

# SELECT COMMITTEE INTO ELDER ABUSE

## INQUIRY INTO ELDER ABUSE



TRANSCRIPT OF EVIDENCE  
TAKEN AT PERTH  
MONDAY, 7 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 9.52 am****Mr PAUL COATES****Chief Executive Officer, Carers WA, sworn and examined:****Mr SEAN GARDYNE****Program Manager, Carers WA, sworn and examined:**

**The CHAIRMAN:** On behalf of the committee, I would like to welcome you to today's hearing. Before we begin, I do need to ask you whether you will take the oath or affirmation.

[Witnesses took the affirmation.]

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

**The WITNESSES:** Yes.

**The CHAIRMAN:** These proceedings are being recorded by Hansard and broadcast on the internet. Please note that this broadcast also will 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 title of any document you refer to during the course of this hearing for the record. Please be aware of the microphones in front of you and try to talk into them, ensuring 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 that the 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 series of questions for you this morning, but before we commence, would you like to make an opening statement to the committee?

**Mr COATES:** Yes, just a very short one. My organisation represents family carers as defined by the Carers Recognition Act 2004. I would just like to make the statement that people in relationships—we are talking about elder abuse here—the relationship is not necessarily a caring relationship in these cases. Caring as defined by the act is an unpaid family member or friend who cares for someone with mental illness, chronic illness, disability, frail aged—which is probably more relevant to what we are speaking about today. I guess my concern with the subject matter is that it is a subject matter of real concern to us as an organisation, but equally, on the other side of the coin, we are dealing with family members who are in very complex and difficult situations, and long-term situations, and often find themselves in a position that they do not want to be in, particularly when you get towards end-of-life issues, and then wills and all that sort of thing come into it. Also the dynamic of the caring role can be that, in many cases, the family member in the caring role has spent a lot of their life in that role, and that has had an impact on their ability to earn money, their work, and in the case of women, they have not been able to build up superannuation or anything of these sorts in particular, so you are leaving people in caring roles in quite a vulnerable situation, so once you get into circumstances where there are accusations of elder abuse, often the carers themselves

are the ones who are in the abusive role, because they are trying to balance their family responsibilities and their emotional responsibilities, caring for somebody who may not necessarily be reasonable and rational all the time. Then there is all the complexity of family members and friends in that circle who also will have views and opinions on a whole range of things. In these sort of topics I am also concerned about the reputation and how people that care and love can be perceived. I think that is it, thank you.

**The CHAIRMAN:** Thank you very much, and thank you both for attending. As is the practice of the committee, I propose to quickly touch on each of the terms of reference. We have certain terms of reference that we particularly want to ask you some questions on, but we still invite you to make any comment that you might wish on others.

At the outset, the first task of the committee is to make a definition of elder abuse. What definition of elder abuse does your agency use, and how does the relationship of trust element of the definition affect carers of older people?

**Mr COATES:** We would use the definition that the government would use in that, because we are a government-funded agency. That definition does not have a great deal of impact on the way we work and behave. This is an issue that we need to be acutely aware of, and it is one that is led by one of our main funders, the Department of Communities now, as one of the issues that they deal with, and we deal with other agencies who have a far greater focus on this as an issue—it is not one of the main focus issues, but there are agencies like Advocare, in particular, who are more focused on that.

**The CHAIRMAN:** You mentioned that Carers WA would use the definition proposed by the government. The government has an organisation called APEA:WA—the Alliance for the Prevention of Elder Abuse—and I note that it has a number of members to that organisation. Your organisation is not one of those members, and they have prepared an elder abuse protocol which does change the definition of elder abuse. Has there been communication to your organisation about that change of definition?

**Mr COATES:** No.

**The CHAIRMAN:** So today is first you have heard of it?

**Mr COATES:** Yes. An organisation like ours, because we are funded by the government, and because of the nature of what we do, we have such a wide range of cover—it is not just mental health, it is not just aged care—there are a whole range of not-for-profit agencies in there, we are not funded to become members of all those organisations. A lot of them have fees and that. What we tend to do is do reciprocal arrangements where they approach us. We have a lot of members. I think there is about 200 or 300 organisations who are members, but it could get into the thousands very easily, given the breadth of what we deal with. It should not be a big surprise that that is the case.

**The CHAIRMAN:** I guess my concern is that sometimes when definitions are changed, it is all very well for the members who decide that definition change to be aware of it, but if the rest of the community—in this case carers—are not aware of it, then it is not particularly helpful.

[10.00 am]

**Mr COATES:** I do get that. We deal with a whole range of complexities in the family situation, so I guess the basic tenets of what abuse could consist of—whether that is physical, financial, mental or otherwise—staff are aware that we have trained counsellors who are aware of the issues. Whether or not that is encompassed in some definition by given agencies is probably not overly challenging for us; it is having emotional intelligence and awareness of what goes on in the family dynamic.

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**The CHAIRMAN:** We will move to term of reference (b), which is to identify the prevalence of elder abuse. Do you have any particular comment you wish to make on that?

**Mr COATES:** Not a great deal. We have done a lot of research, because obviously our focus in research is on carers, and there is very little around that pinpoints people in the caring role and elder abuse. We actually have research around the place that talks about the opposite dynamic, although you could argue that it could be a form of elder abuse if the carer themselves is elderly. For example, Carers Queensland did a survey of carers and I think we said in our submission that about 26 per cent of those in that survey, which is a quarter, themselves felt in an abusive situation in that caring role. People often think that in the caring role, you have got someone in the caring role, and you have got someone being cared for, and therefore the person being cared for is the vulnerable person. That can be the case, but it is not necessarily the case at all; it can be the other way round, in fact.

**Hon ALISON XAMON:** So you are saying that it is 25 per cent?

**Mr COATES:** Twenty-six per cent. The survey, to be precise, Alison, was 26 per cent—the Queensland survey. I think I quoted in there about a few hundred.

**Hon ALISON XAMON:** Was that mainly looking at it in the context of spousal relationships?

**Mr COATES:** It would have been, yes; it would have been.

**The CHAIRMAN:** You mentioned the Queensland survey, which is from 2015. There is no comparable Western Australian survey?

**Mr COATES:** No.

**The CHAIRMAN:** Is there any intention to have a survey in Western Australia?

**Mr COATES:** No.

**The CHAIRMAN:** Do you know if any of the other states are intending to do a survey?

**Mr COATES:** I do not know of any intention. We meet quarterly with other CEOs and we talk about research, and that has not been brought up, but I cannot guarantee that as a fact.

**The CHAIRMAN:** The federal government has announced that it is looking to establish a prevalence study. Has there been any communication with your organisation about that?

**Mr COATES:** No.

**Hon TJORN SIBMA:** With respect to the Queensland survey, would you anticipate that the proportion of people—of carers—being abused would be the same in Western Australia?

**Mr COATES:** Possibly; I have no scientific basis to say that.

**Hon TJORN SIBMA:** Is there nevertheless an insight into the forms of abuse that that might take?

**Mr COATES:** I think there is. As I say, we are dealing with very complex family situations here. You could have an individual—let us take social housing as a good example here. I am just giving a specific example. In our social housing sector, you could have somebody in a role of caring for somebody in social housing, but the tenant is actually the person being cared for. If there is a difficulty in the relationship, the carer, who is basically dedicating their time and living in the social housing home tenanted by the person being cared for, has no rights, so the person they are caring for can have that person removed from them because they are not the official tenants. Even if that person passes away, the person in the caring role, again, has no automatic rights for that tenancy. I guess what I am trying to get across is that there can be some very vulnerable situations, and then people who perceive something happening from the outside—financial issues of abuse—may think,

for example, “The carer here is trying to take advantage; take over the home.” But in some cases they have been placed in a situation where they have not had the opportunity to earn employment and own their own home; in fact, their life has been dedicated to a large extent to caring for that family member. But an outsider may say, “They’ve been caring for that person, and now that person has passed away and they’re trying to grab all the assets.” I am not saying that is right or wrong. I am just saying that is the complexity of the situation. So it is not always as simple as we all imagine it might be.

**Hon ALISON XAMON:** If there is one thing that this inquiry has drawn out, it is the complexity of the issues around elder abuse, and also even with children of parents who themselves have grown up with abuse and are now finding themselves in the position of carer. It is very complex and hard to unpick. What the research has also indicated to us is that the bulk of elder abuse as defined generally is in the form of financial abuse. I want to come back to what you mentioned before, because it sounds as though you are almost describing, particularly if we are talking about spousal relationships, more physical abuse. Is that the type of elder abuse that was generally identified, and also was it mainly women carers who were on the receiving end of that abuse?

**Mr COATES:** I think that the examples I have been trying to give are ones such as financial abuse, and tenancy and employment. I think a more prevalent thing is probably psychological rather than physical —

**Hon ALISON XAMON:** Could you elaborate a little on that, please?

**Mr COATES:** I guess the person in the caring role has an emotional attachment, usually, to the person they are caring for and has a feeling of responsibility in that role, and there is no, necessarily, guarantee of human nature that that caring approach is reciprocated by the care recipient. The care recipient may be angry about all sorts of things or emotionally distraught themselves. They may have a condition which does not enable them to be sympathetic at all to the people who are caring for them. They may actually feel aggressive and angry because of the situation they are in themselves. So I think the relationship often in a caring role, whether there is abuse or not, changes. You marry somebody and you have a loving relationship, and all of a sudden you become the nurse, doctor and housekeeper for this person and the emotional relationship side of it falls away. There are all sorts of issues that can occur between both parties from that. There is certainly a feeling of responsibility and a feeling of guilt. You find that families have tried their hardest and cared for somebody for a long period of time, but it gets to the point where the person being cared for actually needs more professional help and needs to go into a care home and that sort of thing. There is a real sense of guilt and emotional loss even with that sort of transition. So, yes, there is a complexity to relationships, and I would say that a lot of it is more financial and psychological.

**The CHAIRMAN:** I guess that leads us nicely to the third term of reference, which is about forms of elder abuse. I think that you have sufficiently covered that, unless there is anything further you wish to discuss on that.

**Mr COATES:** I mean, for people in caring roles who have been caring for somebody, it would be very hard to have significant physical abuse—there can be; all sorts of things can still happen. But certainly from the other perspective, yes, I think it is a psychological thing—from both sides, potentially.

**Mr GARDYNE:** Can I add a little to that to mention that sometimes the abuse can be unintentional. I think one of the things that was pointed out is that it might be a case of someone just not having the right amount of information, having a low level of health literacy and potentially not having enough information to assist the person. They might not be equipped to help, for example, if someone is lying in bed a lot and they do not know how to move someone appropriately so that

they do not get bedsores et cetera. Occasionally there are issues of abuse that may occur that may look like they are intentional but it just may be a matter of the person not having the right information or skills to be able to assist. Then there are the feelings of guilt and shame associated with that because there is a sense of responsibility and of wanting to assist this person, especially if it is a loved one, and not wanting to maybe get other people involved, because they feel like it is their role, but they just might not have the ability to do that. So it may be unintentional, not direct.

**Hon ALISON XAMON:** What sorts of practical solutions do you think would help to mitigate those risks?

**Mr GARDYNE:** More education, I think. A lot of people in caring roles do not identify as being in a caring role; they just consider themselves a loved one—a husband or a wife. It is trying to provide a bit more education to identify, first of all, who the carers are and provide some information to them as to what supports are out there and available, and to open up more avenues to education, to understand more about health issues and psychological issues et cetera to be able to assist better.

**Hon ALISON XAMON:** Where do you think would be a helpful first line for this information—GPs, for example? If the government were to invest in trying to do this, where do you think that would be best served?

[10.10 am]

**Mr COATES:** Are you talking about how to identify the most effective—cost-effective as well—means of support? There have been lots of inquiries and reports on more effective forms of carer support. I am on a palliative care-wide group that reports to Minister Cook. Certainly, what they have identified there is knowledge and education, not just of the individuals involved—in other words, the carer and the family members—but even if clinicians and so on understand what the carer's role is and what difficulties and challenges they face and what education they may have for that. That will only take you so far. You would probably get to situations where people get so stressed from that role and, therefore, are emotionally heightened in situations, and as time goes by that exhaustion tends to kick in and is more likely to happen. It is about giving the right sorts of supports for the family members themselves. It can be self-identification, as Sean has mentioned, because if people self-identify, they know what they are and how they fit into the remit of if you want government support and they recognise themselves as a carer, there are carer supports that are advertised and available to them, which is social support and respite and a whole range of other things. But it is just keeping those going. What concerns me is the move to individualised funding, where the funding that used to fund general programs is moving to the individual, like in disability, in mental health and in aged care. All that money has been focused on supporting the individual, and there are carer supports which are currently being funded through what we call block funding and which are being lost because they are being used to underpin the care of the actual person with a disability or mental health illness. I recognise that is an erosion of supports, then, in the appreciation of the informal supports—the non-doctors and non-nurses—who actually underpin the whole system. With that tension coming on, you can only imagine that there is going to be more and more prevalence of elder abuse.

**Hon ALISON XAMON:** Of course, with the transition to the NDIS, we are not necessarily going to be talking about the people who this inquiry is looking at, which is elder abuse, because the very definition is people aged over 65. So is there a risk that some of that block funding to assist people who are caring for elderly people might also be losing resources?

**Mr COATES:** With aged care, it is the same principle of individualised packages. That is what I am saying. Even in mental health, it is getting that way. Of course you are right about the NDIS, but only a certain proportion of people are going to qualify for the NDIS. There are going to be lots of people

with disability, and people with disability who are aged, who are not going to qualify for any of these services anyway because they are not defined as having a severe and profound disability and therefore eligible for the scheme. You do not stop being disabled once you get to 65.

**Hon ALISON XAMON:** I suppose what we are hearing is that there is an increased prevalence of elder abuse. That could be an increased level of reporting—we do not know—but nevertheless there is an increased level of elder abuse that we are becoming aware of, and you are telling us that that is happening in an environment where we are looking at diminished services for carers.

**Mr COATES:** For carer supports, yes; that is the point I am making. Those supports could be social supports, training and education, counselling, respite—a whole lot of things. What that is doing is helping to maintain the resilience of families in a caring role. If that is being eroded away, that resilience is going to be eroded away at some point in the future, because the money that was being used to support carer support and, hence, their resilience is being eroded away. We are dealing with the demographics of an ageing population here; we have a tsunami of aged care coming in, so there will only be increasing pressures on families rather than less, particularly in this area.

**Hon ALISON XAMON:** In terms of the support carers are seeking from your organisation and information as well, what is the nature of the information that they generally come to you saying they want assistance with?

**Mr COATES:** We have an advisory line and a lot in this particular area we are talking about today is about advocacy and rights and the Public Advocate. Those sorts of issues and understanding of them are often raised, and financial issues as well, financial strain on the family. That is often the starting point of the conversation but that can quickly develop into identifying that that person actually needs some emotional support or formal counselling or advice or social supports from there, but that is one of the issues. I do not know if there is anything you have come across, Sean, at all?

**Mr GARDYNE:** That is right. It usually starts out of something; it might be assistance: Where do I go to seek financial assistance if I am helping support someone but I do not have the financial skills to be able to deal with that? Where do I go? Usually there are underlying issues that get unpacked and they might need further support, whether it be through the counselling that we do. There are varying issues that they might initially contact us about, but it usually branches out to a lot more complex needs. Understanding of finances, understanding of how to advocate for the individual and any difficulties they might come across—they look for advice on.

**Mr COATES:** It seems that advance care planning, advanced health directives, all that sort of stuff, is also tied in with power of attorney and a whole range of other issues. There are courses being run by a number of organisations and we often refer to that. Another issue that commonly comes through related to this area is the situation I mentioned where you have been in a caring role for a lot of your life but you are getting to the point where the person being cared for actually needs some 24/7 care. It is seeking information about what is around, what can be funded, what can be supported, what aged-care homes are in my area and a whole range of other things that come through there.

**The CHAIRMAN:** This advisory line you have, this is a Western Australian advisory line?

**Mr COATES:** Yes, we actually have two sources of funding. There is a federally funded program that funds counselling and advice, but equally the Department of Communities, when they re-tendered, we put in a bit of an out-of-hours addition to that beyond five o'clock because people and families might be working, so we take that through to 7.30.

**The CHAIRMAN:** Okay, but the advisers on the line are Western Australians?

**Mr COATES:** Yes, they are Western Australians.

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**The CHAIRMAN:** People who are, if you like, eligible to ring the line, it is intended for it to be Western Australians who ring?

**Mr COATES:** Yes.

**The CHAIRMAN:** So therefore the hours of operation—you mentioned there was an out-of-hours component.

**Mr COATES:** It is a nationally funded program, so you can go to any state and territory—because it is a nationally funded program, the advisory line—and there will be an advisory line there because it is funded by the Department of Social Services. In Western Australia, we get an element of that funding, that national contract, as do Tasmania and Queensland. In addition, the Department of Communities gives a small amount of funding to keep that going beyond work hours.

**The CHAIRMAN:** I appreciate that, but what does that mean—beyond work hours? Does that mean it is a 24-hour —

**Mr COATES:** Five o'clock until 7.30.

**The CHAIRMAN:** Is that 7.30 pm?

**Mr COATES:** Yes.

**The CHAIRMAN:** When does the line open in the morning?

**Mr COATES:** Between 8.00 to 8.30.

**The CHAIRMAN:** Okay. How many full-time equivalents do you have working on this advisory line?

**Mr COATES:** One and a bit.

**Hon ALISON XAMON:** And that would be for carers—the broad range of people in the caring community?

**Mr COATES:** As I said, often the call can be somebody presenting and asking for a simple fact: “I’m in this situation; I don’t know what to do. Can you tell me where I can go and get supported Centrelink”, or whatever it is, because people might never necessarily have engaged with these services. Then it can develop into a whole lot of things, because that can trigger all sorts of emotions and things and then you find yourself not just giving information like an address and phone number, but giving all sorts of supports that follow on from that.

**The CHAIRMAN:** Do you have a sense of how well known it is to the carers of Western Australia that this advisory line exists?

**Mr COATES:** We do our best. We advertise on websites, we occasionally advertise in media like radio and stuff, but it is an uphill battle because the estimated number of carers in WA is about 300 000, and a lot of them do not self-identify in that role—so unless you self-identify, why would you even pick up something for aged carers? In other certain sectors, they do not like the word “carer”, but I like to stick with it because it is almost a brand that at least the government recognises, the legislation recognises, and we can advertise that brand so to speak. You could be driving home—god forbid—with your partner, have a bad motor accident and one of you could end up with an acquired brain injury, so you have this perfect life that all changes like that. Why would you know about being a carer, why would you know about disability services, why would you know about any of that? It is like painting the Forth Bridge; you start it off and by the time you finish, it is time to start again. Awareness raising is a continual thing. How many people know about it? I could not tell you; we have never done that survey. We just keep advertising, pushing it out there, and the lines are quite busy.

[10.20 am]



**The CHAIRMAN:** If someone was to ring your line and disclose an incident of elder abuse, what would be the normal practice for your adviser.

**Mr COATES:** It is a difficult one because of the Privacy Act and issues like that. I think the first point in something like that would be probably to counsel and to dig a bit deeper into the broader complex issues there. If someone ultimately is reporting what seems to be a hard-and-fast crime, we are in a really difficult situation. If someone says they are going to slit the throat of the person they are caring for or commit suicide, you have to make a judgement, and it is a judgement. If we think it is serious, we would report it to the police.

**The CHAIRMAN:** You might not know necessarily who the person is because it could be an anonymous call.

**Mr COATES:** Totally. That is one issue. It is having people trained with an understanding of issues like mental health issues and an understanding of why people are saying things and disclosing things and making a judgement, and frequently it is a judgement.

**The CHAIRMAN:** Is there any interaction between your organisation and Advocare, which runs the elder abuse helpline?

**Mr COATES:** Yes, as I said at the beginning, Advocare is one of the ones we are a member of and we do a lot of joint work with a whole lot of organisations. With Advocare, for example, we actually did a joint project with them two or three years ago that was about training and setting up processes in care homes to ensure families continue to be included and supported, even if the client ends up in an aged-care home, keeping that relationship going, because that is a pretty important thing. That is an example of something we work together on, but yes, we have a good close relationship.

**The CHAIRMAN:** Are members happy for me to move on? We will move to term of reference (d), which is to identify the risk factors for elder abuse. Your submission refers to carers themselves experiencing stress and you have touched on that this morning. Are there any other risk factors that you want to draw to the attention of the committee?

**Mr COATES:** I think there were questions—I have referred to all sorts of risk factors, I guess. As I say, the demographic of the ageing population, the sheer numbers, it is going to get more and more like that. Even in disability, for example, people with a disability or who have certain disabilities would have been dead by the time they were in their 20s and 30s, now because of advances in medicine and care people are living to quite old ages, and that itself is creating issues with sort of sandwiched innovation of people—so I think the demographics are only going to increase the demand on the aged-care sector and will increase the incidences of these sorts of issues. Also what I was saying about the funding and the concern about maintaining the resilience of families during all those other demographic pressures, the sheer increase in numbers, is something of concern to me. I think they are the key risk factors—the scale of what we are dealing with in aged care. People are living longer. People attempt to live longer and healthier, but they are living a lot longer and that brings new things like dementia and all sorts of things that were not as prevalent 50 or 60 years ago. All these things come into it. With something like dementia, as an example, how can you possibly start to identify what is going on in that family if the person who might be abused, for example, has something like dementia and can barely remember what day it is, let alone what has happened to them week in, week out?

**Hon ALISON XAMON:** One of the things you started talking about was the complex health needs that emerge and how carers are not necessarily receiving the assistance they need to be able to better manage that. Could you elaborate a little bit more on that in terms of the deficits in services and the sorts of tangible improvements that could be implemented to offset that risk?

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**Mr GARDYNE:** Could you just repeat that, Alison?

**Hon ALISON XAMON:** You identified that complex health needs, particularly for carers looking after elderly people at home, is emerging as a risk area. I would like to know what you think could be done better to help alleviate that as a risk.

**Mr GARDYNE:** One of the things that popped into my head and then escaped me, unfortunately, was that sometimes the carer's abilities are overestimated. That is one of the difficulties we come across. Because carers feel that sense of responsibility, it may be presumed that they are able to look after people in the home, outside of hospital, so moving from hospital back to home again. I think that is probably driven by the fear of the person either being taken away and put into a home et cetera, so sometimes that communication is not quite as transparent, possibly, as what it could be. Then we find carers in the situation that they are out of their depth and potentially either not wanting to engage services in case it is seen that the person needs to be moved on, or, potentially, the person they are looking after may also be refusing services and not wanting other services to be involved with them as well, so that puts the carer in a difficult position if they do not have that skill set to be able to look after the person well. That is a difficult one. We have a program where we are linking into the hospitals, giving information to staff, trying to provide information to the nurses and doctors in the public hospitals around the metropolitan area to highlight issues around carer support and carer needs. We are hoping that those conversations will help build and connect the medical staff to identify carers and care recipients better and be able to have these conversations and hopefully that will reduce the impact of those who are not quite in a position to be able to look after people.

**Hon ALISON XAMON:** How long has that program been going for? Is it metropolitan-wide?

**Mr COATES:** Over 10 years.

**Hon ALISON XAMON:** Is it metropolitan-wide?

**Mr COATES:** Yes—20 hospitals. It is not just metropolitan. There are some centres around the place.

**Hon ALISON XAMON:** Has it been independently evaluated? Do we know if it is working?

**Mr COATES:** It has been in its lifetime—not that recently—and, yes, it has proved successful in increasing awareness. It is about training, but not only training. It is about ensuring the system and hospitals identify families who might have a caring role and then give them a pack. We have a pack that we give to families that gives them all sorts of advice on what they might do once the patient is back in the home and the caring role, but it is also educating clinicians and nurses and therapists and all sorts of people within the hospital about what the issues are for carers. It is basically presenting the medical argument that if you are sending the patient home and people are well enough educated and informed in the home who are going to continue that after-care, you are less likely to see the person back in hospital. Once they are in the home, there are all sorts of things from wound dressing to emotional support, and this is just ensuring that knowledge. In terms of support, for example, we talked about education, and it is often a simple thing to just give people more education, but there is all sorts of education you can have in the home from physical stuff like manual handling and lifting and stuff to emotional support, resilience and tools for that. Also, there might be all sorts of education in different areas. Does the average member of the public know what dementia looks like and how it presents and why people act and behave and say what they say, how long it lasts for and what they mean by that? If you are a family member who is suddenly presented with all sorts of symptoms and strange and unusual behaviours that you have not experienced the last 20 years but all of a sudden are experiencing, it is having an understanding of what that is. It is

the same in the mental health area, is it not? It is identifying and being able to deal with some of those issues in the home environment and what that means and how you can deal with that.

There is education about what service and supports are available in all these areas that you can give in the home as well. Also, if we are pushing more care into the community and more care into the home—because we are trying to have policies where we are trying to keep people in their own home for longer—that has an impact on families and their carers if you are pushing away from institutionalised care to in the home. I am from the UK, as you probably guessed, and care in the community is quite resource intensive. It is a lot more resource intensive than having institutions on a hill at the end of the city and putting loads of old people up in there. That is cost-effective. But doing it in the community, there is a whole lot of supports that you need to get those resources and supports out in the community. I think not a lot of that has been thought through in government policy and how that is going to be funded and supported; and, if it is not, that resilience will break down and you are going to find yourselves with lot more issues, including things such as elder abuse, in the community.

[10.30 am]

**The CHAIRMAN:** One of the various things I am interested in about this morning's evidence is this issue of carers not self-identifying as carers and that being a risk factor in elder abuse, because it appears that if a person does not identify as a carer, self-evidently they are not going to ring Carers WA for advice.

**Mr COATES:** Correct.

**The CHAIRMAN:** As a result, they will not be aware of the supports that are available to them, increasing the probability that they will become stressed as a carer who, for whatever reason, chooses not to identify or is unaware that they should identify as a carer.

**Mr COATES:** They are just not aware.

**The CHAIRMAN:** By virtue of that, that will increase the probability that abuse will occur either through lack of skill or knowledge, or frustration or exasperation or whatever else.

**Mr COATES:** I mean, that is a risk. There are 101 other risks. It may be abandonment. The person may say, "I can't do this anymore." That is a quandary that they are facing. Many people put a lot of time and emotional effort and resources and forgo things such as employment and being able to build up superannuation for their own aged element of their life and they are in a very difficult situation as a result. Their resilience is down, their financial resilience is down, if not minimal, and they themselves are very vulnerable. Then they may be caring for somebody who has dementia and cannot remember who this person who is caring for them is, or they may have mental health issues, which causes all sorts of problems. We develop those as well in older age. There may be all sorts of behaviours towards the person they are caring for. It is a complex and very difficult situation. I guess all I am saying is that if we reduce supports for carers, because of the nature of the focus on individual packages for the person with the aged care packages or disability and that, and then we are pushing more into the community, and you have a population that is ageing and an increasing prevalence of mental health in society, there is a whole tsunami of stuff that is coming, and we need to try to ensure that we have the resilience in the community. It is a lot bigger issue almost that I am implying there.

**The CHAIRMAN:** The next term of reference is for the committee to assess and review the legislative and policy frameworks. Are there any particular comments that you wish to make on that?

**Mr COATES:** Only that there is a whole range of policies that have pretty much been mentioned. You can have a specific policy or framework about elder abuse and its identification and what it

consists of and how it is dealt with and all that sort of thing. It is the wider range of policies and an implication of those, which will have potential impacts on areas such as elder abuse.

**The CHAIRMAN:** For example, do carers provide feedback to your organisation on difficulties pertaining to the use of enduring powers of attorney or enduring powers of guardianship?

**Mr COATES:** It is not so much difficult as it is more not knowing what it is. People do not automatically know what these things are—advance health directive, advance care planning and enduring powers of attorney. They are grey areas, anyway. They are not hard and fast things. Again, with, I guess, things such as enduring powers of attorney, you are almost placed in a bit of a difficult position, are you not, because you are caring for somebody and then you are trying to sort out powers of attorney and wills and that sort of thing, and are you trying to push towards getting yourself favoured for that? Is that a form of elder abuse and financial abuse, because you are trying to influence them to do that, or are you just trying to do the right thing? Again, that complexity comes in, and people's perception of motivations and what is going on there is difficult.

**Hon ALISON XAMON:** Specifically, because you primarily deal with the Carers Recognition Act, can you think of any potential changes to the Carers Recognition Act that might be able to assist in this area of elder abuse?

**Mr COATES:** The department has currently agreed, or the minister has agreed, to review the Carers Recognition Act because it is now getting on a bit, and it was quite limited. It covers health and disability. What I will be pushing for is that we extend that act into a whole range of other government agencies—I am talking about things like education, even industry, and all sorts of areas with a care awareness—to increase awareness and understanding in that range of government activity. That might be an element which might help. I cannot see anything specifically on elder abuse because it is too broad an act. But I think that expanding the act to its non-traditional areas—in other words, outside disability and health—because it affects legal things and all sorts of things, as you mentioned, would be a good move. If the committee can encourage the minister to expand that, that would be good.

**The CHAIRMAN:** Which minister are we talking about?

**Mr COATES:** Simone McGurk.

**The CHAIRMAN:** Communities?

**Mr COATES:** Yes, Communities.

**The CHAIRMAN:** Are you aware whether that review of that legislation has commenced?

**Mr COATES:** I am. It started quite recently, but then they held off on it because I think they want to get some elements of it right, and they want to consult with other ministers because it could well affect them.

**The CHAIRMAN:** Has Carers WA put in a submission to this legislative review?

**Mr COATES:** We were selected as part of that committee. That is obviously in the review. Hopefully, we will be involved in it, yes.

**The CHAIRMAN:** But no written submission has been put in?

**Mr COATES:** No. It started a couple of months ago but then stopped because I think there was a political thing going on and discussion with other ministers.

**The CHAIRMAN:** We might pursue that on another occasion. If there is nothing further on this, members, I will move to assess and review service delivery and agency responses. We have touched

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on that quite a bit through the course of this morning's discussion. Is there any further comment that you wish to make on that?

**Mr COATES:** I just think there needs to be a far greater bringing together of different agencies. I mean, mental health, aged care, disability—there is a lot of crossover—and people with complex needs and all that. I think better planning and bringing together those agencies and the service delivery of those agencies is a way to go from that.

**Hon TJORN SIBMA:** Just on this theme, could I get a sense, please, of the respite services available to people in caring relationships and perhaps what can be done to improve that?

**Mr COATES:** There is a national program, the National Respite for Carers Program. There used to be a fair bit of money going into the Commonwealth Respite and Carelink Centres, and money for respite. That is appearing to be a lot less and less as the government is looking at some of its national policies, one of which is developing the integrated carer support service approach, which is sort of attempting to bring together different packages of money and have more of an integrated approach. They have set up a gateway and a website and a telephone line nationally, but in my opinion it is of limited success. I think the funding for respite has become less and less, and the funding seems to be less and less around, not just in aged care but in mental health, disability and all that. That is another element which will impact on resilience, as I said, simply, having a bit of a break to recharge. Lots of research has shown the beneficial effect of that.

**Hon TJORN SIBMA:** Is there any state-based program that provides respite support or assistance or relief in any way?

**Mr COATES:** There are bits and pieces here and there for different agencies, pockets of money here and there. We try to do a bit ourselves in the Department of Communities, but it is small and it is not significant. For example, we were donated a flat in South Perth, so we let that out to caring families for two or three days at a time for carers to go there. It overlooks the river. It is one flat. A couple of people a week is not any great deal. What we try to do as part of our respite is to create relationships with all sorts of organisations. It could be accommodation providers, you know, people who have their own hotels and things like this, or it could be something like the opera or a range of other things, theatre, and all sorts of other corporates who can give free tickets or maybe some free accommodation for a couple of days. We try to lever that, but it is all a bit pathetic in the scheme of things.

**Hon ALISON XAMON:** It is pretty minimal—it does not sound like it would really be enough to offset the risk of elder abuse.

**Mr COATES:** No; I am just trying to give examples of the bits and pieces around, and that is it.

**The CHAIRMAN:** If someone rings your advisory line and says, "Look, I really need some respite", your organisation will then try to identify one of these pockets?

[10.40 am]

**Mr COATES:** We will try. We will refer them to the Commonwealth Respite Carelink Centres and other agencies we might know. We will do bits and pieces, but it is pretty piecemeal. I am actually working with a couple of organisations—in fact, I am meeting with them today. We are trying to get some groundswell of doing something with the concept of a carers' retreat, which is getting some land outside Perth and having quite a holistic approach to a respite facility. We have approached a number of ministers in different guises at the moment. We are trying to work through a business case for that.

**Hon TJORN SIBMA:** In respect to the way respite is managed, as you said—I think I would use your word—it is a sort of piecemeal or ad hoc approach to this. What I am interested in, though, is in those instances where respite is provided, who actually does the backfilling of the care? Is there a standardised approach to that, or are you just relying on someone else?

**Mr COATES:** That is right. When a carer will come and stay in our flat, for example, they have to find somebody to provide that caring role. The old theory was—even in my organisation when I first began it—was that respite means that the carer has to be separated from the family member. I think that is old thinking. Certainly conceptually I think respite can involve the whole family, including the person being cared for. Just having them going to a different environment can often work. That is one approach. Some people may want a break. The person being cared for might want a break from the person caring for them. We ran a program with the Disability Services Commission, just a one-year program at the time, and we experimented with different forms of that. Yes, some people did not want to go away on a break unless they took the family member with them, and some people did. There is no right or wrong answer. I think you just need to be flexible and, like anything in life, understand the dynamics of the family and what works best for that family.

**The CHAIRMAN:** That one-year trial did not become a permanent arrangement?

**Mr COATES:** No, because it was one-off funding from the DSC. It gave us a significant amount of money for families to have a break and to test it out and see what happened. By “a significant amount of money”, it was literally up to \$5 000 for the family to have a significant and serious respite experience.

**The CHAIRMAN:** Yes, but unless you are a family or carer that was there in that one year —

**Mr COATES:** We did 100 families in that year, and that was it. It was an experiment and it was to evaluate its benefits and what worked and what did not work.

**The CHAIRMAN:** I think we are getting a good sense about the issues with regard to respite. We have less than five minutes to go. I will just quickly get through some of the remaining terms of reference, which will have varying degrees of relevance for you. The first is the capacity of WA police to identify and respond to allegations of elder abuse. What is the professional relationship between Carers Australia WA and WA police?

**Mr COATES:** We do not often get involved with the police, thankfully. I guess we talked earlier that you can get some quite full-on calls, and you are going to make a judgement about how seriously you deal with those. We do not have frequent interactions with the police. It is not a frequent thing.

**Hon MATTHEW SWINBOURN:** Do you have any view about making it mandatory to report suspected incidents of elder abuse, given that you have had an indication through your telephone services that you are having circumstances arise where you could reasonably suspect that it was occurring?

**Mr COATES:** It is not a daily occurrence; it is probably not even a weekly occurrence, but it does occur. It is hard, because you have got someone on the end of the phone and you have no idea what the mental state of that person is on the phone or what their history is. It is a really difficult one over the phone.

**Hon MATTHEW SWINBOURN:** But would you support it being mandatory?

**Mr COATES:** I do not know what I support, to be honest. I cannot offer you a definite view on that, because everything is so difficult. It is so difficult.

**Hon MATTHEW SWINBOURN:** I understand that your line is there to help to provide them with relief rather than to put them in more trouble.

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**Mr COATES:** There is that element to it, but, frankly, if we think somebody is at risk—whether their carer or their family member—we would deal with it. But you do get people who present with all sorts of things and say things that they clearly do not mean. It is hard, especially on the end of a phone line.

**The CHAIRMAN:** Is it identifying initiatives to empower older persons to better protect themselves from risks of elder abuse as they age?

**Mr COATES:** Again, it is probably the education aspect of it and the understanding that there might be other advocacy services—the only person they go to is not just a family member, that there are other staff who are there to support them, just like Advocare, for example. It is an education awareness thing. The complexity is that with aged care comes also a number of conditions often, especially in a caring role—that is why the person is caring for them—which is frailty, emotional frailties. They may be too scared to contact those agencies.

**The CHAIRMAN:** With these carers who do not self-identify as a carer, who would be the most likely frontline professional they would come into contact with who might be in a position to say to them, “Do you realise that you’re a carer and you really should get in touch with Carers Australia WA?”

**Mr COATES:** Your Silver Chains—the sorts of organisations that actually go into the home and provide a service for that family member. We actually have a program, only in the metropolitan area, which is unique to the country where you get, say, a Silver Chain person going in to assess—the person gets assessed anyway for their care—but they go in to deliver a package of care to the person who is frail aged. While you are there, they are assessing the family situation as well. We have a system where that gets referred to us and we can send in our person who will focus on the family, because the direct aged-care client is being cared for there. We have done that and it was unique and I persuaded the state government to do that under the HACC, which has now been transferred federally incidentally, so that might disappear. Also, we are doing an experiment now and trying it in a regional area again with ACNA, which is a subsidiary of Silver Chain—the aged-care network association or something like that—who will do the assessments for the clients. But we are trying it in a regional area in the wheatbelt to see if we can get it to work.

**Hon MATTHEW SWINBOURN:** What about in hospital settings? Are you getting much reference through there, where the nurse or the doctor or someone like that has identified that there is clearly a dependent relationship and the person has not identified themselves as a carer?

**Mr COATES:** I think Sean talked about it—prepare to care.

**Mr GARDYNE:** Yes, the prepare to care program. Essentially, what we are trying to do is educate. The worker will go and do a presentation to a whole group of nurses and doctors et cetera, explaining what we do and how to basically link in and provide a package to take home with them. They can write information down about what the needs are, medications, different exercises and that type of thing that they might be able to try to assist the person that they are caring for with. That is really good. We have varying degrees of success. Some places within the hospitals, some wards, do really well and engage well. With others, the packages might sit there and not be taken on board. I think it depends. There are a lot of factors involved that would, I suppose, influence how well that gets taken on board. You walk through a ward when you are replenishing the stocks and the people are so busy. We are trying to promote that obviously as a huge issue, but obviously there are a lot of factors involved in hospitals, and sometimes the carer factor just might not seem as important as maybe it should be.

**Hon MATTHEW SWINBOURN:** What about social workers through the hospital system? Are you engaging with them?

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**Mr GARDYNE:** Yes.

**Hon MATTHEW SWINBOURN:** They would be the logical point at which that service should be —

**Mr GARDYNE:** Yes, absolutely. Currently, the worker involved in that program has a very good relationship with the varying social workers in the hospitals. There is an ongoing communication around that conversation and we are still trying to build on that. But, again, some take it on board better than others.

**Mr COATES:** I think one of the biggest areas that the committee could focus on for this is in the GP area, because this is typically where you see a lot of the aged spend a lot of time, unlike the younger element of the population. It is a really hard one to crack, because GPs have a string of people at their door trying to take up their time, trying to sell all sorts of stuff like medical aids and things like that. They have busy schedules, trying to churn out all the patients. So there are 101 things thrown at them through awareness raising, which could be anything from palliative care to mental health and a range of other stuff. That is a hard nut to crack, but it is certainly one where there is a lot of interaction with the community.

[10.50 am]

**Hon ALISON XAMON:** That is something I was interested in. I was wondering have you commenced any work with WAFA to be able to look at how best to engage your services with GPs.

**Mr COATES:** We have not, to be honest—a bit, but not a lot really. That sector has changed, has it not? We have gone from—was it Medicare Local?

**Hon ALISON XAMON:** Medicare Local to the primary health networks.

**Mr COATES:** It has gone through various iterations, but the bottom line is you have a lot of GPs out there with a lot of local surgeries and interactions. You can try to engage with the overseeing organisations, but it is really getting down to the ground and getting that information out there. We do go to GPs. You know they have those racks of information. I have forgotten what they call it; it is the medi-info medicine thing. You have to pay to get your space and your leaflet in there. It is things like that, but it is the awareness from the GP and the GP staff. The thing is that in the medical and clinical profession, they are trained for the patient, with the Hippocratic oath and all those things. They are trained to focus on the patient, not trained to focus on the family member, understanding that they are seeing them for 10 or 15 minutes, but for the other 23 hours and six days it is the family member who is trying to keep that person well and implement what the GP has said with medication and things like that. But you are focused on the client; understandably, that is what they are trained to do. If you can get that focus and a medical understanding, if you can get the family supporting, your medical interaction will be more effective. That is how we try to sell it.

**Hon MATTHEW SWINBOURN:** A lot of those carers are probably clients or patients of the same GPs.

**Mr COATES:** Yes.

**Hon MATTHEW SWINBOURN:** It is the old thing about a stitch in time saves nine. If carers are being properly identified at an earlier stage and provided with support, the benefit we will see is perhaps less elder abuse because of the stress factors that you have identified to us that carers often face and then almost accidentally end up being abusers. That is really the key for me, at the hospital setting as well. It is all well and good to say that people are busy, but there is a reason you are busy. Sometimes if you can reduce your inputs because you have taken action early, you might not be quite as busy as you are now.

**Mr GARDYNE:** That is a good point, yes.

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**The CHAIRMAN:** Does Carers Australia WA have any interaction with, for instance, the AMA or any body that provides professional development to GPs?

**Mr COATES:** We have. This is one of the ways we tried to penetrate this sector. At one stage, what we were doing was—it has stopped now—we were giving talks to the university students in their third year. I think they have a community element of their education away from the direct medical and clinical stuff. We gave a talk about an understanding of carers and their roles and how that can improve your medical interaction.

**The CHAIRMAN:** But that has stopped now?

**Mr COATES:** It is ours. We kept it going for a while, but, you know. They agreed to two or three years. We actually gave the talk with Penny Flett, because she was quite a supporter of carers as well. Dr Flett was there lecturing to students initially and then we would talk.

**The CHAIRMAN:** Was it UWA's decision to stop it?

**Mr COATES:** These things peter out, because universities change what they are doing and the curriculum. It more petered out than any direct obvious thing that happened.

**The CHAIRMAN:** It just seems unfortunate that the new crop of medical health practitioners miss out on the opportunity to know about an important resource.

**Mr COATES:** That was my theory. My theory was you maybe cannot change the behaviours of GPs at the end of their career, but if you start training the new ones going through, that is the way to.

**The CHAIRMAN:** Is there any interaction with Notre Dame? They have a medical school as well.

**Mr COATES:** No.

**The CHAIRMAN:** We thank you for your evidence and 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. We thank you very much for your attendance this morning.

**Mr COATES:** Thank you for your time.

**Hearing concluded at 10.55 am**

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