

ACTION ON ELDER ABUSE: A NEW SOUTH WALES PILOT PROJECT ON THE ROLE OF LEGAL AND HEALTH PRACTITIONERS IN ELDER ABUSE SCREENING, RESPONSE AND PREVENTION

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This article reports on a pilot project that involved legal and health practitioners (n=17) in an intervention that aimed to improve detection of and response to elder abuse. Interviews and focus groups elicited practitioners' experiences and their views on the use of structured screening processes to identify abuse or risk situations. Participants reported they mostly encounter financial exploitation and psychological abuse, perpetrated by adult children against older parents. No practitioners reported the use of an elder-abuse-specific screening tool, but perceived the benefits of screening to enable earlier identification of problems. Barriers to screening included practitioners' concerns about communication strategies, professional role boundaries, and inadequate response options. Participants supported a 'triage' approach, with screening questions and responses scaled to the immediacy and severity of the problem. Respect for the autonomy of older people was emphasised, along with professionals' role in providing advice and resources to empower their older clients.

I INTRODUCTION

Elder abuse is defined as an act or omission that results in harm to an older adult, committed in a relationship involving an expectation of trust.¹ Elder abuse can take

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1 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) 81. For discussion of definitions of elder abuse, especially to inform research in Australia, see Rae Kaspiew et al, 'Elder Abuse National Research: Strengthening the Evidence Base' (Research Definition Background Paper, Australian Institute of Family Studies, 2019) <https://aifs.gov.au/sites/default/files/publication-documents/1908_elder_abuse_national_research_strengthening_the_evidence_base.pdf>.

many forms, including financial, psychological, physical or sexual abuse, or intentional or unintentional neglect. In Australia, it is estimated that, annually, between 2–14% of older adults experience abuse.² The harms of elder abuse for older people include emotional distress, loss of assets, higher rates of hospitalisation and premature mortality.³ It has been predicted that by 2025, elder abuse will cost the Australian healthcare system alone over \$350 million, with additional costs across policing, legal, social welfare and other response services.⁴

In March 2019, the Council of Australian Attorneys-General released a five-year action plan on elder abuse.⁵ This plan followed on from several national and state inquiries into elder abuse that called for urgent action to protect older Australians from all forms of elder abuse.⁶ These reports all emphasise the need to strengthen multi-sectoral capacity to recognise, respond to and prevent elder abuse. The coordinated involvement of legal, health and community service providers is generally considered the ‘gold standard for [addressing elder abuse], as no single discipline or sector alone has the resources or expertise needed to address the issue’.⁷

A number of service providers are in a position to identify older clients who may be at risk of or experiencing various forms of abuse. Lawyers assist older clients who are vulnerable to financial and psychological abuse in relation to will-making, the appointment of enduring representatives (eg, financial enduring power of attorney) and transactions concerning real property and other assets. Health practitioners may see signs of physical abuse or neglect manifesting in acute and progressive illnesses in their older patients. Practitioners who visit older people in their home environment, especially community health and aged care professionals, may identify risk situations and family dynamics that are not apparent to practitioners in professional office settings.⁸

As elder abuse is often a hidden problem, these service providers have an important role in initiating conversations with older clients about abuse behaviours and risk factors.⁹ Doing so can raise awareness, support disclosure, and enable prevention and response efforts. However, many professionals lack confidence in discussing possible

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- 2 Adam Dean, ‘Elder Abuse: Key Issues and Emerging Evidence’ (CFCA Paper No 51, Australian Institute of Family Studies, 2019) 1 <https://aifs.gov.au/cfca/sites/default/files/publication-documents/51_elder_abuse.pdf>.
 - 3 Xin Qi Dong, ‘Elder Abuse: Systematic Review and Implications for Practice’ (2015) 63(6) *Journal of the American Geriatrics Society* 1214, 1218; Marguerite DeLiema and Kendon J Conrad, ‘Financial Exploitation of Older Adults’ in Xinqi Dong (ed), *Elder Abuse: Research, Practice and Policy* (Springer International Publishing, 2017) 141, 142.
 - 4 National Older Persons Legal Services Network, Submission No 363 to Australian Law Reform Commission, *Protecting the Rights of Older Australians from Abuse* (March 2017) 22.
 - 5 Council of Attorneys-General, *National Plan to Respond to the Abuse of Older Australians (Elder Abuse) 2019–2023* (19 March 2019) <<https://www.ag.gov.au/RightsAndProtections/protecting-the-rights-of-older-australians/Documents/National-plan-to-respond-to-the-abuse-of-older-australians-elder.pdf>>.
 - 6 Australian Law Reform Commission, *Elder Abuse: A National Legal Response* (Report No 131, May 2017); General Purpose Standing Committee No 2, Parliament of New South Wales, *Elder Abuse in New South Wales* (Report No 44, June 2016); Select Committee into Elder Abuse, Parliament of Western Australia, *‘I Never Thought It Would Happen to Me’: When Trust Is Broken* (Final Report, September 2018).
 - 7 Janice Du Mont et al, ‘Determining Possible Roles and Respective Roles and Responsibilities for a Model Comprehensive Elder Abuse Intervention: A Delphi Consensus Survey’ (2015) 10(12) *PLoS One* e0140760:1–24, 3–4.
 - 8 See generally Amanda Phelan, ‘The Role of the Nurse in Detecting Elder Abuse and Neglect: Current Perspectives’ (2018) 8 *Nursing: Research and Reviews* 15.
 - 9 See generally David Burnes, Ron Aciermo and Melba Hernandez-Tejada, ‘Help-Seeking Among Victims of Elder Abuse: Findings from the National Elder Mistreatment Study’ (2019) 74(5) *Journals of Gerontology: Social Sciences* 891.

abuse with their clients, limiting opportunities for detecting situations of concern.¹⁰ The use of standardised and validated elder abuse screening questionnaires can provide an objective method of identifying situations of potential concern:¹¹ ‘Screening procedures are based on the fact that the person that is being mistreated will not easily come forth and that efforts need to be made by social and health care professionals to identify risks and warning signs’.¹² A variety of screening tools are reported in the research literature,¹³ including several designed for use by community-based service providers.¹⁴ Practice guidelines for health professionals recommend elder abuse screening¹⁵ and the use of screening tools can help lawyers meet their ethical responsibilities to older clients.¹⁶ Despite the existence and rationale for screening tools, Australian and international research points to a dearth of evidence on how best to use such tools in practice, particularly to ensure the benefits of screening outweigh the potential harms, such as raising false alarms and triggering unwanted interventions into the lives of older people.¹⁷

This article reports on a pilot project, funded by the New South Wales (‘NSW’) government, that aimed to learn about legal and health practitioners’ experiences and practices in identifying and responding to elder abuse among their older clients and to elicit their feedback on a training and screening initiative. The study is informed by Roberto and Teaster’s contextual theory of elder abuse, a tool to guide research and practices aimed at identifying, responding to and preventing abuse.¹⁸ The theory – which ‘draw[s] upon multiple literatures’,¹⁹ including prior theoretical work and empirical research – foregrounds the individual, relational, community and societal contexts in which abuse occurs and can be identified, mitigated and prevented, as depicted in Figure 1. At the individual level are the personal characteristics and situational influences of victims and perpetrators of abuse. The relational level concerns the relationships between victims and perpetrators and their broader social networks. The community context considers community capacities and priorities in relation to elder abuse, including formal services and informal networks that attend to the needs of older community members. The societal context highlights social structures, norms and

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- 10 XinQi Dong, ‘Screening for Elder Abuse in Healthcare Settings: Why Should We Care, and Is It a Missed Quality Indicator?’ (2015) 63(8) *Journal of the American Geriatrics Society* 1686, 1687.
 - 11 Margot J Schofield, ‘Screening for Elder Abuse: Tools and Effectiveness’ in XinQi Dong (ed), *Elder Abuse: Research, Practice and Policy* (Springer International Publishing, 2017) 161, 162.
 - 12 Mélanie Couture et al, ‘Implementing a Systematic Screening Procedure for Older Adult Mistreatment within Individual Clinical Supervision: Is It Feasible?’ (2019) 34(13) *Journal of Interpersonal Violence* 2813, 2814.
 - 13 See Chiara Gallione et al, ‘Screening Tools for Identification of Elder Abuse: A Systematic Review’ (2017) 26(15–16) *Journal of Clinical Nursing* 2154.
 - 14 Nola M Ries and Elise Mansfield, ‘Elder Abuse: The Role of General Practitioners in Community-Based Screening and Multidisciplinary Action’ (2018) 47(4) *Australian Journal of General Practice* 235, 237.
 - 15 Royal Australian College of General Practitioners, ‘The White Book: Section 10.1 Elder Abuse’, *Abuse and Violence: Working with Our Patients in General Practice* (Web Page, 2020) <<https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/white-book/vulnerable-populations/section-10-1-elder-abuse>> (‘RACGP Guidelines’); Phelan (n 8) 18–19.
 - 16 Nola M Ries, ‘Elder Abuse and Lawyers’ Ethical Responsibilities: Incorporating Screening into Practice’ (2018) 21(1) *Legal Ethics* 23, 24.
 - 17 Bianca Brijnath et al, ‘“Build Rapport, Otherwise No Screening Tools in the World Are Going to Help”: Frontline Service Providers’ Views on Current Screening Tools for Elder Abuse’ (2020) 60(3) *Gerontologist* 472, 479; Jill Jin, ‘Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults’ (2018) 320(16) *Journal of the American Medical Association* 1718, 1718.
 - 18 Karen A Roberto and Pamela B Teaster, ‘Theorizing Elder Abuse’ in XinQi Dong (ed), *Elder Abuse: Research, Practice and Policy* (Springer International Publishing, 2017) 21.
 - 19 Ibid 21.

attitudes, including their manifestation in laws and legal practices, that strengthen or diminish the status of older people. Our research provides insights at each level, drawing on the perspectives and experiences of legal and health practitioners who work with older clients.

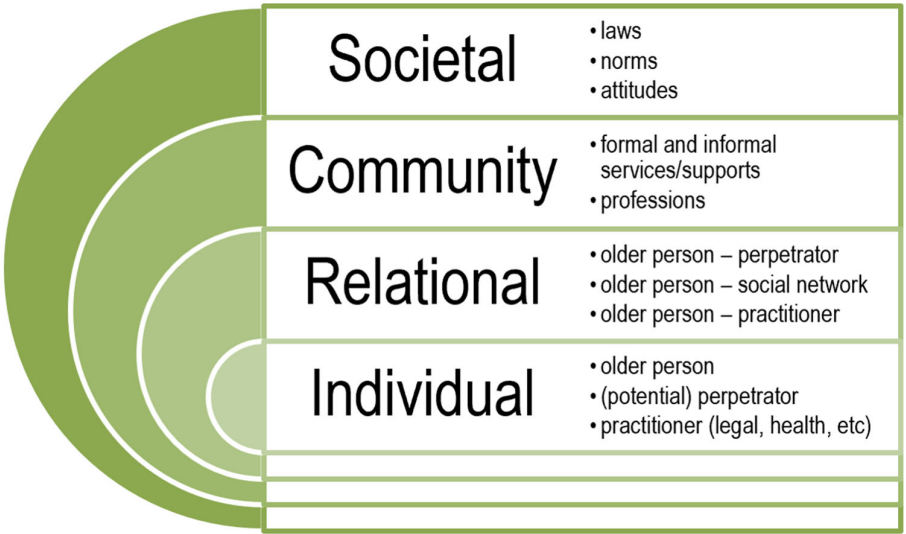


Figure 1. Four levels of the contextual theory of elder abuse²⁰

II METHODS

This pilot study was conducted in the Newcastle/Hunter region of NSW, the State’s largest metropolitan area outside Sydney. Ethics approval for the study was obtained through the Hunter New England Human Research Ethics Committee (Approval 17/06/21/4.06) and University of Newcastle Human Research Ethics Committee (H-2017-0271).

A Design

The study involved the design and implementation of a pilot education and screening initiative to support participants in identifying and responding to older clients at risk of or experiencing elder abuse. We refer to this initiative as a pilot intervention and the project phases are described in further detail below. Interviews and focus groups were the primary method of data collection and were conducted by the study investigators, as indicated below.²¹ A qualitative approach was appropriate as it allowed for an in-depth exploration of participant experiences with the complex issue of elder

20 On the development of this theory, see Roberto and Teaster (n 18).

21 The project investigators are experienced researchers with training in law, social and behavioural sciences (NR) and psychology, cognitive neuroscience and health behaviour (EM).

abuse.²² It also allowed for detailed information to be obtained about participants' perceptions of the feasibility and acceptability of the pilot intervention, to guide future larger-scale studies in this area. A short survey was administered to participants midway through the pilot implementation period; the purpose of the survey was to maintain engagement and gather data to guide a final focus group and it did not aim to produce generalisable data.

B Participants

Legal and health practitioners who work with older clients were recruited from three groups:

1. lawyers working in private practice, community legal centres or legal aid settings;
2. community health practitioners employed through aged care assessment teams ('ACAT') or community nursing services; and
3. clinicians (doctors and registered nurses) working in general practice clinics.

C Recruitment

To recruit lawyers, an advertisement regarding the study was placed in an online newsletter distributed by the Newcastle Law Society. An online search identified law firms and community legal service organisations offering elder law services in the Newcastle region. These services were sent a letter inviting lawyers to participate in the study. To recruit community health practitioners, the service manager for community nursing and ACAT in the Newcastle/Hunter region sent a letter of invitation to eligible health professionals. To recruit doctors and nurses, general practice clinics and general practitioners in the Newcastle region were invited to participate through networks of clinical colleagues. To ensure an informed and voluntary choice to participate, prospective participants were provided with information statements that explained the rationale for the study, the identity of the investigators and the activities the project would involve.

D Project Phases

1 Initial Data Collection

To inform the development of the education and screening initiative, qualitative semi-structured interviews and focus groups were conducted with lawyers and community health practitioners to explore their perspectives and experiences in relation to elder abuse. To accommodate work schedules, interviews were conducted individually with lawyers and as a focus group with the health practitioners. Interviews with lawyers took place at their office or at a university site, depending on interviewees' preferences. The focus group was held at a local health district site. The semi-structured questions, informed by current literature and recent Australian inquiries into elder abuse, focused on participants' experiences in their professional practice, including types of elder abuse encountered, perceptions of elder abuse risk factors, and strategies used to identify situations of concern; and their perceptions of their professional role

22 Carmel Bradshaw, Sandra Atkinson and Owen Doody, 'Employing a Qualitative Description Approach in Health Care Research' (2017) 4 *Global Qualitative Nursing Research* 1, 2.

and barriers and enablers to identifying and responding to elder abuse. Participants were also asked about their awareness of resources, such as the NSW Elder Abuse Helpline and Resource Unit ('EAHRU')²³ and the NSW Government *Interagency Policy* on elder abuse. This policy applies to state government agencies and aims to inform '[o]thers who work with older people, whether local government, non-government organisations or private service providers [who] may also find useful guidance in this document'.²⁴ The lead investigator (NR) conducted the interviews and focus groups, which averaged around 60 minutes in length. Participants preferred not to have these conversations audio-recorded and the interviewer took detailed, contemporaneous notes on a laptop computer.²⁵ These data were used to refine the content and approach for the education and screening initiative.

2 Pilot Implementation

The education and screening initiative consisted of:

1. **Training workshop.** Separate two-hour training sessions were held for lawyers, community health practitioners and general practice clinicians, due to delays between recruiting each of these groups. The workshop for lawyers occurred first, was held at a university site and facilitated by a trainer from the EAHRU with input from project investigators (NR and EM). The workshops for health practitioners were facilitated by the lead investigator (NR), with input from the service manager for community nursing. Training workshops covered: types of elder abuse and risk factors; benefits of standardised approaches to elder abuse screening; introduction to screening tools, especially the Elder Abuse Suspicion Index ('EASI') (discussed below); guidance about when and how to use screening tools; and principles to guide responses when clients are identified as at risk or experiencing elder abuse. The workshops for general practice clinicians, held at their clinic, and community health practitioners, held at a community meeting venue, included discussion of relevant professional practice guidelines and policy on elder abuse.²⁶

The EASI is a six question brief screening tool that is validated for use with cognitively intact adults and covers all major types of elder abuse.²⁷ For example, it asks whether anyone has tried to force the older person to sign papers or use their money against their will, prevented the person from taking part in social activities or accessing necessities such as medical care, talked to the person in a way that made them feel shamed or threatened, or hurt the person physically or touched them in an unwanted manner. Affirmative answers to any

23 As of July 2019, the EAHRU is the NSW Ageing and Disability Abuse Helpline: see 'Frequently Asked Questions', *Ageing and Disability Commission* (Web Page, 2 December 2019) <<https://www.ageingdisabilitycommission.nsw.gov.au/information-for-professionals/faqs>>.

24 New South Wales Government, *Preventing and Responding to Abuse of Older People (Elder Abuse): NSW Interagency Policy* (Policy Document, June 2018) 6 <<https://www.facs.nsw.gov.au/download?file=591024>> ('*Interagency Policy*').

25 The interviewer has extensive experience in taking typed notes in individual and group interview settings.

26 RACGP Guidelines (n 15); New South Wales Government, Ministry of Health, *Identifying and Responding to Abuse of Older People* (Policy Directive, 19 July 2018) <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2018_027.pdf>.

27 See generally Mark J Yaffe et al, 'Development and Validation of a Tool to Improve Physician Identification of Elder Abuse: The Elder Abuse Suspicion Index (EASI)' (2008) 20(3) *Journal of Elder Abuse and Neglect* 276; Ries and Mansfield (n 14) 237.

of the questions should prompt further discussion and assessment of the situation. The EASI was recommended in the training sessions as it is a resource freely available for practitioners via the EAHRU website,²⁸ underwent a rigorous development process and has adequate psychometric properties,²⁹ contains only six items, so can be easily completed within time-limited consultations, and is recommended in professional guidelines and policy.³⁰ An older person's wellbeing checklist, developed by the EAHRU, was presented as an alternative resource, with the caveat that it has not yet been validated. This checklist was designed as a self-assessment tool for older people to reflect on their financial, social, medical and psychological wellbeing, with statements such as: 'I have the freedom to spend my money'; 'I am treated respectfully by my family and friends'; and 'I feel safe at home'.³¹

2. Development and provision of resources. Following the training workshop, participants were provided with a package of resources including copies of the EASI and informational materials prepared by the EAHRU to share with older clients to raise awareness of elder abuse and response options. To address specific resource needs of lawyers, a tailored toolkit of materials was prepared that incorporated guidance on solicitors' conduct rules, especially confidentiality provisions, and linked with other resources, including the Law Society of New South Wales' guidance materials on elder law practice.³²
3. Six month pilot period. Following the training, participants were asked to implement the recommended actions from the workshop and trial the provided resources for a six month period.

3 Data Collection to Assess Pilot Intervention Acceptability and Feasibility

Participants were invited to complete one short, online survey approximately three months into the six month pilot period. This interim data collection included items covering: (i) feedback on using the EASI in practice, including frequency and ease of use and helpfulness in identifying situations of abuse; and (ii) experiences of following up on situations of concern, including use of services and resources, and barriers to following up.

Participants were invited to a one-hour focus group at the end of the pilot period, co-facilitated by project investigators (NR and EM) and held at a university site. One focus group was held including both legal and health practitioners, to allow an opportunity for sharing cross-disciplinary perspectives. A semi-structured focus group guide was used to cover topics including: (i) experiences using elder abuse screening

28 The EAHRU has been integrated into the NSW Ageing and Disability Commission and its resources are now available on that government website: see New South Wales Elder Abuse Helpline and Resource Unit, *Elder Abuse Suspicion Index (EASI)* (Assessment Instrument) <https://www.ageingdisabilitycommission.nsw.gov.au/_data/assets/pdf_file/0007/666421/Elder-Abuse-Suspicion-Index-EASI.pdf>.

29 Yaffe et al (n 27).

30 See, eg, RACGP Guidelines (n 15).

31 New South Wales Government, Ageing and Disability Commission, *My Wellbeing Checklist* (Assessment Instrument) <https://www.ageingdisabilitycommission.nsw.gov.au/_data/assets/pdf_file/0018/728010/My-Wellbeing-Checklist.pdf>.

32 See Law Society of New South Wales, *Best Practice Guide for Practitioners in Relation to Elder Abuse* (Guide) <<https://www.lawsociety.com.au/resources/practice-resources/my-practice-area/elder-law>> ('*Best Practice Guide*').

questions, including practice-informed insights on the acceptability and feasibility of using a standardised tool; (ii) responses and actions when situations of concern were identified; and (iii) feedback on resources to guide professional practice. All participants consented to audio-recording of the final focus group and a de-identified transcript was prepared for analysis.

III FINDINGS

A Participant Characteristics

Nine lawyers, eight health practitioners and one general practice clinic expressed interest and consented to take part in the study. Seventeen participants took part in an interview or focus group to inform the development of the education and screening initiative. The sample comprised 13 females and four males. One lawyer participant and the general practice clinic withdrew from the study prior to the interim survey. There were seven participants in the final focus group. In reporting the pre-intervention data, quoted statements are attributed to either a specific interview (for lawyer participants) or to a group interview (for community health practitioners). Statements quoted from the post-intervention focus group are attributed to participants according to their profession (lawyer or health practitioner). To safeguard participant privacy, no further demographic details are indicated for quoted material.

B Pre-intervention Data Collection on Participants' Experiences and Practices

1 Forms of Abuse Practitioners Encounter

Legal and health practitioners both reported they mostly encounter situations of financial exploitation and emotional/psychological manipulation, with these forms of abuse often co-occurring. Lawyers discussed situations where adult children pressured older parents to loan or gift them money or other assets, appoint them as enduring power of attorney, and change a will in their favour. Community health practitioners estimated that around half of the situations of financial abuse they encounter involve improper conduct of an enduring power of attorney. One participant commented that professionals 'are creating a monster by pushing powers of attorney' (health practitioner, group interview), indicating that these legal instruments are promoted as a way to safeguard the interests of older adults, but can enable financial abuse.

Participants perceived an attitude of entitlement among adult children to their parents' assets. Where adult children assist parents with managing their home or finances, participants described situations where children seek to preserve assets for their inheritance, rather than meeting their parents' living needs. Examples included family members not paying for adequate home support services or home modifications, such as installation of safety rails or ramps. In some situations, this parsimonious neglect contributed to preventable injuries, such as falls, as well as illness and hospital admissions for older people. Adult children may also preserve money for inheritance by moving parents into the most basic residential aged care when assets are available to pay for higher levels of amenity.

Participants encountered exploitation related to accommodation, including adult children moving into their parents' home and not paying rent or making other contributions, making older parents feel unwelcome in their own home, or putting parental tenancy at risk by engaging in criminal activity from the premises. In some

instances, family members moved an older relative to different living situations against their wishes, with the effect of removing them from their social networks and supports.

Participants also described situations of adult children attempting to manipulate ACAT and other processes to orchestrate moving the older parent into residential aged care. For example, family members may report that the older person is not coping at home or make claims about the older person's physical and mental health that lead to psychiatric assessments. In some situations, the older person was ultimately determined to have the capacity to manage at home and was put through unnecessary processes that undermined their rights and dignity.

Community legal centre and legal aid lawyers were more likely to encounter situations involving physical violence, such as an older person seeking an apprehended violence order in relation to adult children, or older people experiencing homelessness due to a breakdown in family relationships. These lawyers felt they were sometimes a 'last resort' (Lawyer 6) when abuse is no longer tolerable for an older person and they also encounter these crisis situations as duty counsel in court.

2 Risk Factors for Older Clients and Perpetrators

Participants were asked for their perceptions of factors that heighten vulnerability to be abused or to commit abuse. Commonly cited factors that increase risks for older clients were: social isolation, sometimes deliberately imposed by a perpetrator;³³ declining physical and cognitive health; increasing dependence on others for help with money management, shopping, transport and home maintenance;³⁴ and lower levels of education.

Participants most often reported that they see adult children as perpetrators, but some had seen situations of abuse by neighbours or in-home service providers, such as housecleaners or hairdressers. Older people with no or minimal family supports nearby were seen as more vulnerable to 'friendly helpers' (Lawyer 4).

As financial and emotional abuse were more commonly encountered, participants observed that family members who pressure older relatives for money had financial difficulties resulting from circumstances such as a failing business or marriage breakdown. Gambling and substance use problems were also seen as driving abusive behaviours in some cases.

Participants described shifts in family power dynamics that may trigger or escalate abusive behaviours. Family members can develop a sense of ownership over the older person, especially in circumstances of physical and/or cognitive decline. Several lawyers cited strong views in some families that elderly parents have a duty to support the next generation;³⁵ moreover, the risk of financial abuse was increased by not documenting arrangements or getting independent legal advice, such as in asset-for-care

33 Examples given included taking away an older person's mobile phone and limiting opportunities to see family and friends.

34 Participants identified examples of trigger events that increase dependence and vulnerability to abuse, such as loss of a driver's licence or death of a spouse who previously managed household finances. Increased reliance on technology, such as online banking, was also cited as a risk factor as it facilitates easier access to bank accounts by perpetrators and may contribute to social isolation if the older person no longer goes out to the bank or shops.

35 Socio-cultural perspectives about intergenerational duties may also intersect with views on gender roles; lawyers noted views in some families that an older mother should defer to an adult son who takes over as head of a family upon the death of the father.

situations. Blended families were seen to have unique risk dynamics when a later life marriage brings adult stepchildren into an older person's life.³⁶

In relation to abuse perpetrated by a person with financial power of attorney, participants had encountered a range of behaviours, from deliberate manipulation and predation to well-meaning relatives with a poor understanding of their legal role and responsibilities. Community health practitioners perceived that 'most people who commit abuse are coming from a sense of care; there are predators but not the majority' (health practitioner, group interview). They also described seeing family carers experiencing stress and burnout, which may contribute to abusive behaviours and rationalisations.³⁷ In many cases participants thought abusive situations develop gradually and worsen over time; the initially hidden or subtle signs can hinder early detection.

3 Strategies for Identifying Abuse or Risk Factors

Participants were asked about their practices in identifying older clients who may be at risk of or experiencing abuse. They were asked whether they ask directly, such as by using screening questions, or whether they use indirect methods such as observing for 'red flags'. No practitioners reported the use of an elder-abuse-specific screening tool, such as the EASI. ACAT practitioners typically undertake a comprehensive, structured assessment as part of their home visit with an older client.³⁸ The range of questions they ask can help to identify situations of concern, including risks to the older person's personal safety and wellbeing. Lawyers in the community legal and legal aid sector had encountered other types of screening questionnaires, such as legal-health checks and domestic violence screening tools.³⁹

Lawyers commonly reported they look for warning signs of third parties attempting to influence or control the older person, for example, someone else arranging the appointment for the older person, accompanying them to the lawyer's office and wanting to speak for them. Requests to radically change existing legal documents or arrangements were also cited as warning signs, such as changing a will to leave assets to a new person in the older person's life.

Determining a client's capacity to give instructions was often seen as intertwined with uncovering potential circumstances of elder abuse. Lawyers said they were alert to coached answers and used open-ended questions to elicit the client's understanding and wishes in their own words. Participants recognised that the acute stress of abusive situations can temporarily impair decision-making capacity. For an older client in crisis, the opportunity to access professional supports can be vital: 'Clients may be very

36 For example, an older couple may appoint a specific child/stepchild as their mutual enduring power of attorney or guardian. However, the appointee may not have a strong relationship with the stepparent, making them ill-suited for the enduring representative role.

37 As a rationalisation, family carers or enduring attorneys may see spending the older person's money for themselves as a fair exchange for providing care and support. Where the older person has cognitive impairment, family members may rationalise their use of money by saying it is what the parent would want.

38 Australian Government, Department of Health, *NSAF User Guide: A Guide to the Information Required to Be Considered and Recorded During the My Aged Care Assessment Process* (Guide, October 2018) <https://www.health.gov.au/sites/default/files/documents/2020/01/my-aged-care-national-screening-and-assessment-form-user-guide_0.pdf>.

39 See, eg, 'Legal Health Check', *National Association of Community Legal Centres* (Web Page, 2020) <http://www.nacclc.org.au/cb_pages/legal_health_check.php>.

distraught, when they calm down and are supported to tell their story, they can instruct' (Lawyer 6).

4 Barriers to Discussing Elder Abuse and Initial Reactions to the EASI

Participants were presented with a copy of the EASI and asked for their reactions to this brief screening tool that covers all forms of abuse. Sharing their initial reactions to screening questions prompted discussion of various barriers to talking with clients about elder abuse and whether screening questions could help to overcome these challenges.

In regard to the EASI, community health practitioners agreed that this set of questions could readily be incorporated into their assessment processes. Many lawyers agreed that a screening tool could help to instil consistent practices in asking a structured set of questions to gain a more complete understanding of the client's circumstances and potential problems. Doing so was viewed as necessary to provide advice best tailored to the client. One lawyer commented that the EASI was helpful in asking whether 'anyone' has engaged in particular behaviours.⁴⁰ This question format could open a conversation about abuse or exploitation by others in the client's life and not focus narrowly on one person in a specific role, such as a financial power of attorney. However, the closed 'yes/no' question format was at odds with training some lawyers had received to ask open-ended questions, especially when assessing for signs of impaired decisional capacity.

Both legal and health practitioners supported the need for increased awareness of and earlier identification and response to elder abuse. Screening questions could be helpful when clients do not perceive or acknowledge certain behaviours as abuse. In addition, identifying problems earlier would enable timely responses to lessen the harmful impacts. Participants had encountered situations where unchecked abuse had drained an older person's financial resources such that they could no longer meet their own needs, negatively impacted their mental health and decision-making capacity, and caused delays and disruptions to accommodation or care transitions.

Despite these benefits, some lawyers thought it would be confronting to ask elder abuse screening questions as a routine practice. They suggested lawyers would have to be 'judicious' (Lawyer 4) and 'subtle' (Lawyer 7) about asking such questions to avoid putting clients 'offside' (Lawyer 9). They felt they would need a conversation strategy to introduce the questions and link their relevance to the lawyer's role, with one lawyer suggesting the following script: 'I will ask you a lot of questions about your family and day to day life to help you make documents that will stand up legally' (Lawyer 7). As a more oblique strategy to support clients to talk about their situations and concerns, lawyers described telling stories of situations they had seen where things had gone wrong with powers of attorney and wills. A storytelling approach was seen as a gentler way to point out potential pitfalls and risks, rather than direct questions about problems in the client's life and family relationships.

Client reluctance to talk about elder abuse can be a significant barrier. As one participant commented:

If the client really doesn't seem to want to talk about it, I don't feel it is my place to push hard. I might talk around it ... I will try from a few different angles, but not in a pushy way. You can lead a horse to water but can't make it drink. (Lawyer 4)

40 For example, the question concerning financial abuse asks: 'Has anyone tried to force you to sign papers or to use your money against your will?': Yaffe et al (n 27) 295.

Both lawyers and community health practitioners stressed the need for sensitivity in asking questions about abuse. They commented that some older clients might feel ashamed to discuss abuse within the family, especially where they feel they have failed by raising a child who mistreats them: ‘They are ashamed that they have let themselves get into the situation. Inherently as a parent they are ashamed they haven’t raised their child properly if the child is doing this to them’ (Lawyer 4). Referring to the stigma of elder abuse, another participant commented that it ‘breaks all the social rules about how people are supposed to behave’ (Lawyer 6).

However, frank conversations about elder abuse were also seen as an opportunity to support and empower older clients:

I bluntly and clearly tell them [the older client] it is elder abuse, you’re not to blame, this is not acceptable. They say ‘I did this stupid thing’ but I reassure them the other person exploited them. Helping them recognise abuse for what it is, this is a major step. They might not have heard the term ‘elder abuse’. Call it out clearly, this is the first step. I have never had someone take offence; they often feel relieved that someone believes what they are saying is true. My hope is that in time this empowers them to take some steps [to stop the abuse]. (Lawyer 4)

For lawyers who were reluctant about asking broader screening questions, they preferred to confine their questions to a specific legal matter for the older client, such as drafting a will, to avoid ‘opening up a can of worms’ (Lawyer 9). They questioned whether it is their place to interfere in other aspects of the older person’s life and noted the absence of a statutory elder abuse reporting requirement for lawyers. One lawyer expressed concern about exposure to increased legal risk, suggesting that if the lawyer who is retained on a specific legal matter (eg, to draft a will) does not ask questions about a broader range of issues, such as physical or sexual abuse, it will not trigger a duty of care in relation to those matters. In this regard, lawyers were not seen as having a duty to look out for all aspects of an older client’s life. Similarly, community health practitioners worried about legal repercussions if they identified a situation as potential abuse but further investigation did not substantiate concerns. This fear of retaliation by wrongly accused family members was cited as a potential deterrent to making inquiries.

For lawyers and health professionals, uncertainty about what to do about elder abuse was a key barrier to discussing the issue with clients. Both practitioner groups commented about the importance of having referral networks and improving connections between legal, health and social service organisations that can assist older people experiencing abuse situations. Community health practitioners saw a need for stronger communication channels within services about potentially vulnerable older clients with better sharing of information and coordinated case management. One participant commented: ‘We’re all watching in siloes, not in a linked up system’ (health practitioner, group interview). Community health practitioners described more experiences of liaising with the Elder Abuse Helpline, local police and guardianship officials in relation to older clients. Few participants were aware of a NSW Government *Interagency Policy* on elder abuse.⁴¹

Lawyers pointed to their confidentiality duties and the need for client consent to contact other services. They also commented on the limits of their expertise, citing the importance of knowing when a lawyer’s responsibility ends and when to refer to another service provider. Yet, one lawyer commented it could be a ‘cop-out to say “I’m not

41 See *Interagency Policy* (n 24).

instructed on this” (Lawyer 1), suggesting that professional boundaries should not be interpreted too narrowly to avoid dealing with potential abuse.

Lawyers also expressed their worries of ‘feeling a bit powerless’ (Lawyer 1) about effective responses to stop elder abuse, especially in the face of complex family relationships and questionable conduct by other practitioners. Several participants described situations where adult children, with the help of lawyers, used enduring power of attorney authority to manage their ‘mum and dad’s affairs as if they are past their use-by date’⁴² (Lawyer 1). Participants also expressed worries about ‘lawyer shopping’ (Lawyer 5, Lawyer 9), where perpetrators take an older person to multiple solicitors until they find one who will assist them with legal documents and transactions with cursory inquiry into the older person’s understanding and wishes.

The workload and economic reality of legal practice were cited as barriers. Drafting wills and enduring documents for older clients were not seen as financially profitable activities, making some lawyers reluctant to ask questions that might demand more attention.⁴³ Lawyers felt that time pressures limited longer conversations that might be needed to untangle the complexity of problems within family relationships.

C Interim Feedback

Participants were invited to complete a brief interim survey approximately three months following the training and start of the pilot period. Six lawyers and six community health practitioners completed the interim survey.

All lawyers agreed that the tailored toolkit they received helped to improve their understanding of elder abuse and awareness of available resources. Knowing the types of questions to ask informed their conversations about elder abuse with their clients. Most, but not all lawyers ($n=4$) felt that the toolkit helped in guiding their response to situations of concern.

Most of the lawyers ($n=5$) reported using an elder abuse screening tool at least once with their clients. Some indicated they had used it when they suspected elder abuse might be occurring, while others indicated they used it as a more general screening tool for older adults. Only two of the lawyers had used the EASI (or a modified version), with the remainder using other screening tools or informal questioning.

Four lawyers reported that in the time since commencing the pilot period, they had detected at least one type of abuse among their clients, with possible financial ($n=3$), and emotional ($n=3$) abuse being most commonly detected. Clients were most commonly referred to the EAHRU, or their doctor. Only one lawyer reported that they had contacted the Elder Abuse Helpline and police directly to seek guidance on situations of concern.

All of the health practitioners reported they had referred to the NSW Government *Interagency Policy* on elder abuse since the commencement of the pilot period. All practitioners agreed that this policy helped to improve their understanding of elder abuse and available resources, and that it had helped to inform their general conversations about abuse with older adults. Almost all practitioners ($n=5$) thought the document had increased their understanding of how to follow up on situations of concern. Fewer

42 Examples included developing land or selling assets without involving elderly parents in decisions.

43 One lawyer described the time taken to explore a situation of potential financial abuse with a client who had questionable decision-making capacity; the amount of time taken meant the hourly rate was \$50 for the work of a senior solicitor (Lawyer 1).

practitioners ($n=4$) agreed that the policy document helped them to provide information to older adults about abuse. However, almost all health practitioners ($n=5$) reported they had not yet tried using the EASI, with a lack of time being the most common reason given for not having used the tool. Only two practitioners reported they had identified at least one type of abuse among their clients since commencing the pilot.

D Post-intervention Feedback

The multidisciplinary focus group was an opportunity for practitioners to share their experiences following the training and pilot implementation period, which prompted further deliberation and practice-informed reflection on the use of elder abuse screening questions. This discussion allowed for elaboration of topics raised in the initial interviews, surfaced additional perspectives and provided an opportunity for interprofessional dialogue on identifying and responding to abuse of older clients.

1 Screening Processes

As positive features, some practitioners commented that the EASI was time efficient and the questions helped in explaining to clients the types of behaviour that fall into a definition of elder abuse. In this way, the screening tool was useful in ‘actually giving it [abuse] a name and saying this is what’s happening’ (Lawyer participant). However, practitioners said it could be confronting to clients to initiate a conversation with questions labelled as an ‘elder abuse’ screening tool. Some participants preferred a resource described as a ‘wellbeing checklist’.

Lawyers felt that the questions pertaining to physical and sexual abuse were difficult to raise in the context of a legal consultation:

It’s really hard, out of the blue, just as a lawyer, to say: ‘Have you been physically harmed?’ ... I mean they’re coming in to write a will. ... You get people who are coming to pay a lawyer to do a particular document and you’ve got to get over [the client’s] affront: ‘Why are you wasting my time asking these questions that have got no relevance? I’m actually quite upset that you’re asking me questions about my relatives as if they’re likely to be bashing me or taking my money’. You get people offside and you can’t build a rapport with them. (Lawyer participant)

Lawyers also suggested it took courage to raise questions about elder abuse:

I don’t think I was brave enough to just launch off and ask people whether they’re being physically abused in a situation where they’ve just come in looking ostensibly perfectly normal without any bruises or anything and they’re writing a will. They just sort of think you’re a bit odd. (Lawyer participant)

To overcome this challenge, the participants described two options, summarised by one lawyer as follows:

You’ve got to have some way of almost either finding a way in by asking them questions like, ‘I see you’re living with your son, tell me about that’, or you’ve got to say, ‘We just ask everybody these [elder abuse screening] questions’. (Lawyer participant)

As another option, participants discussed a ‘triage’ approach to elder abuse screening, starting with general questions about how things are going at home and whether anything is worrying the older client. If no issues are raised it would not be necessary to progress to more detailed questions.

Participants agreed it is important to normalise the process of talking about elder abuse and risk factors. One participant made an analogy to advance care planning and discussing end-of-life care wishes before medical crises happen: ‘Maybe it [discussing elder abuse] needs to be normalised. Because when you’re in hospital now you’re always asked about CPR and resuscitation [even when] you’re not going in there to die’

(Health practitioner participant). Community health practitioners reported they sometimes felt constrained in what they could discuss when a potentially abusive family member was present during an in-home assessment. In contrast, lawyers described a professional responsibility to meet privately with their clients, noting they explain to clients and anyone accompanying them that a private consultation is important to avoid future challenges to the validity of the client's instructions.

The focus group discussion identified the need for further resources that could support elder abuse screening. Lawyers felt it would be helpful for the Law Society of New South Wales to issue a guidance statement that endorses elder abuse screening as good legal practice. As client decision-making capacity may be an issue, lawyers also suggested it would be helpful for a screening tool to combine information on legal tests of capacity, along with questions to screen for various forms of abuse.

Community health practitioners, especially dementia nurses, noted the shortcoming of elder abuse screening tools, like the EASI, that are not validated for use in older adults with cognitive impairment. These practitioners had attempted to use the screening questions for some clients with dementia, but had concerns about their ability to understand and respond. They highlighted the need for resources tailored for use with clients with cognitive impairment.

Efforts to use screening in practice underscored the importance of earlier identification of potential problem situations. Both lawyers and health practitioners felt screening was sometimes too late in situations where 'the horse had already bolted', meaning abuse was already occurring. Beyond lawyers and ACATs, they suggested other opportunities where screening could be implemented, such as among people attending Memory Clinics for assessment or supports and as part of the Medicare-funded comprehensive health assessments for patients aged 75 or older in general medical practice settings. They also commented on the importance of informal support networks. One participant described

the great intelligence that our community – our informal supports – bring to older folk. That's Meals on Wheels workers, that's the people that are mowing their lawns, that's the people that are the next-door neighbours and they've known them for 45 years ...
(Health practitioner participant)

2 Response to Situations of Concern

Where elder abuse screening identifies risk factors or abuse situations, participants commented again on a triage-style approach, where response options are scaled to the immediacy and severity of the problem. In a lower risk situation, a professional can inform the older person about their rights and follow up to monitor the situation. In a higher risk situation, referral to another service may be appropriate to access specialist assistance. In this regard, legal and health practitioners agreed that having solid referral networks and relationships would help to provide timely and appropriate supports. Elder mediation and counselling services were also identified as desirable resources.

In discussing responses to elder abuse, the focus group participants gave considerable thought to the question of how much abuse or neglect, including self-neglect, is tolerable in our society. Participants recounted situations where older clients tolerated or rationalised abusive behaviour, especially by adult children or other family members. Some participants described this as 'the path of least resistance', resulting at times in situations where an 'older person ... feels completely compromised by this whole circumstance [of abuse and conflict], so they shut down' (Health practitioner participants). Many older clients also expressed to lawyers and health professionals a

strong wish to avoid placement in residential aged care, which they viewed as more ruinous than a home environment marked by family dysfunction or mistreatment.

While participants were troubled about inaction in the face of abusive situations, they also worried that interventions to address abuse could leave the older person worse off. Legal or other interventions could contribute to an irrevocable breakdown in family relationships and subject the older person to guardianship or financial management orders. Having decision-making taken away from an older person was viewed as potentially worse than making choices – such as financial or property arrangements with adult children – that legal or health practitioners considered unwise. As one participant asked: ‘When does overriding their [the older person’s] will become abuse of another form?’ (Lawyer participant).

As older clients may be reluctant to assert their rights and disrupt family relationships, practitioners had mixed views on law reform to require mandatory reporting of elder abuse. One participant strongly advocated adult protection services modelled on child protection laws, with mandatory duties to report. This view was an exception, however, as most participants felt that when an older person understands the nature and implications of their choice not to act, it is not the role of a lawyer or health professional to interfere and trigger potentially unwanted interventions. Some participants considered that limited reporting obligations could be helpful in cases of scammers targeting older people or in situations of serious physical abuse or neglect.

As a compromise position between doing nothing and mandatory reporting, participants discussed the notion of ‘buffering’. This approach acknowledges it may not be feasible at a particular time to stop abusive behaviour, especially by a family member who provides care and companionship for an older person. However, its harmful impacts can be buffered with supports, for example, by increasing home care services to reduce dependence on the family member, or activities that prevent social isolation. As one participant commented: ‘Buffering in some ways ends up probably being the best realistic outcome, doesn’t it?’ (Health practitioner participant).

IV DISCUSSION

This study reveals insights from legal and health practitioners on identifying and acting on elder abuse and on the feasibility of using elder abuse screening tools. Our study found that legal and health practitioners did not currently use any standardised elder abuse screening tools. This finding echoes recent research in Victoria and overseas that found that elder abuse screening is not commonly and consistently implemented,⁴⁴ despite the availability of screening tools, and recommendations for their use in relevant guidelines and policies.⁴⁵ A key message from this study is that screening is normatively accepted, but attitudinal and practical barriers hinder implementation. Practitioners acknowledge the importance of identifying situations where older clients are experiencing abuse, however, they worry about interference in the lives of older people and inadequate resources to assist clients when problems are brought into the open.⁴⁶ As we discuss further below, a triage approach to asking and acting in relation to elder abuse was identified as a preferred strategy.

44 Brijnath et al (n 17) 476; Couture et al (n 12) 2828.

45 Gallione et al (n 13) 2173.

46 Joanna Theiss and Marsha Regenstein, ‘Facing the Need: Screening Practices for the Social Determinants of Health’ (2017) 45(3) *Journal of Law, Medicine and Ethics* 431, 438.

Our study findings are an opportunity to extend Roberto and Teaster's contextual theory of elder abuse by focusing on the individual, relational, community and societal contexts that hinder or enable professionals in prevention and response efforts.⁴⁷ To date, the individual context of the theory focuses on the characteristics and experiences of the victims and perpetrators of abuse. The relational context considers the relationship of the victim to the perpetrator as well as to family, friends and others in their social network. The community context considers formal and informal supports for older people, including health, legal and social services. The societal context 'involves overarching ideological values and norms that can foster a climate in which abuse is either normative or non-normative, encouraged or discouraged'.⁴⁸ These values and norms may be expressed in cultural beliefs and practices, as well as in legislation and policies.

In proposing next steps for the development of the contextual theory, Roberto and Teaster counsel:

Only by grounding research in theoretical principles of human nature and behavior will scholars and practitioners achieve a full understanding of what empirical findings reveal about the complexity of elder abuse and be able to apply this information widely. Thus, the exchange of research findings and best practice strategies among researchers, practitioners, and policymakers is critical for understanding the growing phenomena of elder abuse and the development, implementation, and evaluation of services and evidence-based interventions.⁴⁹

Responding to this call, our work further develops the contextual theory of elder abuse by highlighting the position and perspectives of legal and community health professionals in identifying and responding to older clients at risk of or experiencing abuse.

A Individual Context

Factors pertaining to the individual legal or health practitioner will affect their use of screening tools and responses to situations of concern. Relevant factors that emerged in our study related to practitioners' perceptions and skills. Perceptions were in relation to their professional role, the value of screening tools and the options available to respond to abuse. Skill factors related to communication and approaches to asking questions.

Unsurprisingly, community health practitioners perceived elder abuse screening as part of their professional role to ensure the safety and wellbeing of their clients. Most, but not all, lawyers agreed that screening for elder abuse falls within their professional role. It has been argued that the use of screening tools can help ensure lawyers meet their ethical responsibilities to older clients,⁵⁰ however our study suggests that some lawyers will be reluctant to probe issues beyond the immediate legal transaction the client wishes to undertake. However, even the lawyers who perceived constraints on their own professional role supported the need for greater community attention and resources to address elder abuse.

In principle, our study participants acknowledged the value of elder abuse screening. This finding is consistent with other recent studies in which professionals

47 Roberto and Teaster (n 18) 32.

48 Ibid 34.

49 Ibid 36.

50 Ries (n 16) 24.

perceived that screening would enable earlier detection of problem situations. A Canadian study involving home care social workers reported that they found ‘the screening procedure increased their sensitivity to risk factors and that usually, they are not on the lookout for clients presenting more subtle signs. They know that type of [subtle] case is often overlooked and that the situation will probably get worse with time’.⁵¹ Research into domestic violence affirms that the routine use of screening can overcome the limitations of idiosyncratic or haphazard approaches that rely on professionals’ ad hoc recognition of warning signs.⁵²

In practice, however, lawyers and community health practitioners experienced various barriers to asking screening questions. Our findings show that professionals can experience feelings of powerlessness in the face of elder abuse and they must be supported with training and resources to know how to identify and respond to abuse. The challenges and emotional impacts for professionals dealing with elder abuse situations is increasingly recognised as a matter for attention.⁵³ Importantly, they must feel that their actions will make a positive difference for their older clients.⁵⁴ These factors also intersect with professionals’ relational context with older clients, as well as the community and societal contexts in which they are embedded.

B Relational Context

For our study, the relational context centred on the relationship between professional service providers and their older clients and investigated elder abuse screening and response practices in that relationship. Views on the acceptability, feasibility and appropriateness of screening and response options influence their implementation.⁵⁵ Our study findings highlighted relational aspects such as communication between practitioners and clients, professional roles and obligations, and empowerment of clients through appropriate professional advice and supports.

For professionals, reluctance to ask confronting or personally sensitive questions was identified as a barrier to elder abuse screening. Three points may help to allay this concern. First, available research indicates that many older adults are willing to answer screening questions, including ‘extremely sensitive’ questions.⁵⁶ Second, from the point of view of people experiencing abuse, not asking questions poses harms⁵⁷ and older people who have been assisted through elder abuse services advocate for earlier

51 Couture et al (n 12) 2825.

52 Melissa E Dichter et al, ‘Intimate Partner Violence Detection and Care in the Veterans Health Administration: Patient and Provider Perspectives’ (2015) 25(5) *Women’s Health Issues* 555, 558.

53 Carole Anne Kirk et al, ‘Social Workers’ Perceptions of Restorative Approaches with Families in Cases of Elder Abuse: A Qualitative Study’ (2019) 21(3) *Journal of Adult Protection* 190, 194.

54 Kathleen H Wilber, ‘Combating Elder Mistreatment: Still Muddling – Not Yet Transformed’ (2019) 67(6) *Journal of the American Geriatrics Society* 1117, 1118.

55 Enola Proctor et al, ‘Outcomes for Implementation Research: Conceptual Distinctions, Measurement Challenges, and Research Agenda’ (2011) 38(2) *Administration and Policy in Mental Health and Mental Health Services Research* 65, 66.

56 Terry Fulmer et al, ‘Screening for Elder Mistreatment in Dental and Medical Clinics’ (2012) 29(2) *Gerodontology* 96, 102. See generally Sheryl M Strasser et al, ‘Screening for Elder Mistreatment among Older Adults Seeking Legal Assistance Services’ (2013) 14(4) *Western Journal of Emergency Medicine* 309.

57 Karin V Rhodes, Melissa E Dichter and Kristofer L Smith, ‘Challenges and Opportunities for Studying Routine Screening for Abuse’ (2018) 320(16) *Journal of the American Medical Association* 1645, 1646.

identification and response.⁵⁸ Third, a triage approach to screening for abuse provides a measured way to have conversations about elder abuse and risk situations.

The latter point resonates with prior American literature endorsing an incremental approach to client interviewing and counselling in the context of elder abuse.⁵⁹ Sandusky describes an approach to facilitate lawyer–client communication about motivations and goals:

The process begins with the lawyer stating the client’s problem and the goals the client wants to achieve. If an abused client is refusing to consent to disclosure, his or her initial stated goal may be to keep the abuse a secret. Next, the lawyer needs to identify the client’s values and motives behind the decision. The lawyer should ask probing questions into motivations ... does the victim fear institutionalization if the abuse is reported? Does the victim want to protect the abuser and keep the family together? Does the victim fear going to court? ... It is essential that lawyers address their abused clients’ fears and inform them about alternative options that are available to them.⁶⁰

This process of communication and counselling is essential to empowering older clients to make informed decisions. Chesterman advocates a shift away from vulnerability to empowerment: ‘When it comes to responses to elder abuse, the strategies seem to focus unduly on vulnerability. ... Rather than focusing on the victim’s vulnerability, elder abuse response strategies could be improved by prioritising what service responses, if any, the person wants’.⁶¹ Self-determination and empowerment of older people was a central theme in the Australian Law Reform Commission’s 2017 inquiry into elder abuse and has been endorsed in the 2019 National Elder Abuse Plan; both highlight the importance of ‘empowering all older Australians to live with their preferred level of autonomy, and have a say in decisions that affect their day-to-day life’.⁶²

Since the completion of our project, the National Ageing Research Institute has released a draft Australian Elder Abuse Screening Instrument, developed in Victoria.⁶³ Notably, this instrument uses a triage approach to screening. The first step asks whether the older person is receiving help from anyone for tasks including taking part in social activities, managing money, shopping and personal care. If the person has ‘helpers’ in their life, the next question is whether the older person feels they are treated with respect. If yes, no further questions about potential abuse situations may be necessary. If the older person discloses treatment they consider disrespectful, the next step asks questions about specific problem behaviours, such as coercing the older person to sign

58 Freda Vratsidis et al, *The Older Person’s Experience: Outcomes of Interventions into Elder Abuse* (Report, May 2016) 5, 29.

59 Linda F Smith, ‘Representing the Elderly Client and Addressing the Question of Competence’ (1988) 14(1) *Journal of Contemporary Law* 61, 82.

60 Sarah S Sandusky, ‘The Lawyer’s Role in Combating the Hidden Crime of Elder Abuse’ (2003) 11(2) *Elder Law Journal* 459, 487.

61 John Chesterman, ‘Taking Control: Putting Older People at the Centre of Elder Abuse Response Strategies’ (2016) 69(1) *Australian Social Work* 115, 117–18.

62 Council of Attorneys-General (n 5) 6.

63 National Ageing Research Institute, *Draft: Australian Elder Abuse Screening Instrument (AUSI)* (Assessment Instrument)

<https://www.nari.net.au/files/files/documents/nari_mv080_australian_elder_abuse_screening_instrument_ausi_-_a4_2pp_-_update_v1_0.pdf>. See also Brijnath et al (n 17) 479. A consultation process to develop the tool involved 61 participants representing aged care, health, legal, police, family violence and community advocacy services: see Luke Gahan et al, ‘Advancing Methodologies to Increase End-User Engagement with Complex Interventions: The Case of Co-designing the Australian Elder Abuse Screening Instrument (AuSI)’ (2019) 31(4–5) *Journal of Elder Abuse and Neglect* 325, 328.

documents, taking money without their permission, or interfering with access to services. Following identification of the frequency of such behaviours, the older person is asked whether they want help, such as legal interventions or referrals to specialist services. The screening instrument notes that a decision to decline help should be respected. However, a final step asks about threatening behaviour, unwanted touching and physical harms. Depending on the severity of safety risks for the older client, contact with police or other authorities may be considered.

This stepwise approach to screening supports lawyers in meeting confidentiality requirements in the solicitor–client relationship. Effective responses to elder abuse situations may require multi-agency involvement, however it has been argued that ‘the traditional nature of [legal practice] isolates lawyers from engaging in communal responses due to limiting ethical principles’,⁶⁴ particularly confidentiality duties. While there is a general duty not to disclose information without client consent, a triage approach to screening can help to identify situations of serious risk where lawyers are ethically permitted to disclose client information to prevent the ‘probable commission of a serious criminal offence’⁶⁵ or ‘imminent serious physical harm to the client’.⁶⁶

A triage response approach was also recommended in a recent Canadian study with social workers, where participants ‘stressed the importance of combining the level of risk and a protocol to indicate which action should take place according to the level of potential threat’.⁶⁷ This approach accords with respect for client choices, including decisions not to act. This value was endorsed by our study participants and is a strong theme in elder abuse literature: ‘Unless an older adult lacks capacity, victims [of elder abuse] have the right to self-determination and often choose to pursue a least restrictive intervention path to preserve family relationships and/or avoid exposing a familial abuser to the legal/justice system’.⁶⁸

Our study also highlighted client capacity as an important issue at the relational level. Screening tools can be a strategy to open communication between practitioners and clients, however the findings highlighted the limitations of current tools for clients with impaired memory or other cognitive difficulties. The challenges of screening among clients with cognitive impairment was also noted as an issue in the recent Victorian study of elder abuse screening.⁶⁹ American experts have recently developed the Interview for Decisional Abilities (‘IDA’), a semi-structured interview tool for use by practitioners assessing elder abuse situations among older adults with cognitive

64 Margaret Castles, ‘A Critical Commentary on the 2017 ALRC Elder Abuse Report: Looking for an Ethical Baseline for Lawyers’ (2018) 18 *Macquarie Law Journal* 115, 129.

65 Law Council of Australia, *Australian Solicitors’ Conduct Rules 2015* r 9.2.4 (‘ASCR’). A serious criminal offence encompasses indictable offences such as common assault, including threats to harm where no physical contact is made, assault occasioning actual bodily harm, including bruises, scratches and psychological trauma, sexual and indecent assaults, and most frauds, including obtaining property or a financial advantage by deceptive or dishonest means: see generally *Crimes Act 1900* (NSW).

66 *ASCR* r 9.2.5.

67 Couture et al (n 12) 2827.

68 David Burnes, Mark S Lachs and Karl Pillemer, ‘Addressing the Measurement Challenge in Elder Abuse Interventions: Need for a Severity Framework’ (2018) 30(5) *Journal of Elder Abuse and Neglect* 402, 403. See Jennifer E Storey and Melanie R Perka, ‘Reaching Out for Help: Recommendations for Practice Based on an In-Depth Analysis of an Elder Abuse Intervention Programme’ (2018) 48(4) *British Journal of Social Work* 1052, 1055.

69 Brijnath et al (n 17) 476–8.

impairment.⁷⁰ The authors point out that ‘gathering information about decision-making abilities is critical to the ethical assistance of older adults’, noting that ‘decisional ability assessments are fraught with the potential for consequential errors, for example, accepting the refusal of services from a client who lacks the ability to make such decisions, or wrongly finding a client unable to make a particular decision’.⁷¹ The IDA guides practitioners and clients in a purposeful conversation that focuses on the older person’s ability to make decisions about their risk situations, including accepting or refusing services.

C Community and Societal Contexts

At the community level, practitioners’ awareness of and linkages with health, justice, aged and social care services is an important component of elder abuse prevention and response. Importantly, access to community supports can ‘buffer’ risk situations to prevent escalation of abuse and to encourage engagement with services. Recent research demonstrates the vital role of supporters in the lives of older people. Victims of elder abuse who have a ‘concerned person’ in their life are significantly more likely to access formal services compared to their peers without this support.⁷²

Our study indicates that a practitioner’s own profession is an influential component of the community context. Policy statements and guidelines can articulate professionals’ roles and responsibilities, recommend screening tools and other communication strategies, and provide principles to guide responses to elder abuse. For example, the Law Society of New South Wales provides elder law resources for practitioners,⁷³ including recommended practices when meeting and advising older clients⁷⁴ and a guide to client decision-making capacity.⁷⁵ To add to guidance available to members of the legal profession, the toolkit of resources developed for practitioners in this project has since been updated and is freely available online for lawyers to access.⁷⁶ A 20-page booklet, it covers background information about elder abuse; talking to clients about elder abuse, including the use of screening tools; and assisting clients at risk of or experiencing abuse.

70 Robert C Abrams et al, ‘The Interview for Decisional Abilities (IDA): A Tool to Assess the Decisional Capacity of Abused and Neglected Older Adults’ (2019) 31(3) *Journal of Elder Abuse and Neglect* 244, 245. For a copy of the questionnaire, see Weill Cornell Medicine Division of Geriatrics and Palliative Medicine and Jason Karlawish, *Interview for Decisional Abilities: IDA 3.0* (Assessment Instrument, 2007) <https://nyceac.org/wp-content/uploads/2017/12/IDA_3.0_NYC.pdf>.

71 Abrams et al (n 70) 245.

72 David Burnes et al, ‘Utilization of Formal Support Services for Elder Abuse: Do Informal Supporters Make a Difference?’ (2019) 59(4) *Gerontologist* 619, 621.

73 See Law Society of New South Wales, *Best Practice Guide* (n 32).

74 Ibid. This three-page guidance document recommends good practices for meeting set-up (eg, meeting alone with the older client to ensure instructions are taken directly), meeting procedures (eg, ensuring the client has capacity to instruct) and documentation (eg, taking detailed notes and seeking a medical opinion on capacity if necessary).

75 Law Society of New South Wales, *When a Client’s Mental Capacity Is in Doubt: A Practical Guide for Solicitors* (Guide, 2016) <<https://www.lawsociety.com.au/sites/default/files/2018-03/Clients%20mental%20capacity.pdf>>.

76 See Nola Ries et al, *Identifying and Acting on Elder Abuse: A Toolkit for Legal Practitioners* (Guide, March 2019) <<https://www.uts.edu.au/sites/default/files/article/downloads/elder-abuse-toolkit.pdf>>. This resource, and many others, are also available on Compass, a website launched in December 2019 by Elder Abuse Action Australia: see ‘Useful Tools’, *Compass: Guiding Action on Elder Abuse* (Web Page) <<https://compass.info/resource/useful-tools?page=2>>.

While agreeing that lawyers and community health practitioners have an important role in identifying and responding to elder abuse, our study participants stressed that elder abuse requires community-wide attention. Their views echoed the position of the Australian Law Reform Commission that elder abuse is ‘everybody’s responsibility – a responsibility not only to recognise elder abuse, but most importantly, to respond to it effectively’.⁷⁷ It is important to increase general community awareness of elder abuse, risk factors and warning signs, and resources such as helplines, police crime prevention officers and other support services.

At a societal level, there is a need to tackle the shame and stigma that surrounds elder abuse. Strategies to open conversations between professionals and older clients are a helpful step to shift social attitudes; talking about abuse means the phenomenon can be identified, named and addressed. However, our study revealed misgivings among practitioners and their clients about guardianship processes and residential aged care placement. This underscores the need for system level improvements in these areas, especially to ensure that interactions with such systems do not cause further trauma for victims of abuse.⁷⁸ During the course of this study, the NSW Law Reform Commission completed a review of the state’s guardianship legislation, recommending new legislation that would change norms by emphasising access to supports to enable decision-making and making removal of decision-making authority and Guardianship Tribunal involvement as last resorts.⁷⁹ A Royal Commission into Aged Care Quality and Safety was also established near the end of our study and is scheduled to release a final report in November 2020.⁸⁰ On 1 July 2019, a new Charter of Aged Care Rights came into effect, covering the rights of consumers receiving home and residential care services.⁸¹ This Charter includes the right to be free from abuse and neglect, to retain control over health-related, financial and personal decisions, and to choose trusted supporters and advocates.

In regard to other legislative responses, mandatory reporting of elder abuse was not favoured by a majority of our study participants. Federal and state inquiries into elder abuse have considered arguments for and against mandatory reporting, but recommended strengthening systems to support voluntary reporting in the community.⁸² Societal norms that support compulsory reporting of child abuse cannot simply be extended to older adults; doing so can be infantilising and diminish the autonomy of older people.⁸³ The Australian Law Reform Commission recommended the implementation of adult safeguarding laws with a default requirement of consent from

77 Australian Law Reform Commission (n 6) 29 (emphasis omitted).

78 Joy Swanson Ernst and Tina Maschi, ‘Trauma-Informed Care and Elder Abuse: A Synergistic Alliance’ (2018) 30(5) *Journal of Elder Abuse and Neglect* 354, 364.

79 New South Wales Law Reform Commission, *Review of the Guardianship Act 1987* (Report No 145, May 2018) <https://www.lawreform.justice.nsw.gov.au/Pages/lrc/lrc_current_projects/Guardianship/Report-145.aspx> 33, 214.

80 See ‘Home’, *Royal Commission into Aged Care Quality and Safety* (Web Page) <<https://agedcare.royalcommission.gov.au/Pages/default.aspx>>.

81 ‘Delivering Quality Aged Care Services: Charter of Aged Care Rights’, *Australian Government, Department of Health* (Web Page, 22 January 2020) <<https://agedcare.health.gov.au/quality/single-charter-of-aged-care-rights>>; ‘Charter of Aged Care Rights (Information for Providers)’, *Australian Government, Aged Care Quality and Safety Commission* (Web Page, 20 January 2020) <<https://www.agedcarequality.gov.au/providers/provider-information>>.

82 See, eg, Australian Law Reform Commission (n 6) 415–17 [14.187]–[14.197].

83 Eve M Brank, Lindsey E Wylie and Joseph A Hamm, ‘Potential for Self-Reporting of Older Adult Maltreatment: An Empirical Examination’ (2012) 19(2) *Elder Law Journal* 351, 362.

the older person for services, which ‘avoids unwanted paternalism and shows respect for people’s autonomy’.⁸⁴ However, consistent with a triage approach, situations of severe harm may warrant protective interventions, including when a victim of serious abuse or neglect lacks decision-making capacity.⁸⁵

D Limitations

We acknowledge several limitations of our study. It was designed as a pilot project and therefore involved a smaller sample of participants from one region in NSW. The lawyers and health professionals who volunteered to participate likely had a greater interest in elder abuse issues and opportunities to improve their knowledge and skills, compared to practitioners who did not respond to the study invitation. In addition, a general medical practice clinic that expressed interest in the study and took part in a training session subsequently withdrew from the project, citing time and resource constraints. As a consequence, we were unable to gain the insights of family doctors and nurses who see older patients in this primary healthcare context.

V CONCLUSION

Legal and health professionals who interact with older clients have an important role in identifying, responding to and preventing elder abuse. Yet, detection of abuse and risk situations is challenging, as recognised in Australia’s new National Elder Abuse Action Plan:

The abuse of older people occurs within a complex interplay of individual, interpersonal, community and social factors. It can be challenging to identify abuse when it occurs, as there is no single type of older person who is at risk, and no single type of person who may cause harm.⁸⁶

Our qualitative study of a pilot elder abuse intervention, consisting of training and the implementation of a screening tool, provides valuable insights to guide future work in this area.

Our findings strongly support further work on graduated screening and response strategies, and testing the effectiveness of such strategies in identifying and reducing abuse among older adults. The Australian Elder Abuse Screening Instrument and the IDA are promising tools to investigate in future studies. Given concerns that elder abuse is detected too late when harms have already occurred, screening could be implemented across a wider range of health, legal, aged care and community services. Our study reinforced the importance of multidisciplinary and community-wide strategies to normalise such conversations and to improve awareness and responses to elder abuse.

The project illuminated the views and experiences of legal and community health practitioners. Detection of elder abuse is identified as a responsibility of clinicians in primary care guidelines and further research is needed to explore strategies to support implementation of screening in this setting. Finally, building on person-centred research

84 Australian Law Reform Commission (n 6) 376 [14.6]. Following the Australian Law Reform Commission report, South Australia has implemented an *Office of the Ageing (Adult Safeguarding) Amendment Act 2018* (SA) and NSW has established an Ageing and Disability Commissioner as of 1 July 2019 with statutory powers to investigate complaints of elder abuse: see ‘Home’, *NSW Government Ageing and Disability Commission* (Web Page, 2 December 2019) <<https://www.ageingdisabilitycommission.nsw.gov.au/>>.

85 Australian Law Reform Commission (n 6) 376 [14.7]–[14.8].

86 Council of Attorneys-General (n 5) 2.

and advocacy,⁸⁷ more work is needed to understand the expectations, preferences and needs of older people in their interactions with professionals, especially those who have experienced abuse situations.

87 Julia Rowan et al, 'Person-Centric Care of Elder Mistreatment: Lessons Learned from a Service Advocate' (2018) 2(Suppl 1) *Innovation in Aging* 526.