SELECT COMMITTEE INTO ELDER ABUSE

INQUIRY INTO ELDER ABUSE

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 21 MAY 2018

SESSION ONE

Members

Hon Nick Goiran, MLC (Chair)
Hon Alison Xamon, MLC (Deputy Chair)
Hon Matthew Swinbourn, MLC
Hon Tjorn Sibma, MLC

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Hearing commenced at 9.49 am

Dr HELEN McGOWAN
Clinical Co-Lead, WA Mental Health Network, sworn and examined:

The CHAIRMAN: This is the thirteenth public hearing for the Select Committee into Elder Abuse. We are meeting with the Older Adult Mental Health Sub Network. Before we begin, I welcome you to the meeting.

[Witness took the affirmation.]

Dr McGOWAN: I am a psychiatrist of old age and I am appearing before this committee in my capacity as clinical co-lead of the WA Mental Health Network, which oversees the Older Adult Mental Health Sub Network.

The CHAIRMAN: You will have signed a document this morning entitled "Information for Witnesses." Have you read and understood that document?

Dr McGOWAN: Yes.

The CHAIRMAN: These proceedings are being recorded by Hansard and broadcast on the internet. Please note that this broadcast will also be available for viewing online after this hearing. Please advise the committee if you object to the broadcast being made available in this way. A transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you refer to during the course of this hearing for the record. Please be aware of the microphones and try to talk into them. Ensure that you do not cover them with papers or make noise near them. I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request your evidence be taken in closed session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Please note that until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that publication or disclosure of the uncorrected transcript of evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege.

We have a number of questions for you this morning, but before we move to that, would you like to make an opening statement to the committee?

Dr McGOWAN: I was certainly closely involved with the submission to the select committee, so I would probably just refer to that. The key, overarching points that I would like to make, which I think the committee is probably well aware of, is that elder abuse is a serious issue, it is prevalent and it is probably growing. It does require a policy response as well as, in my view, a resourcing response to ensure that there is appropriate resourcing for services and organisations that can best respond to this issue. That would be my overarching point.

The CHAIRMAN: Great; we will drill into that a little bit further. It has been the normal practice of this committee during the public hearings just to take the witnesses through each of the 10 terms of reference. I am keen to move to the fourth term of reference about identifying risk factors. However, before we do so, perhaps I will just group the first three, which are: to determine an appropriate definition of elder abuse; identify its prevalence; and identify the forms of elder abuse, including but not limited to neglect. Perhaps in summary I will just indicate that the vast majority of evidence provided to the committee has directed us to the World Health Organization's definition

of elder abuse, which the Alliance for the Prevention of Elder Abuse in Western Australia has recently taken up. They have amended their definition accordingly. You would also be aware that the federal government has announced a study into prevalence, which seems to have been well received. Certainly in terms of the forms of elder abuse, it is well known to the committee that financial elder abuse is a particularly prevalent form. I would invite any comment that you might like to make in respect to definition, prevalence and forms before we move to risk factors.

Dr McGOWAN: I think it is really important, obviously, that there is a clear definition and I would certainly support the adoption of the World Health Organization definition. I think that the Western Australian one has been a little narrow and I think it makes it difficult to interpret a lot of evidence depending on which definition is used. So I think adopting the World Health Organization definition is a good way forward and I am assuming that the commonwealth research that is going to be looking at prevalence will use that. Obviously it is difficult to be explicit about the extent and scope of elder abuse and any changes in prevalence unless the definitions are really tight and well understood. I think, on top of that though, it is also important to be aware that the methodologies used in the research is particularly important. Elder abuse is not necessarily readily disclosed and there is a variety of different methodologies that have been used to try and assess the extent of elder abuse. So if, for example, you look at the amount of elder abuse that might be reported to some sort of statutory authority, it would be much less than what is actually occurring in the community. If you even ask individuals whether they have been victims of elder abuse, they are less likely to disclose it even in a research process. I think with clinicians, again, what you would expect is there is going to be under-reporting at every sort of methodology but some are better than others in terms of getting more accurate figures. There are a whole lot of complex sociological as well as, I think, psychological reasons why people do not disclose. I think there is a lot of shame, obviously, associated with elder abuse. I think busy carers, clinicians and primary health providers tend not to look for it and avoid acting on it unless they know they are going to be able to do something useful. So again, when questioned how frequently they see it, it is likely to be under-reported.

The CHAIRMAN: On the under-reporting issue, the committee has been consistently told that financial elder abuse is the most prevalent form. However, in the next breath, people will tell us that a close second is psychological abuse. I do not have any empirical evidence to support this; it is just an instinct of mine, but I wonder whether people might be more willing to report financial elder abuse than they would be psychological elder abuse. I just wonder if you might have a comment on that.

Dr McGOWAN: My personal view, in my clinical experience, would be yes. It is difficult again to define psychological abuse, whereas it is much easier to define financial abuse. It is easier to track the figures and say, “Yes, definitely something has gone wrong”, and people will feel more comfortable about being assertive. If you think about within a family, for example, if it is clear that one of the siblings has been diverting some funds that do not seem to be in the parents’ best interest, then that is very clear and people can say, “That’s not right. That shouldn’t have happened; I need to follow this up.” If somebody is talking dismissively to an older person, reducing their social options, disregarding their wishes, providing them with fewer options or giving them less than optimal care, people will tend to consider those sorts of issues in the context of the resources available in both the family and the community. I also think that is nested in a generally ageist view. I think there is still a problem with ageism, certainly in Australia most of the Western world. As people get older, there is an unstated but prevalent view that they are less important than younger people. Taking all of those issues into account, I certainly think financial abuse is an issue. It is easier to quantify and it does happen commonly. I think it is much more difficult to quantify clearly the amount of emotional abuse or psychological abuse that occurs. I think that researchers are really

going to need to consider some careful methodologies to try and unpick this and evaluate and quantify these issues.

Hon ALISON XAMON: I am thinking about a lot of the clientele that you would see. In terms of older people accessing public health services, I imagine there would be a number who have psychiatric conditions. I am trying to get an idea of your thoughts about how many people might be turning up because they are living with depression or anxiety that has been brought about by potentially elements of elder abuse or the results of elder abuse?

Dr McGOWAN: It is really difficult to quantify that because we have not looked at it in a systematic way, but I certainly see cases where that occurs and it is not infrequent. It is quite understandable, of course, if people are feeling undervalued, undermined and emotionally abused, then their sense of self-esteem deteriorates, their stress increases, and that is likely to precipitate anxiety or depressive issues. The other issue though, of course, is that anxiety and depressive issues in older people are under-diagnosed and under-treated so, again, it probably reflects a more ageist issue.

[10.00 am]

Hon ALISON XAMON: One of the things I am interested in looking at also is whether there is likely a correlation between instances of elder abuse and increased levels of suicidality amongst older people. I was wondering whether in your experience you have seen any such correlation?

Dr McGOWAN: I have seen one case when that occurred. Suicidality is obviously less common than demoralisation. In older adult mental health, we see a bit of a tip of the iceberg, so I certainly have seen cases where there has been elder abuse that has led to demoralisation, depression, suicidality and suicide attempts. I would not say it is a common occurrence, but I have certainly seen it.

Hon ALISON XAMON: You are also seeing people who have various levels of cognitive impairment, dementia and psychosis. Do you notice any particular vulnerabilities for those people to elder abuse?

Dr McGOWAN: Absolutely.

Hon ALISON XAMON: Could you elaborate little bit more on that?

Dr McGOWAN: Certainly. The issues of cognitive impairment and capacity to make complex decisions for oneself impacts on elder abuse markedly across all of the different types of abuse. It is for a range of reasons. First of all, an individual who has got these issues is less likely to be able to assert themselves, to make sense of complex issues and to make good decisions for themselves, so other people are going to be making decisions for them. Depending on a range of issues, including whether there are advance health directives or care directives or whether there has been a good relationship with the person who is making the decision for them and whether the person making the decision for them is well equipped to make those decisions, there is going to be much more vulnerability to elder abuse. The other issue that is associated with cognitive impairment—obviously it is a spectrum—is that it places a particular strain on relationships as well, and carers are often under-resourced, under-supported and under-educated. They do not necessarily start the caring journey with any malevolent intent; in fact, most people do not, but the stresses and strains of caring for somebody who has dementia or cognitive impairment and is displaying difficult behaviours—of course that is going to be interactive, because the environment will precipitate behaviours, but the behaviours will also affect the environment—also make it more likely that there is going to be some sort of abuse, because people are going to feel more entitled to be dismissive, curtail somebody's social options or utilise funds to support themselves in what is often a difficult process. Does that answer your question?

The CHAIRMAN: I think it moves us neatly into the issue of risk factors. The committee needs to identify risk factors, and one of them that you mentioned in your submission is social isolation. Can you just explain social isolation as a risk factor?

Dr McGOWAN: People who are vulnerable to elder abuse are often socially isolated, because there are no other people around to just raise an eyebrow to ask a question or to advocate in some way. So it is clear that an individual who is socially isolated is at increased risk of elder abuse, because there is nobody else peering over the abuser's shoulder under those sorts of circumstances. It is also an issue in that as people get older, they often become more socially isolated; it is a social phenomenon. It is partly to do with the fact that perhaps they are less mobile, they have got fewer friends and less family support, and if they are cognitively impaired or more immobile, there may be fewer people around who are willing to be supportive and engage with them. Even just the isolation itself can be quite abusive, because people start to feel less relevant and less engaged. What we certainly find with people with dementia is that, even if they are not consciously aware that somebody is disregarding them or talking to them in a way, they will pick up the tone of what is going on and they will certainly get a sense of when they are not being responded to in an affirmative way, in a positive way and in an appropriately respectful way, even if they do not understand the words or what is actually being done. Social isolation in itself can be a form of abuse, but it can also make people much more vulnerable to the abuse. The other thing that the more socially isolated people become too, of course, is they are less able to be assertive. They often tend to be more immobile. They are less able to recruit supports for themselves if there is any abuse going on. It is an important factor and it interacts with elder abuse in a variety of ways.

The CHAIRMAN: In terms of risk factors, you have referred to them falling broadly into four clusters—this is page 2 of your submission. You say that that relates to factors associated with the victim, the perpetrator, the quality of the relationship between the victim and perpetrator, and systems and services that have opportunity to prevent, monitor and/or respond to elder abuse. Can you just take us through these four clusters?

Dr McGOWAN: A victim is much more likely to be abused if they are cognitively impaired, socially isolated and immobile and have some chronic illness, for example. It depends on the different sorts of abuse. For financial abuse, for example, if somebody is cognitively impaired and not managing their finances themselves, of course they are much more likely to be vulnerable to financial abuse. If they have dementia and some really challenging behaviours and are perhaps physically aggressive, it is not surprising that they are more likely to be the victims of some physical aggression as well and that sort of physical abuse, for example. So there will be factors about the victim that will make it more likely that they are going to be a victim of elder abuse.

Regarding the perpetrator, clearly people who are extremely mature and well resourced, understand all their responsibilities and have had a long and good relationship with the elderly person are much, much less likely to perpetrate elder abuse. Conversely, we see with carers who have had an ambivalent relationship with the older person—perhaps they were a victim of aggression or sexual abuse when they were younger themselves—now all of a sudden the tables have turned and although they are still trying to do the right thing, there are certainly some triggers to perpetrate physical or sexual aggression on somebody under those circumstances. It is also more likely if the individual has fewer resources or has their own mental health issues, drug and alcohol issues or social pressures, for example. I think it is a pretty universal phenomenon that people cope variably depending on context and their own emotional and personal resources at a point in time, and it is no different in this situation. I have talked about the quality of the relationship. Again, perhaps if they were under financial pressures, you are more likely to see a perpetrator who is going to perpetrate financial abuse, for example. If they have drug and alcohol problems, their judgement

and impulse control is likely to be impaired and so they are likely to perpetrate elder abuse in ways that they might not if they were not using those sorts of substances. There is the quality of the relationship between the victim and the perpetrator, and I started to allude to that earlier. If somebody has had a lifelong good relationship with an elderly person, they are much more likely to be able to tolerate the stresses and strains of caring for an older person if there are stresses and strains.

To then go on to the systems and services, in my experience the systems and services are quite fragmented, and if I come back to perhaps a few clinical examples, it might explain this. What I have seen at times is that, say, for example—I will try to keep it as de-identified as possible. I saw a patient who was suicidal and very depressed after being the victim of financial abuse by her only surviving son. We ended up treating her under the Mental Health Act and she did recover. Once she had recovered, we then needed to address some of the issues that had triggered this sort of deterioration. She had capacity and she was very clear that she did not want her son prosecuted for the abuse. He was the only surviving relative and she felt that the quality of that relationship was still something she wanted to preserve. He was also very penitent, regretting his previous behaviour and wanting to make amends and wanting to support. Under those sorts of circumstances, we managed that in a clinical way. Certainly, we had no legal option anyway, because the victim had capacity and did not want to pursue a legal option, and we were bound under confidentiality to support her in that process. In a specialist older adult mental health service, we have got a very specialised and skilled multidisciplinary team, including senior social workers, psychiatrists and nursing staff, so we were able to have family meetings with the woman and the son to clarify their wishes and their intentions, and to work with them such that there were safety mechanisms in place. She did not have a lot of financial resources left anyway, so there was not that much to preserve, but we still went through formal processes through the State Administrative Tribunal so that he was clearly identified as the power of attorney and had enduring power of guardianship. That was subject to checks and balances and he understood there would be auditing that would occur further down the track. That is a complex example, I suppose, of how, in a specialist service, we were able to manage those issues in the long run to give the best outcome that was possible for the individual and for her family.

We did not involve the legal services. Not all services have the same sorts of skill mix that our services have. It is a very complex process to deal with the conflict between families, to resolve conflict, to actually identify some reasonable solutions to go forward and to support the family to do that. Frequently, care services that perhaps come across elder abuse do not have those sorts of resources. There certainly is evidence that if services do not have resources, are not well trained and do not understand what they can do within a situation, they are much less likely to pick up elder abuse, they are much less likely to follow it up and they are certainly much less likely to deal with it. It is a complex system, I think, that needs to be set up, where the primary carers—by that, I mean both aged care as well as general practice—need to be well trained in surveillance and picking up elder abuse, but I think it is probably a bridge too far to expect them to manage it. I think it is complex and it often requires a lot of time that, at this level of an organisation, they do not have. But they do need to have easy access to skilled teams that can provide that. So what I would be saying is perhaps older adult mental health services are a skilled team, but they are only seeing a very small percentage of people who present with these sorts of issues. I think an organisation such as Advocare, which is able to respond to individuals, to services, to organisations and to care providers and give them a stepped approach to responding to elder abuse, would be a more sensible way of going.

I think I have forgotten the start of your question now! I segued a bit there.

Hon ALISON XAMON: No, it is very useful.

The CHAIRMAN: What we were dealing with was the four clusters of risk factors, and you were just touching on the systems and services that have the opportunity to prevent, monitor and/or respond to elder abuse. Clearly, Advocare area is one of those services that does have that opportunity.

Dr McGOWAN: Yes. What I would be saying is I think that there needs to be a complex network that is well understood as to how to provide appropriate responses to elder abuse at all tiers of complexity.

Hon ALISON XAMON: Do you have an idea, if it is a government agency that undertakes that work, what is the logical government agency that would lead that activity?

Dr McGOWAN: I would say Advocare is the one that has the most experience.

Hon ALISON XAMON: They are, of course, a non-government organisation, so in terms of a government agency, where would you say the leadership should probably naturally lie?

Dr McGOWAN: I would think perhaps the aged-care policy directorate in WA would be another organisation to consider, although —

Hon ALISON XAMON: That is out of the Department of Health?

Dr McGOWAN: Health, yes. I have to say I do not think I am sufficiently aware of which government organisations may be best placed to lead that. Within Health I would think the aged-care policy directorate, and they have been involved in responding to elder abuse and are members of the Alliance for the Prevention of Elder Abuse.

Hon ALISON XAMON: I suppose it is always quite difficult to get Health to work with anyone else, so it is trying to figure out how you get that all-of-government approach that has broad buy-in.

Dr McGOWAN: Yes. I am not sure I can really advise on that.

Hon ALISON XAMON: Okay. I was just interested in your thoughts.

The CHAIRMAN: I might move to the fifth term of reference, members, which is for the committee to assess and review the legislative and policy frameworks. At the outset, I think you indicated that your view was that elder abuse required both a policy and resourcing response. In your submission, you stated that it seemed therefore likely that a community is more likely to have an increased prevalence of elder abuse if there is not sufficient regulation policy, legislation or resourcing. The committee would just invite your comment on what kinds of regulation or policy frameworks are necessary to decrease the prevalence of elder abuse in our community.

Dr McGOWAN: There certainly has been discussion about whether elder abuse should warrant mandatory reporting, in much the same way as child abuse requires mandatory reporting. My own view is that I do not think that is the way to go with elder abuse, for complex reasons. Older people, unlike children, are deemed to have capacity unless proven otherwise, and in my view their wishes need to be respected at times. If they do not have capacity, then there are alternative mechanisms such as seeking the appointment of a guardian, for example, to make decisions on their behalf. There is often a grey area in between that, but I think that there are mechanisms there. I think that if you go to mandatory reporting, you are more likely to end up in a legal response, which in my experience is not what most victims want. That is not to say that the legal response should not be there and available and followed up assertively when it is required, but I think it needs to go through a complex sieve of skilled people who will work with the individual and the family, assuming the risks are not severe or urgent, to arrive at a process that they are comfortable pursuing. If I park that in terms of, in my view, I do not think mandatory reporting is the way to go, I do think all government departments should be mandated to have a policy that their staff follow, and that

includes mandatory training for relevant staff on surveillance of possible elder abuse and training on how to escalate their concerns if they are picking it up. I think what is probably most important is that there is an increasing focus on picking up elder abuse. I think that would perhaps also reduce some of the stigma associated with it as well. I think it could be mandated as policy within organisations that are providing care, so when I talk about government departments, obviously Health would be one, but I think it would be also worth working with aged-care organisations at the commonwealth and state levels as well to look at having some sort of mandated approach to surveillance and escalation of concerns and training of relevant staff. We were talking earlier about identification of an organisation, whether government or non-government, that has experience and expertise in supporting both individuals who might be victims of elder abuse, concerned family members who are concerned that something might be going on or community members, general practitioners, primary care providers and any member of the community who is concerned, so that they can actually both support and guide an appropriate response in a stepped fashion and, at times, they may well need to work with specialist legal and police services and know when and how to escalate to that level appropriately.

The CHAIRMAN: Yes, on that, I was going to ask you in respect of the next term of reference, which is the assessing and reviewing of service delivery and agency responses. In your submission at page 4, you recommend that any government response includes a focus on training service providers who come into contact with the elderly and ensuring that there is access to appropriate expertise to support services or take over the case if the service provider is unable to manage, which is a theme you have expressed a few times this morning. Would that provision of training by government include government training an organisation like Advocare, or would Advocare actually be the trainers? Could government, if you like, task an organisation like Advocare to be the trainer?

Dr McGOWAN: I think the government could task an appropriate organisation to do that sort of training.

The CHAIRMAN: Yes; okay. Is there anything further on terms of reference (e) or (f), members?

You may or may not wish to respond or feel that it is your role, but for what it is worth, I will mention that the committee is also asked to assess the capacity of the Western Australia Police Force to identify and respond to allegations of elder abuse. Do you have any comments or experience in that respect?

Dr McGOWAN: I think it is quite variable. I have certainly had contact with police that manage it extremely well and others where I think people are likely to turn a bit of a blind eye. I would suggest that there does need to be some training for all police in terms of surveillance, in much the same way as we talk about it for aged-care service providers, because it may be that what they are seeing does not warrant a police response or a legal response, but it still might require a social response and maybe police need to be trained to ensure that those sorts of concerns are referred to the right sort of agency. It may be a specialist agency within the police force that they liaise with first, and then take it on and take it over. Obviously, the police are highly skilled in responding to acute urgent issues of elder abuse and they would generally escalate to the specialist police services to support that, but I am talking more about lower-level concerns that they might come across.

The CHAIRMAN: That fits in well with your earlier remark that there should be mandatory training. Even though you do not support mandatory reporting, you do support mandatory training, and WA Police would be a prime suspect for mandatory training.

Dr McGOWAN: Yes, I think so.

The CHAIRMAN: Term of reference (h) is for the committee to identify initiatives to empower older persons to better protect themselves from risks of elder abuse as they age. On page 6 of your submission, you refer to community-based activities being organised to reduce the social isolation that many older people experience. What activities or programs would you suggest would be most useful to achieve this?

Dr McGOWAN: It depends very much on the care needs of an older person. I think you need a range of activities available for older people that are designed to keep them socially engaged and socially supported. Even very functional older people, if their children have moved away and their friends have died or moved into care, can become quite socially isolated, and they may not have actually developed the skills to start new relationships or be involved in the community just because that has not been their social style to date, for example. You have people at that end of the spectrum through to people who perhaps have chronic illness and mobility issues, maybe some sensory deficits and/or some cognitive impairment. Even people with that degree of disability still require some social engagement. Anybody will start to feel miserable if they do not have some sort of social interaction, so you are clearly going to need to have a range of social activities, depending on people's care needs and abilities. A personal favourite would be setting up, increasing and supporting some funding for community exercise programs for older people. I think that works at lots of different tiers, partly because people feel they are doing something positive, they are out and about, they might be joining walking groups which improves their mobility and maintains their ability to engage socially in lots of different ways because their mobility is well maintained. It also gives them a lot of opportunistic social contact. It maintains a sense of agency, so therefore they are more likely to be able to be assertive and organise themselves, follow things up and perhaps ensure that their finances are being properly managed et cetera.

[10.30 am]

It is also a relatively low-cost way of reducing risk of cardiovascular disease, cerebellar-vascular disease, dementia, anxiety and depression, all of which are not only risk factors for elder abuse, but also risks in their own. It is also relatively socially acceptable, because many people do not like to feel like they are the recipient of care services; whereas if they go along to an exercise program, they feel like that is something positive that they are doing for themselves. That is a very general shotgun approach to what might be helpful. But I think there needs to be a much more nuanced range of options as well so that aged-care services are incentivised and supportive to ensure that social engagement for an older person is one of their priorities, not just the management of personal care and other issues.

The CHAIRMAN: Something like that—the community exercise program—and the various obvious benefits that it would provide, including mitigating against social isolation, still does not in and of itself address the capacity for any person, older or otherwise, to mask what is really going on. They might well be in a community environment engaging, going walking and all the rest of it, but, because of that sense of shame, not willing to disclose what is really happening.

Dr McGOWAN: Absolutely, but, on the other hand, if they do not have social contact, they do not have the opportunity to even raise the issue or feel comfortable enough to have a confidant. I think one of the other concerns for older people of course is that as they get older and they have lost family, friends and spouses, they may not have a ready, easy confidant that they can start to gently raise those concerns with. But, on the other hand, if they are part of a walking group and there is a physio who is involved and is noticing there are aches and pains, or maybe they are looking a bit demoralised, sometimes it is just that. Certainly we find clinically that many of the older people who we have in our mental health inpatient units are much more willing to talk to the physio about issues

than they are to the social worker at times, and it just because it is incidental—they are working on something and the physio will pick up something and work with them. I think it is that opportunity that really makes a difference.

I will just follow up on the issue about shame. I think that is a real concern. I think most people are very ashamed when a family member is abusing them in any way, whether it is financially or emotionally. They feel incredibly distressed by that usually. It is because I think most parents feel responsible for their children's behaviour. They feel that somehow when something like that has happened, it is their fault because of the way they have raised the child. There are all sorts of issues that feed into that sense of shame. I think that there needs to be a community education process that addresses that and just makes it really clear that older people have got rights to social engagement, to their resources being used in their best interests, et cetera. Certainly, there are some good campaigns. I cannot quote them off the top of my head, but I have seen some good posters that address those sorts of things well, but it probably does need to be more widely available and trained and circulated.

Hon ALISON XAMON: You see a wide variety of people because you are a public service. In your experience, have you found that there are particular cultural groups that are either going to be at a high level of risk or, alternatively, have better protective factors in place? Could you make some comment about that?

Dr McGOWAN: Certainly in some of the services that I have worked in, we have had a high prevalence of people from multicultural backgrounds. There certainly is a cultural influence in the way that older people are treated, both for better and for worse. These are generally some of the more traditional cultures—cultures where there is a tradition of older people being cared for in the home. To some extent, those people often have a much better quality of life because they are kept at home, they are supported and are part of a large multigenerational family. But, at the same time, some of those communities are more likely to see the financial resource as a family resource because that is more in keeping with the family tradition. There are risks. Maybe if I could just be a little clearer. I think depending on the cultural background, there are different risks and advantages when it comes to elder abuse. You may find that in an English-speaking western culture, where there is less of a tradition—in more recent years at least—of older people being cared for in an intergenerational household, it is more likely that the elderly person will go into a residential care facility and under those circumstances have more scrutiny of their financial resources; but, on the other hand, maybe they do not have the same sort of emotional support that others might get. You would not want to make sweeping statements; it is just that there are a different vulnerabilities and different advantages and disadvantages of those systems.

Hon TJORN SIBMA: On that, and it ties in, I suppose, to your call for better training and probably a more sophisticated awareness of early warning signs, do you see similarities in the pattern of elder abuse as it is perpetrated on a victim across cultures or does the dynamic slightly play out a little differently, to the point that it may be harder to detect at an earlier stage in a particular group versus a control sample, for example?

Dr McGOWAN: In terms of picking it up, I think some cultures will be more or less closed than others as well, so maybe surveillance is not as easy. If there are fewer external people going into support, then there is less opportunity for abuse perhaps to be picked up. It is interesting across different cultures, in that there is quite a marked variation in incidents of suicide in older people across cultures—I use this as an example. For example, many countries that were part of the former Soviet Union have quite a high suicide rate in the older population. It seems to reflect a lack of community and aged-care resources, and people just got to the point where they really could not

get up and down from their apartments and felt they were a burden on society and there were no resources for them, and so there was quite a tolerance of suicide in that population. When people from that background come to Australia, we still see that the suicide rate is still higher in that particular group, for example.

In most cultures, the male suicide rate is three to four times that of the female suicide rate in the older population, whereas, in rural Chinese culture, the male to female has been quite similar. I am using those as examples to really say that it is a specific culture, often of a particular political background, cultural experiences in terms of social supports, as well as the traditional family dynamics, that all feed into the issue that you are raising—are we more likely to pick it up and are we more likely to do something about it? Certainly some cultures, as you know, place enormous value on face, and on reputation and standing in the community. Under those circumstances, it would not be hard to predict that the reporting of elder abuse is going to be lower than when people come from a community that is perhaps a bit more transparent and a bit more willing to acknowledge deficits, for example. Does that answer your question?

Hon TJORN SIBMA: It does.

The CHAIRMAN: Let us move to term of reference (i), which is for the committee to consider new proposals or initiatives that may enhance existing strategies for safeguarding older persons who may be vulnerable to abuse. You have recommended an education and training program to target GPs, clinicians and other care providers to identify potential cases of elder abuse. We have two questions on this. Firstly, how would you describe or assess the current capacity of GPs and clinicians, and how skilful are our Western Australian GPs and clinicians in this area? Of course, none of us is suggesting that there is not goodwill and not good intent by our practitioners, but how skilful are they in this area, which you could describe as an emerging area? Secondly, what sort of education and training would you recommend for GPs and health professionals?

Dr McGOWAN: There is not a lot of evidence in this so I am really just giving you my personal experience when you ask that question, and it is incredibly variable. There are some GPs who are very skilled in this area and there are some who do not know much about it at all and probably would avoid looking for it because as soon as you pick it up, if you do not have a hammer and all you are seeing is nails, it is a bit distressing, I think. So unless people know what they are doing and know what options there are, they are much less likely to pick up an issue. I think it is very variable across the workforce. Certainly, those parts of the workforce that are more focused on aged care are more likely to be involved in this and certainly have started to develop their own internal policy responses for surveillance and reporting, for example, but it is by no means consistent. Having said that, too, our care providers, particularly in this space, are often relatively poorly resourced when it comes to time and the individual capacity to respond. There are huge demands on our general practitioners to be experts in all things, and if you talked to a general practitioner and you told them that they needed to do more training in anything, they would be exasperated because they feel like they are expected to be expert in so much.

I think within that it is important that there is a tailored education program to clinicians, and particularly one that is web-based and available in a just-in-time manner. You could, for example, do something that was more along the lines of surveillance, helping people pick up the early warning signs and what they might do in responding to that, and then referring them to websites that are much more detailed once they have an issue in front of them. That is generally the way that GPs work—to have a good general understanding of some of the issues and what the early warning signs of something are, and then they will actually delve into the detail, often referencing current literature, but they do not expect themselves to be expert on everything at their fingertips. I think

you could take a similar approach with elder abuse. I would be wary of berating GPs and telling them that this is the next thing that they need to know about.

Hon ALISON XAMON: But this could be picked up in the HealthPathways project or something like that, could it not?

Dr McGOWAN: Yes, exactly. There is a good project at the moment —

Hon ALISON XAMON: The WA Primary Health Alliance.

Dr McGOWAN: Thanks, Alison—that the WA Primary Health Alliance is running, which is a web-based program where they look at a particular issue. It is targeted to GPs and it is available on their desktop, so if somebody comes in with an issue, they can look it up and see that. It is a mix of both a care pathway and advice on early detection and treatment of lower-level issues, and it can be applied across all sorts of issues. This in terms of elder abuse would be a good simple and relatively easy win to ask WAPHA to consider doing a pathway for elder abuse.

Hon ALISON XAMON: Then it could also be referred through to agencies such as Advocare and the older adults rights service?

Dr McGOWAN: Absolutely.

Hon TJORN SIBMA: Could there also be value in tailoring such a detection toolkit, for want of a better expression, across areas of non-clinical or even non-health practice? GPs are an obvious target, but I just put this to you—I do not know whether it is a good idea or not—people like barbers and hairdressers who are the sort of informal confidant of many people? Will we get to a point where we could possibly roll out something a little more generic that allows people to be conscious of the one or two odd signs that do not quite fit and then have them refer direct or provide informal guidance and support?

[10.45 am]

Dr McGOWAN: I do not really know, would be my frank answer, but I do wonder whether, if you are going to be looking at that sort of level where maybe it is just a more generic thing for a community, you might also find that there are neighbours or that there is a cleaning agency that is going into a house—all sorts of different opportunistic contact that people might have with an older person and/or their family or a care provider. So if there was just general communication, such that the community becomes increasingly aware of the risks of elder abuse—what are the early warning signs and what is a simple reporting process for them to be able to say, "I'm a bit concerned about so-and-so." They may not have the capacity, the skills, the time, the resources or even the ability to follow it up themselves. You can imagine if you are a cleaning lady going into somebody's house and you think, "I'm just not sure about that." They are not paid very much, their job is not necessarily very secure, they do not have the time, it is not really their role, but it would be good if perhaps they could ring a number and have a conversation and say, "I'm concerned about this", and maybe an agency could follow it up.

Hon TJORN SIBMA: I suppose where I might be heading to is: would you see value in a broader public awareness campaign along the lines of campaigns that are being run for domestic violence? Would you see a particular efficacy in that, and would that make —

Dr McGOWAN: Definitely.

Hon TJORN SIBMA: — your clinical role a little bit easier to discharge?

Dr McGOWAN: Definitely; I think so. That is what I would be talking about when I think about a tailored education program. There are some people that need to know more about it, but I think a general community awareness and an understanding of how to respond would work in lots of

different ways. First of all, I think it would increase people's willingness to report and to follow up—they would feel more comfortable doing it—because I think sometimes people are not quite sure what is right and what is wrong, and what is elder abuse and what is not. At the thin edge of the wedge it is often not that clear, so I think community education would be really helpful. I am obviously talking about certainly a tiered education program, including community education. That is the short answer.

The CHAIRMAN: Okay. The final term of reference is to consider any other relevant matter, so are there any other questions that members have to ask?

Hon ALISON XAMON: You have been pretty comprehensive.

The CHAIRMAN: Yes. Are there any final comments that you would like to make for us this morning?

Dr McGOWAN: No, except to say I think the sector really appreciates the attention on this issue. I know you would not be giving it this sort of attention if you did not share the concerns that older people who are vulnerable and are victims of elder abuse have. It is a dreadful violation of people's rights and dignity, and it is something that we need to be much more aware of and do more about. It is appreciated that you are giving it this sort of attention.

The CHAIRMAN: Thank you very much for attending today. A transcript of this hearing will be forwarded to you for correction. If you believe that any corrections should be made because of typographical or transcription errors, please indicate these corrections on the transcript. If you want to provide additional information or elaborate on particular points, you may provide supplementary evidence for the committee's consideration when you return your corrected transcript of evidence. Thank you very much.

Dr McGOWAN: Thank you.

Hearing concluded at 10.49 am

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