetrator of abuse is usually a family member or carer;

(ii) The abuse is often of a dependent person;

(iii) Stress may be a significant factor in the perpetration of the abuse; and

[71] Ibid.

(iv) Social isolation and poverty are more common in families experiencing both types of abuse.

It is the perception of older people as dependent individuals whose care is stressful for the carer and may precipitate anger, resentment and abuse, which leads to a shared element of theoretical models of child abuse and elder abuse. A model of child abuse emphasises that stress, which is perceived by the perpetrator to be caused by the behaviour of the child, triggers irrational responses and results in the abuse. For example, Bridget Penhale suggests that the stress that carers may experience in dealing with difficult or non-compliant behaviours of either older adults or children in their care, may result in an escalation of abusive behaviours in response by the carer.[72] Critics of this theory argue that does not adequately explain in either setting why some caregivers experience stress and do not abuse the person in their care. Lynn McDonald and April Collins suggest that instead of constituting a theory for either child abuse or elder abuse, stress should be viewed at most as one of a variety of risk factors.[73]

Another possible difference between the occurrence of elder and child abuse is that elder abuse is obscured from the view of society more often than child abuse. In developed countries where school attendance rates are high and infant and child health checks are provided, the systems and opportunities for detection of child abuse are enhanced. By contrast, older people may be more isolated from employment, educational and health and social networks. The lack of contact with these forums decreases the opportunity for abuse to be reported by the victim or detected by a professional, friend or other individual.

There is a significant danger in the overstatement of the analogy of elder abuse with other types of abuse. Too great a reliance on the similarities between the forms of abuse will

[72] Ibid 103.
[73] McDonald and Collins, above n 15, 27.

divert attention away from the far more significant points of difference: 'the truth lies in the detail' of the differences between elder abuse and child abuse. As Rachel Pain comments;

> uncritical application of one body of knowledge/theory onto another never works out well, and there are problems with simplistic parallels between elder abuse, domestic violence and child abuse.[74]

The details of the circumstances and settings of abuse, the characteristic of the relationships between the victim of the abuse and the perpetrator of abuse, the characteristic of older victims of abuse and their perpetrators, all vary significantly from the details in respect to child abuse. Consequently, the analogy has limited practical significance. For example, as will be explored further below in respect to cultural perspectives on elder abuse and in Chapter 8 in discussions on global perspectives on the abuse of older women, situations such as the abuse of older women accused of witchcraft, or the abuse of older women in societies allowing polygamous marriages, can be overlooked. While such examples and settings of abuse may seem idiosyncratic from an Australian perspective, a global perspective on elder abuse demands a thorough appreciation of these forms of abuse. Reliance on child abuse and child protection models developed almost exclusively to analyse and respond to child abuse within western, developed nations, is a barrier to understanding the detail of elder abuse and responding to its challenges.

[74] Rachel Pain, *Theorising Age in Criminology: The Case for Home Abuse* (British Society of Criminology Conferences: Selected Proceedings, Volume 2, London, 1999), [3].

F. Cultural Perspectives on Elder Abuse

Cultural considerations may influence elder abuse at every level: in perceptions of the types of acts that constitute abuse as well as the factors that affect risk and that affect the availability and access to appropriate responses and interventions. Cultural influences shape the perspectives of both older people who may be the victims of abuse, but also the perspectives of health and community professionals who are involved in the provision of care and other services and support to an older person who has experienced abuse.

To date, there has been little in the way of systematic investigation into the influence of cultural considerations on the incidence and prevalence of elder abuse and neglect. It is often remarked that elder abuse, as it is framed and constructed in the vast majority of academic literature and policy and programme design, may be described as being a product of a white, middle-class perspective. In reality, the belief systems and cultural norms shared by members of any particular community which may underlie the prevalence of abuse in that community are as numerous as there are cultural groups across the globe. Therefore, it is inherently difficult to address all of these cultural diverse perspectives in this thesis. However, as indicated in the introductory chapter the primary objective of this thesis is to recommend future directions for social, legal and health disciplines towards elder abuse prevention in Australia. Therefore, global cultural, policy and human rights perspectives on ageing, together with a clear understanding of the impact of demographic changes in the world's population, fundamentally inform Australian directions in confronting elder abuse. The World Health Organization has noted that its investigations have revealed 'remarkable similarities' across the countries it has surveyed.[75]

[75] World Health Organization, above n 66.

Put simply, there are more similarities than differences in global and cultural perspectives on elder abuse. This is good news when considering the prospect of the development of cohesive international measures to target elder abuse. Nonetheless, the World Health Organization's 'Toronto Declaration on the Global Prevention of Elder Abuse' states: '[a] cultural perspective is mandatory in order to fully understand the phenomenon of elder abuse – i.e. the cultural context of any particular community in which it occurs.'[76] The differences matter too.

Cultural considerations can, however, raise some difficult challenges for both researchers and practitioners involved in combating elder abuse. Ethical and moral dilemmas may emerge for researchers, practitioners and community members when those notions of abuse conflict directly with their own personal, cultural or professional perspectives on whether an act or omission might constitute the abuse of an older person, and what measures and interventions should or might be taken in response to the abuse.

There are two main threads to a discussion directed to the cultural aspects of elder abuse. The first centres on how theoretical perspectives, policies and programmes formulated at an international level can be inclusive of the diverse and sometimes divergent cultural norms and practices across the globe. The second thread is concerned with how the cultural and linguistic diversity of many minority groups within a nation or jurisdiction can be recognised and accommodated in national plans and policies to address elder abuse. Within these two settings, it is also helpful to analyse:

- How the forms and nature of abuse are perceived within different cultural groups;
- Variations in the prevalence of different forms of abuse; and

[76] World Health Organization, *Toronto Declaration on the Global Prevention of Elder Abuse* (2002), above n 4.

- The availability, accessibility and acceptance of different prevention measures and responses in cultural and ethnic groups.

1. Global perspectives

Elder abuse is a global public health issue; elder abuse is also a human rights issue. Viewed within a public health framework, elder abuse demands global perspectives for the effective development of primary and secondary prevention strategies. Viewed within a human rights framework, elder abuse demands clear recognition of the rights and freedoms of older persons. Subsequent chapters of this thesis will advocate strongly for the incorporation of both public health and human rights principles and measures as essential elements of a global response to elder abuse prevention. This is the approach adopted by international organisations such as the World Health Organization, the United Nations and many other regional bodies.

The cultural context of elder abuse is a fundamental component. It encompasses, for example, designing strategies to incorporate cultural perspectives into the objectives and provisions of the major human rights instruments.

The first major contribution to an understanding of global perspectives on elder abuse was provided by the World Health Organization in a report produced in conjunction with the International Network for the Prevention of Elder Abuse, entitled 'Missing Voices: Views of Older People on Elder Abuse.'[77] The study involved focus groups of older people and primary care health workers within eight countries: Argentina, Austria, Brazil, Canada, India, Kenya, Lebanon and Sweden. The aim was to identify the perceptions and attitudes

[77] World Health Organization, above n 66.

of older people and health care professionals towards elder abuse, in order to guide global public health and primary care policy on elder abuse.

The 'Missing Voices' report lists the main categories of abuse identified by the participants;

- Structural and societal abuse;
- Neglect and abandonment;
- Disrespect and ageist attitudes;
- Psychological, emotional and verbal abuse
- Physical abuse; and
- Legal and financial abuse.[78]

A significant trend noted by the researchers was that a denial of the existence of abuse, in particular sexual and physical abuse, was pervasive among some cultural groups. In particular, it was observed by the researchers within the India focus group, that

> There was a general uneasiness about discussing cases of physical abuse and a genuine attempt was made to avoid the issue. The groups all denied the existence of physical violence in their communities. This created an issue in getting definitions of "abuse," because for them, "abuse" does not exist in India.[79]

Psychological, emotional and verbal abuse and neglect were most frequently identified by older people in the study groups across all countries. Within the developing countries in the study, there was a great emphasis on societal factors perceived to be contributing to elder abuse. For example, common features identified across reports from such countries included attitudes reflecting a belief that mistreatment is a result of societal factors such as the failure of governments to provide health care, accommodation and pensions. The

[78] Ibid 8.
[79] Ibid 9.

change in the role of older people within society and family structures was also identified by respondents across all country groups as a major contributor to the experience of physical and emotional abuse and neglect. As the care-giving role of older people has diminished their 'value' in society was perceived to have decreased.

Particular elder abuse concerns within specific countries highlighted cultural perspectives. For example, witchcraft accusations against older women are particularly prevalent in sub Saharan African countries such as Mozambique. The problem of abandonment of older people by relatives was also identified in specific countries. In the Kenyan report it was identified that 'abandonment of older people in hospitals was considered *the most significant issue in elder abuse'*.[80]

2. National perspectives

Information on cultural perspectives of the cultural and minority groups within a nation is often limited in the reports of studies on elder abuse. In relation to prevalence data, often, methodological factors in study design mean that this data is not able to be collected. Studies based on data collected from case reports to agencies such as protective services, often rely on databases that do not record ethnic, cultural or religious criteria. In the United States National Elder Mistreatment Study, race was not found to be a significant independent predictor of abuse.[81]

Cultural factors in the prevention and responses to elder abuse are of importance in Australia. The percentage of the Australian population born overseas continues to rise and immigrants bring a wide range of cultural, ethnic and religious identities. The Australian Bureau of Statistics reports that in 2011, 36 per cent of older Australians (aged 65 years or

[80] Ibid 12 (emphasis in original).
[81] Acierno et al, above n 22, 296.

over) were born overseas.[82] Furthermore, those older people migrated from over 120 different countries. The traditional post-war immigration trends from the United Kingdom and European countries such as Italy and Greece have changed and within recent years there has been increasing diversity in the range of countries that were the birthplace of older Australians. Additionally even greater diversity can be predicted into the future: there is currently an even greater diversity within population under 65 years that will be translated into the cohort of older people in the coming decades. In particular immigrants from India, Sri Lanka, Lebanon, Vietnam, Philippines, Malaysia Hong Kong and China and New Zealand comprise an increasing proportion of Australians born overseas.[83]

This issue of service provision to older people from culturally and linguistically diverse backgrounds (CALD) has been given recent consideration in the Australian context in a series of reports produced in Western Australia. The Office of the Public Advocate conducted a project to examine whether elder abuse was a problem in Western Australian CALD communities; to develop an understanding of what constitutes abuse in CALD communities; and to determine how services providers should respond.[84] A population of 210 older persons from a range of CALD backgrounds were interviewed in seven forums. A second stream of consultations was undertaken with service providers. Financial abuse was the most frequent type of abuse reported by older persons in the project.[85] Other findings showed significant parallels with the views expressed by older people in the WHO 'Missing Voices' Report. For example, psychological, social abuse and neglect was the

[82] Australian Bureau of Statistics, *Who are Australia's Older People, 2071.0 - Reflecting a Nation: Stories from the 2011 Census, 2012–2013* (2013) http://www.abs.gov.au/ausstats/abs
[83] Ibid.
[84] Office of the Public Advocate, Western Australia, *Care and Respect: Project to Research Elder Abuse in Culturally and Linguistically Diverse Communities* (2006).
[85] Ibid 27.

other main category of abuse reported by CALD older people in this project, as in the global study.

A follow-up study addressing elder abuse in CALD communities was undertaken in 2012 in Western Australia. Barbara Black Blundell and Mike Clare conducted community forums involving 152 older persons from CALD backgrounds.[86] The aim of the study was to analyse service delivery designed to intervene in elder abuse in respect of CALD older people.[87] It was not a study aimed at identifying incidence or prevalence among particular cultural groups in Australia. The study concluded:

> Services for vulnerable people who cannot speak and/or read English are inadequate for the current level of service demand – and there is a predicted tidal wave of increases in demand from older CALD Australians.[88]

Older people may have differences in beliefs and interpretations about what may constitute abuse. Cultural perspectives may mean they hold differing beliefs about the stigma and shame that may be associated reporting that abuse to other family members, community or health workers. Older people from CALD backgrounds may be more socially isolated from the broad community with their only social relationships maintained among groups that reinforce those views on the stigma associated with abuse. Economic disadvantage may act as a barrier to reporting abuse and accessing services. Structural factors such as the provision of language services are integral to systems to combat abuse in CALD communities.

[86] Barbara Black Blundell and Mike Clare, *Elder Abuse in Culturally and Linguistically Diverse Communities: Developing Best Practice* (2012) 2.
[87] The study did not included Aboriginal and Torres Strait Islander groups of older persons.
[88] Blundell and Clare, above n 86, 2.

3. Elder Abuse in Aboriginal and Torres Strait Islander Communities.

The physical, sexual, psychological, financial and social abuse and neglect of older people within Aboriginal and Torres Strait Islander communities will not be covered in any depth in this thesis. The discussion is a highly complex and sensitive one, and this is evident at first instance — the cultural meanings and associations of the word 'elder' have a very important and central role in Indigenous communities. The mistreatment of older people is an issue of concern for Indigenous communities. However, in the absence of input from members of the Indigenous community it is not appropriate to explore this in further depth here.[89]

Conclusion

It has been a bumpy ride for the evolution of the global understanding of the phenomenon of elder abuse and neglect. While a general appreciation of types of acts and omissions that may constitute abuse is emerging and population surveys on the prevalence of abuse are beginning to provide a clearer picture of the extent of the problem in developing countries, much work is yet to be done.

Consistency and clarity among definitions is important, but this must not be at the expense of an approach to elder abuse and neglect that can be sufficiently sophisticated to respond to and recognise the actual experience of abuse of older people regardless of their cultural, ethnic or other influences. Elements of the various theoretical constructs of elder abuse will underpin future research into elder abuse prevalence, risk factors and crucially primary preventive measures, interventions and outcomes. Future responses must be designed and implemented on the basis of the combined perspectives of family violence and health

[89] See further, Office of the Public Advocate, Western Australia, *Mistreatment of Older People in Aboriginal Communities Project: An Investigation into Elder Abuse in Aboriginal Communities* (2005).

promotion and with particular regard to the social, economic and cultural influences on the lives of older people. The following chapter will examine the mechanism by which the international human rights system can be implemented to support future strategies to combat elder abuse.

Chapter 5

HUMAN RIGHTS PERSPECTIVES ON ELDER ABUSE PREVENTION

The system of international, regional and national human rights protection is one mechanism which can be harnessed to combat elder abuse. At an international level, human rights perspectives have been integral to ageing policy and programme development for several decades.[1] As identified in Chapter 3, concurrent with and interdependent upon, developmental perspectives on ageing, documents such as the *Universal Declaration of Human Rights,*[2] the *Vienna Plan of Action on Ageing*[3] and the *Madrid International Plan of Action on Ageing*[4] have laid the foundation for both the conceptual approach to acknowledging elder rights and provided a practical framework for elder rights protection.

[1] For a discussion of the interaction between models of elder mistreatment, social ageism and human rights see further, Simon Biggs and Irja Haapala, 'Elder Mistreatment, Ageism and Human Rights' (2013) 25 *International Psychogeriatrics* 1299.
[2] *Universal Declaration of Human Rights*, GA Res 217A, 3rd sess, 183rd plen mtg, UN Doc A/810 (1948).
[3] *Report of the World Assembly on Ageing, Vienna (1982), Vienna International Plan of Action on Ageing,* GA Res 37/51, UN Doc A/CONF.113/31 (1982).
[4] United Nations Second World Assembly on Ageing, *Political Declaration and Madrid International Plan of Action 2002*, UN Doc A/CONF.197/9 (2002).

However, the dearth of specific acknowledgement of the rights of older people in binding international human rights agreements suggests that older people's rights have failed to attract the attention of the international community in the drafting of these documents. The objective of this chapter and Chapter 6 is to demonstrate the role of international human rights law in the protection and promotion of the rights of older people. It is argued that this system must be connected with and relevant to the experiences of older people.

This chapter focuses on the application of international, regional and domestic human rights systems to the protection and promotion of the rights of older people, with particular reference to the mechanisms by which they can facilitate the prevention of elder abuse and neglect. The specific provisions of the major binding human rights instruments, the intended scope, content and the utility of such documents will be identified. Elaboration upon the content of the rights and their relation to older persons as a group can be elucidated from the General Comments of Treaty Bodies, such as the Committee on Economic, Social and Cultural Rights (CESCR) General Comment No 6 on 'The Economic, Social and Cultural Rights of Older Persons'[5], and General Comment No 14 on 'The Right to the Highest Attainable Standard of Health'.[6] The Committee on the Elimination of Discrimination against Women (CEDAW) has also provided specific consideration of the challenges that face older women in General Recommendation No 27 on 'Older Women and Protection of their Human Rights',[7] and is the subject of Chapter 8.

To illustrate the practical implementation of the human rights system for the benefit of older people, three crucial areas have been chosen for closer attention:

[5] United Nations Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 6, The Economic, Social and Cultural Rights of Older Persons*, 13th sess, UN Doc E/1996/22 (1995).
[6] United Nations Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No 14, The Right to the Highest Attainable Standard of Health*, 22nd sess, UN Doc E/C.12/2000/4 (2000) [11].
[7] United Nations Committee on the Elimination of Discrimination against Women, *General Recommendation on Older Women and Protection of Their Human Rights*, UN Doc, CEDAW/C/GC/27(2010).

1. The right to the highest attainable standard of physical and mental health;
2. The rights of older people with dementia; and
3. The rights of older women.

This chapter will assess whether, and to what extent, the protection and promotion of these rights has the potential to have an impact upon the incidence of elder abuse and neglect. A firm understanding is required of the links between the risk factors that contribute to an older person's likelihood of experiencing elder abuse and neglect and the content, availability, accessibility, accountability for and justiciability of these rights in international law.

The most obvious impediment to the practical application of human rights law to elder abuse prevention is that human rights law governs the responsibilities of States in respect of individuals. Human rights law may assist in the prevention of and accountability for abuse of older people in State controlled residential and care facilities. However, the evidence suggests that the majority of incidents of elder abuse occur outside residential care facilities. Close examination is needed to identify the obligations of States under the major international and domestic human rights instruments and how those obligations can be applied to violent, abusive and neglectful behaviour perpetrated by private actors towards older people domestic settings.

A. Older People within the Human Rights Framework

The rights set out in binding international human rights treaties are universal. Older persons are subject to the full range of rights embodied in these documents. However there is no binding international instrument specifically attendant to the rights of older persons. In fact, there is scant specific reference to age throughout the international treaty system.

This is in vivid contrast to the International Conventions relating to the rights of other groups including women,[8] children,[9] migrant workers[10] and people with disabilities.[11] These Conventions provide an avenue for the acknowledgement and protection of issues of specific concern for those groups; for example, the promotion of maternal and reproductive health in several provisions of the *Convention on the Elimination of Discrimination against Women*[12] and the protection of children in armed conflict within the *Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict.*[13]

In the absence of an international binding and specific document attendant to older persons, it is necessary to examine the existing human rights documents in order to identify specific legal protections within them which will assist in combating elder abuse and neglect. Three main considerations emerge which help the following discussion and analysis:

1. the overriding principle of non-discrimination;
2. the special relevance of some of the general human rights norms to the prevention of elder abuse and neglect; and
3. specific reference to older persons and ageing within human rights instruments.

[8] *Convention on the Elimination of All Forms of Discrimination against Women,* opened for signature 1 March 1980, 1249 UNTS 13 (entered into force 3 September 1981).
[9] *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3(entered into force 2 September 1990).
[10] *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families,* opened for signature 18 December 1990, 2220 UNTS 3, (entered into force 1 July 2003).
[11] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).
[12] *Convention on the Elimination of All Forms of Discrimination against Women,* opened for signature 1 March 1980, 1249 UNTS 13 (entered into force 3 September 1981).
[13] *Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict,* opened for signature 25 May 2000, 2173 UNTS 222 (entered into force 12 February 2002).

Each of these will be considered in turn to highlight the normative gap that exists in the context of elder abuse prevention.

1. The Principle of Non-discrimination

The *Universal Declaration of Human Rights* (UDHR)[14] entrenched the principle of non-discrimination into human rights protection. In principle, the requirement for rights to be respected, protected and fulfilled in the absence of discrimination provides a mechanism for addressing the challenges facing older persons as a group. An obstacle to the practical realisation of the requirement for non-discrimination exists for older persons: age is not specifically listed as a prohibited ground for discrimination in the UDHR, the *International Covenant on Civil and Political Rights* (ICCPR),[15] nor the *International Covenant on Economic, Social and Cultural Rights* (ICESCR).[16] For example, Article 2.2 of the ICESCR states:

> The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

The Committee on Economic, Social and Cultural Rights in General Comment No 20 on 'Non-discrimination in Economic, Social and Cultural Rights', expressed the view that 'the inclusion of "other status" indicates that this list is not exhaustive and other grounds such as age and disability, may be incorporated into this category.'[17]

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[14] *Universal Declaration of Human Rights*, GA Res 217A, 3rd sess, 183rd plen mtg, UN Doc A/810 (1948), art 2.
[15] *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976), see for example, art 2.
[16] *International Covenant on Economic, Social and Cultural Rights*, opened for signature 19 December 1966, 993 UNTS 3 (entered into force 3 January 1976).
[17] Committee on Economic, Social and Cultural Rights, *General Comment No.20, Non-discrimination in Economic, Social and Cultural Rights*, UN Doc E/C.12/GC/20 (2009), [15].

In December 2008, the General Assembly adopted *the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights* (the 'Optional Protocol to ICESCR').[18] The Optional Protocol entered into force on 5 May 2013 with 10 signatories and Article 2 enables individual communications with respect to alleged violations of the ICESCR.[19] It can be anticipated that further delineation of the prohibition of discrimination on the basis of age under 'other status' may come to light and adjudication may occur upon alleged violations of the right to health and other economic, social and cultural rights that influence the well-being of older people and their vulnerability to abuse.

Under the *Optional Protocol to the International Covenant on Civil and Political Rights*[20] the Human Rights Committee (HRC) may consider individual communications regarding alleged violations of rights by States Parties to that treaty. The HRC has directly considered the matter of whether 'other status' is inclusive of a prohibition of discrimination on the grounds of age. In *Love et al v Australia*,[21] the HRC considered an alleged violation of Article 26 of the ICCPR which provides for equality before the law and non-discrimination on specified grounds or 'other status.' The case concerned the mandatory retirement age of Australian Airlines domestic aircraft pilots. The HRC found that a violation of Article 26 of the ICCPR was not established in that case because the distinction made on the basis of age constituted reasonable and objective grounds for discrimination, specifically, maximizing flight safety. Importantly however, the HRC

[18] *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights*, opened for signature 24 September 2009, UN Doc A/63/435 (entered into force 5 May 2013).
[19] As of August 2013, Australia is not a signatory to the Optional Protocol to ICESCR.
[20] *Optional Protocol to the International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 302 (entered into force 23 March 1976).
[21] Human Rights Committee, *Love et al v Australia, Communication No. 983/2001*, UN Doc CCPR/C/77/D/938/2001 (views adopted 25 March 2003) [8.2].

stated in the decision that 'a distinction related to age which is not based on reasonable and objective criteria may amount to discrimination on the ground of "other status."'[22]

In *Solis v Peru*,[23] the HRC considered Article 25(c) of the ICCPR which recognises the right to equality of access to public service without discrimination. This case involved the dismissal of an employee on the basis of age in the restructuring of the National Customs Authority of Peru and provided further confirmation of the principle that age is included amongst the scope of 'other status' and that distinction based on age must be reasonable and objective.[24]

While General Comment No 20 of the CESCR provides support for the recognition of age as a prohibited ground for discrimination, there is still scope for the elaboration upon the nature and circumstances of discriminatory practices in relation to older people that are prohibited by international human rights law. General Comment No 20 provides little expansion upon the specific concerns of older people, making reference only to CESCR's own previous determinations in relation to employment, education and access to social security.[25] The appointment of a Special Rapporteur on the rights of older persons would provide the platform for a greater analysis and delineation of the specific circumstances in which older persons commonly and significantly encounter discriminatory practices.[26]

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[22] Ibid [8.3]
[23] Human Rights Committee, *Solis v Peru*, Communication No.1016/2001, UN Doc CCPR/C/86/D/1016/2001 (views adopted 27 March 2006).
[24] It is worth noting the dissenting opinion of four of the Committee members that on the facts of this case the distinction made for mandatory retirement age was not on reasonable and objective grounds. See further individual opinion of dissenting Committee members, *Solis v Peru*, Communication No.1016/2001, UN Doc CCPR/C/86/D/1016/2001 Appendix [1].
[25] Committee on Economic, Social and Cultural Rights, *General Comment No.20, Non-discrimination in Economic, Social and Cultural Rights*, UN Doc E/C.12/GC/20 (2009), [27].
[26] The appointment of a Special Rapporteur on the Rights of Older Persons is one of the issues currently under consideration by the UN Open Ended Working Group on Ageing.

2. General Human Rights Norms of Special Relevance to Older Persons and Elder Abuse Prevention

While all of the rights within the core treaties apply to older persons, a second strategy is to identify the sources of several specific rights which have particular relevance to the prevention of elder abuse and neglect. The list below is intended to be illustrative, not exhaustive:

i) The right to an adequate standard of living;

ii) The right to the highest attainable standard of physical and mental health;

iii) The right to work;

iv) The right to social security;

v) The right to family life;

vi) The right to privacy; and

vii) The right to liberty and security of person.

The content of these rights as they relate to older persons and how they may be practically implemented to the benefit of older persons has been given consideration by several of the treaty bodies.

Article 5 of the *Universal Declaration of Human Rights*, Article 7 of the ICCPR and Articles 2 and 16 of *the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*[27] ('CAT') all impose obligations upon States Parties to prevent any acts of torture, cruel, inhuman or degrading treatment or punishment. The operation of the CAT has direct relevance to interpretations of the perpetration of violence,

[27] *Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 UNTS 85 (entered into force 26 June 1987), ('CAT').

abuse and neglect of older persons by private individuals or private bodies and how they can be influenced by international human rights law.

The Committee against Torture in General Comment No 2 on the 'Implementation of Article 2 by States Parties', elaborates upon the scope of State obligations.

> [E]ach State Party should prohibit, prevent and redress torture and ill-treatment in all contexts of custody or control, for example, in prisons, hospitals, schools, institutions that engage in the care of children, the aged, the mentally ill or disabled, in military service, and other institutions as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm.[28]

The Committee against Torture makes special acknowledgement of 'groups made vulnerable by discrimination or marginalization'[29] which can be specifically related to older persons who may be vulnerable to abuse or neglect. The State Parties have an obligation to ensure legislative, administrative, judicial and other measures[30] are in place and in effect to prevent the ill-treatment of older persons within state controlled hospital or residential facilities, places of detention, as well as prohibited acts that take place within private domains in any territory under its jurisdiction. The extension of obligations on States to prevent and respond to acts of abuse in the private sphere is an important one, as the majority of older persons continue to live in community settings as they age. The Committee against Torture reiterates an obligation of State authorities to exercise due diligence to 'prevent, investigate, prosecute and punish such non-State officials or private actors.'[31] The Special Rapporteur on Torture has reiterated that in the context of definitions of torture, cruel, inhuman and degrading treatment, reference to 'acquiescence by a public

[28] Committee against Torture, *General Comment No 2, Implementation of Article 2 by States Parties*, UN Doc CAT/C/GC/2 [15] (2008).
[29] Ibid [20].
[30] *Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 UNTS 85, art 2(1) (entered into force 26 June 1987)
[31] Committee against Torture, *General Comment No 2, Implementation of Article 2 by States Parties*, UN Doc CAT/C/GC/2 (2008), [18].

official' in Articles 1 and 16 of the CAT 'clearly extends State obligations into the private sphere and which should be interpreted to include State failure to protect persons within its jurisdiction from torture and ill-treatment committed by private actors.'[32]

Aside from the application of the CAT to acts within the private sphere, another concern arises in the application of the CAT provisions. Violent, abusive or neglectful acts that may in nature or severity fail to be deemed acts of torture, cruel or degrading treatment under the CAT, may nonetheless constitute unacceptable violations of the rights of older persons. Recent positive developments in this regard have arisen in the context of the *Convention on the Rights of Persons with Disabilities*, and early drafts from the Pan-American States of a Convention on the Rights of Older Persons. These will be discussed further below.

3. Explicit References to 'Older Persons' and 'Age' in International Human Rights Documents

The final strategy involves identifying explicit references to age, or older persons within the major human rights instruments. Such a review provides little encouragement, as age rarely receives particular acknowledgement. Specific mention of 'age' or 'older persons' can be found in the following international and regional human rights documents.

i) The *Universal Declaration of Human Rights*

Article 25(1) states that:

> Everyone has the right to a standard of living adequate for health and well-being of himself and his family, including food, clothing housing and medical care and necessary social

[32] Manfred Nowark, *Study on the Phenomenon of Torture, Cruel, Inhuman or Degrading Treatment or Punishment in the World, Including an Assessment of Conditions of Detention*, UN Doc A/HRC/13/39/Add.5 (2010) [196].

> services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.[33]

ii) The *Convention on the Elimination of All Forms of Discrimination against Women*

Article 11 regarding the elimination of discrimination against women in employment requires States Parties to ensure:

> (1)(e) The right to social security, particularly in cases of retirement, unemployment, sickness, invalidity, and old age and other incapacity to work, as well as the right to paid leave.[34]

Article 12 addresses the elimination of discrimination against women in health care and makes specific acknowledgement of matters relating to family planning, maternal and reproductive health. The emphasis reflects the broader dialogue on maternal and reproductive health issues, prompted in part by the challenges that the HIV/AIDS pandemic posed to women's health that was contemporaneous with the drafting of this treaty.

However, the life course view did not incorporate specific acknowledgement of the latter stages of women's lives in Article 12. The Committee on the Elimination of Discrimination against Women first directed attention to this gap in its General Recommendation No 24 on Article 12, 'Women and Health'[35] and again in General Recommendation No 27 on 'Older Women and the Protection of their Human Rights.'[36]

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[33] *Universal Declaration of Human Rights*, GA Res 217A,3rd sess, 183rd plen mtg, UN Doc A/810 (1948), art 25(1).

[34]*Convention on the Elimination of All Forms of Discrimination against Women*, opened for signature 1 March 1980, 1249 UNTS 13, art 11 (entered into force 3 September 1981)

[35] Committee on the Elimination of Discrimination against Women, *General Recommendation No 24 on Article 12, Women and Health*, 20th sess (1999).

[36] Committee on the Elimination of Discrimination against Women, *General Recommendation No 27 on Older Women and Protection of Their Human Rights,* UN Doc, CEDAW/C/GC/27 (2010).

iii) The *International Convention on the Protection of All Migrant Workers and Members of Their Families*

Article 7 specifically identifies age as a prohibited ground for discrimination.[37]

iv) The *Convention on the Rights of Persons with Disabilities* (CRPD)[38]

To date, the CRPD includes the most explicit reference to measures which may facilitate the prevention of abuse and neglect of older persons with disabilities. This is achieved through:

a) requirements for 'age-appropriate measures' and to direct identification of older persons with disabilities as a group requiring attention; and
b) through inclusion of specific provisions to deal with the types of acts that constitute abuse.

For example, in relation to the access of persons with disabilities to justice, Article 13 imposes an obligation on States Parties to

> [e]nsure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses in all legal proceedings, including investigative and other preliminary stages.[39]

The language of Articles 25 and 28 of the CRPD includes direct references to 'older persons'. For example, Article 25(b) 'Health', requires that States Parties shall

[37] *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families,* opened for signature 18 December 1990, 2220 UNTS 3, art 7 (entered into force 1 July 2003).
[38] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).
[39] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3, art 13(entered into force 3 May 2008).

> provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons.[40]

Article 28 concerning 'Adequate standard of living and social protection' requires States Parties to take measures

> (2)(b) '[t]o ensure access by persons with disabilities, in particular women and girls with disabilities and older persons with disabilities, to social protection programmes and poverty reduction programmes'.[41]

These provisions represent an encouraging development and a clear manifestation of the recommendation within the *Madrid Plan of Action on Ageing* for mainstreaming of ageing perspectives across human rights.

v) Regional Human Rights Instruments.

The *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights* (the '*Protocol of San Salvador'*) is noteworthy as it specifically recognises the rights of older people. Article 17 entitled 'Protection of the Elderly' states:

> Everyone has the right to special protection in old age. With this in view the States Parties agree to take progressively the necessary steps to make this right a reality and, particularly, to
>
> a. Provide suitable facilities, as well and food and specialized medical care, for elderly individuals who lack them and are unable to provide them for themselves;
> b. Undertake work programs specifically designed to give the elderly the opportunity to engage in a productive activity suited to their abilities and consistent with their vocations or desires;

[40] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3, art 25(b) (entered into force 3 May 2008).
[41] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3, art 28 (entered into force 3 May 2008).

c. Foster the establishment of social organizations aimed at improving the quality of life for the elderly.[42]

Several other regional documents contain specific acknowledgement of the rights of older persons. For example, Article 23 of the *Revised European Social Charter* contains obligations in respect of social protection for older persons, in particular participation in community life, housing and health care provision.[43] Article 18 of the *African Charter on Human and People's Rights* identifies a right of the aged and those with disabilities to special measures of protection.[44] The detail of how the rights relate to the specific challenges confronting older persons is less evident. The Pan-American States have been particularly active in their efforts to bring substance to the broad statements of rights of older people and these developments are discussed in the following sections.

B. The Rights of Older Persons with Disabilities

1. Ageing and Disability

Negative societal stereotyping of older persons as dependent and frail poses a significant obstacle to the successful enjoyment by older people of the full spectrum of the human rights they share with all others in society. On the other hand, it is clearly unhelpful to avoid the recognition and analysis of the real challenges that face many older persons as they age. As discussed earlier in the context of definitions of 'ageing', contemporary interpretations of 'disability' have moved away from exclusive reliance on either

[42] *Additional Protocol to the American Convention on Human Rights*. Adopted November 17 1988, OASTS No 69 (1988) (entered into force 16 November 1999) ('Protocol of San Salvador').
[43] *European Social Charter (Revised)*, opened for signature 3 May 1996, ETS 163, 3.V.1996, art 23 (entered into force 1 July 1999).
[44] *African Charter on Human and Peoples' Rights*, adopted 27 June 1981, OAU Doc. CAB/LEG/67/3rev.5, art 18(entered into force 21 October 1986) ('Banjul Charter').

medical/biological models or social models of disability. A medical model of disability places an emphasis on the physical, sensory or intellectual impairment of the individual and consequently 'calls for medical or other treatment or intervention, to correct the problem with the individual.'[45] Alternately, a social model of disability places emphasis on the disadvantage caused by inadequate responses within the social environment of an individual. A social model therefore demands responses to disability that are driven by social and political policy. The contemporary view of disability incorporates aspects of both models. For example, the World Health Organization has developed the 'International Classification of Functioning, Disability and Health' (ICF) which draws upon assessments of body function and structure, activity and participation as well as environmental factors for an individual.[46]

Physical and cognitive disabilities are neither synonymous with, nor inevitable consequences of ageing; for many older people, ageing is not accompanied by chronic mental or physical disability. Those older people who do experience disability in older age require considerable efforts to be directed to individualised support plans that accommodate and attend to the subtleties and the variations that may occur over time in the older person's needs and circumstances.

The association between disability and ageing is certainly of practical significance when identifying and utilising legal interventions against elder abuse and neglect which are derived from the human rights framework. As identified above, to date the *Convention of the Rights of Persons with Disabilities* offers the most promising, concrete and specific

[45] World Health Organization, *Towards a Common Language for Functioning, Disability and Health* (2002), WHO/EIP/GPE/CAS/01.3, 8.
[46] See, World Health Organization http://www.who.int/classifications/icf/en.

acknowledgement of those rights of particular significance to older persons. Article 16 'Freedom from Exploitation, Violence and Abuse' warrants further consideration.

2. Article 16 CRPD - 'Freedom from Exploitation, Violence and Abuse'

This provision of the CRPD is revolutionary because it was included in addition to the Article 15 prohibition of torture, cruel, inhuman or degrading treatment or punishment. Article 16 reads:

> 1. States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.
> 2. States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse. States Parties shall ensure that protection and services are age-, gender- and disability-sensitive.[47]

Article 16 provides a deliberate, alternative mechanism for the protection against and prosecution of violent and abusive behaviours that may not otherwise satisfy the definitions of torture or cruel, inhuman or degrading treatment or punishment, or 'ill-treatment'.[48] To date the elaboration upon the scope of torture, cruel inhuman or degrading treatment in the specific context of elder abuse has not received specific attention by the courts. Some general insight on the matter was provided in the decision of the European

[47] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3, art 16 (entered into force 3 May 2008).
[48] O Akinpelu, E Flynn, C Laurie-Bowie, O Lewis and E Rosenthal, 'Perspectives from the Drafting of the UN Convention on the Rights of Persons with Disabilities' (Discussion Paper for Side Event at UN Open-ended Working Group on Ageing, New York, 2011).

Court of Human Rights decision in *Mayeka and Mitunga v Belgium.*[49] The Court held, that in respect of Article 3 of the *Convention for the Protection of Human Rights and Fundamental Freedoms*[50] concerning the prohibition of torture, inhuman or degrading treatment or punishment that

> [I]n order to fall within the scope of Article 3, the ill-treatment must attain a minimum level of severity, the assessment of which depends on all the circumstances of the case, such as the duration of the treatment, its physical or mental effects, and in some cases the sex, age and state of health of the victim.

In addition to the specific prohibition on medical or scientific experimentation without consent, acts such as physical or pharmacological restraint could readily be envisaged to satisfy the definition of cruel, inhuman or degrading treatment. However the 'minimum level of severity' requirement of the provisions on cruel, inhuman or degrading treatment leaves open the question of whether many acts and omissions that constitute physical and psychological abuse and neglect would satisfy the requirements under these provisions.

Article 16 of the CRPD provides a new avenue through which the types of behaviours that constitute elder abuse may be attended to by the courts within the scope of human rights law. The positive acts of violence and abuse towards older people with disabilities are within the scope of Article16. However, the application of Article 16 to abuse by omission and neglect is less clear. As described in Chapter 1, the evolution of the theoretical and practical aspects of the phenomenon of elder abuse has led to the broad acceptance of definitions of elder abuse that include neglect. The wording of Article 16 of the CRPD however, does not specifically include the term 'neglect'. This was a missed opportunity to strengthen the perception and acknowledgement that neglect can constitute a serious and

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[49] *Mayeka and Mitunga v Belgium*, European Court of Human Rights, Communication No 13178/03 (Final Judgement 2007).
[50] *Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 222 (entered into force 3 September 1953).

measurable threat to the enjoyment of active and healthy lifestyles of people with disabilities, who require assistance with their personal care and activities of living. This includes older persons with disabilities. The direct inclusion of neglect within human rights provisions dealing with the abuse of older persons or persons with disabilities is desirable in order to give sufficient weight to the problem, to have an educative role to increase understanding that neglect is not simply a passive failure to attend to the 'incidental' needs of people requiring care assistance and to provide a clear avenue for individuals to seek redress for violations of their rights through acts of neglect. Neglect can constitute a deliberate pattern of abusive behaviour in some relationships and can pose a real and serious threat to the health and well-being of some older persons with disabilities. For example, failure to attend to the critical preventive pressure care of bed-bound older persons can result in pressure ulcers which can be extremely painful, refractory to treatment once present, prone to secondary infection and ultimately can become life-threatening.

Failing to provide and/or failing to give assistance in using visual, hearing and dental aids to older persons with moderate to severe cognitive disability may occur as a result of an incorrect perception that individuals with significant cognitive disabilities are largely disconnected from their environment and therefore would not benefit in any event from visual and hearing aids. But neglect may not only result from passive failure to provide care due to poor understanding of what is required. It also encompasses a deliberate failure to attend to the fitting of denture or hearing aids as a part of the responsibilities of care givers towards older persons with physical or cognitive disability who require that assistance.

Article 20 of the CRPD concerns the access of persons with disabilities to 'mobility aids, devices, assistive technologies'[51] and creates an obligation in respect of personal mobility which has particular relevance to many older persons. Article 25 identifies States' obligations to protect and fulfil the equal rights of persons with disabilities to health care and services.[52] These provisions provide for the rights and obligations of people with disabilities which support some aspects of the behaviours which may constitute neglect if the rights are violated or obligations not met.

The inclusion of a separate article in the *Convention on the Rights of Persons with Disabilities* for 'freedom from exploitation, violence and abuse' represents a significant step forward for providing people with disabilities a legal avenue of protection in international law that may not have been available through international treaty provisions dealing with torture, cruel, inhuman or degrading treatment. However, the opportunity to include an emphatic statement that recognises patterns of neglect as significant aspects of abuse has been missed. It is hoped that in the development of any future international covenant on the rights of older persons that this gap will be closed in the context of the prevention of physical and psychological abuse of older persons.

3. Regional Developments in the Recognition of Elder Abuse and Neglect

While it represented an early step towards the creation of a Convention on the Rights of Older Persons, the language adopted in the 'Guidelines for a Convention on the Rights of Older Persons' (the Guidelines), produced in 2009 at the Third Follow-up Meeting of the Brasilia Declaration, was encouraging.[53] It gave detailed consideration of the rights of

[51] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3, art 20 (entered into force 3 May 2008).
[52] *Convention on the Rights of Persons with Disabilities* opened for signature 30 March 2007, 2515 UNTS 3, art 25 (entered into force 3 May 2008).
[53] Organisation of American States, 'Guidelines for a Convention on the Rights of Older Persons' (Third Follow-up Meeting of the Brasilia Declaration, "For the Rights of Older Persons", Santiago, Chile, 2009).

older persons and the challenges that confront older people in the fulfilment of those rights and demonstrated gathering momentum at the level of regional bodies and organisations such as those from the Pan-American region that participated to produce the Guidelines.

There are multiple specific references within the Guidelines to the types of behaviours that constitute violence, abuse and neglect that confront and challenge the enjoyment of rights by older persons both with and without disabilities. There is specific use of the terminology of 'neglect' in the Guidelines which directly state a prohibition on the types of behaviour that constitute neglect and mistreatment. The evolution of the Guidelines has resulted in the preparation by the Organisation of American States, of the 'Preliminary Draft Inter-American Convention on the Protection of the Human Rights of Older Persons'[54] (the 'Draft Inter-American Convention').

As in the CPRD, in addition to the provision prohibiting torture, cruel, inhumane or degrading treatment or punishment, Article 8 of the Draft Inter-American Convention defines a right to 'physical, mental emotional safety, safety of their inheritance, and not to suffer mistreatment.' It states:

a. Older persons have the right to be able to live in dignity and safety, to receive dignified treatment that avoids infantilizing them, independently of race, colour, sex, language, religion, political or any other type of opinion, social, national, ethnic or indigenous origin, economic position, disability, sexual orientation, gender, gender identity, or any other condition, and to be valued independently of their economic contribution.
b. Older persons have the right to live free of violence and mistreatment of a physical, sexual or psychological nature; of emotional and financial abuse; exploitation in the workplace, and any form of abandonment or negligence that causes avoidable harm.[55]

(Hereafter 'The Guidelines.') NB Non-official translation document accessed via www.scm.oas.org (Organisation of American States).

[54] Organization of American States, *Preliminary Draft Inter-American Convention on the Protection of the Rights of Older Persons*, OEA/Ser.G, CAJP/GT/DHPM-37/12 (30 April 2012) http://www.oas.org/consejo/cajp/personas%20mayores.asp

[55] Ibid 11.

Article 8.c. elaborates further on State obligations to adopt legislative and other measures to prevent and punish, create support services, supervisory and monitoring mechanisms, and the education of professional actors and civil society in respect of violence and abuse.

The equivalent provision of the Guidelines for a Convention that arose from the Brasilia Declaration Follow-up Meetings (the predecessor document for the Draft Inter-American Convention) contained specific inclusion of the types of behaviour constituting 'mistreatment', 'abandonment' and 'neglect'. Article 8 of the Draft Inter-American Convention adopts the terminology of 'violence, mistreatment, abuse, exploitation and abandonment'. The elaboration of these concepts in the Draft Inter-American Convention is contained separately in Article 2 'Definitions.' A notable shift in language from 'neglect' (in the Guidelines) to 'abandonment or negligence' is present in Article 3. This is inconsistent with broader acceptance of the terminology of neglect, and could lead to confusion. Nonetheless, it is defined in Article 2 as:

> any failure or omission in performing certain actions or leaving unprotected a persons who depends on care provided by a long-stay facility, the private sector or family members, and for whom this type of facility or actors have some legal or moral obligation. Negligence or abandonment may be intentional or unintentional.[56]

Early evidence, therefore, is emerging through developments at a regional level indicating that a Convention on the Rights of Older Persons could build upon the significant advances that the CRPD had made in promoting the rights of persons with disabilities. In particular, it is hoped that momentum has been given to a specific and detailed prohibition on the violent, abusive and neglectful behaviours that constitute elder abuse, in addition to the prohibitions on torture, cruel and degrading treatment and punishment. This would help eliminate ambiguity about the nature of mistreatment or neglect and thereby help to ensure

[56] Ibid 6.

that all forms of violence and abuse will be clearly open to adjudication by the courts. Detailed enunciation of the prohibitions on violence against older persons, including the specific acts of violence to which older women are particularly vulnerable,[57] must be included in order to close the normative gaps that exist in the protection of older people and help in the education of professional groups and the broader community on the nature of those rights and freedoms.

C. End of Life Concerns

Elder abuse and neglect at the end of life is for most people, in both a professional and personal capacity, particularly abhorrent and unsettling. Because of, or in spite of this, discussions and responses to the abuse of older people in the final stages of life are often avoided.

Similarly, international human rights law has not directed detailed attention to and analysis of the particular experiences and concerns of older people who are terminally ill and the vulnerability of those people to abuse and neglect. Non-government organisations such as HelpAge International which actively advocate for the promotion of older persons rights within the international human rights system, have consistently reiterated the 'failure to fully examine the specific context of violations of people's rights.'[58]

The Committee on Economic, Social and Cultural Rights only briefly acknowledged the issue of older people at the end of life in General Comment No 6 on the 'Social, Economic

[57] For further discussion of the specific challenges facing older women see Chapter 8. While beyond the scope of discussion in this thesis, it is also promising to note the inclusion of financial abuse within the Guidelines.
[58] HelpAge International, *HelpAge International's submission for the Consultation on the Human Rights of Older Persons Follow-up to the Second World Assembly on Ageing* (2011), www.helpage.org

and Cultural Rights of Older People'.[59] The CESCR reiterated that the realisation of the right to the highest attainable standard of physical and mental health encoded in Article 12 of the ICESCR, demands a whole of life approach 'ranging from prevention and rehabilitation to the care of the terminally ill.'[60] There was little substance added to the content of this in General Comment No 14 on 'The Right to the Highest Attainable Standard of Health', as the CESCR added measures for the realisation of health included 'attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.'[61]

More recently the United Nations Special Rapporteur on the Right to Health, Anand Grover, has provided some elaboration of how the right to health may be fulfilled for the benefit of people at the end of life. In particular, he noted concerns over the availability and adequacy of the use of analgesic medications used in the management of pain experienced by people receiving palliative care.[62] The Special Rapporteur reiterated States' obligations to ensure the supply and distribution of such medications, including opioid-based medications, as well as the responsibility to ensure adequate professional training on the appropriate and effective use of such medications in order to allow people to die with dignity.

The Draft Inter-American Convention is inclusive of a statement on end of life dignity for older persons. Article 7.d states:

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[59] United Nations Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No 6, The Economic, Social and Cultural Rights of Older Persons*, 13th sess, UN Doc.
[60] Ibid [34].
[61] United Nations Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No 14, The Right to the Highest Attainable Standard of Health*, 22nd sess, UN Doc E/C.12/2000/4 (2000) [25].
[62] Anand Grover, *Thematic Study on the Realization of the Right to Health of Older Persons by the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc, A/HRC/18/37 (2011), [54-56].

> The States Party shall offer equitable access to palliative care, nutritional support, measures to prevent isolation and appropriately manage problems related to the fear of death, the terminally ill, allowing them to avoid pain, therapeutic cruelty and to die with dignity.[63]

Further evidence that regional bodies and institutions are playing an increasingly important and central role in the discussions and development of responses to the issues of older persons' rights is provided by the *European Charter on the Rights and Responsibilities of Older People in Need of Long-term Care and Assistance*.[64] This document was produced in 2012 by 'AGE Platform Europe', with the aim of promoting 'a discussion within the EU Member States on how best to recognise and affirm the rights of the most vulnerable older people.' Article 8 attends specifically to the 'right to palliative care and support, and respect and dignity in dying and death'.

Article 8.1 states:

> You should have the right to compassionate help and palliative care when you reach the end of your life and until you die. You have the right to measures to relieve pain and other distressing symptoms.

Further provisions of Article 8 include the rights of older people in long term care to have their wishes respected, to issue advance instructions and have those instructions respected and to determine the extent of their treatment.

In conclusion, the need to address the particular obstacles that older persons and older persons with disabilities encounter in enjoyment of their human rights is paramount. Historically, the explicit recognition of the rights of older persons has evolved in an ad hoc manner. The result is a fragmented and incomplete enunciation of the rights of older

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[63] Organization of American States, *Preliminary Draft Inter-American Convention on the Protection of the Rights of Older Persons*, OEA/Ser.G, CAJP/GT/DHPM-37/12, 30 April 2012, p 11, available at http://www.oas.org/consejo/cajp/personas%20mayores.asp

[64] AGE Platform Europe, *European Charter of the Rights and Responsibilities of Older People in Long-term Care and Assistance* (2010), text available at www.age-platform.eu/en/daphne

people in international law as they relate to actual experiences of older people in different parts of the globe. The case is compelling for the development of a single document that can adequately specific rights that can be harnessed to combat the abuse and neglect of the aged.

Chapter 6

THE RIGHT TO HEALTH – IMPLICATIONS FOR OLDER PERSONS AND ELDER ABUSE PREVENTION

The *Convention on the Rights of the Child* [1] and the *Convention on the Elimination of All Forms of Discrimination against Women*[2] provide examples of the way in which international documents related to particular groups can raise awareness and give detailed attention to the specific barriers to the enjoyment of rights by vulnerable or marginalized groups of society. The *Madrid Plan of Action on Ageing*[3] advocates strongly for the mainstreaming of ageing issues into broader policy and programme development and human rights discourse. In light of this, the following discussion focuses on the right to the highest attainable standard of physical and mental health (the right to health) as an illustration that the entitlements of individuals and obligations upon States that arise from specific rights in international human rights law can be harnessed in the context of the prevention and mitigation of the effects of elder abuse and neglect.

[1] *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3(entered into force 2 September 1990).
[2] *Convention on the Elimination of All Forms of Discrimination against Women*, opened for signature 1 March 1980, 1249 UNTS 13 (entered into force 3 September 1981) ('CEDAW').
[3] United Nations Second World Assembly on Ageing, *Political Declaration and Madrid International Plan of Action 2002*, UN Doc A/CONF.197/9 (2002).

A. The Right to Health as a Component of Elder Abuse Prevention

There is general acknowledgement of the manner in which health is determined by social, economic and cultural influences in people's lives, and conversely of the manner in which health can have a powerful impact upon economic, cultural and social opportunities. Reliance on the biomedical view of ageing does carry the risk that the multiple influences on older people's lives which may heighten vulnerability to abuse and that vary regionally within populations and between individuals will be underestimated.

In the domain of elder abuse prevention, concerns regarding too great an emphasis on medical issues have arisen in part because elder abuse data collection is problematic — particularly in respect of identifying independent risk factors for elder abuse and neglect. Early data that emerged on the aetiology of elder abuse associated increasing age, dependence, physical and mental disability, economic and social disadvantage with an elevated risk of older people being exposed to abuse and neglect.[4] Subsequent research into elder abuse risk factors has provided evidence that dementia and cognitive impairment are independent risk factors for abuse, together with other non-health related factors such as the pre-existence of violent spousal and domestic relationships.[5]

However, the contribution that physical dependency and disability makes to the increased risk of elder abuse is the subject of some controversy and differing opinions. Concerns have been raised that the painting of a picture of older people who have been abused as the frail, dependent people are not accurate. Mark Lachs and colleagues report that studies have not conclusively demonstrated that dependency on others and health status

[4] See for example, Susan Kurrle, Paul Sadler, and Ian Cameron, 'Patterns of Elder Abuse' (1992) 157 *Medical Journal of Australia* 673; Karl Pillemer and David Finkelhor, 'The Prevalence of Elder Abuse: A Random Sample Survey' (1988) 28 *The Gerontologist* 51.
[5] See chapter 4 for discussion of risk factors associated with elder abuse.

contributes to an increased susceptibility to abuse.[6] Others however report that dependency and ill health are risk factors for abuse and even more significantly to elder neglect. For example, in a report for the New Zealand Families Commission conducted in 2008, researchers identified risk factors at an individual level that included isolation, poor physical health and mental impairment.[7]

Despite these conflicting viewpoints, several important observations emerge from these reports and data:

i) Research into elder abuse and neglect is in its early stages and firm evidence of independent risk factors is yet to be settled;

ii) The factors influencing the incidence of elder abuse and neglect are dynamic for any particular individual as well as complex and interrelated, ensuring that the identification of individual risk factors is a complex task;

iii) Current data has been plagued by inconsistent definitions, inconsistency in reporting and collection methods (for example self-reporting, reporting to Adult Protective Services data) which may influence the rates of reporting overall and the identification of different types of abuse and neglect; and

iv) Research to date has been largely conducted in developed countries. Data on the independent risk factors for abuse in developing countries is scant. In light of the marked health disparities for older people in developed countries and the different economic, social and cultural factors which may influence the lives of older people in these countries, the impact of poor health, disability and physical dependency

[6] Mark Lachs, Christianna Williams, Shelly O'Brien, Leslie Hurst and Ralph Horwitz et al 'Risk Factors for Reported Elder Abuse and Neglect: A Nine-Year Observational Cohort Study' (1997) 37 *The Gerontologist* 469, 473.

[7] New Zealand Families Commission, *Elder Abuse and Neglect: Exploration of Risk and Protective Factors* (Research Report No 1/08, 2008) 8.

upon the incidence of elder abuse and perhaps more significantly, elder neglect, needs more attention.

It is readily apparent, however, that poor physical and mental health, disability and physical dependency, whether or not they constitute independent risk factors, all have the potential to:

i) act in an intricate and powerful way upon other factors such as social isolation and the interpersonal relationships between the person and the perpetrator of the violence against him or her; and

ii) dramatically affect an older person's access to knowledge of and practical ability to exercise his or her human rights by seeking advice, support, security, safety and redress in the event of actual abuse and neglect occurring.

On this basis, it is important to examine how the right to health can be realised in the context of its role as a positive determinant of active ageing. The right to health will not provide all the solutions and remedies to the dilemmas of elder abuse and neglect. However, the right to health can have practical application through States:

- Ensuring obligations in respect of health related rights are entrenched in international, regional and national instruments;
- Assisting with the elucidation of content of those obligations and right to health;
- Developing practical strategies to enable States to fulfil those obligations;
- Enabling the enjoyment of those health rights by individuals and groups to the highest attainable level;
- Providing avenues to assess the outcome of practical programmes and policies;
- Providing mechanisms of accountability for the fulfilment of those obligations; and
- Allowing for adjudication upon alleged violations rights.

Health is a component of all the major human rights instruments — either recognised directly or as a corollary to the full spectrum of rights embodied in those documents. This discussion will focus on theoretical considerations of the right to health which can underlie practical efforts to combat elder abuse and neglect and other violations of the rights of older persons.

B. Sources of the Right to the Highest Attainable Standard of Health of Older People

Early recognition of the right to health was contained in both the Constitution of the World Health Organization and the *Universal Declaration of Human Rights* Article 25(1) (UDHR). Defined by WHO as 'a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity',[8] further detail was ascribed to the right to health in the UDHR as everyone's 'right to a standard of living adequate for health and well-being of himself and of his family, including food clothing, housing and medical care and necessary social services'.[9] While these definitions contained broad aspirations, crucially they also contained an acknowledgement of the interdependence of the fulfilment of the right to health with the underlying determinants of health.

The purpose of the *International Covenant on Civil and Political Rights*[10] and the *International Covenant on Economic Social and Cultural Rights*[11] was to enunciate legal

[8] *Constitution of the World Health Organization*, opened for signature 22 July 1946, 14 UNTS 186, preamble (entered into force 7 April 1948).
[9] *Universal Declaration of Human Rights*, GA Res 217A, 3rd sess, 183rd plen mtg, UN Doc A/810 (1948).
[10] *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976)
[11] *International Covenant on Economic, Social and Cultural Rights*, opened for signature 19 December 1966, 993 UNTS 3 (entered into force 3 January 1976)

entitlements and obligations. The ICCPR does not, however, define the right to health. Indirectly, through the enunciation of the freedoms such as the right to life, liberty and security of person, right to freedom from torture, cruel and degrading treatment and freedom from discrimination, the ICCPR has the capacity to have an impact on the ability of older people to enjoy the right to health.

The right to health is more explicitly recognised in the *International Covenant on Economic, Social and Cultural Rights*.[12] Article 12 states:

1) The States Parties to the present Covenant recognize the right to everyone to the enjoyment of the highest attainable standard of physical and mental health.
2) The steps to be taken by the states parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
    a) The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;
    b) The improvement of all aspects of environmental and industrial hygiene;
    c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
    d) The creation of conditions which would assure to all, medical service and medical attention in the event of sickness.[13]

In General Comment No 14, the CESCR reiterated that the content of Article 12.2 is intended to be illustrative and not exhaustive of States parties' obligation in respect of the fulfilment of the right to health.[14] Articles 12.2 (c) and 12.2 (d) appear most readily to have relevance to older people. However, it is evident that Article 12 alone does not provide sufficient form or content specifically in respect of the right to health of older people.

[12] *International Covenant on Economic, Social and Cultural Rights*, opened for signature 19 December 1966, 993 UNTS 3 (entered into force 3 January 1976).
[13] Ibid art 12.
[14] United Nations Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No 14, The Right to the Highest Attainable Standard of Health*, 22nd sess, UN Doc E/C.12/2000/4, [11].

The obligations of States at a regional level in relation to the right to health are evident in documents such as the *African Charter on Human and People's Rights* which recognizes every individual's right to 'the best attainable state of physical and mental health' (Article 16).[15] The *European Social Charter* makes reference to 'the right to protection of health' in Article 11,[16] which includes obligations on parties to remove as far as possible the causes of ill-health; to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health; and to prevent as far as possible epidemic, endemic and other diseases. Article 10 of the *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights* (*'San Salvador Protocol'*) identifies specific steps that must be taken, including the education of the population on the prevention and treatment of health problems and emphasis on the health needs of high risk and vulnerable populations.[17]

Through incorporation into national constitutions or statutes, a growing number of countries have acknowledged both the right to health specifically, and through the broader protection of both first and second generation rights that are integral to the maintenance of health. For example, the Bill of Rights contained in Chapter 2, ss 7–37 of the *Constitution of the Republic of South Africa* recognises economic and social rights including the right to adequate housing, the right to sufficient food and water, as well as the right to social security. Section 27 states that

> (1) Everyone has the right to have access to a) health care service, including reproductive health care; b) sufficient food and water; and (c) social security

[15] *African Charter on Human and Peoples' Rights*, opened for signature 27 June 1981, OAU Doc. CAB/LEG/67/3rev.5, art 18 (entered into force 21 October 1986) ('Banjul Charter').
[16] *European Social Charter*, opened for signature 18 October 1961, CETS no 35 (entered into force 26 February 1965), *European Social Charter, Revised* (1996) CETS no 163 (entered into force 1 July 1999).
[17] *Additional Protocol to the American Convention on Human Rights*, adopted November 17 1988, OASTS No 69 (1988) (entered into force 16 November 1999) ('Protocol of San Salvador').

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights
(3) No one may be refused emergency medical treatment.

Judicial consideration of these provisions has provided further elaboration of the content of the right to health and has been instrumental in demonstrating the justiciability of this right. However, adjudication in the specific context of violations of the right to health of older persons is still required.

C. Content of the Right to Health of Older People

Impeded for decades by indeterminacy, the realisation of the right to health has been given impetus more recently by the increased delineation of its content and scope. Two significant obstacles have hampered that delineation of the right to health of older people;

i) the absence of specific reference to older people in any of the Millennium Development Goals; and
ii) the absence of an international convention on the rights of older people.

A broad range of both binding and non-binding sources must be relied upon to give depth to the content of the right to health of older persons, including the *Vienna Plan of Action*, General Comments Nos 6 and 14 of the Committee on Economic, Social and Cultural Rights, the *Madrid International Plan of Action on Ageing* (2002) and most recently in 2011, the 'Thematic Study on Realization of the Right to Health of Older Persons'

conducted by Anand Grover, the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health.[18]

The *Vienna Plan of Action on Ageing* considered the broad areas of concern to ageing individuals, proposing 51 recommendations which encompassed matters of housing, family, social welfare, education, income security and employment and the protection of older consumers. Recommendations 1–17 on 'health and nutrition'[19] provided valuable information concerning the right to health and its interpretation in relation to the specific challenges that confront some older people. Bearing in mind the temporal relationship between the formulation of the *Vienna Plan of Action* and the recognition of elder abuse as a phenomenon, there is no specific reference to elder abuse within the document and consequently no specific strategies directed towards it. Recommendation No 2 does, however, make clear reference to the underlying determinants of health that influence some of the risk factors for the occurrence of elder abuse and neglect. It states:

> The care of elderly persons should go beyond disease orientation and should involve their total well-being, taking into account the interdependence of the physical, mental, social, spiritual and environmental factors. Health care should therefore involve the health and social sectors and the family in improving the quality of life of older persons. Health efforts, in particular primary health care as a strategy, should be directed at enabling the elderly to lead independent lives in their own community for as long as possible instead of being excluded and cut off from all activities of society.[20]

The United Nations Committee on Economic, Social and Cultural Rights' General Comment No 14 (2002) is most often noted as giving content to the right to health.[21]

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[18] Anand Grover, *Thematic Study on the Realization of the Right to Health of Older Persons*, UN Doc, A/HRC/18/37 (2011).
[19] *Report of the World Assembly on Ageing, Vienna (1982), Vienna International Plan of Action on Ageing*, GA Res 37/51,[52]-[63], UN Doc A/CONF.113/31 (1982).
[20] Ibid para [53].
[21] United Nations Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No 14, The Right to the Highest Attainable Standard of Health*, 22nd sess, UN Doc E/C.12/2000/4, [31]. See generally, Helen Potts, 'The Right to Health in Public Health: Is this a New Approach?' (2008) 15 *Journal of*

Although it is silent on the specific application to the challenges confronting older persons in the attainment of the highest possible standard of health, it recognises that the right to health contains both freedoms and entitlements, extending to health care and the determinants of health. In the specific context of the provision of health care to older persons, freedoms might encompass freedom from inappropriate and unwanted institutionalisation, inappropriate physical and chemical restraint, unwanted medical procedures, sexual abuse, and discrimination in health care. Entitlements extend to the provision of preventive health measures, community services and acute hospital health care, encompassing early diagnosis and treatment of illness including mental health care, rehabilitation and chronic health care service, as well as the provision of adequate nutrition and dental care.

Most usefully, General Comment No 14 presents an analytical structure for identifying the elements of the right to health which could be applied to practical programmes in specific areas of health. The former Special Rapporteur on the right to health, Paul Hunt, noted that 'although neither complete, nor perfect, nor binding, General Comment No 14 is compelling and ground-breaking'.[22] The CESCR expanded upon the normative content of the right to health and identified the following essential and interrelated elements. They include:

i) Availability of functioning health care facilities, goods and services and programmes including the underlying determinants of health;

Law and Medicine 725; and Ian Freckelton, 'Health and Human Rights: Challenges of Implementation and Cultural Change' (2008) 15 *Journal of Law and Medicine* 794.

[22] Paul Hunt, *Report of the Special Rapporteur on the Right of Everyone to the Highest Attainable Standard of Physical and Mental Health*, UN Doc A/HRC/4/28 (2007) [9].

ii) Accessibility of health facilities, goods and services without discrimination, which is physically accessible to all including older persons, affordable (economically accessible), and encompasses accessible information regarding health care issues;

iii) Acceptability requires that health facilities must be culturally and gender appropriate; and

iv) Quality must be provided in medical and scientific services, including the provision of skilled personnel and safe drugs and equipment and adequate sanitation and water.[23]

Obligations to 'respect', 'protect', and 'fulfil' provide a valuable analytical framework for assessing the fulfilment of economic, social and cultural rights. CESCR gave detailed consideration of this in General Comment 14. This framework can be directly applied to address factors that may contribute to the incidence of elder abuse and neglect.

The obligation to 'respect' requires a state to refrain from denying or limiting the access of older persons to health services, abstain from imposing discriminatory practices in relation to the health of older persons and refrain from applying coercive medical treatments. An obligation to 'protect' requires States to take measures to prevent third parties from interfering with a persons' enjoyment of the right. This will require States, through legislative and other measures, to prevent and intervene in activities such as the coercion or 'informal admission' of older persons with physical or cognitive disabilities into institutional or residential care, the unlawful imposition of restrictions upon the liberty of older persons through physical, pharmacological or environmental restraints,[24] or the

[23] United Nations Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No 14, The Right to the Highest Attainable Standard of Health*, 22nd sess, UN Doc E/C.12/2000/4 [12].
[24] These practices will be discussed in detail in Chapter 7 in relation to older person with cognitive disability due to dementia.

neglect of the physical, emotional and social needs of older people with disabilities who require assistance with their care and activities of daily living. Furthermore, States have obligations to ensure health care providers such as aged care workers have appropriate skill levels, and that pharmaceutical treatments and medical equipment meet adequate standards. The final obligation to 'fulfil' mandates the recognition of the right to health in national policy and legal systems. Elder health policies must be developed and implemented through legislative reforms which assist individuals and which promote the health of the population by providing information and systems for the making of informed choices.

D. Progressive Realisation and Core Obligations

Analytical frameworks, such as the one set out above, are invaluable for overcoming the indeterminacy that has hampered the implementation of the right to health. 'Progressive realisation', however, has the capacity to undermine the effective implementation of the right to health. Article 2(1) states:

> Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures. [25]

By allowing States to delay implementation of the right to health by claiming a lack of resources, 'progressive realisation' potentially eliminates any effective practical content

[25] *International Covenant on Economic, Social and Cultural Rights*, opened for signature 19 December 1966, art 2(1),993 UNTS 3 (entered into force 3 January 1976).

from right to health. This concern has received acknowledgement in the particular context of the right to health of older persons. Lindsay Judge comments:

> how the principle of progressive realization operates in practice, and whether this leads to rationing on the basis of age is pertinent, given that the major policy concern in both developed and developing countries is spiralling health care costs as the population ages.[26]

The CESCR rejects such a contention, instead reiterating that the concept of progressive realisation accommodates an understanding that full realisation of certain rights will not be able to be achieved instantaneously, rather that the purpose of the Covenant is to 'establish clear obligations for States Parties in respect of the full realisation of the rights'.[27]

Certain obligations are considered to be of immediate effect. Article 2(2) of the ICESCR requires States Parties to 'undertake that the rights enunciated in the present covenant will be exercised without discrimination of any kind.'[28] The obligation of non-discrimination is not subject to the qualification of progressive realisation. The requirement to 'take steps' which must be 'deliberate, concrete and targeted towards the full realisation of the right to health' is a further obligation which takes immediate effect.[29] All appropriate means include legislative measures, the provisions of judicial remedies, administrative, financial, educational and social measures.

The CECSR's view is that the ICSECR imposes clear 'minimum core requirements' which, in the context of the right to health, represent minimum essential levels of health care that States are obliged to ensure such as non-discriminatory and equitable access to

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[26] Lindsay Judge, 'The Rights of Older People; International Law, Human Rights Mechanisms and the Case for New Normative Standards', (International Symposium on the Rights of Older Persons, London, January 2009), 6.
[27] United Nations Committee on Economic, Social and Cultural Rights, *General Comment No 3; The Nature of States Parties Obligations*, 50th sess, UN Doc E/1991/23 (1990), [9].
[28] *International Covenant on Economic, Social and Cultural Rights*, opened for signature 19 December 1966, art 2(2),993 UNTS 3 (entered into force 3 January 1976)
[29] United Nations Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No 14, The Right to the Highest Attainable Standard of Health*, 22nd sess, UN Doc E/C.12/2000/4.

health care; minimum access to the underlying determinants of health such as adequate food, clean water, sanitation and shelter; the provision of essential pharmaceuticals; and the formulation and implementation of national public health policies which include right to health indicators and benchmarks for monitoring and review.[30]

The concept of 'core obligations' in respect of particular rights is problematic if the remaining rights then assume an inferior status, unlikely to achieve realisation. Ian Freckelton has commented that the practical implementation of core obligations

> is a new and important step for most governments because it involves the potentially politically problematic task of encouraging members of the community to regard themselves as having reasonable entitlement to services which currently may not be provided, adequately provided and accessibly provided. This is a realpolitik impediment of significant dimensions.[31]

Nonetheless, it is foreseeable that some nations may fail to meet minimum core requirements when acting to the maximum of their available resources due to the economic circumstances within that nation.

E. Practical Implementation of the Right to Health of Older Persons.

The power of incorporating a right to health based approach to the promotion of active and healthy ageing of older persons lies in the influence that it may exert on ageing policies and programmes. Helen Potts suggests, for example, that

[30] Ibid [43].
[31] Ian Freckelton, 'Health and Human Rights: Challenges of Implementation and Cultural Change' (2008) 15 *Journal of Law and Medicine* 794, 801.

> [t]he right to health approach would help define the objectives of public health strategies, guide their formulation and implementation as well as guide the formulation of relevant laws and other appropriate measures required to implement a public health strategy.[32]

Mechanisms continue to evolve through which human rights considerations can affect practical advances in eliminating elder abuse. The effective human rights promotion of health will occur in concert with careful disaggregation of statistical data in relation to the identification of risk factors for morbidity and mortality and for the development of indicators and benchmarks to evaluate the extent of progressive realisation. It has been suggested by Paul Hunt, the former United Nations Special Rapporteur on the Right to Health that while the General Comment No 14 was instrumental in identifying and drawing much needed attention to the right to health at an international level, further attention must be directed to the right to health in respect of different groups.[33] Paul Hunt observes that '[t]he average condition of the whole population is unhelpful and can even be misleading: improvements in average health indicators may actually mask a decline in some marginal groups.'[34]

The health concerns of older people must be clearly identified. The incidence of dementia, for example, highlights the importance of detailed disaggregation of health data relating to older persons, as it constitutes a significant risk factor for elder abuse.[35] The rapid increase in the prevalence and incidence of dementia, and the increased severity of dementia within that population among the very old (over 85 years), would be masked without adequate disaggregation of data. An incomplete picture of the impact of dementia with advancing

[32] Helen Potts, 'The Right to Health in Public Health: Is this a New Approach?' (2008) 15 *Journal of Law and Medicine* 725, 741.
[33] Paul Hunt, *Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health,* UN Doc E/CN.4/2003/58 (2003), [51].
[34] Ibid.
[35] See Chapter 4.

age may then lead to gaps policy and practical responses that could otherwise reduce risk and have a role in elder abuse prevention.

The *Political Declaration and Madrid International Plan of Action on Ageing* stressed the importance of the formulation of 'policies on ageing, based on reliable and harmonized indicators developed by, inter alia, national and international statistical organizations'.[36] Furthermore, it recognized 'the need to achieve progressively the full realization of the right to everyone to the enjoyment of the highest attainable standard of physical and mental health'. It also committed to 'providing older persons with universal and equal access to health care and services, including physical and mental health services' and acknowledged that 'the growing needs of an ageing population requires additional policies, in particular care and treatment, the promotion of healthy lifestyles and supportive environments.'[37]

Anand Grover, the Special Rapporteur on the right of everyone to the highest attainable standard of health, has reiterated this approach. He states in the 'Thematic Study on the Realization of the Right to Health of Older Persons':

> [T]he right-to-health approach is indispensable for the design, implementation, monitoring and evaluation of health related policies and programmes to mitigate consequences of an ageing society and to ensure the enjoyment of this human right by older persons. Such an approach to health-related issues includes human dignity, the needs and rights of this vulnerable group, and puts emphasis on ensuring that health systems are accessible, available and affordable to all.[38]

This defines the aim and there are several analytical tools to achieve it. The obligations to 'respect, protect and fulfil' in the context of the right to health, combined with the knowledge of the elements of 'availability, accessibility, acceptability and quality' are

[36] *Report of the Second World Assembly on Ageing, Madrid*, UN Doc A/CONF.197/9 (2002), art 11.
[37] Ibid art 14.
[38] Anand Grover, *Thematic Study on the Realization of the Right to Health of Older Persons*, UN Doc, A/HRC/18/37 (2011), [10].

clear terms of reference for policy development. Human rights 'impact assessments' have been designed for the evaluation of 'future consequences of a current or proposed' policy or programme on the enjoyment of human rights.[39] A human rights impact statement should analyse compliance with legal obligations in respect of the right to health and should address the manner in which a policy would promote or impede progressive realisation of core obligations, non-discrimination, participation, accessibility of health information and accountability. The effectiveness of human rights impact statements would be influenced by factors that impinge on impact statements of all types such as the lack of systems, infrastructure and expertise to conduct such analysis; the lack of reliable data for analysis; and the lack of international assistance and co-operation.

The specific challenges for health policy makers in respect of aged care vary between regions and countries. For example, circumstances may be envisaged where established health care systems are in place, but older persons are excluded or impeded from accessing that care. Alternatively policies will differ in countries where there is global deprivation of health care. All aged health policies must incorporate human rights principles such as non-discrimination, respect and autonomy.

Health indicators are another tool to be applied in the practical delivery of health as a human right embodied in international human rights instruments. Paul Hunt has advocated for a human rights based approach to health indicators which requires States to evaluate and modify health policies and programmes and be held accountable for their progressive realisation.[40]

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[39] Paul Hunt and Gillian MacNaughton, 'Impact Assessments, Poverty and Human Rights: A Case Study Using the Right to the Highest Attainable Standard of Health' (UNESCO, 2006) 8.

[40] Paul Hunt, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc E/CN.4/2006/48 (2006). See especially for detailed discussion of the application of human rights to health indicators. The indicators selected above in the text of this chapter for illustrative purposes, represent a small selection of those proposed.

'Structural' right to health indicators in the context of the health of older people may include whether:

- a State has ratified the major international human rights treaties giving effect to the right to health of older persons;
- a State's constitution or legislative bill of rights expressly acknowledges the right to health of older people;
- there is universal access to health care for older people (particularly for older people living in rural areas, and for older women); and
- there is a national plan of action and strategy for universal health care provision for older people.

'Process' indicators may include:

- reports submitted to international treaty monitoring bodies;
- expenditure on aged health care per capita;
- data collection and evaluation; and
- training and education of health professionals.

'Outcome' indicators may include:

- reported incidence of violence and abuse against older persons; and
- rates of hospitalisation and institutionalisation among older persons and particularly the very old (aged 85 and over).[41]

These are a small number of illustrative examples of the possible indicators that may be employed to assess the delivery of health care and services to older people within the

[41] See for example, Federal Interagency Forum on Aging Related Statistics, 'Older Americans 2012; Key Indicators of Wellbeing' http://www.agingstats.gov/Main_Site/Data/Data_2012.aspx

human rights context. Health indicators viewed from a human rights perspective transform public health and epidemiological indicators into key human rights accountability measures. Such measures monitor the fulfilment of progressive realisation on an intergovernmental level by non-government organisations and by treaty monitoring bodies.

F. Accountability and Justiciability of the Right to Health

While imprecision, non-justiciability and progressive realisation have all been major hurdles for the implementation of the right to health, recent years have seen increased attention to the right to health and meaningful theoretical content of the right has been elucidated. These positive developments which contribute substance to the right to health, can most readily be imagined to operate to the benefit of groups of older persons who share regional cultural, social and economic challenges. Harder to envisage is the process in which avenues of accountability and enforcement of rights that stem from the body of international law will be readily and practically made accessible to older individuals who seek redress for the abuse of their human rights.

Mechanisms are evolving to enforce accountability for policy formation and implementation as '[c]ritically, rights and obligations demand accountability: unless supported by a system of accountability they can be no more than window dressing.'[42] While judicial and quasi-judicial accountability on both a national and international level are also integral to the effective realisation of economic, social and cultural rights, as yet

[42] Paul Hunt, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc A/60/348 (2005) [66].

there has been minimal specific judicial consideration given to these rights in the context of older people.

Broadly, however, the delineation of the content of the right to health has evolved over the last two decades. This evolution repudiates arguments that the right to health is too ill-defined to be justiciable. It is now evident to whom the obligations belong, what those obligations encompass and that those obligations are subject to progressive realisation. Clarity of content promises increased adjudication upon the right to health in international and domestic tribunals which, albeit incrementally, will significantly contribute to the range of accountability mechanisms at hand. Helen Potts suggests 'the application of the accountability process to specific issues would be one way of further refining accountability in the context of the right to the highest attainable standard of health.'[43]

States are responsible for their international treaty obligations under the major human rights instruments primarily to the treaty monitoring bodies. The overarching principle guiding the application of these treaties is that they are to be interpreted the benefit of individuals, and not for the State's benefit. Compliance with periodic reporting procedures and an obligation to demonstrate compliance with their international treaty obligations are monitored by the treaty bodies.

Varying processes and requirements exist for the incorporation of international human rights obligations into national law within different legal systems. National courts are required to interpret domestic law consistently with international obligations unless there is a specific exception, or laws that are irreconcilable. The constitutional incorporation of human rights provides a direct avenue for adjudication on human rights violations and can

[43] Helen Potts, 'Accountability and the Right to the Highest Attainable Standard of Health' (Human Rights Centre, University of Essex, 2007).

shape legislative development and compliance with human rights principles within a national context.

National legislative bodies may formulate and implement preventive and remedial strategies for the violation of human rights through the criminal law, civil law, or regulatory and disciplinary measures (such as professional regulation). While legal initiatives are a vital component of the reinforcement of the right to health, the existence of legislation must be supported by effective implementation. National and regional human rights commissions are being encouraged to attend to social, economic and cultural rights.

Many barriers exist for older persons who experience violations of their rights through actions of violence, abuse or neglect in accessing accountability mechanisms and judicial intervention. These include a lack of awareness of rights, an absence of practical and financial means to gain advice on how to fulfil entitlements to rights and a lack of enforcement of those rights. Unless legislative reform is accompanied by public education campaigns on the nature and availability of health rights, along with legal services and infrastructure to facilitate claims alleging violations of those rights under domestic law, these rights will not be effectively realised.

There has been a paucity of jurisprudence to date on the application of the right to health, specifically in regard to the fulfilment of the right by older people. However, an analysis of the cases in relation to the right to health more generally, can provide insight as to how older persons' rights may be adjudicated upon on in the future.

1. South African Jurisprudence on the Right to Health

The South African Constitution contains a Bill of Rights which has enabled the Constitutional Court to give consideration to the rights contained within its provisions,

including jurisprudence on the right to health. Section 27 of *the Constitution of the Republic South Africa (1996)*[44] provides that:

> (1) Everyone has the right to have access to a) health care services, including reproductive health care; b) sufficient food and water; and c) social security
> (2) The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights
> (3) No one may be refused emergency medical treatment.

A series of cases before the Constitutional Court considered the elements of progressive realisation and resource allocation in relation to the economic, social and cultural rights contained within the Bill of Rights. In *Soobramoney v Minister for Health (Kwazulu-Natal) ('Soobramoney')*[45] the applicant suffered from chronic renal failure complicated by significant comorbid illnesses, including cardiovascular disease and diabetes mellitus. The applicant alleged that a violation of section 11, 'the right to life' and subsection 27(3), the 'right to emergency medical treatment' had been committed, on the grounds that he had been refused dialysis for failing to meet the state hospital guidelines. Under those guidelines dialysis was available only to those patients with acute reversible causes of renal failure or those patients with chronic renal failure awaiting renal transplantation.

The Court found against the applicant that dialysis treatment for chronic renal impairment constituted 'emergency medical treatment' under subsection 27(3), stating alternately that such treatment was an 'ongoing state of affairs resulting from a deterioration of the applicant's renal function which is incurable.'[46]

In the application to the Court, the appellant did not rely on subsections 27 (1) or (2). However in its findings, the Court noted that these provisions were of greater application

[44] *Constitution of the Republic of South Africa 1996*, (date of commencement 4 February 1997)
[45] 1998 (1) SA 765 (Constitutional Court).
[46] Ibid [21] (Chaskalson P).

to the applicant's case. Discussing the issue of resource allocation, the Court reiterated that the right to health care was subject to 'available resources' and that a policy had been developed in good faith to take account of the limited resources available. This policy was 'not unreasonable' and had been applied 'fairly and rationally' to the applicant.[47] The Court failed to embrace the opportunity to analyse whether the protocols and systems conformed to the human rights obligations in respect of availability and accessibility on non-discriminatory grounds.

The Constitutional Court considered the operation of section 27 further in *Minister of Health and Others v Treatment Action Campaign and Others ('TAC Case').*[48] The facts of the case concerned the availability of anti-retroviral therapy to mothers in order to reduce the maternal to child transmission of HIV at delivery. It was submitted by the Treatment Action Campaign that the restriction of the availability of the drugs to mothers in two pilot programmes in public hospitals was in violation of subsection 27(1) of the South African Constitution, and that the failure of the government to develop comprehensive health strategies to reduce the maternal to child transmission of HIV was in violation of the minimum core requirements under the ICESCR.

In its decision in favour of the Treatment Action Campaign, the court made valuable observations on the operation of section 27. The court reiterated its findings in the previous determination in *Soobramoney* and *R v Grootboom*[49] that 'the question in the present case, therefore, is not whether socio-economic rights are justiciable. Clearly they are.'[50] The court held that there had been a violation of the requirement of the government to act

[47] Ibid [25].
[48] 2002 (5) SA 721 (Constitutional Court).
[49] *Government of the Republic of South Africa v Grootboom* 2000(11) BCLR 1169 – a case concerning the right to adequate housing.
[50] *TAC Case,* 2002 (5) SA 721 (Constitutional Court, [25].

progressively through legislative and other measures and within available resources to reduce the maternal transmission of HIV. Section 27(1) was ruled as not giving rise to 'a self-standing and independent positive right enforceable irrespective of the considerations mentioned in s27(2)'.[51] The court determined that subsections 27(1) and (2) must be 'read together as defining the scope of positive rights that everyone has and the corresponding obligations on the state to "respect, protect, promote and fulfil" such rights.'[52]

Criticism of the Court's decision has been focussed on the rejection of minimum core obligations: the minimum core requirements will operate to the extent that they have an impact on the 'reasonableness' of an action depending upon the particular circumstances. Furthermore, the Court held that there is 'a focussed role for the courts, namely, to require the state to take measures to meet its Constitutional obligations and to subject the reasonableness of these measures to evaluation.'[53] This includes the courts ability to make orders affecting policy. The *TAC Case* demonstrates that a legally enforceable right in relation to a health care matter can result in a legally enforceable remedy for a group of individuals whose human rights have been violated.

The South African legal landscape in respect of the access of older people to rights including health care rights, is further influenced by more recent legislative developments. It is with reference to the Bill of Rights as set out in the *Constitution of the Republic of South Africa,* that the *Older Persons Act 2006* of South Africa was enacted. The preamble to the *Older Persons Act* emphasises the applicability of the Bill of Rights to all citizens but notes that 'it is necessary to effect changes to existing laws relating to older persons in order to facilitate accessible, equitable and affordable services to older persons…'[54]

[51] Ibid [39].
[52] Ibid.
[53] Ibid [38].
[54] *Older Persons Act 2006*, (South Africa), Preamble.

The landmark cases discussed above, which have been addressed in the national and Constitutional setting of South Africa, have given insight as to how the right to health may be elaborated upon in the context of the discrimination experienced by older people in accessing health care and services in many societies. Until now, the absence of a system of individual complaints in relation to alleged violations of economic, social and cultural rights has been a significant impediment to the development of a body of jurisprudence on the right to health at an international level. The entry into force of *the Optional Protocol on the International Covenant on Economic, Social and Cultural Rights*[55] in May 2013 is a welcome and exciting development. The denial of access to health services for older people, for example on the basis of issues resource allocation and progressive realisation, may be the subject of future determinations. The opportunity is available for the Treaty Body to provide adjudication upon the right to health in respect of the special requirements of older people and the discriminatory practices they face, which would give further depth and content to how economic, cultural and social rights can be fulfilled for the benefit of older people.

G. Australian Perspectives on the Right to Health and Elder Abuse Prevention

The series of inquiries and subsequent policy reforms in relation to the ageing demographic changes that have taken place in the last 10 years in Australia have seen a gradual incorporation of human rights principles. The direct application of principles of non-discrimination, availability, accessibility, acceptability, quality and accountability has

[55] *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights*, opened for signature 24 September 2009, UN Doc A/63/435 (entered into force 5 May 2013).

been specifically addressed by the Australian Human Rights Commission (AHRC). The AHRC has provided support for the incorporation of a human rights approach into ageing policy and programme development in Australia in the report entitled 'Human Rights Approach to Ageing and Health: Respect and Choice – 2012.'[56] In this report, the AHRC proposes that human rights principles should be incorporated into aged care reform processes and be integral to the provision of aged care in Australia:

> The aged care sector has long been concerned with equitable access to services and participation. However, the sector policy tends to speak in terms of priorities and goals rather than in terms of rights. The application of a human rights approach will assure a strengthened focus on a people-centred approach to aged care and the meaningful participation by older Australians. The approach will assist with ensuring that older recipients of home and residential care can help to set their own agenda and have their decisions respected.[57]

The principles that underpin the implementation of the right to health form the framework for the AHRC study. The report proposals include;

- The incorporation of indicators to monitor the implementation of the rights of older people in respect of availability and accessibility of aged care;
- The incorporation of indicators to monitor the implementation of rights contained in the *User Principles 1997* (Cth) which contains the 'Charter of Residents Rights and Responsibilities';
- The appropriate disaggregation of data; and
- Other proposals related to education and training of health care workers on a human rights approach to care of older people.[58]

[56] Australian Human Rights Commission, *Respect and Choice: A Human Rights Approach for Ageing and Health 2012* (2012).
[57] Ibid 3.
[58] Ibid 31.

The development of the clear enunciation of human rights principles in the context of the recent aged care reforms is encouraging. It represents steps towards Australia's obligations to 'fulfil' the right to health and other rights of older people. Yet there is a significant danger that the jurisdictional and funding arrangements of the federal system will mean that attention is directed predominantly towards obligations to respect, protect and fulfil the human rights of older people who utilise the aged care system either through residential or community based care. There are many older persons who live in the community who have little or no contact with the formal aged care services that are described by the aged care policies and reform proposals.

Australia's ageing population ensures that the absolute numbers of people requiring aged care services will increase over the coming decades. However, it is hoped that with the improvement in the provisions of health care and the promotion of active and healthy ageing, that greater numbers of older people will age further without major limitations due to disability. In this event, more people may be residing in their own homes in the future without the connection with the formal aged care system that are the subject of the reforms.

Elder abuse and neglect which occurs among older people in their homes need to be addressed by a comprehensive framework that attends to the implementation of all human rights. Structural, process and outcome indicators must be identified and defined for their utility in specifically addressing elder abuse and neglect at the levels of primary, secondary and tertiary prevention. Furthermore, national policy frameworks must exist that address the principles of accessibility, availability, acceptability and quality beyond the provision of aged care services, to promote the respect, protection and fulfilment of the rights of all older people, regardless of their place of residence or their care needs.

The aspirations, opinions and concerns of older people have been too often overlooked in the past and the specific challenges and threats to the enjoyment of the human rights of older people have failed to receive comprehensive attention. Non-binding international documents such as the *Madrid International Plan of Action on Ageing* and the various General Comments and General Recommendations of the Treaty Bodies indicate that human rights law can assist in the delineation of the scope and content of rights which will help to combat violence, abuse and neglect of older persons. However, it appears a painfully slow process at times; there remain normative gaps that require the attention of international, regional and national systems. In addition, methods of accountability for and judicial deliberation upon violations of rights of older people need further development. The substance and content of those rights must be elaborated upon in the specific context of the abuse, neglect and exploitation of older people. Examination of the right to health of older people provides a valuable illustration of the methods to ensure practical implementation and fulfilment of the full spectrum of rights of older people in order to eliminate the circumstances, risks and experiences of violence and abuse that confront many older people.

Whether future developments in the responses of the human rights legal system involve the development of a covenant specific to older persons, or through the elaboration of rights enunciated in existing legal instruments, they all must take account of the different circumstances of older people which may affect the vulnerability of individuals to abuse and neglect. The particular inequities that older women and older people with physical and cognitive disabilities experience demand special consideration. This is examined in the following two chapters.

Chapter 7

ELDER ABUSE AND DEMENTIA

Dementia is not a normal part of ageing.[1] Dementia poses a serious threat to the health, well-being and active ageing of older people. Both through the physical and cognitive consequences of the disease itself and through the stigma and discriminatory practices they may encounter, older persons living with dementia may face challenges to the enjoyment of their fundamental human rights.

This chapter examines the relationship between dementia and the phenomenon of elder abuse with the aim of highlighting the main themes of this thesis. For example, global health, cultural, policy and social perspectives, the promotion of education and awareness of aspects of elder abuse, solutions that take mainstream elder issues into policy development and human rights as a key component of responses to the challenge of elder abuse, are all indispensable elements of preventive strategies. These themes have relevance to practical responses to elder abuse among people living with dementia by any

[1] See World Health Organization, *Dementia: A Public Health Priority* (2012); Australian Institute of Health and Welfare *Dementia in Australia* (2012); and World Health Organization, 'Dementia' http://www.who.int/mediacentre/factsheets/fs362/en/

professional discipline (health, public health, social or legal), or from any theoretical perspective, or driven by any political or economic imperative.

This discussion builds upon the previous chapters which have focussed on the human rights framework as a mechanism for the promotion of the rights of older persons and the prevention of elder abuse. This chapter analyses how the framework can be utilised to protect and promote the rights of older people with a specific health challenge which is associated with an increased risk of elder abuse — the challenge of dementia. The epidemiological consequences of an ageing population upon the prevalence of dementia, the compounding effects of cognitive and physical disability in old age, the natural history for progression of dementia and the vulnerability of people with dementia to a violation of many of their human rights, together demand that special attention is given to dementia in this context. Legal responses which form part of a broad spectrum of medical, public health, social, economic and political must be informed by, take account of and work effectively and collaboratively with these various perspectives in order to address the abuse and neglect of people living with dementia.

This chapter begins by outlining the nature of dementia and the epidemiological, social and policy importance of dementia both in the Australian and international context. The research evidence for an association between dementia and elder abuse will be presented. The discussion then focuses upon legal protections available within Australian domestic law and how they reflect international human rights obligations in respect to older persons with dementia. These protections are drawn from obligations to older people as persons with a disability, such as through the *Convention on the Rights of Persons with Disabilities*.[2]

[2] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).

To illustrate the complexity of the challenges posed by dementia to the fulfilment of the rights of older people affected by the disability, the discussion will focus on

i) the practice of administering anti-psychotic medication to older people with dementia for the particular purpose of controlling people who experience the behavioural and psychological symptoms that may be associated with dementia;
ii) the use of physical restraints on older persons with dementia;
iii) the use of environmental restraints and restriction upon older people with impaired cognition due to dementia, within 'secure' residential facilities; and
iv) the practice of 'informal' admission of compliant older people with dementia who lack the decision making capacity to consent.

The quality and extent of social, economic, health and legal responses that will be developed and promoted in Australia and in the global context now and in the future, have the potential to limit the use of these restrictive practices, and ensure that the restriction and deprivation of liberty is a measure of last resort.

The lives of individuals with dementia are not static — the critical issue for all strategies is that they must be rapidly adaptable to accommodate the changing physical and cognitive disabilities of individuals with dementia. Health, social and legal responses to dementia are ideally accommodated within the mechanisms of 'ageing in place' which was explored in Chapter 3. The structures which promote supported decision making for individuals with impaired decision making capacity in relation to matters such as place of residence, acceptance of community services and health care, are an important contribution of the legal system to the effective operation of ageing in place.

A. The Epidemiology of Dementia

As foreshadowed in the introduction, the appropriateness, effectiveness and scope of the legal, social, health, political and other preventive interventions and policy responses to the complex relationship between elder abuse and dementia will determine the success of society's attempts to combat such abuse. The projections for the prevalence and burden of disease associated with dementia are stark, and dementia is a major public health concern of this century. Certainly the epidemiological data outlined below present a powerful case for the investment of resources and energy into such areas as evidence-based research into the aetiology of dementia, pharmacological research for preventive and curative treatments and improved screening tools for the detection of dementia. In the context of elder abuse prevention, epidemiological data provides a compelling picture of the importance of identifying how dementia interacts with other risk factors for elder abuse. Such data can also aid in directing society's responses to the health, social and economic challenges that the disease creates in order to mitigate those risks.

The difficulty in ascertaining accurate prevalence data on dementia has been noted by the major reviews on prevalence.[3] Factors such as the insidious onset of the disease, failure to recognise early symptoms and signs of dementia by both patients themselves, family members or professionals, and the lack of diagnostic and biochemical screening tools for early detection, all contribute to diagnostic and reporting deficiencies. Consequently, population surveys[4] where large sample populations are questioned and respondents report the presence/absence of the condition, are not reliable in the context of dementia

[3] Australian Institute Health and Welfare, *Dementia in Australia*, Cat. No. AGE 70, 28 (2012) 12, World Health Organization, *Dementia: A Public Health Priority* (2012) 30, Alzheimer's Disease International, *World Alzheimer's Report* (2011) 26.

[4] For example, those discussed in Chapter 4 in the context of research methods in the analysis of the prevalence of elder abuse.

prevalence estimates. Both the Alzheimer's Disease International study and the Australian Institute of Health and Welfare study discussed below, have applied rates derived through meta-analyses to population data.[5]

1. Global prevalence

Worldwide, it is estimated that more than 35 million people live with dementia.[6] It is estimated that with an approximate doubling every 20 years, by 2030 this number will have risen to over 65 million people, and by 2050 to over 115 million people.[7] In 2009, a systematic review of dementia prevalence data from 21 Global Burden of Disease regions was conducted by Alzheimer's Disease International. This review found that the highest rate of proportionate increase in the number of people with dementia is among low and middle income countries.[8] The review found that 58 per cent of all people with dementia in the world, live in low and middle income countries. This is projected to rise to 71 per cent by 2050.[9]

The increased projections for dementia in the developing world are in keeping with the shift in developing countries to a greater contribution to global disease burden by non-communicable diseases, and the overall increased life-expectancy of people in developing countries.[10] The majority of research on both the prevalence and the impact of dementia has been carried out within high income countries. An important contribution to data on dementia prevalence in low and middle income countries was provided by studies of 10/66 Dementia Research Group conducted population based surveys on the prevalence and

[5] See further, Australian Institute of Health and Welfare, above n 3; and Alzheimer's Disease International, *World Alzheimer Report* (2009).
[6] World Health Organization *Dementia: A Public Health Priority* (2012), 2.
[7] Ibid.
[8] Alzheimer's Disease International, *World Alzheimer Report* (2009) 7.
[9] Ibid.
[10] World Health Organization *Global Burden of Disease Survey 2004:Update* (2004).

impact of dementia in low and middle income countries in Latin America, India and China.[11] The title 10/66 refers to the fact that two thirds of people living with dementia reside in low and middle income countries, but only 10 per cent of population based dementia research has been carried out in those countries.[12]

Global prevalence data for dementia does have relevance to Australia. When accurate estimates of incidence and projected prevalence of dementia are collected, they provide additional momentum to global efforts through organisations and institutions such as the World Health Organization and the United Nations to address ageing issues. Mainstreaming of these issues at an international level increases accountability for all countries to implement dementia strategies, including those which address stigma, discrimination and abuse.

2. Australian prevalence data

The Australian Institute of Health and Welfare reports that in Australia in 2011, an estimated 298 000 people were living with dementia.[13] This estimate was based upon the prevalence rates established in the Alzheimer Disease International meta-analysis. Of those people, 62 per cent were women. The prevalence rises steeply with age; the estimated dementia prevalence is 9 per cent of all Australians aged 65 years or over, and 30 per cent of Australians aged 85 years or over.[14] Overall, 55 per cent of people with dementia had mild dementia, 30 per cent moderate dementia and 15 per cent severe dementia as defined by the Clinical Dementia Rating (CDR) scale.[15] Dementia prevalence is expected to rise in Australia as more people live into very old age.

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[11] Alzheimer's Disease International, 'The 10/66 Dementia Research Group'(2008), http://www.alz.co.uk/1066/
[12] Ibid.
[13] Australian Institute of Health and Welfare, above n 3, 11.
[14] Ibid 13.
[15] Ibid 17.

B. The Impact of Dementia

The impact of dementia can be viewed from many perspectives: the impact upon the health of the individual affected; the impact on the carers living with a person affected by dementia; the broader public health impacts measured as the 'burden of disease'; the economic costs of caring for people with increased dependency; or the social costs of the loss of participation and the 'missing voices' of older people within society.

The risk of a discussion where the language incorporates terms such as 'burden of disease' and 'core limitation' is that it is perceived to contribute to the ageist stereotypes of burden, dependency and frailty that are said to undermine positive ageing strategies. Indeed, ageist stereotypes have frequently been attributed to an historical over-reliance on medical and public health models of ageing and abuse. It is acknowledged that responses to elder abuse and the other challenges to active ageing that confront older people in the 21st century must be drawn from all disciplines. The information, data, personal and societal, health and legal perspectives all have an integral role. Understanding the impact of dementia upon all levels of society is necessary to generate meaningful responses and that includes accurate disaggregation of data to paint the clearest picture possible.

1. Place of residence

The Australian Institute of Health and Welfare reported that in 2011, 30 per cent of people with dementia lived in cared accommodation and the remaining 70 per cent lived in the community.[16] Furthermore, the majority of those people in cared accommodation had moderate dementia (63 per cent) while the majority of those people living with dementia in

[16] Ibid 16.

the community had mild dementia (76 per cent).[17] Of particular note is that 37 per cent of people with severe dementia reside in the community.

2. Disability and limitation

One measure of the impact of a disability such as dementia is the 'burden of disease' measure. The burden of disease is measured in Disease Adjusted Life Years (DALY); one DALY being equivalent to one year lost in complete health. A DALY is the sum of the Years of Life Lost (YLL) and the Years Lost Due to Disability (YLD). To calculate the YLD for a particular condition, the Global Burden of Disease report assigns to each different health condition a 'disability weight' factor based upon the severity of disease. Severity is measured on a scale of 0 (complete health) to 1 (equivalent to death).[18] Dementia is allocated a disability weight of 0.666 which is one of the highest. The Global Burden of Disease Report indicates that among those aged 60 years or over, dementia accounts for 4.1 per cent of the DALYs, 11.3 per cent YLD and 0.9 per cent of YLL. In Australia in 2011, the projected burden of disease due to dementia was projected to be 4 per cent of the total disease burden, or the fourth leading cause of burden of disease in this country.[19]

The combined effect of epidemiological factors related to dementia must be recognised and anticipated, including the absolute increase in the population of the very old and the rapid increase in rates of dementia with age. Those aged over 75 years account for the greatest proportion of the burden of disease with 40 per cent among people aged 75–84 and 32 per cent of those people aged 85 and over.[20] In relation to its impact on disability, dementia is

[17] Ibid 18.
[18] See for example, World Health Organization, 'Disability Weights, Discounting and Age Weighting of DALYs' http://www.who.int/healthinfo/global_burden_disease/daly_disability_weight/en/
[19] Australian Institute of Health and Welfare, above n 3.
[20] Ibid 28.

more likely to cause severe or profound core activity limitation than do other conditions causing disability. This prevalence data has important implications for the provision of services dedicated to the care of people living with dementia, and it is estimated that unless significant investments are made, there will be a dramatic shortfall in both paid dementia care staff and family carers.[21]

3. Economic and policy matters in relation to dementia

The ageing of the 'baby boomer generation' has led to a flurry of recent attention to the economic impacts of this cohort reaching old age. While a detailed analysis of the economic impacts of this demographic change is beyond the scope of this thesis, several general observations are appropriate.

A report by Access Economics in 2009, commissioned by Alzheimer's Australia noted that:

- Dementia will become the third greatest source of health and residential aged care spending within about two decades, these costs amounting to 1 per cent of GDP; and
- By 2060, spending on dementia is projected to be greater than any other condition, and will represent 11 per cent of health and residential aged care spending.[22]

In 2012 the federal government introduced 'Living Longer, Living Better' — a package of aged care reforms which incorporated dementia initiatives under the banner of 'Tackling Dementia.' The initiatives focussed upon additional financial support for appropriate home and residential care provision for people living with dementia and those with

[21] Ibid 1.
[22] Access Economics, *Keeping Dementia Front of Mind: Incidence and Prevalence 2009-2050* (2009) (Report for Alzheimer's Australia), v.

behavioural disturbance.[23] The new Coalition federal government elected in September 2013 has undertaken to fund a further $200 million in dementia research over five years under its 'Healthy Life, Better Ageing Agreement'.[24]

C. The Aetiology of Dementia

An understanding of the underlying aetiological factors contributing to dementia and an appreciation of the varying natural history of the diseases that constitute the syndrome of dementia, provide necessary depth in order to plan and implement strategies to combat the processes by which dementia increases older people's vulnerability to elder abuse.

Dementia is classified on the basis of aetiology in the International Statistical Classification of Diseases and Health Related Problems 10th Revision (ICD-10).[25] Dementia is not a single condition but rather a range of pathological processes characterised by impairment of higher brain functioning. Language, memory, perception, personality and cognitive skills are progressively and irreversibly affected by the underlying pathological condition, while patterns and rates of decline vary from one disease type and one individual to another.[26] Consciousness is not impaired. It is also possible for one individual to be affected by dementia of more than a single underlying aetiology.

While the natural history of dementia varies from one disease type to another and from individual to individual, dementia is characterised by a progressive decline in cognitive

[23] Department of Health and Ageing, 'Tackling Dementia' (2012) http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/tackling-dementia
[24] 'The Coalition's Policy for Healthy Life, Better Ageing' (2013) http://www.liberal.org.au/our-policies
[25] World Health Organization, *International Statistical Classification of Diseases and Health Related Problems 10th Revision* (ICD-10) (1994).
[26] Dan Longo, Dennis Kasper, J Larry Jameson Antony Fauci, Stephen Hauser and Joseph Loscalzo (eds), *Harrison's Principles of Internal Medicine* (McGraw-Hill, 18th ed, 2012) 3300.

and then physical abilities. Early symptoms of short term memory loss, mild changes in mood or personality, may be followed by a progressive decline in ability to perform ADLs and PADLs, and more significant changes in personality, behaviour and mood and in the latter stages may result in the need for full nursing care.[27] The clinical signs and symptoms of dementia may occur on a background of pre-existing mental illness such as anxiety or depression.[28]

1. Alzheimer's Disease

Alzheimer's disease is the commonest type of dementia accounting for approximately 50–75 per cent of global cases of dementia.[29] While the aetiology is not fully understood, Alzheimer's disease is caused by the death of brain cells, and the disruption of neurotransmission between cells, particularly in the areas of the brain concerned with memory. The disease is associated with the abnormal deposition of 'tangles' and 'plaques' of protein with the brain.[30] The course of the disease is slow in onset and progressive. It may begin with lapses in memory, word finding difficulty and as the disease progresses be accompanied by regular short term memory lapses, inability to follow clear and simple instruction, mood disturbance with apathy or depression and behavioural disturbances.

2. Vascular dementia

Vascular dementia accounts for approximately 20 per cent dementia and most commonly is a result of the cumulative effects of stroke and/or Transient Ischaemic Attacks (TIAs) which are multiple small strokes.[31] It is sometimes referred to as multi-infarct dementia. A

[27] Ibid 3305.
[28] For further discussion on the different types of dementia, see for example, Alzheimer's Australia, 'Types of Dementia' a http://www.fightdementia.org.au/understanding-dementia/types-of-dementia.aspx ; and Alzheimer's Disease International, 'Types of Dementia' http://www.alz.co.uk/info/types-of-dementia.
[29] Australian Institute of Health and Welfare, above n 3, 2.
[30] Longo et al, above n 26, 3306.
[31] Ibid 3309.

TIA may not be evident to the person or family if slight, only becoming evident due the cumulative effects. Multiple risk factors have been associated with vascular dementia, including hypertension, smoking, diabetes and hypercholesterolaemia and irregular heart rhythms such as atrial fibrillation.[32] While pathological evidence has indicated that vascular dementia very often co-exists with Alzheimer's disease,[33] in practice, it can be difficult to distinguish on the basis of clinical signs and symptoms. Some features of difference are; onset may be more sudden with a stoke episode; memory loss may be less prominent in the early stages while mood disturbance may be of greater prominence in the early stages; the progression is more stepwise — deterioration occurring with each TIA; seizures and episodes of acute confusion may be associated with strokes/TIAs. Therefore intervention to manage blood pressure, cholesterol and diabetes control is important.

3. Dementia with Lewy Bodies (DLB)

Dementia with Lewy Bodies accounts for approximately 5 per cent of all cases of dementia.[34] Nerve cell death occurs and is associated with the presence of spherical protein deposits in the cells called Lewy Bodies.[35] Characteristic symptoms of DLB include difficulty in concentration which may be more profound than memory loss, significant fluctuations in orientation and confusion which may occur within a timeframe of minutes and hours, visual hallucinations, falls and altered spatial awareness.[36] In addition, people with DLB often have features similar to Parkinson's disease such as a tremor, shuffling gait, stiffness and changes in their facial expression and tone of voice.[37] DLB more often has a rapid progression than Alzheimer's disease. Neuroleptic drugs are contraindicated in

[32] Ibid.
[33] Longo et al, above n 26, 3309 and World Health Organization, above n 6, 20.
[34] Australian Institute of Health and Welfare, above n 3, 2.
[35] Longo et al, above n 26, 3312.
[36] Ibid.
[37] James Galvin et al, *Current Issues in Lewy Body Dementia Diagnosis, Treatment and Research* (Report for Lewy Body Dementia Association, 2008), 3-5.

dementia with Lewy Bodies, as they can dramatically worsen the Parkinson-type symptoms and can even be fatal.

4. Fronto-temporal dementia

Fronto-temporal Dementia (FTD) refers to a range of diseases which are associated with damage to the frontal and temporal lobes of the brain.[38] These areas of the brain are associated with mood, behaviour, personality and language. Memory may be less affected in comparison to the other types of dementia. Fronto-temporal dementia may be associated therefore with changes in behaviour and personality such as disinhibition, inappropriate behaviours, lack of sensitivity or empathy to others, aggression and repetitive behaviours may be evident.[39] A range of language problems can be present in FTD, including word finding difficulties.[40] For example, rather than using the word 'dog' a person with FTD may go to lengths to describe it instead (for example, 'the barking animal'). As the disease progresses, language may become unintelligible.[41] The pattern of symptoms depends greatly on which areas of the frontal or temporal lobes are most affected in any particular individual.

The clinical patterns of these different types of dementia vary and can be important diagnostic indicators. However, over time all dementias are progressive and irreversible. All stages are marked by memory, mood, or personality changes.

[38] David Neary, Julie Snowden and David Mann, 'Frontotemporal Dementia' (2005) 4 *Lancet Neurology* 771, 771. See also, Alzheimer's Society (UK) 'What is Fronto-temporal Dementia (including Pick's Disease)' http://alzheimers.org.uk
[39] Ibid 77.
[40] Longo, above n 26, 3310.
[41] Neary above n 37, 771

5. Non-cognitive, Behavioural and Psychological Symptoms of Dementia

The behavioural and psychological symptoms of dementia ('BPSD') may range from mild anxiety and agitation to psychosis, paranoia and disinhibition.[42] The behavioural and psychological symptoms of dementia can be some of the most challenging and distressing aspects of dementia both for the dementia sufferer, and also family and other carers and for professional health care workers. While not all people living with dementia will experience all or the majority of these symptoms, it is estimated that 60–80 per cent of people with dementia who reside in the community will suffer BPSD, and up to 90 per cent of those in residential care. [43]

A number of factors have been identified as possibly contributing to the occurrence of BPSD and several theoretical models have been proposed to take account of them.[44] In practice, these models can be loosely summarized as proposing that the behavioural and psychological symptoms of dementia may be associated with and triggered by a number of factors:[45]

- BPSD may be a consequence of the underlying pathological process in the brain;
- Behavioural and psychological symptoms may be precipitated or exacerbated by medications use;
- BPSD may be due to environmental triggers, such as changes to living arrangements, changes in carer;

[42] Ian McKeith and Jeffrey Cummings, 'Behavioural and Psychological Symptoms in Dementia Disorders' (2005) 4 *Lancet Neurology* 735, 737.
[43] International Psychogeriatric Association, *Behavioural and Psychological Symptoms of Dementia (BPSD) Education Pack* (2002), 5.
[44] Alzheimer's Australia SA, *Reducing Behaviours of Concern* (2012), 8-9.
[45] A detailed discussion of the theoretical approaches to BPSD is beyond the scope of this discussion. See further for example, see further International Psychogeriatric Association above n 43.

- BPSD may be a manifestation of unmet needs which are unable to be conveyed such as hunger, fatigue or pain;
- BPSD may be exacerbated by an acute illness; and
- BPSD may be evidence of underlying psychiatric illness such as depression.

Identifying optimum methods of intervention for BPSD is an important preventive strategy in the management of elder abuse. Evidence has emerged that attention to the behaviours of the individual with dementia as well as the interaction of a carer with that individual are both important for the management of BPSD.[46]

D. The Relationship between Dementia and Elder Abuse

The relationship between dementia and the occurrence of elder abuse is a complex one. Multiple studies have indicated an increased risk of abuse for older persons with dementia. For example, in a study conducted by Claudia Cooper and colleagues, a cross-sectional survey of family carers of people with dementia referred to psychiatric services, 52 per cent reported some abusive behaviour towards the care recipient, with 34 per cent reporting 'important' levels of abuse.[47] The commonest form of abuse was verbal abuse (51 per cent); physical abuse was reported by only 1.4 per cent of carers. Colm Cooney and colleagues in a survey of carers of dementia sufferers, identified similar rates of verbal abuse (51 per cent); but higher rates of physical abuse with 20 per cent of carers admitting

[46] Kirsten Moore, Elizabeth Ozanne, David Ames and Briony Dow, 'How Do Family Carers Respond to Behavioural and Psychological Symptoms of Dementia?' (2013) 25 *International Psychogeriatrics* 743,744.
[47] Claudia Cooper, Amber Selwood, Martin Blanchard, Zuzana Walker, Robert Blizard and Gill Livingston 'Abuse of People with Dementia by Family Carers: Representative Cross Sectional Survey' (2009) 338 *BMJ: British Medical Journal* 583, 584.

to physical abuse.[48] A study by Aileen Wiglesworth and colleagues also identified that 47 per cent of care recipients with dementia experienced mistreatment: 88.5 per cent experienced psychological abuse, 19.7 per cent physical abuse and 29.5 per cent neglect. [49]

Population based surveys such as the large United States prevalence studies discussed in Chapter 4 are inherently problematic for the study of elder abuse prevalence amongst older people with dementia. Older people with moderate or severe dementia have been excluded from these studies. An alternative approach is the study of carer survey responses. Again, study design is critical to ensure the greatest likelihood that respondents answer honestly about behaviours constituting abuse. However, it is still problematic that the most severe forms of abuse are less likely to be reported in self-reported surveys of carers.[50] The *New York State Elder Abuse Prevalence Study*[51] model which combined data collected from both population surveys and agency reports has clear advantages here. While that study was directed to collecting data on elder abuse prevalence among older people in general, not among dementia sufferers, the methodology could assist in overcoming the problem that the most serious cases of abuse are less likely to be self-reported by carers and are more likely to come to the attention of adult protective services, law enforcement or social support agencies.

Various analytical frameworks have been explored in the literature to explain the abuse of older people with dementia by their caregivers. These can be summarised as all identifying, to varying extents, the common themes of caregiving demands, caregiver

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[48] Colm Cooney, Robert Howard and Brian Lawlor, 'Abuse of Vulnerable People with Dementia by Their Carers: Can We Identify Those Most at Risk?' (2006) 21 *International Journal of Geriatric Psychiatry* 564, 566.
[49] Aileen Wiglesworth, Laura Mosqueda, Ruth Mulnard, Solomon Liao, Lisa Gibbs and William Fitzgerald, 'Screening for Abuse and Neglect of People with Dementia' (2010) 58 *Journal of the American Geriatrics Society* 493, 496.
[50] Claudia Cooper et al, above n 47, 584.
[51] Mark Lachs and Jaquelin Berman, *Under the Radar: New York State Elder Abuse Prevalence Study, Self Reported Prevalence and Documented Case Surveys: Final Report* (2011), 1.

stressors, and interactions between caregiver and care recipient. Again, the vast majority of the literature has focussed upon elder abuse occurring in domestic settings. More recently with an increased acknowledgement that inappropriate and unlawful use of restraints upon people's liberty constitutes abuse, there has been growing attention directed to abuse in residential and institutional settings.

There has been no clear evidence that the degree of cognitive impairment or physical disability of the person with dementia is a contributing factor to the occurrence of abuse. This was the finding of the study by Cooney and colleagues and confirmed earlier reports of abuse in domestic settings.[52] This was supported by a 1994 Australian study by Paul Sadler, Susan Kurrle and Ian Cameron which did not establish a link between the severity of dementia and the occurrence of abuse, or other victim characteristics such as the level of dependency.[53]

Some studies however, have shown evidence of the existence of higher levels of behavioural disturbance of the dementia sufferer is a risk factor for the occurrence of abuse. A 1997 Northern Ireland study by Stephen Compton, Peter Flanagan and William Gregg found that behavioural problems in the person with dementia were more frequent and more severe in cases of abuse.[54] Cooney and colleagues reported that overt behavioural disturbance and mood disturbance were important determinants of the occurrence of verbal abuse by the carer.[55] The study by Wiglesworth and colleagues also documented the higher

[52] Colm Cooney et al above n 27, 565. See also GJ Paveza et al, 'Severe Family Violence and Alzheimer's Disease: Prevalence and Risk Factors' (1992) 32 *Gerontology* 4, 493-497; and K Pillemer and J Suitor, 'Violence and Violent Feelings: What Causes Them Among Family Caregivers?' (1992) 47 *Journal of Gerontology* 4, S165.
[53] Paul Sadler, Susan Kurrle and Ian Cameron, 'Dementia and Elder Abuse' (1994) 14 *Australian Journal on Ageing* 36, 37.
[54] Stephen Compton, Peter Flanagan and William Gregg, 'Elder Abuse in People with Dementia in Northern Ireland: Prevalence and Predictors in Cases Referred to a Psychiatry of Old Age Service' (1997) 12 *International Journal of Psychiatry* 632, 634.
[55] Cooney, above n 48, 566.

incidence of caregiver abuse, physical and verbal abuse in situations where the care recipient with dementia engaged in physical or psychologically aggressive behaviours.[56]

There is some evidence that the incidence of abuse of people with dementia is linked more strongly with the characteristics of the perpetrator such as mental illness and substance abuse than with the characteristics of those abused.[57] Caregivers who abuse older people with dementia in their care have been demonstrated to have few social contacts, higher rates of depressive symptoms, greater anxiety, and worse general emotional health than those carers who did not abuse.[58] Gregory Paveza and colleagues have found a strong association between carer depression and the perpetration of severe physical violence on care recipients with dementia.[59] They also reported a higher perceived burden from the responsibility of caring for the older person with dementia.

In conclusion, screening tools for abuse among dementia sufferers have been difficult to design because of the wide variability in statistical data in and methodological issues in study design that limit the ability of dementia sufferers to participate. Given the emerging evidence of the factors that increase the vulnerability to abuse of older people with dementia, there is a strong support for attention being directed to the characteristics and circumstances of the perpetrators of violence against older people with dementia. It is also necessary to promote an understanding of the behavioural manifestations of dementia, among both health professionals and carers of people with dementia. This may have an impact upon the occurrence of elder abuse and the detection and early intervention.

[56] Wiglesworth et al, above n 49, 496.
[57] Sadler et al, above n 53, 37.
[58] Wiglesworth et al, above n 49.
[59] Gregory Paveza et al, 'Severe Family Violence and Alzheimer's Disease: Prevalence and Risk Factors' (1992) 32 *The Gerontologist* 4, 493, 496.

E. Elder Abuse, Dementia and the Law

The international human rights framework offers support to older people with dementia who may be vulnerable to the violation of their rights because of abuse, discrimination and stigma. In the last two decades, as conveyed in the previous chapters, increased recognition has emerged of elder abuse constituting a direct challenge to the enjoyment of older people of their human rights. Now, specific attention is also being directed to the particular vulnerability that older people with dementia face in respect of these same rights. A major impetus for this has been the adoption of the *Convention on the Rights of Persons with Disabilities* [60] and the implications that arise for older people with dementia as their rights are elaborated upon in the context of being persons with disabilities.

Domestic legislation in Australia, both at a federal and state level, should reflect broad international policy and human rights developments in respect of older people, as well as fulfil obligations in international law. The remainder of this chapter will explore four specific, but closely related, circumstances where the rights of older persons may be violated. All have special, but not exclusive, relevance to the prevention of abuse in residential or institutional care.

The first involves the use of inappropriate chemical/pharmacological therapy to restrain dementia sufferers, in particular those who experience behavioural and psychological symptoms of dementia; the second is in the setting of the use of physical restraints on people with dementia; and the third circumstance involves the use of 'environmental restraint' or the imposition of restrictions on the movement of people residing in 'locked' or 'secure' residential facilities or institutions. Finally, the discussion will focus upon the

[60] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).

practical, moral and legal implications of the widespread practice of informal admission and detention of people with dementia within residential and institutional care facilities when they are compliant, but in the absence of the active or informed consent of those people or a duly appointed guardian in respect of such decisions.

Each of these restrictive interventions conflicts directly with the rights inherent in all of the major human rights instruments as well as regional and national laws. Anand Grover, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, has stressed:

> the impact of institutionalisation on the autonomy of older persons and its often harmful effect on their dignity. Loss of full independence, restricted freedom of movement and lack of access to basic functions would cause feelings of deep frustration and humiliation in any individual. Older persons are no exception to this.[61]

These areas for discussion do not represent the only challenges to the fulfilment of rights of older people in residential care; for example issues of privacy and the maintenance of family and intimate relationships are important factors that require consideration.

At the core of most, if not all, of these issues for older people with dementia who are vulnerable to abuse and neglect, are the opportunities that exist for them to receive information about the choices available to them, and to participate in the decision making processes in respect of those choices. Informed consent and active decision making opportunities are central to all strategies that can empower older people with dementia.

[61] Anand Grover, *Thematic Study on the Realization of the Right to Health of Older Persons by the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc A/HRC/18/37 (4 July 2011) [49].

1. The *Convention on the Rights of Persons with Disabilities* and supported decision making

As a preface to the specific discussion of restrictive interventions and deprivations of liberty of older people with dementia, it is valuable to outline recent developments in international human rights law that may have a significant impact upon the legal context in Australia for people with impaired decision making capacity due to dementia. The United Nations *Convention on the Rights of Persons with Disabilities*[62] clarifies and delineates a broad range of rights embodied in other human rights treaties, in the context of people with disabilities. People living with dementia are people living with a disability and are ascribed those rights under the CRPD.

Several of the provisions of the CRPD have particular significance in the context of the elaboration of rights which protect older people from abuse, and empower them in asserting their rights. Article 12 deals with 'equal recognition before the law' and has the potential to foster discussion about the application of legal capacity to the context of older people with declining memory and other cognitive processes due to dementia. Article 12 affirms the right of persons with disabilities to 'enjoy legal capacity on an equal basis with others in all aspects of life.'[63]

Further paragraphs of Article 12 which are of great importance in the context of the vulnerability of people with dementia to abuse and neglect include:

> 3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity

[62] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).
[63] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008). See for example, Bernadette McSherry, 'Legal Capacity under the Convention on the Rights of Persons with Disabilities' (2012) 20 *Journal of Law and Medicine* 22, for discussion on the concept of legal capacity.

> 4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for *appropriate and effective safeguards to prevent abuse* in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preference of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest possible time and are subject to regular review by competent, independent and impartial authority or judicial body.[64] (Emphasis added)

A significant body of analysis now exists, both internationally and within Australia, on the implications of Article 12 upon substituted decision making laws and policies and the need for the introduction of legislative reform to provide a framework for supported decision making.[65]

To date, the majority of discussion on the implications of Article 12 has occurred in the context of the supported decision making for people with intellectual disability and mental illness. There is a growing awareness of the implications for older people with impaired decision making capacity due to dementia. There are some special considerations for the application of supported decision making in the context of dementia. Dementia is a progressive health condition, and as such there is a progressive decline in cognitive functioning. In the advanced stages of dementia, decision making capacity is profoundly affected.

Substituted decision making, through the appointment of a guardian under guardianship legislation who is required to act in the 'best interests' of the person, is currently the core measure in Australia to respond to the situation of people with significantly impaired

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[64] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).

[65] See for example, Michael Bach and Lana Kerzner, *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity* (Report Prepared for the Law Reform Commission of Ontario, October 2010); Peter Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75(5) *The Modern Law Review* 752; Bernadette McSherry, 'Legal Capacity under the Convention on the Rights of Persons with Disabilities' (2012) 20 *Journal of Law and Medicine* 22; and Piers Gooding, 'Supported Decision-Making: A Rights-Based Disability Concept and its Implications for Mental Health Law' (2013) 20(3) *Psychiatry, Psychology and Law* 431

decision making abilities due to dementia. Whether Article 12 mandates a complete dismantling of substituted decision making systems remains contentious. In Victoria, the recent review of Guardianship legislation undertaken by the Victorian Law Reform Commission in response to its terms of reference, gave detailed consideration to the implications of the ratification of the CRPD for Victorian guardianship laws.[66] It recommended the development of a spectrum of decision making arrangements, including new supported decision making arrangements, new co-decision making arrangements, and continuation of existing substitute decision making.

The manner in which supported decision making is ultimately addressed will have an important impact on the ability of people with dementia to exert their autonomy in relation to many matters that influence many aspects of their lives, including their place of residence.

2. Unlawful Use of Chemical and Physical Restraint

(a) Chemical restraint

The use of potent psychotropic medications in the management of behavioural and psychological symptoms among dementia patients is a practice that requires close scrutiny. Psychotropic medications include drugs prescribed as anti-psychotics, anti-depressants, anxiolytics, sedatives and hypnotics. The inappropriate administration of pharmacological substances, including psychotropic medications constitutes a threat to the well-being of older people. Older people may be more susceptible to the adverse effects of these medications.[67]

[66] Victorian Law Reform Commission, *Guardianship, Final Report 24* (2012).
[67] Anne Spinewine et al, 'Appropriate Prescribing in Elderly People: How Well Can it be Measured and Optimised' (2007) 370(9582) *The Lancet* 173.

The intentional use of pharmacological means to restraint a person's behaviour is termed 'chemical restraint'. In section 3 of the *Mental Health Act 2013* (Tas), for example, chemical restraint is defined as 'medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition'. Chemical restraint may occur when medication is administered in any of the following circumstances:

(i) There is no underlying medical condition or medical indication for the administration of the medicine;

(ii) The medicine is not necessary for the management of an underlying condition and other less invasive and less restrictive measures are available for the management of that condition; or where

(iii) The medication may be indicated for the underlying condition but is being over-prescribed in frequency and/or dose.

This section will outline how and why these practices, in particular the use of anti-psychotic medication to sedate and manage behaviour, may violate the rights of older people with dementia. In order to fully describe the human rights and legal consequences of the inappropriate administration of anti-psychotic medication, this section begins by outlining the associations between dementia and mental illness and the practices in the management of the behavioural and psychological symptoms of dementia.

Psychiatric illness and dementia may co-exist in old age. This may be the result of the continuation of long-term mental health issues from earlier age into old age, or may be the new onset of disorders such as depression and anxiety in older age. When these mental health issues are combined with the cognitive impacts of Alzheimer's disease, vascular dementia or other dementias, the clinical picture of signs and symptoms can be very complex. The diagnosis of depression and anxiety in people with dementia can be difficult

because cognitive impairment may affect the reporting of symptoms. In addition, some signs and symptoms are common to both dementia and depression (for example poor concentration) and anxiety (sleep disturbance and agitation). Depression is common in people with dementia, with 40–50 per cent of people with dementia experiencing depressive symptoms.[68] Anxiety disorders are reported to co-exist with dementia in eight per cent of people.[69]

The behavioural and psychological symptoms of dementia such as agitation, restlessness, sleeplessness, wandering and aggression are frequently managed by pharmacological methods.[70] By contrast, psychosis refers to a clinical condition marked by disturbed thinking where typically the person affected may experience auditory or visual hallucinations, or have delusional thoughts.[71] Psychosis is a symptom of conditions such as schizophrenia, and while it can be a feature of BPSD it is relatively uncommon among people suffering from dementia. Evidence indicates that there is minimal efficacy of anti-psychotic drugs on the treatment of BPSD.[72] A Cochrane review of studies conducted to assess the effectiveness of the withdrawal of anti-psychotic medication from dementia patients with neuropsychiatric symptoms found that the majority of older persons could be withdrawn from anti-psychotics without adverse effects.[73] There was some evidence that people with more severe dementia and psychosis benefited from remaining on anti-psychotic medication. There is also evidence of increased cerebrovascular adverse events

[68] Alzheimer's Australia, 'Depression and Dementia' http://www.fightdementia.org.au/services/depression--dementia.aspx
[69] Australian Institute of Health and Welfare, above n 3, 48.
[70] Abhilash Desai and George Grossberg, 'Recognition and Management of Behavioral Disturbances in Dementia' (2001) 3(3) *Primary Care Companion, Journal of Clinical Psychiatry* 93, 93-94.
[71] American Psychiatric Association, Diagnostic and Statistical Manual of Disorders, DSM-5 (American Psychiatric Association, 5th ed, 2013) 87.
[72] Sube Banerjee, *The Use of Anti-Psychotic Medication for People with Dementia: Time for Action* (Report for the United Kingdom Department of Health 2009), 25.
[73] T Declerqc et al, 'Withdrawal Versus Continuation of Chronic Antipsychotic Drugs for Behavioural and Psychological Symptoms in Older People with Dementia' (Review for the Cochrane Foundation, 2013), 2.

and increased mortality associated with atypical anti-psychotic use in people with BPSD, and that the mortality increases with the length of time the drugs are administered.[74]

Anti-psychotic medications are used in the treatment of psychotic signs and symptoms as a result of mental illness. They are however, increasingly being used to manage behavioural symptoms of dementia which are not associated with psychotic symptoms. Sube Banerjee reports that while there is a small amount of published data, studies in a few countries including the United States of America and the United Kingdom have indicated that between 25–50 per cent of nursing home residents receive anti-psychotic medication, particularly atypical (newer) anti-psychotics.[75] Based on the analysis of data, Sube Banerjee makes a conservative estimate that up to a quarter of people with dementia in the United Kingdom may be receiving anti-psychotic medication at any given time.[76] For example, anti-psychotics are commonly used to manage agitation, restlessness, repetitive behaviours, and wandering.

Anti-psychotic medications broadly fall into two main groups:

a) Early generation anti-psychotics such as a chlorpromazine and haloperidol. They are associated with significant side effect profiles such excessive sedation, Parkinson-like gait and other dystonic symptoms as well as cardiac conduction disturbances, which are exacerbated in older people and in those with comorbid conditions.[77]

[74] Banerjee, above n 72, 27.
[75] Ibid 19.
[76] Ibid 20.
[77] See generally Sube Banerjee, *The Use of Anti-Psychotic Medication for People with Dementia: Time for Action* (Report for the United Kingdom Department of Health 2009); and Abhilash Desai and George Grossberg, 'Recognition and Management of Behavioral Disturbances in Dementia' (2001) 3(3) *Primary Care Companion, Journal of Clinical Psychiatry* 93 for further discussion of anti-psychotic medication use in the management of BPSD.

b) ‘Atypical’ anti-psychotic drugs which are newer generation medications with a lower side effect profile.[78]

There is more research required on the risk versus benefit profile of these drugs in BPSD as the side effect profile of the majority of these drugs, including newer generation drugs, is significant.

The reasons for the high levels of anti-psychotic use in the management of dementia associated behavioural and psychological symptoms may include a:

- Lack of professional training and education of nursing and medical staff on dementia and BPSD;
- Lack of education on the significant associated risk of anti-psychotic use and increased mortality risk;
- Poor understanding of first line measures such as management of environmental triggers such as noise, lighting, pain or discomfort, or a lack of activities and socialisation;
- Lack of formal management policies to prevent the first line use of anti-psychotic medication;
- Failure to diagnose underlying depression or anxiety or an episode of acute delirium;
- Perceived ‘convenience’ due to pressures from low staffing levels;
- Incorrect belief that the medications will minimize risks from falls;
- Lack of awareness of the human rights perspectives on use of inappropriate use of anti-psychotics as a chemical restraint; and

[78] Ibid.

- Lack of oversight and monitoring of the administration of potent anti-psychotics by specialist care.

The issues surrounding the use of chemical restraint as a method of behaviour control of older persons are receiving increasing attention. In Australia, this has occurred following the media reporting of the death of residents in nursing homes allegedly due to over sedation with anti-psychotic medication.[79] Concerns exist that the use of anti-psychotic drugs for the management of BPSD is often implemented as a first line intervention.

Highlighting the use of chemical restraint within the context of a human rights framework can assist in bringing attention to how domestic legal mechanisms may be harnessed, such as those provided in Australia by state guardianship and mental health legislation as well as the *Charter of Residents' Rights and Responsibilities* and a *Charter of Rights and Responsibilities for Community Care* contained within the *Aged Care Act 1997* (Cth).

(b) Physical restraint

The inappropriate use of physical or mechanical restraints upon older people with cognitive impairment also violates the rights of older people. Physical restraint may be defined as:

> Any device, material or equipment attached to or near a person's body which cannot be controlled or easily removed by the persons, and which deliberately prevents or is intended to prevent a person's free body movement to a position of choice and/or a person's normal access to their body.[80]

Physical restraint practices include the use of shackling to bed rails, restraint in chairs using belts around a person's wrists, ankles or waist, restraint vests, or 'geri-chairs' where

[79] Australian Broadcasting Corporation Television, 'Families Count Cost of Dementia Drugs Prescriptions' *Lateline*, 16 August 2012, http://www.abc.net.au/lateline/content/2012/s3569736.htm.
[80] Australian and New Zealand Society for Geriatric Medicine, *Position Statement No 2: Physical Restraint Use in Older People* (2012). [1]. See also Department of Health and Ageing, (Cth), *Decision-making Tool: Responding to Issues of Restraint in Aged Care* (2004), 6.

a person's movement is restricted by a chair/fixed table arrangement. There is some variation in the use of terminology in relation to restraint. Physical restraint is sometimes used to refer only to the situation where a person is physically held by one or more other individuals to control that person's ability to move freely. The term 'mechanical restraint' is then used to refer to the use of a device to limit a person's movement.[81] For the purposes of this discussion, physical restraint is taken to include both the use of mechanical restraint and the act of physical restraining another person using one's body (for example, by holding the person).

The prevalence of the use of physical restraint is difficult to ascertain. There is little in the way of systematic research on the use of physical restraints upon older people in domestic/ community care, either internationally or in Australia. Varying definitions of restraint across different countries have been adopted, but prevalence rates from international studies range from 40–65 per cent in nursing homes and 30–68 per cent in hospital settings.[82] A prospective observational study conducted by Doris Bredthauer and colleagues in Germany found that 30 per cent of included patients in the psychogeriatric unit of an acute psychiatric hospital were physically restrained on at least one occasion during the study period.[83]

In Australia, early evidence suggested that the rates of physical restraint use in nursing homes were high. A 1998 survey of the use of physical restraint in Victorian nursing homes found that 25.5 per cent of nursing home residents were physically restrained and

[81] See for example, Department of Health (ACT), *Policy: Restraint of Patients* (2011) 4.
[82] JPH Hamers and AR Huizing, 'Why Do We Use Physical Restraints in the Elderly' (2005) 38 *European Journal of Geriatrics* 19, 20.
[83] Doris Bredthauer, C Becker, B Eichner, P Koczy and T Nikolaus, 'Factors Relating to the Use of Physical Restraints in Psychogeriatric Care: A Paradigm for Elder Abuse' (2005) 38 *European Journal of Geriatrics* 10, 13.

the most common reason identified was for the prevention of falls (80.9 per cent).[84] Of concern was the finding that almost 35 per cent of staff identified using restraints because they felt 'no other alternative' existed.[85] A corresponding survey conducted in New South Wales nursing homes identified a physical restraint rate of 15.3 per cent, again the most commonly identified justification being for the prevention of falls (84 per cent).[86]

Often the indication for the use of physical restraint is cited on the grounds of being a means for protection against falls and disruptive behaviour such as aggression and wandering.[87] This occurs in both acute care institutions and in long term residential and other facilities. The evidence to support the use of physical restraints for safety and or other purposes, is questionable and furthermore, it may contribute to both physical and psychological harm. For example, a systematic review by David Evans and colleagues found that the use of physical restraint devices and patient injury increased risk of death, falls, serious injury and increased length of hospitalisation.[88] Fall related injuries and fractures were more commonly identified among restrained patients. Indirect injuries such as nosocomial (hospital acquired) infections, pressure sores, urinary and bowel incontinence were also identified as more likely to occur in patients.[89] Several studies from different countries have found that physical restraints are more commonly used upon people with greater degree of cognitive impairment, those with mobility impairment, those experiencing behavioural symptoms associated with dementia and those who require greater degree of assistance with the activities and personal activities of daily living.[90]

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[84] Andrew Retsas, 'Survey Findings Describing the Use of Physical Restraints in Nursing Homes in Victoria, Australia' (1998) 35 *International Journal of Nursing Studies* 184, 186.
[85] Ibid 186.
[86] Andrew Retsas and Heather Crabbe, 'Use of Physical Restraints in Nursing Homes in New South Wales, Australia' (1998) 35 *International Journal of Nursing Studies* 177, 177.
[87] Hamers and Huizing, above n 82, 21.
[88] David Evans, Jacquelin Wood and Leonie Lambert, 'Patient Injury and Physical Restraint Devices: A Systematic Review' (2003) 41 *Journal of Advanced Nursing* 274, 274.
[89] Ibid.
[90] Bredthauer, above n 83, 13; and Hamers and Huizing, above n 82, 21.

(c) Legal Considerations in the Use of Restraint upon Older Persons with Dementia

The inappropriate or unlawful use of chemical or physical restraint upon a person deprives that person of his or her liberty and autonomy and undermines the opportunity of that person to live with dignity. Therefore, the use of chemical or physical restraint must be restricted to emergency situations where the benefit of such use outweighs the risks and where the restraint may be necessary to discharge a duty of care to protect the individual from harm or protect others from harm. A thorough assessment and implementation of alternative strategies prior to the use of restraint is essential.

Guardianship and mental health legislation provides a legal basis for the provision of emergency medical treatment to persons who are unable to give consent. For example, section 42A of the *Guardianship and Administration Act 1986* (Vic) authorises a registered practitioner to carry out emergency medical treatment without consent. A responsible person designated under the Guardianship Act can provide consent for medical treatment if the person is unable to consent. However, a family member or legal representative does not have the authority to require the arbitrary restraint of a family member.

The Australian and New Zealand Society for Geriatric Medicine position statement identifies that physical restraint may be 'justified in an acute or emergency situation to protect the safety of the patient, other people and staff, if no other less intrusive option is available or appropriate.'[91] For example, the use of restraints in an acute care setting such as an intensive care or acute medical unit may be necessary to prevent the removal of life-saving treatments such as endotracheal tubes or intravenous lines. However, it is critical

[91] Australian and New Zealand Society for Geriatric Medicine, 'Australian Society for Geriatric Medicine Position Statement No 2: Physical Restraint Use in Older People' (Revised 2012).

for practitioners to assess whether other underlying factors can be modified such as reducing pain.

Several principles, therefore, underlie guidelines for the use of physical and chemical restraint:

- that the restraint is the option of last resort;
- that the restraint is used for the shortest time possible — it is temporary solution;
- that the least restrictive form of restraint is employed;
- that review and documentation are carried out;
- that the use of restraint is a stimulus for identifying underlying triggers and causes of the factors that have prompted the restraint.

These principles also underlie the legal protections that exist against the arbitrary use of restraints. However, there has been little specific attention given to the common practice of the use of restraint upon older people with dementia.

The legal rights of people to be free from arbitrary restrictions on their movement and liberty are entrenched in international human rights law. Article 7 of the *International Covenant on Civil and Political Rights* contains a prohibition on torture and cruel, inhuman and degrading treatment or punishment.[92] Article 9 promotes the right to liberty and security of persons and the right to be free from arbitrary detention. Further support for these principles is found in the *Convention against Torture and Other Cruel, Inhuman or*

[92] *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

Degrading Treatment or Punishment[93] and *the Convention on the Rights of Persons with Disabilities*.[94]

Regional developments have increased the recognition of the specific challenges that face older people with dementia in the exercise of their rights. The *Charter of Rights for People with Dementia and their Carers in Scotland* has been proposed as a response to the barriers that people face in fulfilling their rights.[95] The *European Charter of Rights and Responsibilities of Older People in Need of Long-Term Care and Assistance* (the European Charter) was created to provide a common reference framework for use across the European Union with the aim of promoting the 'well-being and dignity of older dependent people.'[96] The European Charter is particularly encouraging in respect of the direct and explicit acknowledgement of the threat to older people that is posed by the use of unauthorised and inappropriate physical and chemical restraint.

Article 1 of the European Charter concerns the right to dignity, physical and mental well-being, freedom and security and contains the following specific provision in relation to chemical restraint.

> Protection against medical and pharmaceutical abuse
>
> 1-2.9 protection from all medical and pharmaceutical abuse, maltreatment and neglect, including: inappropriate, unnecessary or excessive medical treatment or drug use or denial of treatment.

[93] *Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 UNTS 85 (entered into force 26 June 1987).
[94] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).
[95] *Charter of Rights for People with Dementia and their Carers in Scotland* (2009) http://www.dementiarights.org/
[96] *European Charter of Rights and Responsibilities of Older People in Need of Long-Term Care and Assistance* (*2010)* (the 'European Charter') http://www.age-platform.eu/age-policy-work/quality-care-standards-and-elder-abuse/1018-a-european-strategy-for-older-people-in-need-of-long-term-care-and-assistance

Article 2 sets out the right of older people to self-determination, including the right to be free from restraint.

> Restraints to your self determination
>
> 2-8 You may not be subject to any form of physical or mental restraint unless it is a proportionate response to a risk of potential harm. In which case, it must be determined to be in your best interest through a transparent and independently verifiable process that can be reversed. Assessments of your level of mental capacity to make decisions are neither absolute nor enduring and must be re-evaluated regularly.

As will be discussed below, unlike the *European Charter*, none of the relevant legislative instruments in Australia that deal directly or indirectly with the rights of older people with dementia elaborate on these rights in the context of chemical or physical restraint.

In the common law, an application for a writ of *habeas corpus* is a cause of action that may be available for the unauthorised restriction on liberty caused by the use of restraint upon a person with dementia in care, in the absence of that deprivation of liberty being authorised by law. Restraint of a person without informed consent or legal authorisation may be an offence under the criminal law and persons applying restraint may be liable for criminal prosecution or civil penalty for the tort of false imprisonment or trespass to the person.

The *Aged Care Act 1997* (Cth)

The *Aged Care Act 1997 (*Cth) does not specifically address the issue of physical or chemical restraint, nor does it directly authorise the detention or restraint of a person. Under the *User Rights Principles 1997* made pursuant to *the Aged Care Act 1997* (Cth), a *Charter of Residents' Rights and Responsibilities* is outlined.[97] It provides that a resident of a residential care service has the right

[97] Ibid Schedule 1

- to be treated with dignity and respect, and to live without exploitation, abuse or neglect; and
- to live in a safe, secure and homelike environment, and to move freely both within and outside the residential care service without undue restriction. [98]

The *Quality of Care Principles 1997* made pursuant to section 96-1(1) of the *Aged Care Act 1997 (*Cth) set out Accreditation Standards which concern the quality of care and quality of life standards for the provision of residential care.

Standard 2 which concerns matters of health and personal lifestyle sets several expected outcomes that may be directly infringed upon by the unauthorised and unlawful use of physical restraint:

- Residents' specialised nursing care needs are identified and met by appropriately qualified nursing staff;
- Residents' continence is managed effectively;
- The needs of residents with challenging behaviours are managed effectively; and
- Optimum levels of mobility and dexterity are achieved for all residents.[99]

Standard 3 outlines the principles for resident lifestyle such that aged care residents will 'retain their personal, civic, legal and consumer rights, and are assisted to achieve active control over their own lives within the residential care service and in the community.'[100]

The Accreditation Standards are framed as positive expected outcomes. While a comprehensive and emphatic statement of outcomes is desirable and necessary, it is also insufficient. This framework does not prohibit certain types of behaviour (such as the use of physical, or chemical restraint). Given the evidence of the continued practice of applying restraints to older persons in residential care, particularly those with cognitive

[98] Ibid.
[99] Ibid 19.
[100] Ibid 20.

impairment, the *Aged Care Act*, through the *Users Rights Principles* and *Quality of Care Principles,* require reform. These principles should incorporate a clear enunciation of the rights of residents to live free from arbitrary restriction on their liberty through the use of physical or other forms of unlawful restraint. In this regard, the *European Charter of Rights and Responsibilities of Older People in Need of Long-Term Care and Assistance*[101] provides an appropriate model. Provisions that deal with the use of physical and chemical measures that limit the autonomy, freedom, security and dignity of older persons should be incorporated into the *Aged Care Act*. The terms chemical and physical restraint should be defined, and the prohibitions on arbitrary and unlawful application of such restraint upon people without consent should be specifically stated.

Mental Health Legislation

Mental Health legislation across the Australian states and territories regulate the use of seclusion and mechanical restraint for those who are subject to involuntary treatment for mental illness. The *Mental Health Act 2013* (Tas), for example, imposes limitations upon the use of restrictive practices for people receiving treatment for mental illness as involuntary or forensic patients within an approved mental health service. 'Mental illness' is defined in section 4(1) of the *Mental Health Act 2013* (Tas). Section 4(2) states:

> However, under this Act, a person is not to be taken to have a mental illness by reason only of the person's
>
> ….
>
> (n) dementia…

Therefore, the scope of the *Mental Health Act 2013* (Tas) excludes the application of the provisions of the Act to circumstances of the use restraints upon older people with

[101] EUSTaCEA, *European Charter of Rights and Responsibilities of Older People in Need of Long-Term Care and Assistance: Accompanying Guide* (2010).

dementia in residential care or acute, non-psychiatric hospital wards. Inpatients in psychogeriatric facilities may benefit from the legislative protections of the *Mental Health Act 2013* (Tas).

Section 56 of the *Mental Health Act 2013* (Tas) specifies the restrictions upon and requirements for the use of restraint. Section 56 states:

> (1) Except if authorised under any other law, an involuntary patient who is not a forensic patient may be placed under restraint if, and only if
>
> (a) the patient is in an approved assessment centre or approved hospital; and
>
> (b) the restraint is authorised as being necessary for a prescribed reason by
>
> (i) in the case of chemical or mechanical restraint, the CCP; or
> …..
> (iii) in the case of physical restraint where the patient is not a child, the CCP, a medical practitioner or an approved nurse; and
>
> (c) the person authorising the restraint is satisfied that it is a reasonable intervention in the circumstances; and
>
> (d) the restraint lasts for no longer than authorised under this section; and
>
> (e) the means of restraint employed in the specific case is, in the case of a mechanical restraint, approved in advance by the CCP; and
>
> (f) the restraint is managed in accordance with any relevant CCP standing orders or clinical guidelines.[102]

Section 56 (2) also provides for a specified time period for restraint, approval by authorised person, and requirements for continuous observation of the person. The *Mental*

[102] CCP refers to Chief Civil Psychiatrist. Similar provisions for the use of restraint upon forensic patients are contained in section 95 of the *Mental Health Act 2013* (Tas)

Health Act 2013 (Tas), while it could be foreseen to have application in a minority of cases of older people with dementia and concurrent psychiatric illness, is of minimal assistance in minimizing and protecting against the use of restrictive interventions such as physical and mechanical restraint of dementia sufferers who reside in residential care.

Disability Legislation

The definition of 'disability' within Australian law varies widely. Depending on the objectives and scope of each particular legislative instrument, the application of disability legislation to the circumstances of older people with dementia is variable. Consequently, there is limited specific protection against the use of restrictive interventions such as physical/ mechanical restraints against older people with dementia within disability legislation.

For example, provisions of the *Disability Act 2006* (Vic) deal with the use of restrictive interventions upon persons within disability services. The *Disability Act* provides for a Disability Services Commissioner to investigate complaints in respect of service and supports for people with disabilities. The *Disability Act* also provides for the appointment of a 'Senior Practitioner' who is

> generally responsible for ensuring the rights of persons who are subject to restrictive interventions and compulsory treatment are protected and that appropriate standards in relation to restrictive interventions and compulsory treatment are complied with.[103]

However, the Act has no application in context of older people with dementia as section 3 defines disability as:

> (a) A sensory, physical or neurological impairment or acquired brain injury or any combination thereof, which−
>
> (i) is, or is likely to be, permanent; and

[103] *Disability Act 2006* (Vic), s 24(2)(a).

(ii) causes a substantially reduced capacity in at least one of the areas of self-care, self-management, mobility or communication; and
(iii) requires significant ongoing or long term episodic support; and
(iv) is not related to ageing (Emphasis added)[104]

Dementia satisfies the first three of the four requirements of part (a) of this definition. The distinction between types of disability covered by the Act and those not covered appear somewhat arbitrary. For example, disability caused by stroke qualifies as a disability for the purposes of the Act (which is also an underling aetiological factor in vascular dementia), but dementia as an aged-related condition is not a disability for the purposes of the Act. Nonetheless, the *Disability Act* framework of processes for and regulation of the use of restrictive interventions provides a valuable model. The Office of the Public Advocate (Vic) advocates for

> clear, uniform legislative controls and reporting requirements, which could be modelled on Part 7 of the Disability Act. This includes both federal and state funded and supported accommodation, including aged-care facilities.[105]

Anti-discrimination legislation covers the rights of people with disabilities. For example, the *Equal Opportunity Act 2010* (Vic) provides for complaints of discrimination on the basis of 'impairment' (rather than disability).[106] At a Commonwealth level, the *Disability Discrimination Act 1992* (Cth) defines disability broadly as the 'total or partial loss of the person's bodily or mental functions.'[107] While impairment and disability are defined more broadly in both the legislative instruments than in the *Disability Act*, such that people with dementia fall within the scope of the definition, they are both silent on the use of restrictive interventions.

[104] *Disability Act 2006* (Vic), s 3.
[105] Office of the Public Advocate (Vic), *OPA Position Statement on Restrictive Interventions* (2011).
[106] *Equal Opportunity Act 2010* (Vic), s 4.
[107] *Disability Discrimination Act 1992* (Cth),s 4.

This analysis of the legal mechanisms which regulate the use of physical restraint upon vulnerable persons, demonstrates that a gap is clearly evident in the current protection and monitoring of the use of these restrictions of liberty upon older people with dementia. These practices may be addressed alone or in combination, by the following possibilities:

i) The incorporation within the *Aged Care Act 1997* (Cth) of provisions modelled upon Part 7 of the *Disability Act 2006* (Vic) to provide for the supervision of the use of restrictive interventions by a designated person.

ii) A new legislative instrument that is directed towards the specific challenges that older people face which includes a statement of rights and freedoms in respect of the right to liberty and security of person. This avenue for the protection and promotion of the rights of older people in Australia will be explored in greater detail in Chapter 10, but it would necessarily need to be reflective of the principles of the major human rights instruments.

The *Charter of Human Rights and Responsibilities Act 2006* (Vic) (the *'Charter'*) reflects the rights contained in the *International Covenant on Civil and Political Rights*, and provides for the promotion and protection of human rights in Victoria. The *Human Rights Act 2004* (ACT) also operates to similar effect in the Australian Capital Territory. While the *Charter* is of general application and is intended to influence the making and interpretation of all laws within that jurisdiction, some provisions have particular relevance in the context of older people with dementia and protection against physical restraint.

Section 10 of the Victorian *Charter* prohibits the use of torture and cruel, inhuman or degrading treatment. Section 21 protects a person's right to liberty and security and states

that ‘a person must not be deprived of his or her liberty except on grounds, and in accordance with procedures, established by law.’[108]

In summary, the use of chemical and physical restraints upon an older person with dementia over a prolonged period in the absence of emergency medical or security indication, or when other less restrictive alternatives have not been employed, is a violation of the rights of that person and constitutes both physical and psychological abuse. There is a clear need for further regulation of these practices.

3. Environmental Restraint

There are two further important considerations in respect to the autonomy and liberty of older people with dementia who reside in residential care, or who are admitted to institutional settings such as hospital wards or geriatric or psychogeriatric facilities. The first concerns the practice of accommodating older people with dementia in ‘secure’ residential or institutional settings and restricting their ability to move outside that secure environment. The second circumstance of concern arises when people are admitted to residential or institutional care without their informed consent or where they are compliant but do not give active consent.

In the context of older persons making decisions about their environment, place of residence or admission to a facility including health care institutions, informed consent requires that individuals have the opportunity, information and time to make voluntary decisions, free from coercion or other undue influence. The Special Rapporteur on the right to health has commented:

> Persistent denial of the right to informed consent could constitute a form of physical and psychological abuse of older persons, who are much more prone to treatment and care

[108] *Charter of Human Rights and Responsibilities Act 2006* (Vic), ss 10, 21.

> without consent. This is compounded by discrimination directed against older persons who in some cases may have diminished capacity to consent to treatment.[109]

(a) Secure facilities

Environmental restraint may be defined as the restriction of movement of a person without his or her explicit and informed consent.[110] Arbitrary restrictions on a person's liberty for the management of the behavioural symptoms associated with dementia constitute a form of 'environmental restraint' and in the absence of authority or an emergency situation, violate human rights. In practice, this may take the form of facilities where the exit is controlled by locked doors requiring a code, pass card or keypad. Access to courtyards or rooms may be restricted. A person may be restricted to his or her bedroom, or be placed in a deep-seated chair from which he or she is unable to rise without assistance, with the intention of restraining the person in that place.

Restriction of movement within a secure facility is a method employed for the management of people who wander as a manifestation of the behavioural and psychological symptoms of dementia. A scenario might arise whereby members of staff impose restrictions upon a person from leaving such a facility if there is a belief that it is necessary to protect the safety of that person if they leave the facility. Often this occurs through an informal agreement between family members, staff of the residential facility and health professionals. However, in the absence of an order by a court or tribunal, or the authority of a duly appointed guardian with appropriate authority, the restraint of a person with dementia in a secure facility is not authorised by law. Family members or friends have

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[109] Anand Grover, *Thematic Study on the Realization of the Right to Health of Older Persons by the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc A/HRC/18/37 4 July 2011 [66].
[110] Department of Health and Ageing (Cth*), Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care* (2012), 27.

no authority under common law or statute to provide substituted consent for the detention of a person with dementia in a secure facility.[111]

So what are the alternative measures available to staff in the setting of a person who wishes to leave, but may be at risk of harm? The principle of the least restrictive option again applies. Policies and good clinical practice guidelines for the management of people with wandering behaviours have been published in a number of states. For example, New South Wales Health has issued 'Guidelines for Working with People with Challenging Behaviours in Residential Aged Care Facilities – Using Appropriate Interventions and Minimizing Restraint'. Practice guidelines direct staff to identify and appropriately manage underlying contributing factors such as restlessness due to pain or anxiety, boredom and isolation, or depression. Positive strategies to address wandering behaviour may include formal walking or exercise programmes, diversion and distraction, active participation in activities within the facility including household duties, and the use of alarms.[112]

The Victorian Law Reform Commission (VLRC) has considered the issue of the use of restrictive practices in residential care in its recent review of Victoria's Guardianship legislation.[113] After extensive consultation with professional organisations, advocacy and community groups, and consideration of the strategies developed in the United Kingdom in response to European Court of Human Rights decisions, the VLRC recommended a 'collaborative authorisation process' for the management of restrictions upon the liberty of persons in residential care.[114] This will be discussed in greater detail below in the context

[111] Victorian Law Reform Commission, above n 66, 318.
[112] NSW Health, *Guidelines for Working with People with Challenging Behaviours in Residential Aged Care Facilities – Using Appropriate Interventions and Minimizing Restraint* (2006). http://www.health.nsw.gov.au/policies
[113] Victorian Law Reform Commission, above n 66, 318.
[114] Ibid 342.

of the detention of compliant people with dementia and other disabilities which impair their ability to consent to such detention.

(b) 'Informal Admissions'

A common situation which illustrates the consequences upon liberty for those with dementia occurs when family members may arrange for the informal admission of a relative to residential care in the absence of the informed consent of that person. In the circumstance where a person with dementia is unable to understand the nature of the deprivation of his or her liberty, his or her consent to it cannot be implied from their submission to or compliance with the detention. A similar scenario was considered by the House of Lords in *R v Bournewood Community and Mental Health NHS Trust; Ex parte L* [1999] 1 AC 458, and subsequently by the European Court of Human Rights in *HL v United Kingdom* (2004) 40 EHRR 32 (the '*Bournewood* case'). These decisions have implications for the legality of the informal admission of people with dementia to residential and institutional care in Australia. This is particularly emphasised by Australia's ratification of the United Nations *Convention on the Rights of Persons with Disabilities*.[115] The *Bournewood* case illustrates the potential application of relevant legal principles within Australia, in order to facilitate the protection of people with dementia from the violation of their right to liberty through environmental restraints.

(i) The 'Bournewood Case'

The *Bournewood* case concerned the informal admission and detention of a 48 year old patient, HL, who suffered severe autism, at a psychiatric institution, Bournewood Hospital. HL did not resist the detention and did not have the decision making capacity to give valid

[115] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).

informed consent to the admission and detention.[116] An application to the High Court for a writ of *habeas corpus* and for damages for false imprisonment was sought by his carers on his behalf, and was unsuccessful. A series of subsequent decisions were handed down.

The Court of Appeal

The Court of Appeal found that HL had been unlawfully detained.[117] The Court noted:

> In our judgment a person is detained in law if those who have control over the premises in which he is have the intention that he shall not be permitted to leave those premises and have the ability to prevent him from leaving. We have concluded that this was and is the position of L.[118]

The House of Lords

The Bournewood Hospital Trust appealed to the House of Lords which upheld the appeal.[119] Lord Goff (with whom Lords Hope and Lloyd agreed) considered the impact of the Court of Appeal decision on the large number of individuals who were informally detained in mental health facilities, who would then require compulsory detention under the *Mental Health Act 1983*.[120] Lord Goff also noted concerns that the decision potentially created significant impacts for patients, families and carers, and resource implications.[121] The implications for older people informally admitted to nursing homes who lacked the capacity to consent was noted by the Court.[122]

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[116] For a full account of the facts see Bernadette McSherry and Damien Bruckard, 'Mental Health Laws for those "Compliant" with Treatment' (2009) 17(1) *Journal of Law and Medicine* 16. See also Bernadette McSherry, 'The Right of Access to Mental Health Care: Voluntary Treatment and the Role of the Law' in B McSherry and P Weller (eds), *Rethinking Rights-based Mental Health Laws* (Portland: Hart Publishing 2010).
[117] *R v Bournewood Community and Mental Health NHS Trust; Ex parte L* [1998**]** 2 WLR 764, 769.
[118] *R v Bournewood Community and Mental Health NHS Trust; Ex parte L* [1998**]** 2 WLR 764, 769.
[119] *R v Bournewood Community and Mental Health NHS Trust, Ex parte L* [1999] 1 AC 458.
[120] Ibid 481 (Lord Goff).
[121] Ibid 482.
[122] Ibid.

Lord Goff (with whom Lords Lloyd and Hope agreed) ruled that the steps taken in respect of HL 'in so far as they might otherwise have constituted an invasion of his civil rights, were justified on the basis of the common law doctrine of necessity'.[123] Lord Goff also focussed on the necessary requirements of the tort of false imprisonment to be made out, emphasising the authority for the conclusion that 'it is well settled that the deprivation of liberty must be actual, rather than potential.'[124]

However, in his judgment, Lord Steyn commented that the effect of the decision of the House of Lords was to 'leave compliant incapacitated patients without the safeguards enshrined in the Act of 1983. This is an unfortunate result.' [125] He further noted 'the common law principle of necessity is a useful concept, but it contains none of the safeguards of the Act of 1983.'[126]

The European Court of Human Rights.

An appeal was brought to the European Court of Human Rights (ECHR) which found, contrary to the House of Lords decision, that the informal admission of HL was unlawful.[127] The ECHR found that the admission contravened Article 5 (1) of the *European Convention on Human Rights* which states:

> 1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
>
> (e) the lawful detention ... of persons of unsound mind ...; [128]

[123] Ibid 488 (Lord Goff).
[124] Ibid 486.
[125] Ibid 497 (Lord Steyn).
[126] Ibid.
[127] *HL v United Kingdom* (2004) 40 EHRR 32.
[128] *Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 222 (entered into force 3 September 1953) (European Convention on Human Rights)

The ECHR found that a lack of procedural safeguards to protect against the arbitrary deprivation of liberty on the basis of necessity failed to comply with the purpose of Article 5 (1), and as such constituted a violation of the Convention.[129] Furthermore, the ECHR determined in response to the majority finding in the House of Lords, that a distinction between actual and potential detention in the context of whether a ward may be locked or unlocked was not relevant to the finding of whether a violation of liberty had been perpetrated.[130] HL had been detained in the view of the Court on the basis that HL was 'under continuous supervision and control and not free to leave'.[131]

The consequence of the findings of the European Court of Human Rights was that uncertainty existed in respect of the common practice of informal admission and detention of persons who lack capacity but who did not object. Termed 'the Bournewood Gap', the implications of the decision of the European Court of Human Rights, have been considered in the United Kingdom and other common law jurisdictions and in the context of the application of the *Convention on the Rights of Persons with Disabilities* which will be discussed below in the Australian context. Clearly, the decision casts doubt over the perpetuation of the practice of informal admission of people with impaired decision making capacity due to dementia. However, the legal and practical responses required are monumental. Lord Goff considered the resource implications of the Court of Appeal's earlier judgment in depth.[132] Nevertheless, he concluded that the resource implications of the decision were not a matter for the House of Lords 'whose task is to construe, and to apply, the Act as it stands.'[133]

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[129] *HL v United Kingdom* (2004) 40 EHRR 32 [124].
[130] Ibid [92].
[131] Ibid [91]
[132] *R v Bournewood Community and Mental Health NHS Trust, Ex parte L* [1998] All ER 289, 294-95 (Lord Goff).
[133] *R v Bournewood Community and Mental Health NHS Trust, Ex parte L* [1998] All ER 289, 295 (Lord Goff). 'The Act' refers to the Mental Health Act 1983 (UK).

The responses in the United Kingdom to the decision of the ECHR are both informative and instructive as to how Australia might proceed in the future to address the issue of people with dementia or other disability. The 'Deprivation of Liberty Safeguards' were introduced in 2009 in England and Wales as amendments to the *Mental Capacity Act 2005* (England and Wales) in response to the findings of the European Court in the *Bournewood* case. The aim of these safeguards is to provide protection to vulnerable people against overly restrictive care while they are in residential or institutional care. The protective scheme is intended to cover those people who may also fall within the scope of the 'Bournewood gap' including compliant older people with dementia detained in hospital or residential settings.

The third report on the operation of 'Deprivation of Liberty Safeguards' scheme found that there had been 11 393 applications[134] in 2011–12, which represents a 27 per cent increase on the 8982 in 2010–11 and a 59 per cent increase on the 7,157 applications in 2009–10.[135] It had been estimated prior to the introduction that assessments would diminish at a constant rate.[136] The 2011–12 Report also found that dementia accounted for 53 per cent of all applications [137] and 59 per cent of those applications for people with dementia were granted.[138] In the three years since the introduction of the 'Deprivation of Liberty Safeguards' in England and Wales, the independent Quality Care Commission points out that 'the relationship between care, appropriate restrictions of liberty, the Deprivation of Liberty Safeguards and the wider MCA has become complex and potentially confusing.'[139]

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[134] 'Application' refers to the application process for deprivation of liberty to the supervisory body. See, Health and Social Care Information Centre (UK), *Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England) – Third Report on Annual Data, 2011/12* (2012), 4.
[135] Ibid.
[136] Ministry of Justice and Department of Health (UK), *Impact Assessment of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards to Accompany the Code of Practice and Regulations* (2008), 17.
[137] Health and Social Care Information Centre, above n 131, 5.
[138] Ibid 17.
[139] Quality Care Commission (UK), *Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2011/12* (2012), 9.

(ii) Implications for Older People with Dementia in Residential and Institutional Care in Australia.

In the context of the current discussion on the legal responses to the abuse of older people with dementia, the *Bournewood* decision has significant implications for Australia. The wording of Article 5 of the *European Convention on Human Rights* very closely resembles the wording of Article 14 of the *Convention of the Rights of Persons with Disabilities*, which Australia has ratified.[140] Article 14 states:

> 1. States Parties shall ensure that persons with disabilities, on an equal basis with others:
>   (a) Enjoy the right to liberty and security of person;
>   (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.[141]

In addition, Article 9 of the CRPD provides that:

> (a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement.[142]

People with disability as a result of dementia fall within the scope of persons with a disability for the purposes of the Convention. The rights and freedoms embodied in the CPRD (and in particular here Articles 14 and 19) therefore apply to people living with dementia. Article 1 states:

> Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.[143]

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[140] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).
[141] Ibid art 14.
[142] Ibid art 19 (a).
[143] Ibid art 1.

The Victorian Charter and the *Human Rights Act 2004* (ACT) also contain specific protections of liberty and security which reflect the Convention provisions.[144]

The question that requires consideration then, is whether Australian jurisdictions should model their response to the *Bournewood* case and future strategies to improve the safeguards for the detention of people with disability including dementia upon the English and Welsh 'Deprivation of Liberty Safeguards'. The matter has been given considerable attention during the recent review of Guardianship legislation in Victoria, undertaken by the Victorian Law Reform Commission (VLRC).[145] The VLRC considered several possible alternatives for future legal measures to protect against the deprivation of and restrictions upon liberty of vulnerable persons in residential and institutional care, including the option of a system similar in design to the 'Deprivation of Liberty Standards'.

The Commission received submissions from the Office of the Public Advocate in Victoria recommending that there is a:

> need for Victoria (and indeed Australia) to better regulate the means by which people with disabilities are subjected to some degree of 'deprivation of liberty' or are subjected to unregulated or under-regulated restrictive interventions.[146]

However, the Commission concluded that it

> does not believe there is widespread support for new formal processes to govern place of residence decisions for every person who lacks capacity to consent to living in supported residential care. The existing combination of informal arrangements and formal decisions by VCAT-appointed guardians in some difficult cases appears to operate reasonably well for the moment.[147]

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[144] *Human Rights Act 2006* (ACT), s 18.
[145] Victorian Law Reform Commission, above n 66. See especially Chapter 15 for findings on 'Restrictions on Liberty in Residential Care', 317.
[146] Office of Public Advocate (Vic), *Submission to the Victorian Law Reform Commission in Response to the Guardianship Information Paper* (May 2010) [1.18].
[147] Victorian Law Reform Commission, above n 66, 336.

The Commission rejected the adoption of a system modelled on the 'Deprivation of Liberty Safeguards' on the basis that the system is costly and administratively burdensome. It noted the difficulties experienced with the process and time involved in assessments and the concerns that have arisen between jurisdictions due to varying interpretations of the meaning of 'deprivation of liberty.'[148] The Commission also rejected the option of extending the authority of an automatically appointed substitute decision maker for medical treatment decisions to include authority in relation to residential care decisions. The rejection was made on the basis of too significant a potential for conflict of interest to arise between an appointed family member and the individual in respect of whom the appointment was made.

It is of concern that conflicts of interest may arise and people's liberty restricted or totally deprived without the level of scrutiny or professional regulation that supports the making of medical treatment decisions. Any solution or response must take account of the seriousness of these matters — substituted decisions made on behalf of older people with cognitive impairment due to dementia can have broad and long-lasting consequences for the remainder of that person's life.

Persistence with the widespread current practice of 'informal' admission and restrictive practices in residential care is also not desirable. Informal admission is fraught with the risk that ongoing and frequent violations of the rights of older people with cognitive impairment and diminished capacity for informed decision making will be perpetrated without appropriate safeguards that the human rights principles of the *Convention on the Rights of People with Disabilities*, the *International Covenant on Civil and Political Rights* and other international, regional and domestic human rights instruments prescribe.

[148] Ibid 337.

Through a combination of inadequate understanding about the legal implications of such practices among health and aged care staff, complacency about the need for thorough and specific assessment of the indications for their use, and a failure to appreciate the human rights implications of such practices, older people in residential care may be subjected to unlawful restrictions on their liberty.

As a minimum requirement, the regulation of restrictive interventions and deprivation of liberty could be enforced as a routine component of the admission of people with cognitive impairment to residential care in order to preserve and protect the rights of people with dementia and other disabilities affecting cognitive capacity to liberty, autonomy and dignity. Furthermore, in respect of individuals already in residential care, if restrictive interventions or the detention of a resident in a secure environment are contemplated, it is essential that a requirement exists for formal care plans whereby the use of identified interventions such as physical, chemical or environmental restraints must be documented and authorised. For example, if a person is denied access to an exit code or the means to unlock a locked door, this should be identified as a formal change to that individual's care plan. Such a denial should provide a trigger for the formal assessment of that person's individual capacity to consent to the proposed restriction on his or her liberty.

The system of collaborative authorisation of restrictive practices proposed by the Victorian Law Reform Commission in Recommendations 234 – 258 of the *Guardianship Report*[149] proposes a three person process involving:

a) The person in charge of the residential care facility;

b) A medical or other health practitioner approved by regulation; and

[149] Ibid 338.

c) The person's health decision maker (an automatically appointed substitute decision maker for medical treatment decisions, or 'person responsible' in the current Guardianship legislation).

The Commission proposes that in the circumstance where the person consistently resists and opposes the restrictions upon his or her liberty, the matter should be referred to VCAT to consider the appointment of a guardian. This model clearly addresses the administrative burden of an alternative scheme based on the English and Welsh 'Deprivation of Liberty Safeguards'. While the extension of the person responsible (or health decision maker as renamed in the proposal) to residential care decisions has been incorporated into the model, the inclusion of two other parties may not satisfactorily address the needs for safeguards to counter the influence of conflicts of interest, nor prevent inappropriate authorisation of restrictive practices and deprivation of liberty of people with dementia.

The Victorian Law Reform Commission has noted that there is no legal compulsion upon the government for measures such as the 'Deprivation of Liberty Safeguards' to be undertaken in Victoria in the absence of obligations under the Victorian *Charter* even when a court has identified a breach of those rights.[150]

The Victorian Equal Opportunity and Human Rights Commission opposes any extension of the powers of 'person responsible' to authorise decisions about residential care.[151] It states that the admission of persons to residential care without their consent 'is such a limit on the right to liberty and security of the persons concerned that it should only be allowed under the strictest safeguards possible.'[152]

[150] Ibid 329, 336.
[151] Victorian Equal Opportunity and Human Rights Commission, *Submission to the Victorian Law Reform Commission in Response to the Guardianship Consultation Paper* (June 2011) 48.
[152] Ibid.

This chapter has explored the challenges posed by dementia to the enjoyment of healthy ageing and the opportunity of older people living with the condition to enjoy their human rights, through an examination of practices that are commonplace in the care of older people with dementia that threaten their liberty, dignity and autonomy.

Restrictive practices such as the use of physical, chemical and environment restraints often occur due to a failure in the full understanding of the nature and consequences of dementia and a misapprehension by health workers, carers and the broader community that these options are the only options available for the management of challenging behaviours experienced by some people with dementia. There is a need to provide both professional and community education about alternatives, and clearly and emphatically provide legal guidance and formal recognition that restrictive interventions are interventions of last resort and must be applied in the least restrictive manner possible.

There is both a moral and legal imperative to find new ways to address the challenges faced by older people with dementia in the fulfilment of their rights. Legal instruments must embody principles of autonomy, non-discrimination and human rights. Strong, clear and decisive language is warranted, designed to address issues of restraint and the other challenges to the rights of older people.

Human rights principles underlie the terms of reference of the Victorian Guardianship review:

> The purpose if the review is to ensure that guardianship and administration law in Victoria is a response to the needs of people with impaired decision making capacity, and advances, promotes and protects the rights of people with an impaired decision making capacity.[153]

[153] Victorian Law Reform Commission, 'Guardianship: Terms of Reference' http://www.lawreform.vic.gov.au/projects/guardianship/guardianship-terms-reference

The Office of the Public Advocate in its response to the Guardianship Report, has expressed concern about the recommendations in relation to the three person collaborative process for the authorisation of restrictive practices.[154] Those concerns are echoed here. The option proposed by the OPA for the reform of Guardianship legislation to provide for increased investigative powers of the Public Advocate and for the incorporation of 'deprivation of liberty principles' has significant merit. However, in order to accommodate the jurisdictional issues generated by the division of authority in the federal system, it is critical that particular attention is directed to the situation of older people in residential care. As discussed earlier in this chapter, the *Quality of Care Principles* and the *Users Rights Principles* pursuant to the *Aged Care Act 1997* (Cth) do not adequately address issues of deprivation of liberty. Informal admission to residential care facilities and the use of unlawful restrictive interventions must be addressed within the framework of the *Aged Care Act 1997* (Cth), by the incorporation of the 'deprivation of liberty principles' proposed by the OPA.

F. Conclusion

This chapter, in focussing on the interaction between dementia and elder abuse, has highlighted many of the themes that form the basis of this thesis. A study of the relationship between dementia and elder abuse and neglect permits global and public health perspectives as well as policy and human rights perspectives to be examined. The problem of dementia illustrates that the need for mainstreaming of the challenges confronting older people into broader legal, economic and social measures is critical in

[154] See further Office of the Public Advocate (Vic), *Response to the Victorian Law Reform Commission's Final Report of Guardianship* (2012) 6.

order to illicit a ‘whole of society’ response to an issue that has ‘whole of society’ implications. Education and awareness of the causes, natural history and impact of dementia upon the lives of people living with the disability will ensure legal, health and allied health professionals, carers and the broader community will develop and give effect to primary prevention of elder abuse among older people with dementia. A study of the relationship between dementia and elder abuse also emphasises the imperative to empower people to retain their decision making rights — legal responses must take account of international obligations to respect the rights and autonomy of older people.

Finally, the focus on dementia and elder abuse draws attention to the need to correct the historical failure to specifically address the needs of all older people in a structured and comprehensive manner. Older people with cognitive disability due to dementia will benefit from the reform and strengthening of existing legal frameworks such as Guardianship legislation. They will also benefit from the consideration of new and innovative legal responses which incorporate human rights principles and which acknowledge and respond in detail to the challenges that *all* older Australians may face. This will be the subject of discussion in the final chapter of this thesis. The next chapter focuses on gender issues in relation to elder abuse.

Chapter 8

A GENDER PERSPECTIVE ON ELDER ABUSE

Both the International Conference on Population and Development (ICPD) which was held in 1994 in Cairo[1] and the Fourth World Conference on Women in Beijing held in 1995 were milestones in the recognition of fulfilment of the right to health of women. The Report on the latter conference states:

> Women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men. Women are affected by many of the same health conditions as men, but women experience them differently. The prevalence among women of poverty and economic dependence, their experience of violence, negative attitudes towards women and girls, racial and other forms of discrimination, the limited power many women have over their sexual and reproductive lives and lack of influence in decision-making are social realities which have an adverse impact on their health.[2]

2011 saw the production by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, of the first

[1] *Report of the International Conference on Population and Development (ICPD), Cairo, 13-15 September 1994*, UN Doc A/CONF.171/13.
[2] *Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995*, UN Doc A/CONF.177/20/Rev.1, (1996) [92] (Beijing Declaration and Platform of Action').

thematic study of the realisation of the right to health of older persons.[3] This important contribution to the body of international work in human rights and ageing, states that '[d]ifferences between the genders in respect of the ageing process must be acknowledged'.[4] This chapter turns the focus from an analysis of a particular right, such as the right to health, which has an impact upon the occurrence of elder abuse, to the study of older women, a group that due to particular social, economic, health, cultural and other factors may be exposed to an increase risk of abuse and neglect in later life.

Both older men and women may experience abuse and neglect as they age, particularly in very old age. However, a gender perspective on elder abuse is warranted. At first glance, the risk for older women of experiencing elder abuse may seem a simple matter of life expectancy — because greater numbers of women survive into older age and in particular very old age (age 85 years or over).[5] This fact alone means that women, more than men, are exposed to a higher lifetime risk for the occurrence of abuse.

The risk for an individual woman of experiencing abuse in old age is elevated by the multiple fronts on which she may encounter discrimination throughout her lifetime. Both gender and age discrimination can have significant separate and cumulative influences on the chances of experiencing physical, sexual and psychological abuse in old age. It is thus necessary to understand the life course factors which may have an impact on the experience of ageing by women as group and as individuals. This life cycle approach to understanding and promoting health in older age has become the cornerstone of the strategies developed at an international level to combat disease and prevent the sequelae

[3] Anand Grover, *Thematic Study on the Realization of the Right to health of Older Persons by the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc A/HRC/18/37 (2011).
[4] Ibid [17].
[5] World Health Organization, *World Health Statistics 2013* (2013), 58-59.

which can have an impact upon the life expectancy and quality of life that people enjoy in their old age.

Several key documents in the last five years have strengthened this approach. As discussed in Chapter 2, the World Health Organization (WHO) laid the 'life course' approach as the foundation of its 'active ageing' policy. An acknowledgement that 'gender is a lens through which to consider the appropriateness of various policy options and how they will affect the well-being of both women and men'[6] provided the impetus for closer attention being given to the specific influences on women's health and active ageing.

Two documents by the WHO offer particularly useful and strong support for the life cycle approach. 'Women, Ageing and Health: A Framework for Action' provides a valuable analysis of the health challenges and emphasis the life cycle approach to improvement of the opportunities for women to enjoy active ageing.[7] 'Women and Health: Today's Evidence, Tomorrow's Agenda'[8] advocates strongly for a life course approach to women's health on the basis that it 'fosters a deeper understanding of how interventions in childhood, through adolescence, during the reproductive years and beyond, affect health later in life and across the generations.'[9] This is particularly pertinent when analysing gender perspectives on elder abuse and neglect.

This chapter is divided into three parts. Part 1 examines violence against older women, discusses the nature of violence experienced by older women and outlines the frameworks traditionally utilised for policy and programmes developed to prevent violence against

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[6] World Health Organization, *Active Ageing: A Policy Framework* (2002) http://www.who.int/ageing/publications/active_ageing/en/index.html.
[7] World Health Organization, *Women, Ageing and Health: A Framework for Action* (2007) http://www.who.int/gender/documents/ageing/9789241563529/en/index.html.
[8] World Health Organization, *Women and Health: Today's Evidence' Tomorrow's Agenda* (2009) http://www.who.int/gender/women_health_report/en/.
[9] Ibid xi.

women. Part 2 examines a selection of the major health issues affecting women in the 21st century in both developed and developing countries and highlights global and regional differences in women's health concerns. The discussion will identify the life cycle perspectives of women that may have an adverse impact upon their risk of experiencing elder abuse and neglect and which create impediments to older women accessing remedies and strategies to combat abuse.

Part 3 examines the legal frameworks that operate to promote health and active ageing for older women. The impact of the major human rights instruments, in particular the *Convention on the Elimination of All Forms of Discrimination against Women*[10] and the *Convention on the Rights of Persons with Disabilities*[11] upon the primary, secondary and tertiary prevention of the abuse of older women will be reviewed.

A. Older Women, Violence and Abuse

Perhaps because of a general perception that violence against women is the concern of younger women, specific data regarding older women's experience of abuse has not been widely studied or reported. Some evidence is gradually emerging which suggests that older women are increasingly reporting incidents of abuse. For example, the Australian Bureau of Statistics 'Personal Safety Survey 2005' reports the proportion of women aged 45 or older who have experienced physical violence in the previous 12 months to survey had increased from 15 per cent in 1996 to 25 per cent in 2005.[12]

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[10] *Convention on the Elimination of All Forms of Discrimination against Women*, opened for signature 1 March 1980, 1249 UNTS 13 (entered into force 3 September 1981) ('CEDAW').
[11] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).
[12] Australian Bureau of Statistics, *4906.0 Personal Safety, Australia, 2005, (Re-issue)* (2006) www.abs.gov.au/ausstats

One United States study that investigated the baseline prevalence and 3 year incidence of physical and verbal abuse amongst functionally independent women aged 50–79 years found that 11 per cent of surveyed women reported abuse sometime during the previous year; 2.1 per cent reporting physical abuse alone, 89.1 per cent verbal abuse alone, and 8.8 per cent both physical and verbal abuse.[13] An additional 5 per cent of women reported abuse over the subsequent three year interval.[14] These figures support the contention that older women are subject to experiences of abuse at similar rates to younger women.

It is possible that the apparent lower proportion of older women experiencing violence is a consequence of the under-reporting of such violence. Self-reporting to police, health and social services may be low due to several factors such as physical and social barriers to reporting, isolation in rural or remote communities, an inability to speak English, a fear that reporting may lead to removal from home into residential care, concerns that reporting may lead to removal of their decision making rights, a different perception to younger women of what constitutes abuse, and fear or shame associated with reporting abuse. The recognition and reporting of abuse by family members, community workers, social and health care professionals may be influenced by a lack of awareness of abuse as an older person's issue and by inconsistent recognition of the scope of abusive behaviours, in particular neglect and psychological abuse.

An acknowledgement of the different approaches to the theoretical and practical understandings of elder abuse that stem from the domestic and family violence sector and the aged care sector has been the subject of significant discussion in the literature concerning elder abuse. While it is beyond the scope of this discussion to provide a

[13] Charles Mouton et al, 'Prevalence and 3-Year Incidence of Abuse among Postmenopausal Women' (2004) 94 *American Journal of Public Health* 605, 606.
[14] Ibid 609.

detailed analysis of the theoretical aspects of violence against women, a broad discussion assists in reiterating the need to adopt a multifaceted and multidisciplinary response to the abuse of older women.

As discussed in Chapter 4, debate has continued since the early years of the recognition of the concept of elder abuse as to how much emphasis should be placed on the characteristics of the perpetrator of abuse as distinct from the characteristics of the victims of abuse. The debate is more than a theoretical one, as responses to abuse must target all aspects of the individual circumstances of abuse in order that outcomes have the greatest likelihood of success. Undoubtedly the experience of abuse and neglect for any particular older person results from the complex interaction of multiple factors. The factors influencing the behaviour of the perpetrator and those which influence the vulnerability of the victim of abuse require equal attention. It is therefore unhelpful to base responses on any single model of elder abuse. The theoretical divide has particular implications for the abuse of older women where gender perspectives on domestic and family violence are dominant.

In Australia and other developed countries, the domestic family violence sector has increasingly recognised violence against older women as a matter of concern. A central consideration of the domestic and family violence sector has been the continuation of patterns of violence within relationships into older age. Spousal and intimate partner violence is said to ‘grow old’ with partners in a relationship. Some studies have focussed is upon the nature of the relationships in respect of the dynamics and imbalance of power and

control.[15] The emphasis in responses to violence therefore had been on the removal of the perpetrator, and the establishment of the safety of the victim.

Selena Neville criticises the theoretical considerations and practical responses that have arisen from the health and aged care sector for the reliance upon models of 'carer stress.'[16] The underlying explanation for a 'carer stress model of abuse' is that carers when placed under sustained emotional, physical and economic stress by the physical and cognitive disabilities of the person they are caring for, are more likely to become abusive. As discussed in Chapter 4, it has been suggested that evidence for the carer stress model is not substantive. A significant criticism of a framework for elder abuse prevention reliant on a 'carer stress' model, is that too great a focus is placed on the notion of the victims of abuse being a 'burden' upon the perpetrators of the abuse and therefore a perception that they are in part to blame for the abuse they experience. Furthermore, it is suggested that under a carer stress model of abuse, responses focus upon the removal of stress and carer respite, rather than appropriate punishment of the perpetrators for their actions. Dale Bagshaw, for example, argues strongly that it is critical to recognise the issue of the abuse of power and control in the aetiology of violence against older women.[17]

The aged care sector does, however, offer vital perspectives on issues confronting older women that may not feature in the work of the domestic and family violence sector. Of particular significance is that the issue of neglect may be more at the forefront of strategies within the aged care sector. Furthermore, considerations of accommodation issues, aged health care and service access vary. Factors such as the focus of the domestic violence

[15] See for example, Dale Bagshaw, 'The Prevention and Abuse of Older People by their Family Members', (Conference Proceedings, Ageing Safely Forum, Adelaide Oct 2009) http://www.adfvc.unsw.edu.au/conferenceproceedings-ageingsafelyforum.htm.
[16] See for example, Selina Nivelle, 'Carer Stress or Domestic Violence?' (2011) 2 *Domestic Violence Resource Centre Quarterly* 1.
[17] Bagshaw, above n 15, 20.

sector on the provision of services for women with young children will not be relevant, while issues of the appropriateness and accessibility of accommodation, and in particular the transition to residential care may be critical.

The Older Women's Network NSW (OWN NSW) undertook a project in 2008 to examine violence against older women in their own homes.[18] OWN NSW concluded that 'violence against women has fallen in a policy and service gap between domestic and family violence and older adult abuse'.[19] Responses to violence against older women which involve the aged care sector are necessary, as aged care workers provide a significant source of contact for older women who are victims of abuse.[20]

As an outcome of the project, OWN NSW produced 'The Disappearing Age: A Strategy to Address Violence against Older Women', which underlines the need for an integrated response to incorporate the capacities of multiple sectors including health, domestic and family violence, aged care and homelessness services to benefit older women.[21] Specific recommendations include the need to:

i) Develop interagency protocols for 'Responding to the Abuse of Older People' in all states and territories along the lines of the model which exists currently in New South Wales. The 'NSW Department of Ageing, Disability and Home Care Interagency Protocol for Responding to the Abuse of Older People (2007)' is aimed at ensuring a co-ordinated response between aged care, health, police domestic and family violence and legal services;

[18] Older Women's Network NSW Inc, *The Disappearing Age: A Strategy to Address Violence against Older Women* (2008) www.ownnsw.org.au
[19] OWN NSW, *Project on Prevention of Violence against Older Women* www.ownnsw.org.au .
[20] Ibid 9.
[21] OWN NSW, above n 18, 3.

ii) Extend screening, promote and deliver training to primary health care providers;

iii) Develop protocols to ensure access to legal services for older women; and

iv) Raise community awareness and develop campaigns for specific groups of women such as older women with disabilities, Indigenous women and women from CALD communities.

B. The Health Status of Older Women

Health promotion is a critical component of elder abuse and neglect prevention programmes. The World Health Organization's definition of health in the *Ottawa Charter for Health Promotion* encompasses a 'positive concept emphasising social and personal resources, as well as physical capacities.'[22] The discussion on the health status of older women which follows underlines the emphasis throughout this thesis on the need to acknowledge the complexity of the influences which may have an impact on the individual circumstances of an older person's experience of elder abuse and neglect. It is stressed that the promotion of good health and active ageing fundamentally underpins the empowerment of older women to influence the outcomes of situations they experience and provides them with opportunities to exercise their fundamental human rights. This discussion also highlights that while the vast majority of research and discussion into the abuse of older people and older women more specifically has arisen from the perspectives of older people in developed countries, further perspectives are needed on the experiences of older women in developing countries.

[22] World Health Organization, 'Ottawa Charter for Health Promotion', (First International Conference on Health Promotion, Ottawa, 1986) WHO/HPR/HEP/95.1.

Poor physical and psychological health may contribute to an increased vulnerability to elder abuse and neglect, particularly cognitive disability due to dementia, and poor health may also be a consequence of abuse or neglect. Physical and psychological ill-health or disability may have a negative impact upon the opportunity and ability of older women to seek assistance, or access services and remedies for abuse when it occurs. The risk of too great an emphasis upon theoretical understandings and practical responses to elder abuse which rely on the characteristics of the victim of abuse, is acknowledged here. However, attention to the health concerns of older women does not amount to 'blaming the victim'. The *Ottawa Charter* directly addresses the health factors which can contribute to an imbalance of power, and highlights some of the global and regional differences which may have an impact on the necessary practical responses to elder abuse and neglect. The essence of this approach is to acknowledge that good health and active ageing increase the opportunity of and empower all old people to enjoy their rights and freedoms.

This section will focus on gender specific health issues which may have an adverse impact upon women's risk of experiencing abuse or neglect in old age, or alternatively have an impact on women's opportunity to access safe and secure environments and redress from such abuse.

1. The Determinants of the Health of Older Women - A 'Life Course' View

The WHO's gender perspective on its 'Active Ageing' policy and framework provides a tool for assessing the levels at which international law may operate to ensure appropriate systems, structures and mechanisms are in place for protecting and respecting the human rights of older women.[23] This framework promotes the three pillars of 'participation', 'health' and 'security' common to the broader 'Active Ageing' policy. However, the

[23] World Health Organization, *Active Ageing: A Policy Framework* (2002) above n 6.

document emphasises the obligation on states to apply gender responsive considerations to policies, programmes and practices.

In practice, this imposes a requirement to combat discrimination on the dual fronts of age and gender through;

i) mainstreaming ageing and gender issues in policy planning;

ii) addressing inequalities on the basis of age and gender systematically as they occur in relation to other factors such as culture, ethnicity, socio-economic status, disability;

iii) facilitating the full participation of women in the development process; and

iv) adopting a life course approach that recognises cumulative disadvantage.[24]

2. Health Inequalities between Women and Men

The likelihood of survival into old age has risen dramatically since the middle of the twentieth century and improvements in life expectancy have been evident globally, although there remain significant disparities between developed and less developed regions. As discussed in Chapter 2, an epidemiological transition that is underway marked by the improved prevention and treatment of communicable diseases has been the major contributor to these advances in life expectancy. Currently, non-communicable diseases are the major contributor to the mortality and morbidity globally.[25] In low and middle income countries, 45 per cent of the adult disease burden is estimated to be due to non-communicable diseases.[26] Globally, the leading causes of death of women aged 60 years

[24] World Health Organization, *Women, Ageing and Health: A Framework for Action* (2007) above n 7, 8.
[25] World Health Organization, Global Health Observatory, 'Deaths form NCDs' http://www.who.int/gho/ncd/mortality_morbidity/ncd_total_text/en/index.html
[26] World Health Organization, *Global Burden of Disease Update 2004* (2004) 47.

and over are ischaemic heart disease, stroke and chronic obstructive pulmonary disease (COPD).[27] The main risk factor for COPD in high income countries is tobacco exposure. However, in low income countries, women's exposure to the use of solid fuel fires for cooking and heating indoors is responsible for a greatly elevated risk of COPD.[28] However, communicable diseases continue to contribute significantly to morbidity and affect women's quality of life.

Disaggregation of population health data on the basis of gender reveals differences in both mortality and morbidity data. A significant disparity exists in global life expectancy at birth for women and men. Currently, women have a life expectancy at birth of 71 years compared to 66 years for men.[29] The ratio of men to women is not constant throughout different age groups.[30] While males outnumber females in younger age groups, there is a gradual reversal into older age groups where women outnumber men. This has been referred to as the 'gender spiral'.[31]

While women are living longer than men, inequalities affecting women demand attention. Women may lead longer lives than do men, but the evidence shows they do not necessarily live healthy lives in those later years. The Global Burden of Disease (GBD) Study[32] draws on data available from member states to the WHO in order to provide a cohesive analysis of morbidity and mortality, on the basis of age, sex and region in respect of over 100 injuries and diseases across eight regions of the world. The GBD study also introduced a new measurement tool, the Disability Adjusted Life Year (DALY). As mentioned in

[27] World Health Organization, *Women and Health: Today's Evidence' Tomorrow's Agenda* (2009) above n 8, 63.
[28] Ibid 7.
[29] World Health Organization, *World Health Statistics Report 2011* (2011) 54.
[30] United Nations Department of Economic and Social Affairs, *The World's Women 2010, Trends and Statistics* (2010) UN Doc ST/ESA/STAT/SER.K/19, 2.
[31] Ibid.
[32] World Health Organization, *Global Burden of Disease: 2004 Update* (2004) 8.

Chapter 7, DALYs take account of years of healthy life lost due to poor health and disability and years lost due to premature death. One DALY is equivalent to the loss of one year of life in full health. The gap in life expectancy between men and women narrows substantially if DALYs are taken into account. When taken into account in low income countries the gap in life expectancy narrows to about one year and in some countries women's overall life expectancy falls below that of men.

WHO identifies three main phenomena which operate globally to produce inequities affecting the health of women:

i) Women encounter specific health issues and challenges which arise from reproductive and sexual health;

ii) Women may be affected more significantly or differently to men by health issues that mandate different health care and other responses; and

iii) Women may be affected equally to men by particular health concerns but have greater difficulty in accessing health care due to discriminatory health practices, exacerbated by gender inequality and discrimination in areas such as employment and education.[33]

These phenomenon will be examined in the next section in the context of selected health challenges experienced by many women in developing countries.

3. Health Inequalities of Women in Developing Countries

The emphasis of the Millennium Development Goals[34] on the maternal and reproductive health of girls and women is testament to the problems facing women in developing

[33] World Health Organization, above n 8, *Women and Health: Today's Evidence' Tomorrow's Agenda* (2009) xi-xii.
[34] *United Nations Millennium Declaration*, GA Res 55/2, 55th sess, UN Doc A/Res/52/2 (2000).

countries. Attention will be directed in this section to selected dimensions of women's health prior to old age which have the greatest potential to carry chronic effects and which may lead to increased illness and disability into old age, thereby contributing to a heightened risk of neglect or abuse. These include poor vision, hearing loss, arthritis leading to an increased risk of falls and the sequelae of falls for older people, reproductive and sexual health including cervical cancer, HIV/AIDS and other STIs, and mental illness with particular attention to depression and anxiety disorders. Dementia, the other significant health issue for older people, has been considered in detail in chapter 7. This list is not an exhaustive one. Rather it is intended that the health issues highlighted will provide an insight into how the health issues throughout the life-course of women can have implications for the later stages of life, and how individual circumstances, regional and global perspectives must influence strategies and programmes aimed at reducing the negative impacts upon older women and the risk they will experience physical, psychological, sexual, social abuse or neglect.

a) Osteoarthritis, Osteoporosis and Falls

Osteoarthritis is a degenerative disease of the joints which is a significant contributor to the years lost to disability of women aged 60 years or over. It is estimated that globally, 9.6 per cent of men and 18 per cent of women aged 60 years or over have symptomatic osteoarthritis.[35] Damage to the cartilage overlying joint surfaces can result in pain, stiffness and a reduced range of movement in the affected joint(s). Osteoarthritis commonly affects joints that have been subjected to the most weight-bearing and 'wear and tear' over a lifetime such as the spine, hips and knees[36] and can have a significant impact upon

[35] Anthony Woolf and Bruce Pfleger, 'Burden of Major Musculoskeletal Conditions' (2003) 81(9) *Bulletin of the World Health Organization* 646, 647.
[36] Longo, Dan, Anthony Fauci, Dennis Kasper, Stephen Hauser and J Larry Jameson (eds) *Harrison's Principles of Internal Medicine* (McGraw-Hill, 18th ed, 2011) 2828.

people's ability to attend to the activities of daily living. Chronic pain and disability associated with osteoarthritis can also contribute to other health problems such as depression[37] and may have an increased association with falls.[38] Osteoporosis is characterised by a reduction in bone density and strength which leads to an increased risk of fracture with minimal trauma. Women are four times more commonly affected by osteoporosis and the prevalence of osteoarthritis generally increases with age.[39] Osteoporotic fractures contribute to a greater burden of non-communicable disease in high income countries than low and middle income countries.[40] The Australian Institute of Health and Welfare reports that osteoporosis will account for 7.7 per cent of YLD in 2010 and 4 per cent of the overall disease burden in Australia in 2010.[41] There is a risk association between osteoporosis and hip, wrist and vertebral fractures. For example in 2000, one study estimated that there were 1.6 million new osteoporotic hip fractures, 1.7 forearm and 1.4 million vertebral fractures worldwide.[42] Hip fractures are associated with greater mortality and morbidity. It is estimated that hip fracture accounts for approximately 40 per cent of the DALYs associated with osteoporotic fracture.[43] Furthermore, previous osteoporotic fracture increases the risk of another fracture.[44]

Hip fracture is associated with poorer outcomes in relation to morbidity and mortality than other fractures. The rates of hip fracture increase exponentially with age for both men and

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[37] Naila Rahman and Kuldeep Bhatia, *Impairments and Disability Associated with Arthritis and Osteoporosis* (Australian Institute of Health and Welfare, Arthritis Series No 4, Cat No PHE 90, 2007) 28.
[38] Daniel Prieto-Alhambra, Xavier Nogues, M Kassim Javaid et al, 'An Increased Rate of Falling Leads to a Rise in Fracture Risk in Postmenopausal Women with Self-reported Osteoarthritis: A Prospective Multinational Cohort Study (GLOW)' (2013) 72(6) *Annals of the Rheumatic Diseases* 911, 914.
[39] NB A slight decrease in prevalence rate exists for females aged 75 years or over. See Rahman and Bhatia, above n 37, 6.
[40] O Johnell and J Kanis, 'An Estimate of the Worldwide Prevalence and Disability Associated with Osteoporotic Fractures' (2006) 17 *Osteoporosis International* 1726, 1726.
[41] Australian Institute of Health and Welfare, *Australia's Health 2010* (2010), 189.
[42] Johnell and Kanis, above n 40.
[43] Johnell and Kanis above 40, 1730.
[44] J Kanis, and O Johnell, 'A Meta-analysis of Previous Fracture and Subsequent Fracture Risk' (2004) 35 *Bone* 375.

women. The risk is greatest for women in developed countries, and that risk is contributed to by greater bone loss, increased falls and longer life expectancy among women.[45] A woman who has had a hip fracture has a 10 to 20 per cent increased likelihood of dying in the first year following the fracture than would be expected for her age.[46] Hip fractures almost always require hospitalisation, usually require surgical intervention for repair or joint replacement and are more frequently associated with serious life-threatening complications, particularly among the very old. Long term complications of reduced mobility and increased rates of institutionalisation following hip fracture are well documented. A woman who is living independently prior to a hip fracture has about a 50 per cent likelihood of remaining in long-term care or requiring assistance with activities of daily living one year following the fracture.[47] The majority of hip fractures result from a fall from no higher than standing height,[48] and most vertebral fractures occur during normal activities of daily living such as bending and lifting.[49]

Falls and injuries from falls are significant impediments to healthy and active ageing. The rates of falls rise exponentially with age and complex factors contribute to an individual older person's risk of experiencing a fall and the likelihood of significant complications. Biological factors such as osteoarthritis and osteoporosis, cognitive impairment due to dementia, co-morbidity due to other illnesses, or uncorrected visual impairment are important contributors to overall risk. However, specific attention needs to be directed to the effects of polypharmacy, excess alcohol consumption, environmental factors such as home layout of physical obstacles such as loose carpets, hazards in the bathroom and

[45] Stephen Cummings and L Joseph Melton, 'Epidemiology and Outcomes of Osteoporotic Fractures' (2002) 359 *Lancet* 1761, 1761.
[46] Ibid 1764.
[47] Ibid 1765
[48] Ibid 1762.
[49] E Myers and S Wilson, 'Biomechanics of Osteoporosis and Vertebral Fracture' (1997) 22 *Spine* (suppl 24), 25S, 25.

kitchen environment such as wet floors, uneven floors, stairs, pavements, inappropriate footwear or poor lighting.

Whether in domestic or residential care settings, providing a safe environment for older people to move around in with the assistance they require is a fundamental obligation of caregivers. Falls prevention is also a critical component of care provision for older people with physical or cognitive disability who require assistance. It requires both the removal of potential risks and hazards which may increase the likelihood of an older person experiencing a fall and the provision of physical assistance or a mobility aid to provide an older person with the opportunity to attend to their activities of daily living. Providing opportunities for older people to engage in physical activity to an appropriate level for the individual is a key element of active ageing and can mitigate the risk of older people having falls.

Falls prevention through appropriate attention to the physical needs and the environment of an older person is a positive obligation of caregivers in order to promote the enjoyment by older people of active and fulfilling lives. Failure to attend to the mobility requirements of an older person requiring assistance and care with the activities of daily living can have serious acute and long term consequences for the individual, and amount to neglect on the part of the caregiver(s). As discussed in Chapter 7, the use of physical or chemical restraint as a means to prevent falls particularly in older persons with cognitive impairment has not been demonstrated to be of benefit, may actually contribute to an increased incidence of falls, and is inconsistent with the protection and promotion of the rights of older people. A range of strategies including changes to the physical environment by lowering beds and attending to chair heights, the provision of appropriate aids for transferring people and mobility and the education of carers in both domestic and residential care settings on the need for appropriate levels of activity for any particular individual can all contribute

significantly to a reduction in risk of falls and promotion of well-being amongst older people.

Falls prevention for older people should not be attended to simply because of the current and potential economic and social burden that is created by falls and their consequences. Falls prevention is integral to the promotion of older people's ability to enjoy their human rights as active members of society. In the context of elder abuse and neglect, the dilemma of falls experienced by older people encompasses both an obligation by carers to intervene to minimize the risk of falls and to refrain from inappropriate physical restraint or violence which may result in falls. Abuse and neglect can be the outcome of a failure to acknowledge either of these obligations.

b) Loss of Vision

Globally, it is estimated that 285 million people have visual impairment, of which 39 million are blind.[50] People over 50 years of age make up 65 per cent of those with visual impairment and 82 per cent of those who are blind. Furthermore, 80 per cent of the total burden of vision loss is from preventable causes.[51] The contribution that vision loss due to refractive errors makes to the global burden of disease is projected to rise significantly from 14th in 2004 to 8th in 2030 amongst the leading causes of burden of disease.[52]

Vision loss is a significant contributor to disability in older women. Globally, approximately two out of three people who experience complete or partial loss of vision are women and girls,[53] and the proportion of women affected rises with increasing age. In

[50] Donatella Pascolini and Silvio Paolo Mariotti, 'Global Estimates of Visual Impairment: 2010' (2011) *BJ Ophtholmology* http://bjo.bmj.com
[51] Ibid.
[52] World Health Organization, *Global Burden of Disease: 2004 Update*, above n 26.
[53] I Abou-Gareed et al, 'Gender and Blindness: A Meta-analysis of Population Based Prevalence Surveys' (2001) 8 *Ophthalmic Epidemiology* 46, 46.

low and middle income countries, the loss of vision due to the combined impact of uncorrected refractive errors, age-related macular degeneration and cataracts contribute significantly to the years lost due to disability (YLDs) in women aged over 60 years.

Biological factors and increasing age are underlying risk factors for a loss of vision especially in respect of cataract disease and macular degeneration. Social and economic factors which have an impact on women's ability to access ophthalmological care are particularly significant for women with cataract disease. Relatively simple and inexpensive, cataract surgery is nonetheless still unavailable to the majority of women in low income countries for whom it would provide a cure for blindness.

Seventy-five per cent of people with late stage blindness due to Trachoma are women.[54] Trachoma is an infectious eye disease that results from the transmission of the organism Chlamydia trachomatis, via direct contact and respiratory infections, commonly transmitted from child to child and child to mother/grandmother.[55] Chronic and repeated infections can result in the scarring of the cornea due to prolonged irritation from inward turned eyelashes and may lead to blindness (trichiasis). Trachoma induced blindness can be prevented by improved water and living conditions, access to early antibiotic treatment, education of women about the nature of transmission and methods for the prevention of transmission among family members.[56] Similar findings in respect of the under-utilisation of surgery in women for trichiasis have been reported.[57] The WHO has developed an 'Action Plan for the Prevention of Avoidable Blindness and Visual Impairment 2009–2013', and specific targets have been set by global alliances such as the WHO Alliance for

[54] Women's Eye Health, 'Why are there more women blind and visually impaired in developing countries?' http://www.w-e-h.org/in-developing-countries.html
[55] Women's Eye Health, 'Trachoma and Other Infectious Diseases – What is Trachoma?' http://www.w-e-h.org/trachoma-and-other-infectious-diseases.html
[56] Ibid.
[57] Abou-Gareed et al, above n 53, 50.

the Global Elimination of Blinding Trachoma,[58] which aim to treat trachoma induced blindness through the 'SAFE' strategy; surgery for trichiasis, antibiotic therapy, facial cleanliness and environmental improvements.

In Australia, blindness and visual loss are of significant concern in Indigenous communities. Blindness is 6.2 times more common in Indigenous adults than in non-indigenous adults.[59] Vision loss is 2.8 times more common in Indigenous adults.[60] The published data are not disaggregated on the basis of gender. However, the overall statistics provide a valuable measure of the risk posed to older people particularly in remote inland communities. Ninety-four per cent of vision loss among Indigenous adults is preventable or treatable.[61] The main concerns are:

i) Cataract disease which is 12 times more common amongst Indigenous adults than non-Indigenous adults.[62] Only 65 per cent of those people who would benefit from surgery have had cataract operations.[63]

ii) Refractive eye disease where availability and frequency of eye examinations contributes to overall rates of corrected refractive errors.

iii) Diabetic Retinopathy. Thirty-seven per cent of Indigenous adults were reported as having diabetes, and of those 36 per cent have diabetic eye disease[64] and 13 per cent have visual impairment.[65] However, rates of intervention with screening and surgery were low.[66]

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[58] See further, World Health Organization, http://www.who.int/blindness/causes/trachoma/en/index.html
[59] Hugh Taylor et al, '*Minum Barreng* (Tracking Eyes). National Indigenous Eye Health Survey' (Report for the Centre for Eye Research Australia, University of Melbourne, 2009) 3
[60] Ibid.
[61] Ibid.
[62] Ibid 10.
[63] Ibid.
[64] Ibid 3.
[65] Ibid 11.
[66] Ibid.

iv) Trachoma is a disease eliminated in non-indigenous populations. Australia is the only developed country to report the occurrence of trachoma.[67] Evidence of scarring as a result of trachoma is present in 16 per cent of Indigenous adults, as high as 40 per cent in very remote inland communities where the prevalence of more advanced trichiasis and corneal blindness was also the highest.[68]

While the eye health study discussed above is not disaggregated for gender, other studies have found that Indigenous women have higher rates of poor health compared to non-indigenous women across all health areas.[69] The rates of diseases which underlie vision loss such as diabetes are higher in Aboriginal and Torres Strait Islander women than non-indigenous women. Indigenous women are over four times more likely to have impaired glucose tolerance/ diabetes than non-indigenous women.[70] Poor eye health and vision loss are significant health issues for older Indigenous women. Improvement in screening and prevention of eye disease will assist in promoting active ageing, particularly for Indigenous women in rural and remote areas.

c) Mental Health

Gender considerations in mental health operate on two significant levels. First, gender differences exist in the overall reported rates of different forms of mental illness as will be illustrated below. Secondly, gender considerations in mental health operate on how the history and progression of a mental illness is affected by factors which determine the risk

[67] Ibid 12.
[68] Ibid.
[69] Department of Health and Ageing (Cth), *Development of A New National Women's Health Policy – Consultation Discussion Paper* (2009) 16.
[70] J Burns, CM Maling and N Thomson (2010) *Summary of Indigenous Women's Health*. http://www.healthinfonet.ecu.edu.au/women-review.

of experiencing mental illness, diagnosis, treatment and access to treatment and co-morbidity with physical or other mental health concerns: for example, anxiety and alcohol dependence.

The overall rates of mental illness display little gender difference, including for illnesses such as schizophrenia and bipolar disorder. According to the World Health Organization, however, significant gender differences in prevalence do exist for depression, anxiety and somatic complaints. Depression is responsible for the greatest burden of disease within mental and neurological disorders,[71] and it is estimated by the Global Burden of Disease Study that unipolar depressive disorders will be the greatest contributor to the burden of disease (DALY) by the year 2030.[72] Significantly, women are almost twice as likely to experience depression as men in both developed and developing countries,[73] and 41.9 percent of disability arising from neuropsychiatric disorders among women is attributable to depression, compared to 29.3 per cent of disability among men.[74]

The WHO reports that in recent times, in accordance with the life-course view of health, the focus on women's health has shifted from one directed primarily towards the removal and mitigation of individual lifestyle choices and factors to a much broader view of the determinants of mental health.[75] The disparity in statistical rates of illnesses such as depression and anxiety have also precipitated a gender based analytical framework encompassing the economic, social and cultural, environmental and legal influences on mental health.

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[71] World Health Organization, 'Gender Disparities in Mental Health' http://www.who.int/mental_health/prevention/genderwomen/en/.
[72] World Health Organization, *Global Burden of Disease Study 2004 Update'* (2008) 51.
[73] World Health Organization, *Women's Mental Health: An Evidence Based Review*, WHO/MSD/MDP/00.1 (2000).
[74] World Health Organization, 'Gender Disparities in Mental Health', above n 71.
[75] World Health Organization, *Women's Mental Health: An Evidence Based Review* above n 73, 7.

These factors have clear implications for the lives of older women, who may have pre-existing mental illness carried into older age, or for those women who experience depression or anxiety for the first time in older age. A gender and an age perspective upon women's mental health at all levels of prevention can assist in reducing the impact upon the incidence of elder abuse and neglect and the ability of women to seek solutions.

d) Reproductive Health

Marked global disparities exist in the area of maternal and reproductive health, the sequelae of which may be carried into old age and contribute to a burden of disease and disability for older women. Globally the leading causes of mortality of women in the reproductive years (ages 15–44 years) are HIV/AIDS (19.2 per cent) followed by maternal conditions (14.6 per cent).[76] The disease burden and morbidity in DALYs from HIV/AIDS and maternal conditions is most striking in Africa.[77] Furthermore, lack of access to contraceptives and an inability of women to control their fertility leading to unwanted pregnancies make a significant contribution to the burden of disease in women of this age group.

Maternal health is targeted specifically by Goal No 5 of the United Nations Millennium Development Goals.[78] There is a stark disparity between maternal mortality rates in developed and developing countries. A 47 per cent reduction in maternal death has occurred between 1990 and 2010. Sub-Saharan Africa (56 per cent) and southern Asia (29 per cent) accounted for 85 per cent of maternal deaths in 2010.[79] In sub-Saharan Africa a

[76] World Health Organization, *Women and Health: Today's Evidence Tomorrow's Agenda* (2009) above n 8, 39.
[77] Ibid.
[78] *United Nations Millennium Declaration*, GA Res 55/2, 55th sess, UN Doc A/Res/52/2 (2000).
[79] World Health Organization, *Trends in Maternal Mortality: 1990 to 2010* (2012) 1.

woman's lifetime risk of dying from preventable or treatable complications of childbirth is 1 in 39, compared to 1 in 3800 for women in developed countries.[80]

The sequelae of a lack of attendant ante-natal care can have far reaching consequences for women later in life and contribute significantly to disability and discrimination into old age. By way of illustration of such consequences in later life, attention is directed here to the life-long consequences for women when they encounter prolonged labour and delivery, in particular in the absence of a skilled birth attendant. In developed countries the incidence of obstetric fistula as a consequence of labour has been virtually eliminated by early attendant skilled medical care and the availability of caesarean section. However in less developed countries, particularly in sub-Saharan Africa, prolonged obstructed labour without attendant obstetric care often leads to the devastating consequence of obstetric fistula. The incidence is compounded by under-nutrition and childhood pregnancies which can impact on the progress of labour. The physical consequences for women who suffer the complication include an inability to control bladder and bowel function because of abnormal connections (fistulae) between the bladder, vagina and colon.[81] The social consequences for most women with the complication are also profound. Exclusion by community and family is widespread, and many women are forced to exist on the margins of society suffering extreme discrimination and disadvantage.[82] This continues from young reproductive years of a woman's life into old age. The effects can extend from neglect and exclusion to aggression and violence towards women in this situation.

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[80] Ibid 19.

[81] Obstetric fistulae can be a consequence of prolong labour where the pressure of the foetus interferes with the vascular (blood) supply of pelvic organs and tissues. This results in a communication or opening that should not exist between organs and structures. A connection between the bladder and vagina is termed a vesico-vaginal fistula, and can result in uncontrolled leakage of urine through the vagina. A connection between the colon and the vaginal causes a recto-vaginal fistula and results in the leakage of faeces into the vagina.

[82] World Health Organization, *Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development* (2006) 3.

Caution has been urged about over-emphasis on and too narrow a construction of women's health as women's reproductive health and the role of women as mothers and carers.[83] The concern is that such an approach increases the risk that the other determinants of women's health such as occupational health will be overlooked, the emphasis will be predominantly on women of reproductive age and older women's health issues may be ignored.[84]

e) Sexual Health

A lack of education regarding safe sexual practices, the restricted ability to practise safe sex, cultural practices, violence by intimate partners, and sexual violence against women all contribute to the increased risk of mortality and morbidity associated with unsafe sex which may lead to the transmission of HIV/AIDS and other sexually transmitted infections. This can have life-long consequences for women. HIV infection rates are higher in girls than boys in most countries with HIV epidemics, in part due to engagement in sexual activity with older men who are more sexually experienced and more likely to be infected with HIV.[85] Globally the prevalence of HIV infection in women has risen since the 1990s, most significantly in sub-Saharan Africa.

Cervical cancer is the second most prevalent type of cancer in women across the globe.[86] Cervical cancer is linked to infection through sexual transmission of the human papilloma virus, HPV. In the current cohort of older women, access to cervical cancer screening and prevention using pap smears remains the most effective intervention, but is rarely

[83] See for example, World Health Organization, *Women's Mental Health: An Evidence Based Review*, above n 73, 26
[84] Ibid 26-28.
[85] World Health Organization, *Women and Health: Today's Evidence' Tomorrow's Agenda*, above n 8, 34, 44.
[86] International Agency for Research on Cancer (World Health Organization), 'Most Frequent Cancers: Women' (GLOBOCAN Project, 2008) http://globocan.iarc.fr/factsheets/populations/factsheet.asp?uno=900#WOMEN

accessible in developing countries. In the younger cohort of women and girls, the new HPV vaccine offers an effective preventive strategy if access is facilitated.[87]

HIV and other sexually transmitted infections, whether primarily acquired in younger life or through sexual activity in older age, place a disproportionate burden of sequelae on women. Older women can and do continue to be sexually active and therefore remain at risk. The sequelae of AIDS from HIV infection and cervical cancer as a consequence of human papilloma virus transmission may be exacerbated for older women by many factors. These include reduced access to education regarding the early recognition and benefits from early intervention of these illnesses, poor economic and social circumstances hindering and restricting access to health care and intervention and active stigmatization and discrimination against older women with HIV/AIDS and other STIs.

C. Human Rights Law, Older Women and Abuse

The physical, sexual or psychological abuse of older women fundamentally violates the human rights of any woman who experiences such acts. Human rights law, through the major human rights instruments provides for the protection of those rights and empowerment of older women to enjoy those rights. Chapter 6 examined the role of law in relation to a specific right applicable to the prevention of elder abuse and neglect, the right to physical and mental health. This section will examine the sources of the rights which are of particular relevance to older women (including but not restricted to the right to health) and how they may be realised to prevent and remedy elder abuse and neglect. The benefit

[87] Human Papilloma Virus (HPV) is the infective agent associated with cervical cancer. The HPV vaccines are directed towards the high risk types of HPV which are responsible for the majority of cases of cervical cancer. See Cancer Council of Australia, 'The HPV Vaccine' http://www.hpvvaccine.org.au/the-hpv-vaccine/vaccine-background.aspx

of a human rights approach to the issue of the abuse and neglect of older women is that it provides a legal framework at an international, regional and domestic level through treaties, constitutions and domestic legislation which reflect international obligations.

Implicit in the principle that human rights are universal and indivisible is the contention that older people are entitled to enjoy all the rights embodied in the international human rights treaties equally and without discrimination. The need for a Convention specifically attendant to the rights of older people is receiving increasing attention at an international level, and this matter will be discussed further in Chapter 10. The discussion here highlights the sources and the nature of the broad range of rights in international law which have particular relevance to the experience of abuse and neglect of older women. Attention will be directed to the operation of the *Convention on the Elimination of Discrimination against Women* and the *Convention on the Rights of Persons with Disabilities* as they relate to older women.

1. Sources of Rights of Older Women in International Law

The *Universal Declaration of Human Rights*[88] underpins the principle that human rights are universal and inalienable. The recognition of the indivisibility and interrelated nature of human rights is necessary to understand that elder abuse and neglect constitute a violation of these rights and therefore the development of practical strategies to uphold those rights is necessary.

Of the eight core human rights treaties which have the potential to have an impact upon the rights of older women to live without the experience or threat of abuse and neglect, the most salient include the:

[88] *Universal Declaration of Human Rights*, GA Res 217A, 3rd sess, 183rd plen mtg, UN Doc A/810 (1948).

i) *International Covenant on Civil and Political Rights*;[89]

ii) *International Covenant on Economic, Social and Cultural Rights*;[90]

iii) *International Convention on the Elimination of All Forms of Discrimination against Women*;[91]

iv) *Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment*; [92]and

v) *Convention on the Rights of Persons with Disabilities.*[93]

Between and throughout these binding documents, rights are elucidated which have special relevance in empowering older persons, both men and women, to combat the challenges of abuse and neglect that may affect their lives. These rights include:

i) The right to life;

ii) The right to freedom from cruel, inhuman or degrading treatment;

iii) The right to liberty and security of person;

iv) The right to equality and protection under the law; and

v) The right to the highest attainable standard of physical and mental health.

This list is representative only and the interdependence of all rights is a critical component. For example, a person's ability to enjoy the right to health will clearly be influenced by the extent to which his or her rights to education, housing, clean water, food and other rights

[89] *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976).
[90] *International Covenant on Economic, Social and Cultural Rights*, opened for signature 19 December 1966, 993 UNTS 3 (entered into force 3 January 1976).
[91] *Convention on the Elimination of All Forms of Discrimination against Women*, opened for signature 1 March 1980, 1249 UNTS 13 (entered into force 3 September 1981).
[92] *Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 UNTS 85 (entered into force 26 June 1987).
[93] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).

can be fulfilled. The principle of non-discrimination that is intrinsic to human rights law, mandates that both gender and age specific perspectives are taken into account within programmes, policies and laws with the aim of ensuring accessibility and accountability in respect of the rights of older women.

2. Convention on the Elimination of All Forms of Discrimination against Women

The *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW) adopted in 1979 and entering into force in 1981, marks the most comprehensive attention to the rights of women within the United Nations human rights treaty collection. The Convention attends in detail to the substantive matters that are specific to the nature of discrimination that affects the lives of women and indicates how the enjoyment of the full spectrum of rights is influenced by such discrimination against women and girls. The legal and practical demands on States Parties to implement the rights of women and girls to non-discrimination are contained within the document. The *Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women*[94] (hereafter the 'Optional Protocol') allows for complaints by individuals and groups of individuals to be made to the Committee on the Elimination of Discrimination against Women (hereafter the 'Committee'). Australia ratified the Convention in 1983 and the Optional Protocol by accession in 2008.

The Convention is a compelling document in respect of the obligation to respect, protect and fulfil the rights of women. It is vital then to question whether the substantive and procedural aspects of the Convention have the potential to influence the phenomenon of

[94] *Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women*, opened for signature 19 December 1999, 2131 UNTS 83 (entered into force 22 December 2000).

the abuse of older women. Primarily, the intrinsic gender perspective of the Convention upon the elucidation and practical fulfilment of rights should be defined. Article 1 states:

> For the purposes of the present Convention, the term 'discrimination against women' shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.[95]

In addition to the overriding explicit principle of non-discrimination which provides the vantage point for the development of all the substantive rights contained within the Convention, the document's strength arises from the recognition of the interrelated and interdependent nature of the rights within it; civil, political, social, economic and cultural rights receive detailed attention and recognition.

Crucially, the Convention extends obligations beyond those which arise out of public acts by States, to the acts of individuals or enterprises. Article 2 states:

> States parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and to this end to undertake...
>
> (e) To take all appropriate measures to eliminate discrimination against women by a person, organization or enterprise

This has particular significance for the victims of elder abuse whereby the majority of acts of abuse that constitute a violation of rights are perpetrated by private individuals or occur within private institutions. In General Comment No 28 on the core obligations of States Parties under Article 2 of the *Convention on the Elimination of All forms of Discrimination*

[95] *Convention on the Elimination of All Forms of Discrimination against Women*, opened for signature 1 March 1980, 1249 UNTS 13 (entered into force 3 September 1981).

against Women[96] the Committee seeks to clarify how procedural effect is given to this substantive right of individuals to take action if States Parties fail to take action against discrimination in 'all its forms' and in 'all fields'.[97] In particular, General Comment No 28 clarifies that:

> Article 2 also imposes a due diligence obligation on States Parties to prevent discrimination by private actors. In some cases a private actor's acts or omission of acts may be attributed to the State under international law.[98]

In relation to the circumstances which give rise to abuse or neglect, this could be envisaged to encompass an obligation to regulate the activities of private operators of health and residential care and accommodation facilities which provide services and care to older persons.

Secondly, the Convention directs attention to the elimination of cultural and traditional practices and other aspects of violence against women that constitute physical, sexual and psychological abuse and neglect. For example Article 5 states:

> States Parties shall take all appropriate measures:
>
> (a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on the stereotyped roles for men and women.

The Convention itself is less explicit about a concurrent age perspective on discrimination against women. However the Committee on the Elimination of Discrimination against Women has progressively directed attention within numerous General Comments to the

[96] Committee on the Elimination of Discrimination against Women, *General Comment No 28 on the Core Obligations of States Parties under Article 2 of the Convention on the Elimination of all forms of Discrimination against Women*, UN Doc CEDAW/C/GC/28 (16 December 2010).
[97] Ibid [8].
[98] Ibid [13].

reality that multiple forms of discrimination are often experienced by women at the same time and throughout their lives. This parallels the life-course approach adopted by the World Health Organization in policy and programme development for women's health which was discussed earlier in this chapter.

In General Comment No 28 the Committee specifically recognised that the discrimination faced by women on the basis of sex and gender is 'inextricably linked with other factors that affect women, such as race, ethnicity, religion or belief, health, status, age, class, caste and sexual orientation and gender identity.'[99] In the individual communication *Maria de Lourdes da Silva Pimentel v Brazil* (2010),[100] the Committee considered the claim brought on behalf of the deceased victim by her mother against the State. The communication alleged the violation by the State Party of her right to life and health under Articles 2 and 12 of the Convention (the right to non-discrimination in health care and pregnancy and reproductive health). The Committee expressed the view that the right to health and life had been violated under Articles 2 and 12, but importantly also concluded that the victim had been discriminated against not solely on the basis of sex, but also on the basis of her African descent and socio-economic background. The view expressed by the Committee explicitly recalled its General Recommendation No 28 and the need to attend to the specific needs of vulnerable groups, and it clarified that age discrimination may be linked to discrimination on multiple other levels.[101]

The Committee on the Elimination of Discrimination against Women, in response to an acknowledgement that multiple forms of discrimination experienced by older women in particular were not being systematically addressed, adopted 'General Recommendation No

[99] Ibid [18].
[100] Committee on the Elimination of Discrimination against Women, *Decision: Communication No17/2008*, 49th see, UN Doc CEDAW/C/49/D/17/2008 (27 September 2011) (*'Maria de Lourdes da Silva Pimentel v Brazil'*).
[101] Ibid [7.7]

27 on Older Women and Protection of Their Human Rights' in 2010.[102] General Recommendation No 27 identifies the rights and the discrimination faced by older women and emphasises the role of CEDAW as a tool to promote these rights:

> While both men and women experience discrimination as they become older, older women experience ageing differently. The impact of gender inequality throughout their lifespan is exacerbated in old age and is often based on deep-rooted cultural and social norms. The discrimination that older women experience is often a result of unfair resource allocation, maltreatment, neglect and limited access to basic services.[103]

The greatest benefit from the analysis within General Comment No 27 is gained when it is read in concert with several of the other General Recommendations of the Committee that specifically address the challenges that exist for the prevention of abuse of older women. Clearly the emphasis on the many factors set out below will vary greatly in different settings. However, the analysis provides a valuable context for confronting the abuse and neglect of older women and an understanding of specific examples of those challenges.

The multidimensional nature of discrimination experienced by women is reiterated by the Committee. Age, gender, disability, marital status, poverty are all determined to be critical perspectives from which all policies and programmes must be viewed. Ensuring the active participation of older women in society is identified as the cornerstone of all strategies to combat discrimination, violence and abuse.

The impact of gender stereotyping and traditional and customary practices that are harmful must be identified as it contributes to the physical, sexual, psychological abuse that older women may experience. Many countries still have discriminatory laws and social practices which discriminate against widows. The treatment of widows is respect of inheritance of

[102] Committee on the Elimination of Discrimination against Women, *General Recommendation No 27 on Older Women and Protection of Their Human Rights*, UN Doc CEDAW/C/GC/27 (16 December 2010).
[103] Ibid [11.9].

land and property, the abolition of cultural practices that enable men to force arranged marriages on women by linking it to succession through their will after their death can contribute to the actual and potential for abuse of older women. Attitudes to older women in polygamous marriages can lead to abuse, abandonment or neglect when older women are no longer considered to be as useful or productive as younger wives.

Older women who are accused of being involved in witchcraft or sorcery are the victims of violence and abuse in some societies. For example, in a paper prepared for the United Nations by the Expert Group Meeting on good practices in legislation to address harmful practices against women,[104] attention was directed to harmful practices against women in Pacific Countries. It was noted that violence against women believed to be involved in witchcraft is common in some Pacific Island communities and that 'the accused women are usually economically dependent older women who are seen as a financial burden on their tribes, usually with no extended family to defend them'.[105] The paper's author, Imrana Jalal, attributes difficulties in overcoming such practices to their recognition under customary law which in turn receives constitutional recognition in many countries.

Particular risks of abuse exist for older women who are refugees, seeking asylum or internally displaced and older women in conflict zones.[106] The challenges faced by older women in rural areas where disruption of traditional social structures due to the increasing movement of young people to urban areas, has meant that older women are often physically isolated. General Recommendation No 15 on 'Women and AIDS' acknowledges the increased vulnerability of women in some societies to HIV infection

[104] Imrana Jalal, 'Harmful Practices Against Women in Pacific Island Countries: Customary Practices and Laws', UN Doc, EGM/GPLHP/2009/EP.15 (Report, United Nations Division for the Advancement of Women, United Nations Economic Commission for Africa, Addis Ababa, 2009).
[105] Ibid 19.
[106] United Nations High Commissioner for Refugees, 'Women, Particular Challenges and Risks'

because of the particular societal role of women, cultural practices and sexual violence against women and the role women play in the provision of care, as health workers and in the dissemination of information about HIV.[107]

Access to health care, older women's rights to self-determination and consent in health care receive particular attention in the Committee's General Comment No 24 on 'Women and Health'.[108] This General Recommendation elaborates upon the obligations under Article 12 (1) of the Convention.

> States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

While the report attends to the health concerns of all women as they relate to the operation of the Convention, the Committee acknowledges concern about the health conditions of older women and directs States Parties to 'take appropriate measures to ensure access of older women to health services that address the handicaps and disabilities associated with ageing.'[109]

D. Conclusion

A gender perspective on the phenomenon of elder abuse and neglect is mandated by the changing demographics of our society whereby women significantly outnumber men in older age, and by a recognition that the biological, social, economic, and cultural

http://www.unhcr.org/pages/49c3646c1d9.html

[107] Committee on the Elimination of Discrimination against Women, *General Comment No 15, Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS)*, 9th sess, UN Doc GR/CEDAW/15 (1990).

[108] Committee on the Elimination of Discrimination against Women, *General Comment No 24, Article 12: Women and Health*, 20th sess, UN Doc GC/CEDAW/24 (1999).

[109] Ibid [24].

determinants of ageing differ for men and women. However, it must be acknowledged also that women are a heterogeneous group and the individual circumstances of each woman influence the risk she may experience of abuse and neglect in old age. A life-course view is essential for understanding and developing strategies for the prevention of elder abuse and neglect among women at primary, secondary and tertiary levels of prevention.

The promotion of good health and active ageing should be a fundamental pillar of all programmes and responses in all parts of the world. Through improved professional and community education on the nature of abuses committed against older women, primary prevention and early intervention can be improved. Understanding that the physical, sexual and psychological abuse of older women constitute violations of fundamental human rights ensures that the full utility of international human rights law can be harnessed to empower older women to enjoy and fulfil their human rights.

Chapter 9

ADULT PROTECTIVE SERVICES AND THE MANDATORY REPORTING OF ELDER ABUSE

A. Introduction

Legislative control over the reporting of elder abuse has been given consideration within most Australian jurisdictions over the last two decades. State and Territory governments have given detailed consideration to the implementation of mandatory reporting of elder abuse and these will be discussed in this chapter. All State and Territory jurisdictions have rejected the implementation of such regimes. By contrast, following a Senate Inquiry in 2006, the Commonwealth Government enacted the *Aged Care Amendment (Security and Protection) Act 2007* (Cth) which incorporated mandatory reporting provisions into aged care legislation.

The historical approach to legislative intervention in the reporting of elder abuse has varied widely between international jurisdictions. This is reflected in the diversity of strategies adopted by governments for the implementation of a regime of mandatory reporting of elder abuse. This chapter will outline the approaches to the mandatory reporting of elder abuse that have been adopted in the United States of America and the United Kingdom.

This chapter is not intended to provide a detailed catalogue of the various adult protection statutory regimes: direct comparisons of the various regimes are difficult due to the lack of uniformity in scope and definitions. Therefore the objective of this chapter is to; i) identify and critically evaluate key elements of the various reporting regimes; and ii) analyse and discuss whether, and if so how, these elements can be reconciled with human rights principles as they relate in particular to the rights of older persons. The discussion will address the apparent conflict that arises between mandatory reporting obligations and the obligation to respect the autonomy of older persons.

Broadly speaking, mandatory reporting of elder abuse refers to a statutory requirement for specified individuals to report suspected or alleged cases of elder abuse to the recognised authority. However in practice, the legislative regimes enacted across jurisdictions vary in several key respects.

1. Governing legislation

Mandatory reporting obligations in respect of older persons may be incorporated within the scope of a broad 'Adult Protective Services' regime. Under this model, Adult Protective Services are commonly empowered to receive reports, investigate claims of abuse and provide intervention and assistance with legal, medical, financial, housing and other matters.

An alternative framework for mandatory reporting provisions lies within specific 'Aged Care' legislation. The mandatory reporting provisions of the *Aged Care Act 1997* (Cth) are an example of this and will be detailed below.

2. Target population

As a corollary of the different governing legislation, the law in some jurisdictions is targeted at the reporting of violence and abuse against vulnerable adults of any age, while

other protective services regimes are elder focussed. For example, in the United States, there is wide variation in the target population within the relevant state statutory instruments. In a 2012 report by the National Adult Protective Services Resource Center (NAPSRC) in the United States, it was noted that:

> There is no common definition of who is served in each of the states nor what services they receive. Indeed, while 74 percent of the States report that they serve populations ages 18+, the rest of the states have variations from only serving 60 and above to other specific populations. In nearly one third of the states, the alleged victim over the age of 60 must hold the definition of "vulnerable" before an APS case can be opened.[1]

The United Kingdom's legal framework has a broad focus on the protection of 'vulnerable adults' over the age of 18 years, and is not elder specific.[2]

3. Non-uniform definitions of elder abuse

Significant variation in the definitions of abuse exists between various statutory regimes. Most notably, the inclusion of financial abuse is variable within statutory provisions, and several state legislative regimes in the United States of America include self-neglect within the provisions dealing with mandatory reporting obligations. Inclusion of self-neglect is uncommon in jurisdictions outside the United States.

4. Persons mandated to report abuse

Those most frequently ascribed mandatory reporting obligations within statutory provisions include law enforcement officers, aged care workers and health professionals.

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[1] National Adult Protective Services Resource Center, *Adult Protective Services in 2012: Increasingly Vulnerable* (Report for the National Adult Protective Services Association and the National Association of States United for Aging and Disabilities, 2012) 3.

[2] For example, in England adult protection is governed by a range of statutory guidances and legislative instruments including the 'No Secrets' Guidance which is discussed in Part E below; the *Human Rights Act 1998*; and *Mental Capacity Act 2005*. In Scotland, adult protection is governed by the *Adult Support and Protection (Scotland) Act* (2007). For discussion of the legal framework for adult protection in England, see further Michael Mandelstam *Safeguarding Adults at Risk of Harm: A Guide for Legal Practitioners* (Adults' Services Report 50, Social Care Institute for Excellence, 2011).

However, some statutory obligations are ascribed far more broadly to include ‘any person’. For example, in the United States, 15 states mandate reporting of abuse by ‘all persons’.[3]

5. Residential versus non-residential care

Depending on the governing legislation, mandatory reporting obligations may be imposed only within residential care facilities (such as via the Australian *Aged Care Act 1997* (Cth) provisions) or alternatively may be limited to suspected or alleged abuse within domestic settings.

6. Consequences of failure to report

Consequences of a failure of a designated person to report suspected or alleged abuse vary considerably. A spectrum ranges from no statutory consequence, to a fine, to a report to the relevant professional board to possible imprisonment.

Taking account of the diverse constitutional and legislative frameworks in which different jurisdictions construct responses to primary, secondary and tertiary prevention, it is unsurprising that mandatory reporting has received varying support as a legitimate response to the problem of elder abuse and neglect.

B. The Australian Deliberations on Mandatory Reporting

To date, Australian deliberation and action in relation to statutory obligations to report suspected or alleged abuse of older people has taken a different path to the United States of America.

[3] Ibid 7, 9.

Beginning in 1993 with the 'New South Wales Task Force on the Abuse of Older People', several State and Territory inquiries have given detailed consideration to the dilemma of mandatory reporting within the context of broader investigations into the emerging phenomenon of elder abuse and neglect.[4] The 'Final Report of The New South Wales Advisory Committee on the Abuse of Older People in Their Homes', in which the Committee evaluated the social and legal issues surrounding elder abuse, rejected the introduction of mandatory reporting.[5]

In 2001 the Australian Capital Territory followed with a report on 'Elder Abuse in the ACT', conducted by the Australian Capital Territory Committee on Health and Community Care. Citing a concern that mandatory reporting 'may have the effect of depriving older people of control over their destinies and making their own decisions about their futures',[6] this Committee also rejected the introduction of mandatory reporting legislation.

In the 2005 report for the Victorian State Government entitled 'Strengthening Victoria's Response to Elder Abuse',[7] the Victorian Elder Abuse Prevention Project also rejected the introduction of mandatory reporting. The report made particular note of the experiences of the disparate American system and the tendency for such a system to become 'a crisis response service with little or no emphasis on preventive activities.'[8]

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[4] Jan Mason, 'Mandatory Reporting of Abuse of Older People' (Discussion Paper No 4 for the New South Wales Advisory Committee on the Abuse of Older People, Ageing and Disability Department, Sydney, 1997) 23.
[5] New South Wales Advisory Committee on the Abuse of Older People in Their Homes, *Abuse of Older People; The Way Forward, Final Report* (Ageing and Disability Department, Sydney, 1997).
[6] Legislative Assembly for the Australian Capital Territory, *Elder Abuse in the ACT: Report No.1* (2001) 33.
[7] Victorian Government, *Strengthening Victoria's Response to Elder Abuse: A Report of the Elder Abuse Prevention Project* (2005).
[8] Ibid 24.

The 2010 Tasmanian Government report addressing elder abuse entitled 'Protecting Older Tasmanians from Abuse' is the most recent addition. There are two notable features of the Tasmanian report. The first is that the scope of elder abuse outlined in the report specifically excludes abuse occurring in residential facilities and within professional relationships.[9] The categorisation of misconduct or abuse within such relationships as 'abusive relationships other than those caused by trust'[10] appears to be motivated by resource issues, rather than an objective to create a meaningful definition of elder abuse. The policy is explained by the statement that '[t]here are established means for addressing potential misconduct in the areas outlined below, so the Tasmanian response does not duplicate existing processes but assists the appropriate response.'[11]

The second notable feature of the Tasmanian report is that the issue of obligatory reporting of abuse is not specifically addressed. This point of difference from the earlier State reports which specifically attended to the issue and rejected the option of the establishment of a system of mandatory reporting for abuse occurring in domestic settings, may reflect an acceptance of the trend that has evolved in the two decades in other states and territories. While the Tasmanian document emphasises informed choice, self-determination, support and empowerment as strategic themes for the prevention of abuse in private domestic settings, there is a reliance upon the Commonwealth *Aged Care Act (1997)* mandatory reporting provisions to cover the situations of abuse and misconduct 'not related to trust' that may occur in residential settings.

The contradiction inherent in an approach to the prevention of abuse of older people that is dependent upon their place of residence is underlined by the Tasmanian approach. The

[9] Tasmanian Government, *Protecting Older Tasmanians from Abuse* (2010) 10.
[10] Ibid 9.
[11] Ibid.

emphasis on empowerment and the obligation to respect, protect and fulfil the rights of older in the most recent of State government policy statements is to be applauded. But it should also provide the stimulus for federal and state jurisdictions to re-evaluate the disparities in approach in order to adopt a unified strategy to elder abuse prevention in the future. A national policy on the prevention of elder abuse and neglect in residential, institutional and private domestic settings would provide a framework for this goal.

In 2007, the South Australian Government issued a report entitled 'Our Actions to Prevent the Abuse of Older South Australians 2007'[12] which outlined the government's strategic directions in relation to elder abuse prevention. As a consequence of an undertaking in that policy to review the laws and reporting mechanisms in relation to elder abuse,[13] in 2012, the Office of the Public Advocate in collaboration with the University of South Australia undertook a project to examine South Australia's response to elder abuse.[14] The 'Closing the Gaps' project aimed to develop a rights based framework to address the issues of the abuse of older people and concluded that legislative reform was a necessary path forward in order to eliminate the gaps that exist in the current responses in that state.[15] The project recommended that legislation be enacted in the form of an 'Adult Protection Act', incorporating 'a system of voluntary reporting of abuse, but a mandatory response system which is triggered by a report or notification.'[16]

Despite the consistent rejection of mandatory reporting legislation by the States and Territories, the Commonwealth Government introduced amendments to the *Aged Care Act*

[12] Office for the Ageing, Department for Families and Communities (SA), *Our Actions to Prevent the Abuse of Older People in South Australia* (2007).
[13] Ibid 15.
[14] Office of the Public Advocate South Australia and the University of South Australia, 'Closing the Gaps: Enhancing South Australia's Response to the Abuse of Vulnerable Older People' (Report for the Office of Ageing and Disability Services, South Australia, 2011).
[15] Ibid 68.
[16] Ibid.

in 2007 which impose obligations to report abuse within Commonwealth Aged Care facilities. The stark difference in approach warrants further consideration and the debate raised in the State investigations can inform the discussion on recent and future developments in the area.

C. The *Aged Care Act 1997* (Cth)

1. Background to the Mandatory Reporting Amendments

A major catalyst for the development of mandatory reporting provisions at a Commonwealth level was the public disquiet generated in early 2006 by media reporting of allegations of sexual abuse of several residents in an aged care facility in Mt Eliza in Victoria.[17] In particular, these allegations created greater community consciousness of the issue of the elder abuse within institutional and residential care facilities. In response to community concerns, the Aged Care Advisory Committee undertook a range of investigations and community and professional consultations on the matter.

A range of measures was announced to combat abuse in residential facilities which commenced with the introduction of compulsory background checks of staff and volunteers in aged care facilities and increased unannounced inspections of aged care residential facilities. Following the introduction of a Bill in early 2007 to amend the Aged Care Act and its referral to the Senate Standing Committee on Community Affairs, the *Aged Care Amendment (Security and Protection) Act 2007* (Cth) was assented to on April

[17] Australian Broadcasting Corporation, 'Claims of Sexual Abuse at Vic Nursing Home', *Lateline* (28 February 2006) http://www.abc.net.au/lateline/content/2006/s1574384.htm See also, *R v Alexander; DPP v Alexander* [2008] VSCA 191.

12 2007. The objectives of the amending legislation as outlined in the second reading speech of the Bill in the House of Representatives, were threefold:

1. To establish a scheme for compulsory reporting of abuse;
2. To ensure protection for the reporters of abuse; and
3. To establish a new independent Aged Care Commissioner and Office of Aged Care Quality Compliance with increased investigatory powers and capacity to take action.[18]

2. Outline of Important Amendments

Important provisions were contained in Schedule 1 of the amending Act which created the *Investigation Principles* for matters relating to the Act and for the establishment of the Aged Care Commissioner.

Schedule 2 contained the key provisions amending Chapter 4 of the Aged Care Act dealing with the 'Responsibilities of Approved Providers'. The critical provisions dealing with the imposition of mandatory reporting obligations are contained within Section 63-1AA 'Responsibilities Relating to Alleged and Suspected Assaults.' They are outlined here for the purpose of the discussion to follow.

Section 63-1AA (2) states:

> If the approved provider receives an allegation of, or starts to suspect on reasonable grounds a reportable assault, the approved provider is responsible for reporting the allegation or suspicion as soon as is reasonably practicable, and in any case within 24 hours, to
>
> (a) a police officer with responsibility relating to an area including where the assault is alleged or suspected to have occurred: and

[18] Christopher Pyne MP, 'Aged Care Amendment (Security and Protection) Bill 2007 Second Reading Speech' (House of Representatives, Parliament of Australia, Canberra, 8 February 2007) http://parlinfo.aph.gov.au

(b) the Secretary.

Section 63-1AA (5) is entitled 'Requiring staff members to report assaults' and imposes responsibilities upon approved providers for 'taking reasonable measures to require each it its staff members' who suspect a reportable assault has occurred to 'report the suspicion as soon as reasonably practicable' to one or more of the designated persons.

Section 63-1AA applies to a person receiving government subsidised residential care in respect of which the provider is approved.

Further subsections are concerned with the protection of the identity of informants (s 63-1AA (7)), ensuring staff members are not victimised (s 63-1AA (6)), and the protection of disclosures in relation to a reportable assault (s 96-8).

Further detail on the operation of the accountability provisions for reporting of assault is found in the *Accountability Principles 1998* (Cth) and the *Complaints Principles 2011* (Cth) created under subsection 96 (1) of the *Aged Care Act 1997*(Cth). The Complaints Principles replaced the earlier Investigation Principles which were repealed in 2011. This occurred in response to a review of the operation of the Complaints Investigation Scheme. The review recommendations involved a shift from an investigatory focus to an operating scheme involving 'conciliation, mediation and other non-investigative techniques'.[19]

3. The Operation of Section 63-1AA *Aged Care Act 1997*

During the community and professional consultation process which preceded the introduction of the mandatory reporting amendments, the Senate Standing Committee for Community Affairs heard submissions from a range of community and professional

[19] Department of Mental Health and Ageing (Cth), 'Explanatory Statement *Aged Care Act 1997 Complaints Principles*' (2011) http://www.comlaw.gov.au/Details/F2011L01691/Explanatory%20Statement/Text .

organisations.[20] There was broad acceptance among all the interested parties of the need to ensure the effective prevention of abuse of all types amongst the older populations within residential care facilities. However, the considerable range of reservations, concerns and arguments put forward in the many submissions highlights the strength of debate on the issue at the time. This debate continues in relation to strategies to combat elder abuse in both residential and domestic settings.

Many of the points raised in this debate remained unresolved by the introduction of *the Aged Care (Security and Protection) Act 2007* (Cth) and six years following its introduction, it is timely to reflect on these unresolved issues.

(a) Definitions of Abuse

Inconsistencies in definitions of elder abuse have hampered the development of practical solutions to the primary and secondary prevention of elder abuse for decades. However, the greater consensus that has emerged in the last decade, in particular since the Second World Congress on Ageing in Madrid in 2002, has been an encouraging development. Therefore it is of concern to note the inclusion of a restricted definition of a 'reportable assault' within the 2007 amendments to the Aged Care Act as:

> unlawful sexual conduct, unreasonable use of force or assault specified in the Accountability Principles and constituting an offence against a law of the Commonwealth or a State or Territory.[21]

To reiterate, the now widely accepted definition of elder abuse incorporates

[20] Evidence to Senate Standing Committee on Community Affairs, Aged Care Amendment (Security and Protection) Bill 2007, Parliament of Australia, Canberra, 1 March 2007 (Transcripts of public hearings).
[21] *Aged Care Act 1997* (Cth) s 63-1AA (9).

> 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.[22]

The disparity in the scope of the two definitions is clear. Concerns were raised over the scope of the definition to be incorporated into the Aged Care Act amendments, in submissions to the Senate Committee for Community Affairs Inquiry. For example, in a submission by the Aged Care Crisis Team, it was noted that:

> Only a small minority of cases of elder abuse involve breaking the law; so the vast majority of cases do not come under the compulsory reporting. Thus most cases of physical abuse, all emotional abuse, financial abuse and incidents of neglect are not covered.[23]

In additional comments to the Committee's report, the Australian Democrats noted that:

> The Government's narrow focus on physical and sexual abuse ignores the other types of abuse, such a psychological, financial abuse and neglect which older people are equally vulnerable to – whether in residential aged care, community care or even a hospital setting. The government has a responsibility to respond effectively to all types of abuse and implement strategies that will reduce all forms of abuse.[24]

Despite this, the Department of Health and Ageing asserted in the 'Compulsory Reporting Guidelines for Aged Care Providers' that 'the definition of reportable abuse provides a simple, readily understood and universally accepted definition' and that it 'avoids the difficulties of applying legalistic definitions that vary widely throughout Australia.[25]

However, this approach and the s 63-1AA provisions that resulted, fail to acknowledge and take account of the range of acts and omissions that constitute threats to the physical,

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[22] Australian Network for the Prevention of Elder Abuse, *Australian Network for the Prevention of Elder Abuse Working Definition (1999),* http://www.anpea.com.au/.
[23] Aged Care Crisis, Submission No 11 to the Senate Community Affairs Committee, Parliament of Australia, *Inquiry into the Aged Care Amendment (Security and Protection) Bill 2007* (24 February 2007).
[24] Australian Democrats, Additional Comments to the Senate Committee on Community Affairs, Parliament of Australia, *Aged Care Amendment (Security and Protection) Bill 2007 Report* (March 2007) 27.
[25] Office of Aged Care Quality and Compliance, *Compulsory Guidelines for Aged Care Providers: Identifying, Reporting and Responding to Allegations of Assault in Residential Aged Care* (Department of Health and Ageing, Canberra, June 2007) 5.

psychological and social well-being of the persons who are the target population of the legislation. As discussed in Chapters 3 and 4, broader definitions of abuse have been consistently adopted through all the State and Territory investigations into elder abuse. Furthermore, the emphasis of the language within the provisions on 'reportable assault' as distinct from the terminology of 'abuse' is a missed opportunity to reflect the modern understanding of the nature of the threats to the integrity of the rights of vulnerable older persons. No acknowledgement is made in the provisions that the other elements of the definition constitute violations of the rights of the residents of aged care facilities that warrant protection. No obligations in respect of reporting violations of these rights through acts of financial, social, psychological abuse and neglect are created.

(b) Scope of target population

The conceptualisation of elder abuse as either 'domestic' or 'familial' abuse, as distinct from 'institutional' abuse, is a common theme within both academic literature and the policy and programmatic responses to elder abuse. This division is evident in the earliest legislative instruments dealing with the subject. For example, the *Older Americans Act* included amendments in 1987 [26] which defined elder abuse as domestic, institutional or self-neglect and abuse. This distinction has drawn criticism. Jan Mason writes, for example, that an analysis of mandatory reporting systems within which this distinction is integrated 'will provide impetus for the development of 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."'[27] The Australian Democrats submission to the

[26] *Older Americans Act of 1965* 42 USC § 3001, Pub L No100-175, 101 Stat 926 (1987).
[27] Mason, above n 4, 23.

Senate reiterated the need for a 'comprehensive response that would protect the aged, regardless of where their care takes place.'[28]

There are significant consequences for the utility of the Australian mandatory reporting provisions due to their inclusion within the scope of existing Commonwealth legislation. As the scope of the *Aged Care Act 1997* (Cth) limits the protections of section 63-1AA to residents of Commonwealth funded residential care facilities, several problems are immediately evident with this approach.

First, if it is accepted that a distinction between residential and domestic abuse is legitimate, and these measures are purposefully designed to attend to the issues of residential abuse, then there is no provision for similar mandatory reporting obligations for the protection of older residents in non-government funded residential care such as private boarding houses.

Second, concern arises that if mandatory reporting is accepted as a legitimate response to the occurrence of elder abuse, then limitations of the obligations upon staff members of government funded residential aged care services seem to be borne out of administrative and jurisdictional matters, rather than a comprehensive analysis and response distinguishing those members of society who may be most often in a position to detect and report abuse. Residential care staff have existing obligations of a duty of care, as do other health and allied health professionals. Yet the latter have not been made the subject of the additional mandatory reporting obligations.

[28] Australian Democrats, above n 24, 27

(c) Implementation barriers

Aside from the design of mandatory reporting provisions, difficulties may arise with the implementation of mandatory reporting. Inadequate support for staff who report abuse and resourcing of services to investigate reported cases could hamper the implementation of even the most carefully drafted provisions that take appropriate account of the problems identified above. The Australian and New Zealand Society for Geriatric Medicine noted in its submission to the Senate Inquiry, that in the setting of older people with cognitive impairment, 'allegations or suspicions of unlawful sexual conduct may be very difficult to substantiate.'[29] This submission also expressed concerns about the appropriate training for those involved in the questioning of victims and the collection of physical evidence from persons with impaired decision making capacity who may not be able to consent to the taking of physical evidence.

(d) Focus on Tertiary Prevention

Applying the health model of prevention, in the manner proposed in Chapter 3, to a mandatory reporting regime, it is clear that mandatory reporting models operate primarily at the level of tertiary prevention. While it could be argued that such provisions may have a deterrent role, supporting evidence for this proposition would be methodologically difficult to collect. As will be discussed below, rates of reporting are rising under the *Aged Care Act* provisions, although whether this is attributable to an increased incidence of abuse or increased awareness and compliance of the mandatory requirements is unclear. Mandatory reporting occurs after the fact. It is imperative that policy focus at the national level takes

[29]Australian and New Zealand Society for Geriatric Medicine, Submission No 1 to the Senate Community Affairs Committee, Parliament of Australia, *Inquiry into the Aged Care Act Bill (2007),* (21 February 2007).

account of elder abuse prevention strategies at all level of prevention and that a national strategy is broadened beyond the scope of the mandatory reporting requirements.

(e) Policy Implications for Abuse in Domestic Settings

A significant concern arises from the risk that with emphasis on mandatory reporting, impetus will be lost for the development of appropriate and effective policies and programmes at a national level to combat the occurrence of abuse and neglect of older persons in their homes. The direction of resources and attention to the limited circumstance of elder abuse occurring in residential care creates a real possibility that not only would primary prevention in these circumstances be overlooked, significant incidents of actual elder abuse (if not the majority) may be undetected or lack meaningful practical interventions and solutions. Such a categorisation can lead to the undesirable situation whereby the same act of physical, sexual, emotional abuse can have dramatically different implications for the victim and the perpetrator, simply on the basis of the place of residence of the victim of the abuse.

D. The American Experience - Adult Protective Services

The United States of America delivered early statutory recognition to the phenomenon of elder abuse in the *Older Americans Act of 1965.* This sets out:

> s (15) The term ‘‘elder abuse’’ means abuse of an older individual.
>
> s (16) The term ‘‘elder abuse, neglect, and exploitation’’ means abuse, neglect, and exploitation, of an older individual.
>
> s (17) The term ‘elder justice’ –
>
> (A) used with respect to older individuals, collectively, means efforts to prevent, detect, treat, intervene in, and respond to elder abuse, neglect, and exploitation and to protect older individuals with diminished capacity while maximizing their autonomy; and

(B) used with respect to an individual who is an older individual, means the recognition of the individual's rights, including the right to be free of abuse, neglect, and exploitation. [30]

In the decades since, multiple amendments to the *Older Americans Act* have given increasing recognition to the phenomenon of elder abuse. All States of America now have some form of Adult Protective Services (APS) legislation. Despite the presence of the federal legislation, the disparity amongst the various State instruments is reflective of the many key elements in which divergent definitions and responses have been adopted.

The problems commonly identified within the United States APS system include:

i) Lack of evaluation data

The drafting inconsistencies in the American legislative regimes ensure the analysis of statistical information arising from the services becomes a very difficult task. This has been problematic in the evaluation of the rates of reporting, types of abuse reported, the sources of reports and the quality of outcomes. In 2003, the National Association of Adult Protective Services Administrators reported frustration with 'the lack of good outcome data to evaluate programs and establish benchmarks as well as the need to track clients within the APS program'. The '2004 Survey of State and Adult Protective Services: Abuse of Adults 60 Years of Age and Older' prepared for the National Center on Elder Abuse' noted that only four of the responding fifty states and two territories provide any outcome data.[31] Furthermore, in 2011, the General Accounting Office reported to the United States Special Senate Committee on Aging that a lack of co-ordinated data collection had

[30] *Older Americans Act of 1965* 42 USC § 3001, Pub L No100-175, 101 Stat 926 (1987) (15)-(17).
[31] Pamela Teaster et al, *The 2004 Survey of State Adult Protective Services: Abuse of Adults 60 Years of Age and Older* (National Committee for the Prevention of Elder Abuse and the National Protective Services Association, Washington DC, 2006).

impeded an effective response to elder abuse at a national level and recommended the establishment of a national APS data collection system.[32]

ii) Underfunding and under-resourcing

Operational difficulties which have included insufficient funding, staff shortages and a lack of alternative placement options have plagued APS across the United States. Despite the long period of operation of the majority of the Adult Protection regimes in the United States, a 2003 survey of APS administrators indicated that 57 per cent of respondents identified inadequate funding and 43 per cent inadequate staffing as significant impediments to the operation of the adult protection services.[33] Partly in response to these concerns and in frustration over the complexity of the protection systems across the states, *the Elder Justice Act*[34] was enacted in 2010. This Act authorised the first federal funding for the state APS programmes. Other objectives of the *Elder Justice Act* include the development of elder abuse forensic centres, professional training in elder issues, the imposition of requirements for the immediate reporting of crimes in long-term care facilities to law enforcement agencies and civil penalties for a failure to comply. However, many of the aims of the *Elder Justice Act* remain aspirational goals in the absence of the necessary funding support. The Elder Justice Coalition, a national advocacy group that was instrumental in campaigning for the introduction of the Act, recently reported on the funding difficulties for the implementation of the *Elder Justice Act*:

[32] United States General Accounting Office, *Elder Justice: Stronger Federal Leadership Could Enhance National Response to Elder Abuse* (Report to the Chairman, Special Committee on Aging, US Senate, March 2011) 36.
[33] Joanne Otto and Joan Cass Bell, *Report on the Problems Facing State Adult Protective Service Programs and the Resources Needed to Resolve Them* (National Association of Adult Protective Services Administrators, 2003).
[34] *Elder Justice Act* 42 U.S.C §§ 1320b-25, 795, H.R. 3590.

> For the Elder Justice Act to fulfil its promise it must receive funding. After three years less than one percent of the funds authorized have been appropriated, yet the problems of elder abuse, neglect and exploitation continue to increase across our nation.[35]

As at the time of writing, a further Bill is before the United States House of Representatives entitled the *Elder Abuse Victims Act*.[36]

E. The United Kingdom – 'Safeguarding Adults'

As in Australia, the United Kingdom has not historically recognised the phenomenon of elder abuse within the law. The focus of the United Kingdom approach has been in the broader protection of 'vulnerable adults', in particular since the publication of the *No Secrets* guidance by the Department of Health in 2000.[37] The *No Secrets* guidance was developed in part as a response to the introduction of the *Human Rights Act 1998* (UK) and was aimed at facilitating multiagency strategies and ensuring 'a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response'.[38] The *No Secrets* guidance directly acknowledges that 'the circumstances in which harm and exploitation occur are known to be extremely diverse, as is the membership of the at-risk group.'[39] Hence, 'vulnerability' is at the core of the United Kingdom approach to adult protection and a vulnerable adult is defined as a person 18 years or over

[35] Bob Blancarto, Elder Justice Coalition, 'President's Budget Again Calls for Funding Elder Justice' (15 April 2013) http://www.elderjusticecoalition.com/docs/Message%20to%20EJC%204%2015%2013.pdf
[36] *Elder Abuse Victims Act H.R.861* (2013).
[37] Department of Health (United Kingdom), *No Secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults form Abuse* (2000). (the *'No Secrets'* guidance') The Guidance is issued under Section 7 of the *Local Authority Social Services Act 1970.*
[38] Ibid 6, 7.
[39] Ibid.

> who is or may be in need of community services by reason of mental or other disability, age or illness and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation.[40]

The developing policy environment, greater awareness of the issue of the abuse of older people and the introduction of the *Mental Capacity Act 2005* (England and Wales), the *Deprivation of Liberty Safeguards,* and the influence of the operation of the *Human Rights Act 1998* (UK), led to a review in 2005 of the *No Secrets* guidance,[41] and again in 2008 with a major consultation on the review by the Department of Health.[42] While a shift in emphasis from 'vulnerability' to 'safeguarding adults' has been evident since then in the policy and practice in the United Kingdom,[43] some concern continues to be raised about the operation of the adult safeguarding system. AgeUK identifies several areas of concern; uncertainty in definitions, in particular the definition of 'vulnerable adult' which is retained in safeguarding legislation; inconsistency in programmes across different areas; and underfunding and under-resourcing.[44]

In the *Draft Care and Support Bill (2012)* (the 'Draft Bill') a model for a single statutory framework for safeguarding adults was proposed. Clauses 34–38 of the Draft Bill dealt with safeguarding adults at risk of abuse or neglect. The Draft Bill proposed the creation of Safeguarding Adult Boards (SAB). Clause 34 (1) states:

> (1) Where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—
>
> (a) has needs for care and support (whether or not the authority is meeting

[40] Ibid 8-9.
[41] Association of Directors of Adult Social Services, *Safeguarding Adults: A National Framework of Standards for Good Practice and Outcomes in Adult Protection Work* (2005).
[42] Department of Health (UK), *Safeguarding Adults: A Consultation on the Review of the 'No Secrets' Guidance,* (2008).
[43] Scotland implemented the *Adult Support and Protection (Scotland) Act* in 2007.
[44] AgeUK, 'Safeguarding Older People from Abuse: Factsheet' (October 2012) http://www.ageuk.org.uk/Documents/EN

any of those needs),

(b) is experiencing, or is at risk of, abuse or neglect, and

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it,

it must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom. [45]

The subsequent Joint Parliamentary Committee which inquired into the Draft Bill, has recommended that:

> The responsibilities of local authorities to prevent the abuse and neglect of those at risk must be made explicit, while steps must be taken to ensure that any provider of care and support services—whether from the private or voluntary sector—is subject to the same legal obligations as the local authority itself, including the Human Rights Act 1998. We also recommend that where abuses have taken place there must be corporate criminal responsibility, with organisations and key individuals held to account.[46]

Of particular note, the Joint Committee also recommended that primary prevention of abuse should form an explicit part of the statutory responsibilities of the authorities.[47] However, this specific recommendation was not subsequently adopted in the revised Bill put to the Parliament in 2013. At the time of writing, the revised Draft Bill entitled the *Care Bill* [HL] 2013–14 is before the House of Lords for consideration.

The recent developments in the United Kingdom underline that a 'mainstreamed' approach to elder abuse prevention has been adopted. The notion of elder abuse is not the central tenet of the legislative developments in the United Kingdom, but rather an element of a

[45] Care and Support Bill (Draft) UK, (2012),
[46] Joint Committee on the Draft Care and Support Bill, *UK Parliament, Joint Committee on the Draft Care and Support Bill- Report: Summary* (19 March 2013) http://www.publications.parliament.uk/pa/jt201213/jtselect/jtcare/143/14302.htm
[47] Joint Committee on the Draft Care and Support Bill, *UK Parliament, Joint Committee on the Draft Care and Support Bill- Report* (19 March 2013) [150].

broader approach to adult protection. Elder abuse is not defined within the *Care Bill*. Mandatory reporting schemes such as those in the United States which impose widespread reporting obligations upon professionals and other individuals in relation to the abuse of older people have not been adopted. The development of adult protection measures in the United Kingdom has been influenced heavily by the concurrent shift in policy and practice triggered by significant human rights legislative developments in the United Kingdom and the *European Convention on Human Rights*.[48] While the focus of the *Care Bill* is upon the broader adult population, not specifically older people, the influence of the human rights framework is welcome and has tempered the intrusion of mandatory schemes upon the autonomy of older people.

F. Adult Protection and Mandatory Reporting - A Critical Evaluation

This section analyses the utility and impact of mandatory reporting schemes, beyond the limited residential sphere of operation of the Australian provisions of the *Aged Care Act 1997*. During the 1980s in the United States, coinciding with the time of the establishment of Adult Protective Services across the majority of States, there was considerable discussion on the appropriateness of mandatory reporting as a policy response to the phenomenon of elder abuse.[49]

In the Australian context, this debate was first given significant consideration during the 1990s. In particular, in a discussion paper prepared in 1997 for the Advisory Committee on

[48] *Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 222 (entered into force 3 September 1953) (European Convention on Human Rights)

[49] See generally, Ruthann, Macolini, 'Elder Abuse Policy: Considerations in Research and Legislation' (1995) 113 *Behavioural Sciences and the Law* 349.

the Abuse of Older People in Their Homes, Jan Mason provided a critical analysis of the literature in relation to mandatory reporting at that time and concluded:

> In terms of generating data for social policy development there is no support for mandatory reporting systems being any more effective than voluntary reporting systems of reporting abuse of older persons.[50]

The following discussion will focus upon the impact of statutory regimes on reporting rates, the impact of resourcing and support systems for mandatory regimes and the implications for the victims of abuse.

1. Rates of Reporting and Investigation

As noted earlier, the absence of accurate and comprehensive statistical data on the incidence and prevalence of elder abuse has contributed to a long-standing historical neglect of the issue of elder abuse. There has been a consequent lag in the establishment of primary and secondary prevention programmes to address the issue. One of the most prevalent arguments in support of the introduction of mandatory reporting obligations which has been raised both overseas and within Australia, is that the statutory imposition of an obligation to report abuse would translate to higher statistical rates of reporting and hence to a greater understanding of the incidence of abuse among older people.

Analysis of the impact of mandatory provisions on reporting rates of elder abuse following its introduction in America was complicated by non-uniform criteria within the reporting procedures. The most significant impact came from the inclusion of self-neglect within the definition of elder abuse in a number of states. There were conflicting outcomes measured on the numbers of reports of abuse following the introduction of mandatory procedures in the United States. Adult Protective Services (APS) regimes in the United States, in all

[50] Mason, above n 4, 23.

states, cover older people living in community settings and in the majority of states, people living in residential settings also.[51]

A comprehensive study conducted for the National Center on Elder Abuse in 2000 surveyed and received responses from all 50 states within America and concluded that the majority of reports received by APS were initiated by family members, friends and neighbours. These people in the majority of regimes are not mandated to report abuse.[52] Those who are most commonly mandated to report abuse include nurses, physicians, health professional, law enforcement officers and social workers.[53] It was observed in a statement before the United State Select Committee on Ageing that 'reporting laws – whether mandatory or voluntary – [are] much less effective than other factors in maximizing the numbers of elder abuse cases identified, prevented and treated'.[54] Such factors included high levels of public and professional awareness, interagency co-ordination, in-home and respite care services.

Gerald Jogerst and colleagues have advocated for an emphasis on public education in their 2003 study which evaluated the impact of APS legislation across the states and territories of America upon the reporting, investigation and substantiation rates of elder abuse.[55] They found that higher rates of reporting of abuse correlates with states which required public education regarding elder abuse.[56]

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[51] Pamela Teaster, *A Response to the Abuse of Vulnerable Adults: The 2000 Survey of State Adult Protective Services* (National Center on Elder Abuse, 2002) 39.
[52] Ibid 17.
[53] Ibid 22.
[54] United States General Accounting Office, *Effectiveness of Reporting Laws and other Factors in Identifying, Preventing and Treating Elder Abuse* (Testimony of G McDonald, before the United States Subcommittee on Human Services Select Committee on Aging, House of Representatives, Washington DC, 1991)
[55] Gerald Jogerst et al, 'Domestic Elder Abuse and the Law' (2003) 93 (12) *American Journal of Public Health* 2131.
[56] Ibid 2135.

In the findings of the study conducted by Jogerst and colleagues, it was noted that the majority of states that required mandatory reporting had higher *investigation* rates.[57] Furthermore, states which included provisions for penalties for failure to report had significantly higher investigation rates.[58] Again direct comparisons with Australia are problematic — where mandatory provisions do not cover domestic settings of abuse. However, in reporting periods since the introduction of mandatory reporting obligations, the 'Annual report on the Operation of the Aged Care Act' has provided an insight into the numbers of incidents reported under the s 63–1AA of the *Aged Care Act 1997* (Cth).

Table One: Annual Reportable Assaults made in compliance with Section 631AA of the *Aged Care Act 1997* (Cth)

This Table is constructed from Department of Health and Ageing, 'Report on the Operation of the Aged Care Act 1997', Annual Reports 2007-2012.[59]

Reporting period	**2007-2008**	**2008-2009**	**2009-2010**	**2010-2011**	**2011-2012**
Total alleged reportable assaults	925	1411	1488	1815	1971
Unreasonable use of force	725	1121	1232	1499	1627
Alleged unlawful sexual conduct	200	272	239	284	309
Both	0	18	17	32	35

Table One indicates that reportable assaults under s 631AA have increased annually since the introduction of the accountability provisions for mandatory reporting in 2007. The

[57] Ibid 2134
[58] Ibid 2135.
[59] Australian Government, Department of Health and Ageing, 'Report on the Operation of the Aged Care Act 1997', Annual Reports 2007-2012.[59]

Department responds to the allegations by referring the matter to police. No data is publicly available in respect to the outcome of investigations into cases within the Annual Reports on the operation of the mandatory reporting scheme.

2. Resourcing Issues and Policy Direction

Support for mandatory reporting provisions as a component of Adult Protective Legislation is drawn from the proposition that increased public awareness, increased investigative powers of agencies and impetus for further policy responses will result from their incorporation into legal responses to elder abuse. However, the most desirable aim of primary prevention may be compromised by an overreliance upon tertiary prevention strategies. Valuable resources may be diverted from such measures in the event of an over-emphasis on post-abuse strategies. Jan Mason notes that reliance upon post-abuse interventions lacks 'preventative results as a consequence of the fact that protective investigation is by its very nature, a reactive rather than proactive approach, utilising resources on investigation rather than on prevention through service provision.'[60]

Increased resource attention to the fulfilment of the rights contained in the *Charter of Residents' Rights and Responsibilities* contained within the *Aged Care Act*, and increased attention to accreditation standards and other aspects of the quality of service provision must be the focus of elder abuse strategies within the aged care sector. To this end, a national policy on elder abuse is essential and reforms that incorporate elements such as dementia support and supported decision making must be of the highest priority.

[60] Mason above n 4, 23.

3. Human Rights Impacts of the Mandatory Reporting of Elder Abuse

Reporting requirement that mandate a formal response regardless of the consent of the victim of the abuse fundamentally contradict the principles of the *Vienna International Plan of Action on Ageing*,[61] the *United Nations Principles on the Rights Of Older Persons*[62] and the *Convention on the Rights of Persons with Disabilities.*[63] Common to these documents and the other major international human rights treaties to which Australia is a signatory, is an obligation to respect the independence, participation, care, autonomy and dignity of older persons. The imposition of mandatory reporting regardless of the wishes of older persons, and irrespective of their decision making capacity, is irreconcilable with these principles. In particular, the *United Nations Principles for Older Persons* state:

> 12. Older persons should have access to social and legal services to enhance their autonomy protection and care.
>
> 13. Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
>
> 14. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, *including full respect for their dignity, beliefs, needs, privacy and for the right to make decisions about their care and the quality of their lives*.[64] (Emphasis added)

Several submissions and evidence to the Senate Standing Committee on Community Affairs at the time of the inquiry into the proposed mandatory reporting amendments to the *Aged Care Act* raised strong objections of the lack of a right of victim to refuse to consent

[61] *Report of the World Assembly on Ageing, Vienna (1982), Vienna International Plan of Action on Ageing,* GA Res 37/51, UN Doc A/CONF.113/31 (1982) [17].
[62] *United Nations Principles for Older Persons*, GA Res 49/91, UN Doc A/Res/46/111 (1991).
[63] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).
[64] *United Nations Principles for Older Persons*, GA Res 49/91, UN Doc A/Res/46/111 (1991).

to reporting of abuse. Aged and Community Services Australia submitted that older persons rights would be violated by the amendments 'simply because they are residents in residential care.'[65] Similarly, the Australian and New Zealand Society for Geriatric Medicine submitted that '[y]oung rape victims have the option of treatment without police intervention. Cognitively intact elderly residents should be accorded the same right.'[66] The Senate Committee responded to the submissions by emphasising that an individual had the ability to offer varying degrees of co-operation to the investigating officers, and could thereby exercise autonomy over the proceedings.[67]

The issue of the mandatory reporting of violence and abuse has been given policy consideration in the context of domestic and family violence. A 2004 report by the Domestic Violence and Incest Resource Centre noted that 'pursuing arrest and prosecution contrary to the victim's wishes can exacerbate the danger a victim is exposed to, compromise their social empowerment and frustrate their processes of recovery.'[68] Furthermore, in 2005, the Report of the Statewide Steering Committee to Reduce Family Violence commented that 'women who fear reporting violence are unlikely to enter a system where mandatory justice responses are the only option.'[69]

The Northern Territory has incorporated domestic and family violence mandatory reporting requirements within the *Domestic and Family Violence Act* (NT).[70] Section 124A

[65] Aged and Community Services Australia, Evidence to the Senate Standing Committee on Community Affairs, Parliament of Australia, (Report of the Inquiry into *the Aged Care Amendment (Security and Protection) Bill 2007*, March 2007), [1.46].
[66] Australian and New Zealand Society for Geriatric Medicine, above n 29.
[67] Standing Committee on Community Affairs (Australian Senate), Aged Care Amendment (Security and Protection) Bill 2007: Report [1.48].
[68] Domestic Violence Resource Centre, *Developing Integrated Responses to Family Violence in Victoria – Issues and Directions* (2004) 12.
[69] Department of Victorian Communities *Reforming the Family Violence System in Victoria: Report of the Statewide Steering Committee to Reduce Family Violence* (2005), 8.
[70] As *Amended by the Domestic and Family Violence Amendment Act 2009 (No 2 0f 2009)* (NT).

states that an 'adult' commits an offence if he or she fails to report a belief held on reasonable grounds that;

(i) another person has caused, or is likely to cause, harm to someone else *(the victim)* with whom the other person is in a domestic relationship;
(ii) the life or safety of another person (also the *victim*) is under serious or imminent threat because domestic violence has been, is being or is about to be committed

The Act defines harm as 'physical' and 'serious' harm. The most significant feature of the Act is that it mandates reporting by 'adults', not a prescribed group of adults such as health professionals, residential or other care workers. Furthermore, the Act confines the offence to matters of physical and serious concern. The Australian Domestic and Family Violence Clearinghouse (ADFVC) strongly opposed the imposition of mandatory reporting obligations within the Northern Territory legislation. As an alternative, the ADFVC advocated for a community response model, noting:

> Improved safety should be a key outcome for victims resulting from intervention. Not all victims of violence wish to or necessarily benefit from entering the criminal justice system. However, they do deserve to be informed of their rights, to have access to support and assistance to make informed choices. Extension of the community model approach would greatly improve identification of victims and disclosure rates, improve support and assistance for victims, with a view informing and supporting victims sufficiently to make informed choices, including pursuing a criminal justice response.[71]

The Australian Law Reform Commission (ALRC) considered the issue of the mandatory reporting of family violence in the 2010 report, *Family Violence – A National Legal Response.*[72] The ALRC also concluded with concerns about the mandatory reporting of family violence committed against adults:

[71] Australian Domestic and Family Violence Clearinghouse, *Response to Northern Territory Proposal for Mandatory Reporting of Domestic Violence by Health Workers* (February 2008) 10.
[72] Australian Law Reform Commission, *Family Violence – A National Legal Response, Report No 114* (2010), 359.

> in particular, the potential for such laws to isolate victims of family violence by acting as a disincentive for victims to seek assistance, guidance, and medical care. Such laws might disempower victims, and take from them some of the tools which, in their judgment, they are best able to use to combat or escape from violence.[73]

Similar concerns can be raised in the context of the mandatory reporting requirements in relation to residential care in that older people who face a major lifetime decision to reside in institutional care may be reluctant to enter an environment where they perceive their decision making rights may be compromised.

The cultural dimensions of elder abuse have particular implications in the context of discussions about mandatory reporting. The implications for older people within culturally and linguistically diverse communities and among Aboriginal and Torres Strait Islander communities must be taken into account. The impact of a mandatory reporting scheme which fails to take account of a person's wishes may include dramatic consequences for an individual including isolation from their community, greater fear and shame. Strategies which improve access to linguistically appropriate services and information and access to culturally sensitive intervention measures may help overcome the consequences of abuse and improve primary prevention.

G. Conclusion

Elder abuse and neglect are societal problems that demand a multifaceted response. The imposition of mandatory reporting obligations are contrary to the policy directions that have dominated international ageing policy and discourse this century and should not form a part of that response. An elder abuse legislative and policy direction which dictates a

[73] Ibid 365.

course of action without regard to the wishes or perspectives of an older person with no impairment to their decision making capacity, does not respect the human rights principles that are reiterated in all the major international binding and non-binding documents relating to older persons, and that are discussed in depth in this thesis.

Adult protective regimes that incorporate mandatory reporting of abuse and neglect are undoubtedly founded on the presumption that they will improve outcomes for victims of abuse. However, this presumption must be reviewed and tested. As the major policy response to the societal issue of elder abuse and neglect, the emphasis on tertiary prevention through post-abuse mandatory reporting is flawed and discriminatory. The violation of the decision making power of competent individuals and the potential loss of trust and confidence in those carers and other professionals that are mandated to report abuse are significant concerns. Furthermore, fear of the consequences of a mandatory reporting may result in a reluctance to convey experiences to staff and care givers, and exacerbate social isolation. A strategy which focuses attention on mandatory reporting within residential care has the potential to divert attention from the broader issues of violence against all older people and a greater acknowledgement of the need for comprehensive primary prevention strategies.

Future directions in elder abuse policy in Australia at a national level must be compliant with legal obligations at the international level and responsive to the autonomy of older people. Nuanced responses are necessary. These can be achieved through a detailed consideration of the needs and concerns of older Australians within the legislative framework. A consideration of the expansion of adult protective regimes in the future, must be viewed through this lens and mandatory reporting against the express wishes of older people should not form a component of these regimes at either a federal or state level.

Chapter 10

FUTURE DIRECTIONS AND CONCLUSIONS

FOR ELDER ABUSE PREVENTION

For many people who, over the last few decades, have directed professional or personal attention towards the development of substantive content to rights and freedoms for older people, the pace of change has seemed at times to be painstakingly slow. Since the earliest global recognition of elder issues in seminal, but non-binding documents such as the *Vienna International Plan of Action on Ageing*,[1] the *United Nations Principles on the Rights of Older People*,[2] and the *Madrid International Plan of Action*,[3] a genuine discussion on a binding international document has at last gained momentum. The entry into force of the *Convention on the Rights of Persons with Disabilities*[4] has given further impetus to the campaign for a Convention for older people.

[1] *Report of the World Assembly on Ageing, Vienna (1982), Vienna International Plan of Action on Ageing*, GA Res 37/51, UN Doc A/CONF.113/31 (1982) [17].
[2] *United Nations Principles for Older Persons*, GA Res 49/91, UN Doc A/Res/46/111 (1991).
[3] United Nations Second World Assembly on Ageing, *Political Declaration and Madrid International Plan of Action 2002*, UN Doc A/CONF.197/9 (2002).
[4] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).

This chapter explores future directions and draws conclusions based upon the key elements of international and domestic legal strategies which should be directed towards comprehensively addressing the abuse and neglect of older people. The key themes stated in the introductory chapter of this thesis are reiterated in the context of the specific measures advocated to achieve this goal. A human rights framework, married with cogent enunciation of the health concerns, elder abuse preventive interventions and the social, economic and cultural perspectives of older people, is critical to this process.

This chapter draws together the arguments which have been highlighted in the various contexts of the earlier chapters of this thesis in support of an international Convention on the rights of older people. The discussion focuses on the mechanisms by which such a document could crystallise binding obligations that would have a meaningful impact upon elder abuse prevention in the context of the cultural, economic and social diversity of the global communities of older people.

This chapter analyses the implications of an international Convention for Australia at a domestic level and notes that national action and progress on broad ageing issues would be given stronger moral, social and legal impetus by such a Convention. The discussion concludes that a need exists, the momentum is present, and the opportunity is upon Australian society and legislators, for the introduction of specific protections against the abuse and neglect of older Australians. This chapter proposes that the mainstreaming of ageing issues and strategies to address elder abuse within broader Australian legislation is essential. However, it is also necessary to implement new legal responses to the phenomenon of elder abuse that address the specific concerns of older members of society. It is proposed, for example, that in the states and territories, an ‘Older Persons Act’ should be enacted to build upon the substantial protections offered by guardianship laws. Such an Act would help close the normative gaps that exist in the recognition and prevention of the

rights of all older people regardless of their physical and cognitive status, their place of residence, their gender and any other basis upon which they may experience multiple discrimination and increased vulnerability to elder abuse and neglect.

A. The Progress of Older Persons' Rights within International Law

Mainstreaming ageing within the context of a broader human rights dialogue is essential. Forming a central component of the *Madrid International Plan of Action on Ageing*,[5] the drive to mainstream ageing issues into all corners of social, economic, health and human rights activity over the last decade has been strong.[6] Mainstreaming ageing issues undoubtedly assists in raising professional and community awareness of discrimination faced by older people. Mainstreaming can direct the attention of other treaty bodies to the specific challenges facing older people, for example the circumstances of older women subjected to violence and abuse.

Mainstreaming alone, however, does not provide a sufficient impetus for the development of specific and comprehensive solutions to many of the human rights violations that face older people as a group across the globe. A legally binding document directed at the protection and promotion of the rights of older persons, and which draws particular attention to the specific objective of eliminating abuse and neglect is required.

The *Report of the United Nations High Commissioner for Human Rights* in April 2012 called for 'dedicated measures to strengthen the international protection regime for older

[5] United Nations Second World Assembly on Ageing, *Political Declaration and Madrid International Plan of Action 2002*, UN Doc A/CONF.197/9 (2002).
[6] United Nations Department of Economic and Social Affairs, *Mainstreaming Ageing into National Policy Frameworks – an Introduction* (2003) http://www.un.org/esa/socdev/ageing/documents/workshops/Vienna/issues.pdf

persons,'[7] including a new dedicated international instrument. A resolution of the United Nations General Assembly was adopted on 13 February 2013. Entitled *Towards a Comprehensive International Legal Instrument to Promote and Protect the Rights and Dignity of Older Persons*,[8] this resolution affirmed that commitment through mandating the United Nations Open-ended Working Group on Ageing to

> consider proposals for an international legal instrument to promote and protect the rights and dignity of older persons, based on the holistic approach in the work carried out in the fields of social development, human rights and non-discrimination, as well as gender equality and the empowerment of women.[9]

This represents an exciting opportunity to formalise a process for the consideration of an international instrument.

The Office for the High Commissioner for Human Rights concluded recently in the Analytical Outcome Paper, *Normative Standards in International Human Rights Law in Relation to Older People*, that there is a

> demonstrable inadequacy of protection arising from normative gaps, as well as fragmentation and a lack of coherence and specificity of standards as they relate to the experience of older persons.[10]

The commitment of regional bodies to the development of binding legal instruments for the protection of the rights of older persons cannot be undervalued. In particular, the activities of 'Working Group on Protecting the Human Rights of Older People' within the Organization of American States and the 'Working Group on the Rights of Older Persons'

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[7] United Nations Economic and Social Council, *Report of the United Nations High Commissioner for Human Rights*, UN Doc E/2012/51 (July 2012) [66]
[8] *Towards a Comprehensive International Legal Instrument to Promote and Protect the Rights and Dignity of Older Persons*, GA Res 67/139, UN GAOR, 67th sess, 60th plen mtg, UN Doc A/RES/67/139 (2013)
[9] Ibid [1].
[10] Office of the High Commissioner for Human Rights, *Normative Standards in International Human Rights Law in Relation to Older Persons: Analytical Outcome Paper* (August 2012) 3.

within the African Commission on Human Rights, have both been instrumental in the drafting of regional documents on the rights of older people.[11]

B. Global Implications of an International Convention on Elder Abuse Prevention

An international Convention relating to the rights of older persons would allow human rights norms in relation to older people to be brought into line with the acknowledgement of norms in the context of other vulnerable groups such as children, women and persons with disabilities. This would be achieved through the enunciation of norms that have relevance to the lives and experiences of older people and the creation of increased certainty of those rights.

Article 16 of the *Convention on the Rights of Persons with Disabilities* (CRPD) sets out a prohibition on violence, abuse and exploitation of persons with disabilities.[12] However, it is argued that this provision is insufficient to close the gap that exists in the implementation in respect of older people for two significant reasons.

- First, not all older people who are subject to abuse, violence and exploitation have a disability and therefore the specific protection afforded by Article 16 will not have application to all older people.
- Second, the types of abuse that are of concern to particular groups of older people require specific acknowledgement, otherwise there is a significant likelihood that

[11] Committee on Juridical and Political Affairs, Organization of American States, *Preliminary Draft Inter-American Convention on Protection of the Human Rights of Older Persons* (Working Group on Protecting the Human Rights of Older Persons) OAU/Ser.G, CAJP/GT/DHPM (30 April 2012).
[12] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) art 16.

such abuse will be overlooked in policy and practice. For example, the CRPD does not direct attention to older women who are widowed and are subjected to violence, or older women who are accused of witchcraft and are targeted with abuse by both individuals and groups of perpetrators.

The *Draft Inter-American Convention on the Protection of the Human Rights of Older People* addresses the second of these points in Chapter V 'Rights of Specific Groups' which directs attention to the rights of older women (Article 27), the rights of indigenous persons (Article 28), and the rights of older people in at-risk situations and humanitarian emergencies (Article 31).[13] Article 27 a.1 specifically attends to States' obligations to actively 'promote the abolition of the rites of widowhood, and harmful traditional practices that may adversely affect the safety of older women.'

This thesis has highlighted examples of the mechanisms by which rights can be harnessed and promoted to ensure active and healthy ageing of older persons. An international Convention on the rights of older people can address elder abuse and neglect through its capacity to:

i) influence 'positive rights' which enhance the opportunity of older people to enjoy active and healthy ageing; and

ii) fulfil 'negative' rights, in order for example, for older people to be free from unlawful restrictions on their liberty, to be free from coercive medical treatments and those administered without informed consent.

This does not amount to a medical model dominating the response to elder abuse, nor any of the other challenges that face older people in their enjoyment of active ageing. Action on health, security and participation are all viewed within a human rights paradigm.

[13] Committee on Juridical and Political Affairs, above n 11.

Recognising that elder abuse is associated with risk factors, primary prevention is targeted at reducing exposure to those risks.

Risk factors in relation to elder abuse are those that have an impact upon actual health status (for example, risk factors for dementia) and those that have an impact upon the determinants of a healthy and active life. Chapter 6 outlined the mechanisms of 'availability', 'accessibility', 'acceptability' and 'quality' of the right to the highest attainable standard of physical and mental health. A Convention which outlines States' responsibilities to older people in respect of the specific determinants of health would be a powerful legal tool for the elimination of risk and the promotion of primary prevention.

A parallel analysis can be applied to other rights that have special relevance to the lives of older people and their risk of experiencing elder abuse. For example, tools such as 'impact assessments' and 'indicators', when applied to the analysis of older people's rights to housing, social security and employment, have the potential to influence primary preventive strategies in elder abuse. Such analysis is essential in the drafting of an international response to elder abuse. The content of a Convention must be directed to the underlying social, economic and cultural determinants of health via measures targeting the reduction of poverty through access to social security, housing and the benefits of development for older persons.

A Convention for older persons that is underscored by principles of availability, accessibility, acceptability and quality, also supports the secondary prevention of elder abuse and neglect. Presently, data collection and availability in relation to older persons is fragmented and scarce. The imposition of specific reporting obligations in respect of older people would facilitate more effective collation of data disaggregated by age. Both through specific reporting in relation to the Convention, and through the Universal Periodic Review

process, valuable data would assist in the development and implementation of secondary prevention measures. Utilising tools including indicators and impact assessments to disaggregate data is not simply of administrative benefit in fulfilling reporting obligations: it underpins a government's ability to respond with appropriate, comprehensive, and targeted practical intervention.

Elizabeth Broderick, the current Australian Sex Discrimination Commissioner, and then the Australian Commissioner Responsible for Age Discrimination, noted in 2010 in her support for the development of a Convention for older persons, that 'there is a tendency of governments to track their progress against their express international obligations, such as those contained in international instruments and conventions that they have specifically signed and ratified – instruments where the rights of older people are largely invisible.'[14]

At tertiary prevention level, an international Convention would provide structures for accountability and avenues for complaints of violations to be heard. The two main mechanisms to achieve this are through:

i) the inclusion of provisions allowing individual communications in relation to alleged violation of the treaty; and

ii) the imposition of periodic reporting requirements upon States Parties to demonstrate compliance with obligations under the Convention.

The findings of the European Court of Human Rights in the *Bournewood* case discussed in Chapter 7 demonstrate the significant potential impact afforded by a right of individual complaint of a violation of a human rights instrument. Chapter V of the *Draft Inter-American Convention on the Rights of Older Persons* provides for both of the above accountability mechanisms. Article 37 requires the presentation of regular reports, while

[14] Elizabeth Broderick, 'Is it Time for A Convention on the Rights of Older People' (Speech delivered to the International Federation of Ageing, Melbourne, 6 May 2010).

Article 38 provides for a system of individual petitions to the Inter-American Commission on Human Rights.[15]

The Australian Human Rights Commission noted in its *Response to the Public Consultation on the Rights of Older Persons* that was conducted by the Office of the High Commissioner for Human Rights, that:

> At present, Australia has no specific international obligation to report on human rights issues affecting older people. While Universal Periodic Review provides an opportunity for Australia to report on the enjoyment of rights by older people, greater attention is placed on those groups whose rights are enunciated in specific conventions.[16]

This view was reiterated by the United Nations High Commissioner for Human Rights in the report to the Economic and Social Council in 2012.[17] The first round of the Universal Periodic Review required all United Nations Member States to have their human right records reviewed by a panel of 47 members of the Human Rights Council over a four year period. The Commissioner noted that there was 'scarce attention' directed to older people in the initial round of reports by Member States,[18] although the occasional recommendation relating to older persons 'hinted at matters requiring in-depth attention'.[19] These recommendations included the need to provide statistical data on the extrajudicial killings of older women and murder of older women following accusations of witchcraft in Tanzania,[20] and the need to adopt measures to protect older asylum seekers in Belgium.[21] The second and subsequent rounds of the Universal Periodic Review are directed towards

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[15] Committee on Juridical and Political Affairs, above n 11, arts 37, 38.
[16] Australian Human Rights Commission, *Response to the Public Consultation on the Human Rights of Older Persons* (Submission to the Office of the High Commissioner for Human Rights, 15 March 2013), 3.
[17] Economic and Social Council, *Report of the United Nations High Commissioner for Human Rights* UN Doc E/2012/51 (20 April 2012) [16].
[18] Ibid.
[19] Ibid.
[20] Human Rights Council, *Report of the Working Group on the Universal Periodic Review: United Republic of Tanzania*, UN Doc A/HRC/19/4 (8 December 2011) [85.42].
[21] Human Rights Council, *Report of the Working Group on the Universal Periodic Review: Belgium*, UN Doc A/HRC/18/3 (11 July 2011) [100.51].

the ‘implementation of the accepted recommendations and the developments of the human rights situation in the State under review’ and are being undertaken in the period 2011–16.[22]

Difficulties in defining ‘age’ and ‘older persons’ do not provide a sustainable argument against the creation of a Convention. Older people, both within and between cultural groups and nations, share many experiences. Regrettably, in many instances those experiences contribute to the discrimination, violence, abuse, isolation and neglect that form a threat to their healthy and active ageing. Elder abuse must be given specific recognition within the Convention, taking account of the growing international consensus on the nature and types of violence perpetrated against older people. Definitions must also be illustrative of the circumstances in which older people may be at increased risk of abuse, such as the forms of abuse committed through the use of unlawful restrictive practices in violation of a person’s liberty. Elaboration on the content of all rights that influence health, poverty and social inclusion will assist in the elimination of elder abuse.

C. Implications for Australia of an International Convention on the Rights of Older People

At a regional level, there is no Asia-Pacific binding legal document which imposes obligations upon Australia to specifically address the rights of older people. This is despite that fact that the Asia-Pacific region accounts for 59 per cent of the world’s population of older persons, and by 2050, will be comprised of 1.25 billion older persons.[23]

[22] Office for the High Commissioner for Human Rights, ‘Universal Periodic Review’, http://www.ohchr.org/EN/HRBodies/UPR/Pages/UPRMain.aspx
[23] Economic and Social Council, *Report of the United Nations High Commissioner for Human Rights,* UN Doc E/2012/51 (July 2012) [2].

Australia's national response to elder abuse and neglect has been hindered by the lack of a human rights framework — either within the context of the Constitution, or as a national 'Human Rights Act'. Furthermore, many of the matters arising in relation to elder abuse lie within the legislative competence of States and Territories.

The creation of a Convention directed specifically to the rights and responsibilities of older people and its subsequent ratification by Australia would provide the momentum and international legal commitment and obligations, to set a national agenda for elder abuse awareness and prevention in Australia. The Australian Human Rights Commission (AHRC) supports the development of an international Convention on the rights of older people. In a submission to the Office of the United Nations High Commissioner for Human Rights in regard to its public consultation on the rights of older persons, the AHRC acknowledges that:

> Despite the extensiveness of current protection, Australian laws and policies have developed predominantly in response to particular social problems or policy goals rather than a coherent human rights agenda. This approach means that while certain rights and issues of older people are enlarged and supported, other equally important rights are undervalued and unprotected.[24]

Under Australia's federal system of government, legislative power is vested in relation to various matters between the Commonwealth and State Parliaments. It is within this context that the development of international obligations in respect to the rights of older persons is of particular significance. The power to legislate in relation to a significant majority of matters of relevance to older persons resides with the States and Territories. The federal

[24] Australian Human Rights Commission, 'Response to the Public Consultation on the Human Rights of Older Persons', Australian Human Rights Commission Submission to the Office of the High Commissioner for Human Rights (2013) [4].

Parliament has the power under the Australian Constitution to legislate in the federal Parliament in matters relating to age via Section 51:

> The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to:
>
> ….
>
> (xxiii) invalid and old-age pensions;
>
> (xxiiiA) the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances; [25]

Hence, for example, the Commonwealth government administers the funding and regulation of Aged Care Services provided for under the *Aged Care Act 1997* (Cth).

The gradual expansion of Commonwealth involvement in the funding and delivery of home-based aged care services has given some scope to intervene in the aged care arena. However, the limited jurisdiction of the Commonwealth in age-related matters underscores the lack of federal legislative and policy development on matters such as elder abuse. It also highlights the importance of an international document within the Australian context. Ratification by Australia of a Convention on the rights of older persons is within the legislative competence of the federal Parliament in relation to 'external affairs' under section 51 (xxix). It is then necessary for federal legislation to be enacted to implement the law in order to create legally binding domestic obligations which are appropriate and adapted to the implementation of the obligations created under the international

[25] *Commonwealth of Australia Constitution Act 1900* (Imp) 63&64 Vict, c 12, s 9.

Convention.[26] Australian national responses to elder abuse needs a forum beyond the *Age Discrimination Act 2004* (Cth) and the *Aged Care Act 1997* (Cth).

D. Future Directions for Elder Abuse Prevention in the States and Territories

Momentum towards the development of an international Convention for older people is welcome and exciting. However, the process is a protracted one. Australian State legislative authorities need not wait for international developments, in order to show action and leadership in the development of comprehensive legislation to address the discrimination faced by older members of society.

Taking Victoria as an example of state and territory jurisdiction, significant policy and practical development in relation to the prevention of abuse of adults has been undertaken.[27] To date, the majority of this activity has taken place in relation to the guardianship system that attends to the rights of people with cognitive impairment. Major examples of such include the review of the Guardianship legislation by the Victorian Law Reform Commission, and the activities of the Office of the Public Advocate (OPA) directing detailed attention to the development of a structured interagency response system to address violence against adults with a cognitive disability or mental illness. Precipitated by the introduction of the *Charter of Human Rights and Responsibilities Act 2006* (Cth)[28] and the *International Convention on the Rights of Persons with Disabilities*[29], the developments in relation to supported decision making have tangible consequences for

[26] *Victoria v Commonwealth* (1996) 138 ALR 129.
[27] See Chapter 3 for discussion of Victorian policy and practical response to elder abuse.
[28] *Charter of Human Rights and Responsibilities Act 2006* (Vic)
[29] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).

confronting the issues older people face, empowering them to improve the quality of their lives. These systematic responses by the OPA and through proposed Guardianship law reform will be invaluable for implementing primary preventive strategies and in the construction of secondary response systems when abuse of vulnerable adults has occurred. For example, the OPA's *Interagency Guideline for Addressing Violence, Neglect and Abuse* provides direction for organisations providing care to adults who may be at risk of violence due to cognitive impairment or mental illness.[30]

However, an overwhelming reliance upon the guardianship system as a source of legal responses to elder abuse, would raise the risk that older people who do not have cognitive impairment and/or who may not otherwise have had contact with Disability Services, Aged Care Services or other care providers, would be overlooked despite being at risk of experiencing abuse, neglect or exploitation due to their particular circumstances. Cognitive impairment is an important factor in increasing a person's risk of experiencing abuse, but it is not definitive of that risk. As has been emphasised throughout this thesis, discrimination experienced by older people on many fronts contributes to the risk of abuse, neglect and exploitation.

Motivated by many of the same concerns that provide the impetus for a Convention on older people at an international level, the introduction of legislation in the form of an 'Older Persons Act' that specifically addresses the needs of all its older citizens, deserves formal consideration in Victoria and other Australian jurisdictions. Notwithstanding the complexities generated by the federal and state arrangements for the delivery of the range of services that have particular relevance to older people, such legislation could

[30] Office Public Advocate (Vic), *Interagency Guideline for Addressing Violence, Neglect and Abuse (IGUANA)* (2013), see also *Interagency Guideline for Addressing Violence, Neglect and Abuse (IGUANA): Background and Discussion Paper* (May 2013).

complement the protections and processes offered by guardianship laws (and in Victoria, those proposed in the major reform recommendations) and build upon the recognition of the specific challenges facing all older Australians.

1. An Older Persons Act

In order to achieve an overall aim of eliminating the discrimination and stigma that contribute to the abuse and neglect experienced by many older people, the objectives of an 'Older Persons Act' should be to:

i. Incorporate a Charter of Rights that acknowledges and honours the human rights of *older people as a group with special interests*;
ii. Close the normative gaps that exist in the recognition of the rights of older people;
iii. Provide a definition of elder abuse that reflects international consensus on the types and nature of abuse, elaborated upon by descriptions of the types of behaviours that constitute abuse, including the types of acts and omissions that constitute neglect;
iv. Incorporate prohibitions on abuse regardless of the setting in which they occur. That is, the Act should encompass elder abuse regardless of whether it occurs in domestic or institutional/residential settings
v. Develop systems and structures to address the primary, secondary and tertiary prevention of elder abuse and neglect;
vi. Create a comprehensive response to elder abuse prevention through the development of a multidisciplinary and multifaceted range of strategies;
vii. Draw attention at a community and professional level to the nature of elder abuse;

viii. Promote mechanisms for data collection, which will aid research into the development of future responses to elder abuse;

ix. Provide for formal education programs on elder abuse for professionals involved in the care and support of older persons; and

x. Be complementary to the existing legislation, in particular guardianship legislation, in the principles promoting the rights of those older people with impaired decision making capacity.

The inclusion of a Charter of Rights in such an Act and why a scheme for adult protection should not be included in the proposed Act are discussed in the next two sections.

(a) A Charter of Rights

The hurdles that stand in the way of the inclusion of a Charter of Rights in an Older Persons Act that encompasses a range of rights based on the *International Covenant on Civil and Political Rights*[31] and the *International Covenant of Economic, Social and Cultural Rights*,[32] are not underestimated.

In Victoria, for example, the *Charter of Human Rights and Responsibilities (2006) Act* contains some, but not all, of the rights embodied in the *International Covenant on Civil and Political Rights*. Under section 44 of the *Charter*, the Parliament was obliged to review whether additional rights such as economic, social and cultural rights should be incorporated into the *Charter*, four years following the commencement of operation. Multiple submissions supporting the inclusion of such rights placed particular emphasis on the right to health (Article 12 *International Covenant on Economic, Social and Cultural Rights*), the right to education (Article 13 ICESCR) and the right to an adequate standard

[31] *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976).
[32] *International Covenant on Economic, Social and Cultural Rights*, opened for signature 19 December 1966, 993 UNTS 3 (entered into force 3 January 1976).

of living (Article 11 ICESCR).[33] However, the review conducted by the Scrutiny of Acts and Regulations Committee (SARC) in 2011, recommended against the inclusion of economic, social and cultural rights in the *Charter*:

> [E]conomic and social rights should not be added to the Charter because this would involve courts commenting upon the appropriateness of government resource allocations. What is of concern is that courts will be opining about the Parliament's allocation of resources in areas where the Parliament has made a deliberate choice to allocate those resources as a result of balancing competing socio-economic policy goals.[34]

Notwithstanding these developments, it is contended that in the context of an Older Persons Act, economic, social and cultural rights must be given recognition in order to give meaningful content to the rights which influence older people's lives. Indeed the SARC acknowledged that submissions pointed to the belief that 'health, education and living conditions are among the most important issues for many Victorians.'[35] There is growing support for the recognition of economic, social and cultural rights in addition to other rights in human rights documents as exemplified by the *Convention on the Rights of Persons with Disabilities.*[36] As the discussion in Chapter 6 in relation to the right to health has indicated, economic, social and cultural rights *are* justiciable. Furthermore, the indivisibility and interrelated nature of civil and political, economic, social and cultural rights require that for effective enhancement of the well-being and autonomy of older people, the incorporation of these rights in the *Charter* is essential.

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[33] Scrutiny of Acts and Regulations Committee (Parliament of Victoria), *Review of the Charter of Human Rights and Responsibilities Act 2006* (2011), [181].
[34] Ibid [262]
[35] Ibid [194].
[36] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).

(b) Adult Protection

It is reiterated that the aims and objectives set out above, are best served by an Act dedicated to the rights of older people. As discussed in Chapter 9, the issue of the creation of a scheme of Adult Protection is complex and controversial. The incorporation of an Adult Protection Scheme within the proposed model for an 'Older Persons Act' is not advocated here. Adult Protection has a scope and focus that does not directly highlight and address the aims and objectives outlined above. An Act with a broader focus on Adult Protection of persons aged 18 or over, places those aims and objectives in relation to older persons at risk of being diluted in their effectiveness and their focus.

However, there is support for adult protection measures generally within Australia, particularly in the context of guardianship legislation. The majority of discussion on the matter has occurred in the context of people with cognitive disability who receive assistance through disability services, not in relation to older people specifically.

The South Australian report Entitled 'Closing the Gaps: Enhancing South Australia's Response to the Abuse of Vulnerable Older People' advocates for a human rights perspective upon the abuse of older people, and concludes that legislative reform in the form of an 'Adult Protection Act' in South Australia is necessary.[37] The model proposed incorporates the formulation of an Adult Protection Unit which would 'assume responsibility for receiving reports or notifications of abuse and for convening case conferences involving the key agencies and organisations.'[38] The report recommends a system of voluntary reporting of abuse and neglect, but 'a system of mandatory response

[37] Office of the Public Advocate (SA) and University of South Australia, *Closing the Gaps: Enhancing South Australia's Response to the Abuse of Vulnerable Older People* (Report for the Office of Ageing and Disability, 2011), 12.
[38] Ibid 48.

that involved stages or levels of response appropriate to the circumstances of each case, and ensuring the rights and freedoms of the adult condition the nature of any response.'[39]

The OPA in Victoria has similarly supported the 'pressing need for greater policy focus on adult vulnerability',[40] but has emphasised that 'the broadening out of guardianship to cover such situations would often be unhelpful and even problematic'[41] and has drawn attention to the reactionary nature of guardianship.

The United Kingdom revised *Care Bill* currently before the House of Lords imposes a duty on local authorities to make enquiries, or to ask others to make enquiries, where they reasonably suspect that an adult in its area is at risk of neglect or abuse, including financial abuse.[42] As noted by the OPA in a 'Submission to the Victorian Law Reform Commission in Response to the Guardianship Information Paper', the United Kingdom system of adult protection has the benefit of a historically well-established arrangement of local and area council involvement in social care that distinguishes it from Australia and this would influence the practical implementation of a similar system in Australia.[43]

The recommendations of the VLRC Guardianship review are wide-ranging.[44] The VLRC proposes significant increases in the powers of the Public Advocate to receive and investigate complaints relating to the abuse, neglect or exploitation of people with impaired decision making capacity due to disability. The recommendations also include broadening the power of the Public Advocate to initiate 'own motion' investigations.[45] The report also proposes the creation of a new public wrong and civil penalties for 'conduct

[39] Ibid 47.
[40] Office of the Public Advocate (Vic), *Submission to the Victorian Law Reform Commission in Response to the Guardianship Information Paper* (2010) [1.12].
[41] Ibid.
[42] *Care Bill* (UK HOL) Clause 41, (as introduced to the House of Lords, 9 May 2013).
[43] Office of the Public Advocate (Vic) above n 40.
[44] Victorian Law Reform Commission, *Guardianship Final Report 24*, (2012).
[45] Ibid 456.

amounting to abuse, neglect or exploitation of people with impaired decision-making ability.'[46] It is proposed that this wrong would overlap with some existing criminal offences and torts (such as assault and trespass to the person) and apply to 'all substitute decision makers, co-decision makers and supporters as well as all people who care for people with impaired decision making ability and all unpaid carers and informal decision makers.'[47]

The extent to which the recommendations of the VLRC in relation to the reform of guardianship legislation are adopted remains uncertain at the time of writing. Evidently this will have significant implications for the evolution of the preventive capacity of the guardianship system in relation to the abuse of older persons with disability due to impaired decision making capacity.

Overall, however, it seems appropriate to incorporate adult protection schemes via guardianship rather than including such schemes in a separate Older Persons Act.

E. Access to Justice

The content of law is only one element of an effective system of elder abuse prevention. Access to justice, effective implementation and education are vital. The New South Wales Law and Justice Foundation in 2004 published a study that analysed barriers to accessing legal assistance.[48] The study found that many older people experience a 'lack of awareness of their legal rights, a lack of confidence in enforcing these rights, a reluctance to take legal

[46] Ibid 418.
[47] Ibid 419.
[48] Sarah Ellison et al, *The Legal Needs of Older Persons in New South Wales* (Series: Access to Justice and Legal Needs, Vol 1, Law and Justice Foundation of New South Wales, 2004).

action, and a perception that the law is disempowering and cannot solve their problems.'[49] Legal action may be prohibitively expensive, and Legal Aid eligibility restricted due to assets tests and resource limitations. Reliance on the technological delivery of information will affect the current cohort of older persons. Furthermore, the rapid rate of technological development may prevent older persons from keeping pace. Older people may rely on relatives to access legal services. This may give rise to a conflict between the interests of the relatives in facilitating that access and the interests of the older person. Many other factors may act as barriers to older people seeking or accessing legal assistance such as; mental or physical disabilities; different perceptions of what constitutes abuse; feelings of stigma and shame associated with experiences of abuse; a fear of reprisal from the perpetrators of abuse; literacy, language, cultural barriers to accessing assistance; and a lack of knowledge about rights and entitlements.[50]

There has been widespread development of telephone legal advice and advocacy services for older people, staffed with professionals trained in providing advice and services in relation to elder abuse. In order to be effectively utilised, these services must be facilitated by community education and awareness programs.

The Community Visitors Scheme (CVS) provides advocacy and support to residents of Commonwealth funded aged care facilities nationally. The 'Living Longer, Living Better' Aged Care reforms, proposed the extension of the CVS to people receiving home care support. State and national advocacy groups such as the Council on the Ageing and Seniors Rights Victoria contribute to increased community awareness of the issue of elder abuse and inform older people of their rights. The spectrum of advocacy and support services

[49] Ibid xvi.
[50] Ibid 283-284.

available to older people who experience, or are at risk of abuse or neglect is expanding and should be expanded further.

F. Conclusion

Everyone has a vested interest in enhancing the global status of older people through the promotion and protection of human rights in the context of the particular challenges that older people face in societies around the world.

That interest is vested on an individual level, by the connections every person has with older family and friends, and on a fundamental level by the knowledge that as individuals, we are increasingly living into old age and into very old age — an achievement to be celebrated. Every person will benefit from being empowered throughout his or her old age, in order to retain autonomy and to facilitate the enjoyment of the social, economic and cultural determinants of health and well-being during those years.

As a community, interest in enhancing the quality of life of older people is vested in the benefits that a society can draw from a population that ages healthily and actively and that maximizes the opportunities for participation by older people, whilst drawing on the wisdom, knowledge and experiences that they have to contribute. Elder abuse and neglect pose a real and significant threat to the fulfilment of the rights of older people at an individual level to access and assert their rights. It is a societal problem to be addressed so that the benefits of an ageing population can be harnessed and celebrated.

Aspirational goals must be given a framework for implementation. It is not merely enough to ‘hope’ for a future of older people as respected and valued members of society. Whether from a moral, social, legal or health perspective, there is an imperative to ‘act’ to ensure it.

An international Convention that acknowledges the rights of older people as a group with special interests and the particular discrimination experienced by older people, will have greater power than currently exists to harness the potential of older people and ensure fulfilment of all their rights.

Promoting healthy and active ageing are critical components of any strategy to eliminate elder abuse as a threat to the human rights, dignity and security of older people. This thesis has argued that valuable content can be derived from all theoretical and practical arenas of elder abuse prevention and these arenas can be drawn together to form a meaningful and multifaceted strategy for the future.

The development of ageing policy and appropriate elder abuse strategies are not only about matters involving the provision of aged care. Nor are healthy and active ageing strategies simply about a focus on disease prevention. Healthy ageing demands that attention is directed towards all of the social, economic and cultural determinants of health. By promoting healthy ageing older people will reduce their vulnerability to elder abuse.

Human rights principles influence all dimensions of this process. To that end, legal measures must take account of the wishes of older people. Systems that mandate the reporting of abuse despite the wishes of an older person with decision making capacity should not form a part of the landscape of future tertiary prevention measures in Australia. In this regard, the mandatory reporting provisions of the Commonwealth *Aged Care Act 1997* require review. In the event of future ratification of an international Convention on the rights of older people, significant doubt is cast over the compatibility of these provisions with the obligations to respect the autonomy and decision making capacity of people that would form the basis of such a Convention.

The discrimination faced by older people, in particular on the grounds of gender and on the basis of disability, cannot be ignored. The attention directed to and progress made in the promotion of the rights of people with disabilities is to be celebrated. The *Convention on the Rights of Persons with Disabilities* provides a mechanism by which older people with impaired decision making capacity can exert their rights. However the needs of older people with disabilities demand special attention. The normative gaps in the protection of the human rights of older people with dementia and other disabilities must be closed through the strengthening of existing legislation and the formation of specific legislative responses to the requirements of older people.

The relationship between ageist attitudes and the occurrence of elder abuse is a complex one: elder abuse and neglect are both a cause of and a consequence of poor attitudes and behaviours towards older people. Ageist stereotypes and negative attitudes towards older Australians can be overcome by a national policy that is centred upon harnessing the contributions that older Australians can, and do, make to society. Attention must be devoted to the actual experiences of older people: this is only possible through listening to older people and engaging them in the planning and fulfilment of future strategies. In turn, it is the responsibility of Commonwealth and State Parliaments to formulate cohesive policies on elder abuse prevention, implement strategies with appropriate resources and funding, and legislate effectively to provide the tools for older people to access their rights and to enjoy healthy and active ageing.

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