Responding to violence, abuse, exploitation and neglect: Improving our protection of at-risk adults

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# Table of Contents

- Executive Summary ........................................................................................................ 5
- List of recommendations .................................................................................................. 7
- Programme - People and organisations visited ............................................................... 8
- Acknowledgements ......................................................................................................... 9
- Introduction ..................................................................................................................... 11
- Chapter One. A human rights framework ..................................................................... 14
- Chapter Two. Adult protection in Victoria ..................................................................... 17
  - Police and emergency services ................................................................................. 17
  - Disability and aged care ......................................................................................... 18
  - Guardianship ............................................................................................................. 18
  - Mental health .......................................................................................................... 20
- Chapter Three. Notable features of the visited adult protection systems .................... 27
- Washington State, USA ................................................................................................. 27
  - Adult Protective Services ......................................................................................... 27
  - Residential Care Services ....................................................................................... 31
  - Policing and prosecuting cases of elder abuse ......................................................... 32
  - Guardianship ........................................................................................................... 35
  - Mental health .......................................................................................................... 36
  - Observations and conclusions ................................................................................... 36
- Nova Scotia, Canada ......................................................................................................... 38
  - Adult protection ........................................................................................................ 38
  - Guardianship ............................................................................................................ 43
  - Financial abuse ....................................................................................................... 44
  - Mental health .......................................................................................................... 45
  - Observations and conclusions ................................................................................... 45
- Scotland, United Kingdom .............................................................................................. 47
  - Adult protection ........................................................................................................ 47
  - Guardianship ............................................................................................................ 52
  - Mental health .......................................................................................................... 54
  - Mental Welfare Commission .................................................................................... 55
  - Care Inspectorate ...................................................................................................... 56
  - Observations and conclusions ................................................................................... 56
- England, United Kingdom ............................................................................................... 58
  - Social Care Institute for Excellence ......................................................................... 59
  - Local authorities ...................................................................................................... 61
  - Care Quality Commission ......................................................................................... 62
  - Guardianship ............................................................................................................ 62
  - Observations and conclusions ................................................................................... 67
- Chapter Four. Current reform initiatives in Victoria ..................................................... 70
  - Disability reform ...................................................................................................... 70
  - Guardianship and powers of attorney ...................................................................... 71
  - Mental health .......................................................................................................... 74
  - Elder abuse .............................................................................................................. 74
  - Anti-violence ............................................................................................................. 75
- Chapter Five. Conclusions and reform recommendations ............................................. 78
Policing and prosecuting................................................................. 79
Investigation powers of statutory agencies........................................ 80
Protective orders ............................................................................. 82
Public awareness campaign .............................................................. 84
Keeping adult protection on the agenda ............................................. 85
References ....................................................................................... 87
Executive Summary

The level of violence, abuse, exploitation and neglect suffered by at-risk adults, including people with cognitive impairments and mental ill health, is a serious social problem in Australia. Typically, violence towards, and abuse or exploitation of, such people is insufficiently evidenced to enable significant police involvement, while other legal responses, such as guardianship applications, are often not the most appropriate courses of action. Meanwhile there is no uniform approach, or authority to contact, in relation to situations of neglect.

In a bid to find ways to improve Victoria’s and Australia’s protection of at-risk adults, I examined the adult protection schemes in place in four jurisdictions: Washington State (USA), Nova Scotia (Canada), Scotland and England (UK). I met and spoke with 32 professionals, including adult protection managers and coordinators, county prosecutors, judges, disability service providers, public guardians, disability advocates, a police officer, a mental health worker, and local authority staff. I took with me four real-life case scenarios which have arisen in my workplace and which evidence current gaps in Victoria’s (and Australia’s) adult protection system. These scenarios concerned: physical abuse of an at-risk adult in supported accommodation; abuse of an at-risk adult in the general community; a situation of self-neglect; and an instance of financial abuse. I wanted to know how the individuals involved in these real-life cases would be supported, and have their situations investigated, if they lived in the visited jurisdictions.

The highlights of the research phase were as follows:

- my meetings with the key adult protection managers and coordinators in Washington State, Nova Scotia and Scotland, who operate systems, and exercise powers, that are different to those utilised in Victoria to protect at-risk citizens;
- witnessing the concentration in Washington State on the prosecution of individuals involved in elder abuse crimes, particularly financial exploitation, which relies on the work of a small number of police and prosecutors;
- my attendance at an adult protection conference in Stirling, Scotland;
- my visits to organisations with somewhat similar roles to Victoria’s Office of the Public Advocate (OPA) – such as the health decisions arm of the Public Trustee in Nova Scotia, and the Public Guardians in Scotland and England – to see how they exercise their powers and run their organisations.

The major lessons learnt and conclusions are that Victoria could do the following to improve our protection of at-risk adults:

- ensure police have the expertise to investigate, and prosecute individuals involved in, crimes against at-risk adults, in particular crimes involving financial abuse;
- establish a clear non-police contact point where members of the community can register concerns about the well-being of at-risk adults;
- entrust a government or semi-government agency with clear authority to investigate (utilising a supportive intervention approach) the well-being of at-
risk adults, including in private residences as well as in supported accommodation;
• make less usage of adult guardianship as a mechanism for protecting at-risk adults;
• enable the Victorian Civil and Administrative Tribunal to make a wider range of protective orders than it is currently able to make; and
• ensure that the variety of professionals who work in the adult protection area meet regularly and collaborate where appropriate on joint approaches to adult protection.

The dissemination plan in relation to my research involves the following:
• public availability of this report on the OPA and Churchill Trust websites;
• submission of the report to the Victorian Attorney-General, the Hon. Robert Clark, and the Minister for Mental Health, Community Services, Disability Services and Reform, the Hon. Mary Wooldridge, with a request to speak with them about it;
• presentation of the main report findings and recommendations to OPA staff on 2 October 2013;
• discussion of the report’s key themes in a proposed Adult Protection Roundtable in 2014, hosted by OPA (see Recommendation 6);
• distribution of, and presentations concerning, this report to key disability, mental health and other agencies (including the Australian Guardianship and Administration Council) as opportunities arise.
List of recommendations

**Recommendation 1.** Victoria Police and the Victorian Office of Public Prosecutions should be encouraged to examine and replicate the work of the Seattle Police Department and King County prosecutors in investigating and prosecuting individuals involved in crimes against at-risk adults.

**Recommendation 2.** The Victorian parliament should grant the Public Advocate the broader investigation power as recommended by the Victorian Law Reform Commission. This would enable the Office of the Public Advocate to investigate (following a complaint or on its own motion) ‘the abuse, neglect or exploitation of people with impaired decision-making ability’.

**Recommendation 3.** In order properly to exercise a broader investigation power, the Office of the Public Advocate should develop protocols, or amend existing protocols, between it and: Victoria Police; the Department of Human Services; the Department of Health; the Victorian Civil and Administrative Tribunal; the Disability Services Commissioner; State Trustees Ltd; Seniors Rights Victoria; the new Commissioner for Senior Victorians; and other relevant agencies.

**Recommendation 4.** The Victorian Parliament should grant the Victorian Civil and Administrative Tribunal the power to make a wide range of orders in relation to at-risk adults, as alternatives to guardianship orders, including:
- entry and assessment orders;
- removal and placement orders;
- service provision orders;
- banning orders; and
- supported decision-making orders.

**Recommendation 5.** The Office of the Public Advocate should develop a public education campaign modelled on Scotland’s ‘act against harm’ campaign that is centred on a stand-alone website that:
- describes, and gives examples of, situations of concern; and that
- provides the general public and service professionals with one contact telephone number, operational during business hours, through which concerns about the well-being of at-risk adults can be registered.

**Recommendation 6.** The Office of the Public Advocate should host an Adult Protection Roundtable in 2014, with representatives from key agencies invited to discuss the protection of at-risk adults.
Programme - People and organisations visited

I met with the following people and organisations in the period from 7 June to 7 July 2013.

Washington State, USA

- Eileen Alexander, Assistant Attorney General Washington State, Medicaid Fraud Control Unit
- Carol Sloan, Mike Wagner and Vicky Gawlik, Adult Protective Services Program Managers, Department of Social and Health Services, Aging & Disability Services Administration, Home & Community Services Division
- Shirley Bondon, Manager, Court Access Programs, Office of Public Guardianship
- Detective Pamela St John, Seattle Police Department, Elder Abuse Unit
- Page Ulrey and Kathy Van Olst, Senior Deputy Prosecuting Attorneys, Elder Abuse Project, King County Prosecutor’s Office, Seattle
- Karin Taifour, Case Manager, Geriatric Regional Assessment Team, Evergreen Health, Kirkland

Nova Scotia, Canada

- Judy Taylor, Adult Protection Coordinator, Nova Scotia and (via teleconference) Suzanne Brake, Adult Protection Coordinator, Newfoundland, and Kelly Cooper, Adult Protection Coordinator, the Yukon.
- Anne M. Erly, Coordinator, Health Care Decisions, Public Trustee Office
- Justice Mona Lynch, Supreme Court (Family Division)
- Assistant Professor Sheila Wildeman, Schulich School of Law, Dalhousie University

Scotland, UK

- Richard Hamer, Director of External Affairs, and Charlie McMillan, Director of Services and Development, Capability Scotland
- Tony Jevon, Social Work Officer, Mental Welfare Commission
- Joanne Boyle, Adult Support and Protection, Mental Health Legislation & Adult Protection Policy Team, Mental Health and Protection of Rights Division, Scottish Government
- Sandra McDonald, Public Guardian

At the Adult Protection Conference held on 25 June 2013 at the University of Stirling, and at a dinner the evening beforehand, I met and spoke with many people, including:

- Paul Comley, National Adult Protection Co-ordinator, WithScotland
- Beth Smith, Director, WithScotland
- Pene Rowe, Highland Child and Adult Protection Development Officer
- Kate Gibb, Lead Officer, Child and Adult Protection, Shetland
- Max Barnett, Chair, Shetland Adult Protection Committee
England, UK

- Patricia Kearney, Director of Innovation and Development, Social Care Institute for Excellence
- Gary FitzGerald, CEO, and Maggie Evans, Marketing and Support Manager, Action on Elder Abuse
- Martin Sexton, Mental Capacity/DoLS Lead Officer, London Borough of Hackney
- Justice Denzil Lush, Court of Protection
- Alan Eccles, Chief Executive and Public Guardian; Angela Johnson, Head of Practice and Compliance; and Kit Collingwood: Office of the Public Guardian
- Sue Bott, Director of Policy, Services and Development, Disability Rights UK

Acknowledgements

Many of the ideas discussed in this report have been raised in numerous formal and informal discussions I have had with colleagues at the Office of the Public Advocate (OPA) in the context both of OPA’s core responsibilities, and in the context of the review of Victoria’s adult guardianship laws by the Victorian Law Reform Commission. In particular I’d like to acknowledge the valuable insights provided by the following individuals: Mark Feigan, Liz Dearn, Lois Bedson, Magdalena McGuire, Colleen Pearce, Brendan Hoysted, Michael Wells, Barbara Carter, Helen Rushford and Phil Grano. I’d like also to thank some individuals whose short-term work at OPA helped me decide upon, and develop, the research project that I have undertaken. In particular, I thank former intern Levona Lavi, and consultants Tricia Szirom and Michelle Browning.

I’d also like to thank a number of individuals from public sector organisations and universities in Victoria with whom I have discussed many of the ideas considered in this report, including: Lynne Coulson Barr, Ron Tiffen and Anthony Kolmus at the Office of the Disability Services Commissioner; Neil Rees, former Chairperson of the Victorian Law Reform Commission; Paul Radlow and Alistair Craig at State Trustees; Robyn Mills at Victoria Legal Aid; Chris Bigby at La Trobe University; Paul Ramcharan at RMIT; Philip Mendes at Monash University; Jen Hargrave and Keran Howe at Women with Disabilities Victoria; Kevin Stone at Valid; and Jeffrey Chan at Yooralla.

My greatest debts to people in Victoria are undoubtedly to Catherine (and Henry, Johanna and Rachael), who quite literally kept the home fires burning while I was experiencing four weeks of a northern summer.

Naturally I also thank the people I visited and met with, who provided much of the information on which this report is based. In order to receive their frank comments, I undertook not to quote individuals, but drew instead on their comments in my descriptions and analyses of their various adult protection systems. Unless otherwise indicated, information described in the report comes from information supplied in these meetings (though of course any errors remain mine). I thank all the people I met in the course of researching and writing this report, who so generously gave of their time.
Finally, I thank the Churchill Trust for giving me this wonderful opportunity to explore the quite different adult protection systems in place in parts of the United States, Canada and the United Kingdom. I know I will be drawing on what I have learnt for many years to come.

Given the nature of this project (which included the fact that I was meeting with, and talking to, people in their professional capacities), I was not required to seek or receive ethics clearance from the Department of Justice Human Research Ethics Committee for the project to go ahead. I discussed the project with a representative of this Committee, who advised that I needed only the approval of the Public Advocate for it to proceed. This approval was given.

Some of the ideas raised here have been the subject of submissions made by OPA (particularly in relation to the review of Victoria’s guardianship laws) and have been the subject of presentations I have made to the 2nd World Congress on Adult Guardianship (Melbourne 2012) and to three National Disability Summits (Melbourne 2011, 2012, 2013). Many of these ideas have been developed further in this report.
Introduction

The protection of its most vulnerable citizens is one of the most important roles of any society. Social policy experts in Australia agree that more needs to be done to protect our most at-risk citizens. In Victoria the Office of the Public Advocate (OPA), where I work, is one of the key adult protection agencies. OPA is an independent statutory authority which is the guardian of last resort and which also oversees three volunteer programs that protect the rights of people with disabilities. OPA is one of the key agencies potentially affected by recommendations made following a recent review of Victoria’s guardianship laws and practices by the Victorian Law Reform Commission. The Commission’s final report identified a need to improve Victoria’s protection of at-risk adults and called, among other things, for OPA to have a broader investigation role and more substantial investigation powers. Against this background this project has enabled me to examine the effectiveness of the quite different kinds of interventionist protection strategies in place in three different jurisdictions: Washington State, Nova Scotia and Scotland (I also visited England). These jurisdictions were identified by an intern, Levona Lavi, and consultant, Tricia Szirom, in earlier work they conducted on behalf of the Office of the Public Advocate.

While knowledge about legislative and policy frameworks of interventionist protection schemes is available through a desktop study, I wanted to see how such schemes actually work, and to talk with local practitioners. The aim has been to assess the benefits of broad-based interventionist protective regimes, as well as to discover any shortcomings of these systems and any implementation challenges.

As with all social policies, the local contexts in which they operate are crucial to their effectiveness. Witnessing first hand these schemes in operation, and meeting with practitioners, has enabled me to assess these schemes’ potential value to Australia and possible application here.

In conducting my meetings, I was interested in four key questions:

1. Which agencies are involved in investigating instances of violence, abuse, exploitation and neglect?
2. What role does adult guardianship play?
3. What other formal legal responses are possible?
4. What, in the view of the people I met, are the strengths and limitations of their particular jurisdiction’s approach?

I wish at the outset to note that this report is concerned with the state’s obligations to protect at-risk adults. While the concept of ‘protection’ is a multi-faceted one, which incorporates both preventive and reactive elements, the focus here is on the roles and powers of public authorities and public service organisations in ensuring appropriate responses to situations of concern. Thus the focus is on examining the powers and functions of various agencies, rather than on the many important developments taking place that seek to empower individuals to take control of their own lives. I thus do not look in general at preventive and empowerment programs, of which there are some significant and innovative ones in place in Victoria (one such example is the Safer Sexual Lives program that is coordinated by Dr Patsie Frawley). Programs such as
this are an integral element to the variety of strategies that need to exist to reduce incidents of violence, abuse and exploitation suffered by at-risk adults.

The one preventive program that I do briefly consider here concerns enduring powers of attorney. Enduring powers of attorney enable individuals to appoint their own future substitute decision makers, and the reason I look briefly at this topic is because of its relevance to guardianship. This report argues that our system of adult protection should make less use of guardianship, and greater use of other mechanisms. Increased usage of enduring powers of attorney is one of the key means by which we can lessen our society’s reliance on guardianship.

Another introductory point to note is to recognise at the outset the gendered nature of violence, and to recognise that women are more likely than men to be the subject of violence. This dynamic is magnified when women with disabilities are concerned (see Healey et al 2008). This needs to be engaged in anti-violence preventive strategies as well as in responses to violence.

Each of the jurisdictions that have been examined for this report have a range of state authorities which play discreet roles in the protection of adult citizens. Police and emergency medical services are the most obvious of these, as they are in most jurisdictions throughout the world. In addition, the jurisdictions studied here have a complex amalgam of disability and aged care services that cater for many of the citizens whose particular circumstances render them at greater risk of harm than other adults.

The aim of this report is not to outline the operation of police, medical emergency, disability and aged care services in place in the studied jurisdictions (which would see the report run to several volumes), but to draw from notable developments in each of the jurisdictions to inform possible improvements to Victoria’s current offerings.

I have been particularly interested to see how the various jurisdictions seek to fill the gap that exists where there is no obvious medical emergency and no obvious evidence of a crime, but where some level of investigation is warranted into the wellbeing of an adult.

A note on terminology: throughout this report I have used the term ‘at-risk adults’, which is in use in various parts of the world, rather than other possibilities such as ‘adults with disability’ or ‘adults with cognitive impairments’. I chose this term because not all adults with disabilities (or cognitive impairments) are at risk, and because not all at-risk adults have disabilities (or cognitive impairments). While this to my mind is the best terminology to use, and is the least patronising and victim-imbuing terminology to use, I am aware of the argument that, particularly in situations of violence and abuse, we should concentrate policy attention on the abusers rather than the abused. According to this argument the problem to be addressed is the violence and abuse, not the vulnerability of the people who have been abused. While that argument has merit (and indeed is the reason why I use ‘at-risk adults’ rather than ‘vulnerable adults’, as some jurisdictions do) there is an equally pressing policy need to identify and name a target (and apparently growing) population who are poorly served by current social policies. To my mind, usage of the term ‘at-risk adults’ is the best way of doing this. This is all the more the case when we are dealing with
situations of neglect. While some occasions of neglect result from breaches of duty of care, a focus on ‘perpetrators’ will often do little to improve the wellbeing of the individuals about whom we are, and should be, concerned.
Chapter One. A human rights framework

One point of generic importance, and which frames this report, concerns the increasing need for jurisdictions to ensure that their adult protection laws and practices are consistent with human rights obligations.

There are numerous human rights treaties that are relevant to the protection of at-risk adults, including the *International Covenant on Civil and Political Rights*, the *International Covenant on Economic, Social and Cultural Rights*, and the *Convention on the Elimination of All Forms of Discrimination against Women*. The right of all people to live their lives free from violence is central to many of these core human rights treaties. The likely development of a Convention preventing discrimination against older people will also be of relevance in the future.

One convention that is particularly germane to this report is the *Convention on the Rights of Persons with Disabilities*, as many at-risk adults have identified disabilities.

All the studied jurisdictions are signatories to the *Convention on the Rights of Persons with Disabilities*, and all, except the United States, have ratified it. This convention acknowledges that a range of practices undertaken in the name of ‘protection’ have constituted human rights abuses, and two of the key themes in the Convention for the purposes of this report are that:

- State-directed substitute decision making should be minimised, with preference given to supported decision making;
- Positive steps should be taken to prevent, and respond appropriately to, violence against, and abuse of, people with disabilities.

Both of these themes have particular relevance for adult protection. The first calls into question the use of substitute decision making, as exits in guardianship and compulsory mental health settings. The second articulates the onus that exists on signatories to ensure the protection of all citizens.

Article 12 (2) contains one of the key phrases in the Convention, and states that: ‘persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.’ At the very least, this phrase indicates that transferral of decision-making authority (as happens when guardianship orders and other substitute decision making processes, including involuntary mental health treatment orders are made) should rarely occur.

Article 12 (4) is authority for the proposition that the Convention still permits substitute decision-making arrangements, so long as these are limited in time, necessary, and subject to review. Article 12 (4) states that:

‘[A]ll measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse … Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, … apply for the shortest time possible and are subject to regular review …’
The Australian government (2008), in adopting the Convention, declared that it did so on the basis ‘that the Convention allows for fully supported or substituted decision-making arrangements … only where such arrangements are necessary, as a last resort and subject to safeguards’.

The second theme in the Convention of relevance to this report concerns the prevention of violence and abuse. Article 16(1) provides that:

‘States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities … from all forms of exploitation, violence and abuse …’

The full implications of the Convention for current at-risk adult service and protective mechanisms remains unknown and subject to debate. The Committee on the Rights of People with disability will soon be producing its report into Australia’s compliance with the Convention. But even before that occurs, the Convention is certainly affecting the way social policy responses are being crafted, very notably in the guardianship jurisdiction (see Chesterman 2010a, 2010c, VLRC 2012).

In addition to the operation of international instruments that Australia has ratified, a range of other human rights developments are affecting social and legal policy developments.

For instance, the European Court of Human Rights in 2004 in the Bournewood case (H.L. v United Kingdom) found that the effective detention in hospital of a ‘compliant’ patient, which occurred without lawful authority, constituted a deprivation of liberty in contravention of the European Convention on Human Rights. This has had direct implications for the operation of previously ‘informal’ detention practices in Europe, and is now recognised as a legal problem in Australia, particularly in a jurisdiction like Victoria that has adopted a bill of rights (see VLRC 2012, p. 329). This decision and its flow-on effects have particular relevance for the often-utilised practice of keeping at-risk adults physically apart from others in the name of their own protection. This practice, where it amounts to effective detention and where it is done without specific lawful authority, is now far more questioned and legally questionable than ever before.

While international human rights are clearly relevant to adult protection laws and practices, it is worth noting that each of the jurisdictions being examined have their own national or sub-national bills of rights. The amendments to the US Constitution, the Canadian Charter of Rights and Freedoms, and the United Kingdom’s Human Rights Act, all constrain governments from unduly regulating the lives of citizens, but none absolves governments from the responsibility of providing care for those in need.

Victoria is the only state in Australia to have a bill of rights, the Charter of Human Rights and Responsibilities Act 2006 (Vic). The Charter (sections 7, 8 and passim) provides that people have the right to enjoy a range of articulated human rights without discrimination, which includes discrimination on the basis of disability. It also provides (section 7) that human rights can only be limited in such a way ‘as can be demonstrably justified in a free and democratic society based on human dignity,
equality and freedom, and taking into account all relevant factors including … any less restrictive means reasonably available to achieve the purpose’. (This Act was reviewed by the Victorian Parliament’s Scrutiny of Acts and Regulations Committee (2011), which proposed a number of reforms that have not yet been adopted by the Victorian government.)

My arguments throughout the report are informed by the knowledge that any policy and practice changes must in sum advance rather than limit the human rights of at-risk adults.
Chapter Two. Adult protection in Victoria

Australia has never had a named ‘system’ of adult protection so much as a slowly evolving range of services provided within particular social policy arenas. In addition to the role of police and emergency services, the two most significant of these for the purposes of this report concern disability and aged care.

Police and emergency services

Ambulance Victoria is responsible for the provision of emergency medical assistance. Victoria Police have obvious roles to play in the protection of at-risk adults, having both an emergency response and an investigation role concerning crimes that have been committed. The most relevant of these in terms of this report are crimes concerning violence towards, and financial abuse of, at-risk adults (including assault, theft, and obtaining property by deception).

Victoria Police also have responsibilities under Victoria’s family violence laws. The Family Violence Protection Act 2008 enables police to protect vulnerable family members by utilising orders and notices through which alleged offenders can be removed from premises without waiting for criminal justice proceedings to take place. The key mechanisms here include Family Violence Safety Notices (part 3), which are issued by police, and Family Violence Intervention Orders (part 4), which are issued by Magistrates’ and Children’s Courts. The Act (section 8) defines ‘family member’ broadly to include people the person in question ‘regards … as being like a family member’, which can include carers.

The Act (section 5) includes as ‘family violence’:

‘(a) behaviour by a person towards a family member of that person if that behaviour—
(i) is physically or sexually abusive; or
(ii) is emotionally or psychologically abusive; or
(iii) is economically abusive; or
(iv) is threatening; or
(v) is coercive; or
(vi) in any other way controls or dominates the family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person’.

Of interest here is the inclusion of ‘economically abusive’. Statistics are not available on the extent to which the family violence provisions have been used in relation to financial abuse, though one would expect, given that prosecutions for financial abuse are generally rare, that it is likely to be low (for the relatively small amount of literature on evidence of financial abuse in Victoria see Darzins et al 2009, Wainer, Darzins et al 2010, Wainer, Owada et al 2010, Wainer et al 2011, King et al 2011, and Corrie and McGuire 2013). On this point it is worth noting that in 2009 Victoria Police did launch a campaign entitled ‘You are not alone’, which was aimed at addressing abuse of older Victorians (see Victoria Police 2013).
In Victoria a person can also obtain a Personal Safety Intervention Order (*Personal Safety Intervention Orders Act 2010*) where their safety is under threat. Interim and final orders can be made to ensure safety and preserve property (sections 35 and 61), though final orders cannot be made against family members (with Family Violence Protection Orders the preferred path for such situations).

It is worth mentioning that Australia does have a ‘national abuse hotline’, though its relevance to this report is its function as essentially a referral service to state and territory emergency services, government service providers and associated complaints bodies.

The key point I want to make here is that in situations of concern where there is no pressing medical need or obvious criminal activity, neither police nor ambulance workers have a direct role.

**Disability and aged care**

Australia’s federal system of government sees the provision of disability support in the hands of the states and territories, though with the introduction of DisabilityCare (the National Disability Insurance Scheme), the federal government is likely to increase over time its regulatory involvement. Support ranges from accommodation provision, supported living assistance and a significant number of support services.

Aged care support is delivered through a range of federally and state regulated service providers (services range from the provision of aged care accommodation, to the provision of in-home help).

Many at-risk adults are in receipt of assistance through the disability or aged-care sectors, and one of the key responses to violence, abuse, exploitation or neglect will be the alerting of aged or disability services to the situation of the individual concerned. Where, for instance, concerns exist about an adult with a recognised disability, one standard response would be to alert the Department of Human Services Intake and Response service, which would assess the person’s eligibility for disability services, including supported accommodation and case management. To take another example, where someone over the age of 65 is living in the community and is in a situation of neglect, a standard response would be to alert the Aged Care Assessment Service to investigate and consider an offer of residential aged care or in-home (Home and Community Care) support.

**Guardianship**

The closest Australia has come to adopting a named adult protection system is the development of modern adult guardianship laws, which began in Victoria in 1986 and eventually spread to all Australian jurisdictions. These modern guardianship laws largely supplant the common law parens patriae jurisdiction that, at least in theory, enables the state to exercise protective authority over adults who are unable to protect themselves.
Modern guardianship laws in Australia, which began with Victoria’s *Guardianship and Administration Act 1986*, were progressive by world standards for the way they utilised informal and free tribunal processes to establish the need for, and appointment of, substitute decision makers (see Carney and Tait 1997). The guardianship system in Australia enabled the appointment of substitute decision makers when a person with a disability was unable to make reasonable decisions. An administrator could be appointed to make legal and financial decisions, and guardians could be appointed to make personal lifestyle decisions (concerning predominantly accommodation and medical treatment). These laws were enacted at a time when large-scale institutions for people with profound disabilities were being closed, which resulted in the placement in community settings of thousands of at-risk adults with high support needs (see Feigan 2011).

Victoria also led the way in 1986 with the creation of the Office of the Public Advocate (OPA), which was established to promote and protect the rights of people with disabilities. OPA is the guardian of last resort, a role exercised in 1708 matters in 2011/12 (OPA 2012a, p. 10).

Gradually all Australian jurisdictions have adopted guardianship legislation that followed Victoria’s paradigm, though with some local differences (see, for example, Victorian Law Reform Commission (VLRC) 2012, pp. 109 to 111). All jurisdictions also established last resort guardians, including Offices of the Public Advocate in South Australia, Western Australia and the ACT, Offices of the Public Guardian in New South Wales and Tasmania, and the Adult Guardian in Queensland (where there is also a stand-alone Public Advocate with a systemic advocacy function).

Enduring powers of attorney laws have also gradually evolved, meaning that in most jurisdictions individuals, prior to any loss of decision-making capacity, can appoint their own substitute decision makers in the same areas as those covered by tribunal guardianship and administration appointments.

The modern guardianship system was only ever meant to operate in relation to a very small section of the community. Most adults with decision-making disabilities do not have formally appointed substitute decision makers in place. Instead, ‘informal’ care arrangements are the norm (though the term ‘informal’ is one that understandably troubles carers, who feel it undervalues their role).

Guardianship numbers have risen significantly in recent years (see, for instance, Dearn 2010), and the VLRC (2012, p. 37) has predicted that this will continue to be the case for the foreseeable future. A range of societal developments are causing this. These developments include: smaller family sizes, with fewer available informal carers; and an increasing service system requirement for substitute decision-making authority, which is itself related to increasing risk management consciousness and risk aversion in the provision of services (on this topic see Green 2007; Green and Sawyer 2008; Brett et al 2010). In addition, a rise in the number of aged guardianship clients with dementia is one factor that warrants specific policy attention at the federal level (see Chesterman 2013).
Mental health

Victoria’s mental health system is in a state of flux, with new legislation due to be introduced shortly into parliament. Victorians are able to be detained and treated under the current Mental Health Act (sections 8 and 12) so long as they meet certain criteria, including that they have the appearance of a mental illness, and are at risk to themselves or others. Currently an involuntary treatment order must be reviewed by the Mental Health Review Board within eight weeks (section 30). At any one point in time there up upwards of 500 Victorians detained under the mental health legislation, with over 3,000 Victorians on community treatment orders, meaning they are in the community but required to take prescribed medication (see Chesterman 2012, p. 68).

This broad framework for compulsory mental health treatment will continue when new legislation is introduced, though tighter review timeframes and eligibility criteria are likely (Department of Health (Vic) 2012a). As indicated in Chapter One, the compatibility of involuntary mental health treatment with the Convention on the Rights of Persons with Disabilities is a matter of ongoing debate.

Statutory agencies

A range of agencies in Victoria currently have roles that concern at-risk adults. In addition to being guardian of last resort, OPA has a variety of roles under the Guardianship and Administration Act 1986.

OPA has the power to conduct investigations at the request of the Victorian Civil and Administrative Tribunal (VCAT), a role exercised in 531 matters in 2011/12 (OPA 2012a, p. 15).

OPA also has the power to ‘investigate any complaint or allegation that a person is under inappropriate guardianship or is being exploited or abused or in need of guardianship’ (Guardianship and Administration Act 1986, section 16(1)(h)). As I shall argue shortly, this power is more limited than first it appears.

OPA also manages the Community Visitors program, which utilises volunteers to inspect the care being provided to people in group homes and other supported accommodation settings, including mental health facilities. Over 5,000 site visits are conducted now each year by over 350 volunteers (OPA 2012b, p. 10). OPA also runs the Independent Third Person program, which sees over 200 volunteers sit in on over 2,000 police interviews each year of adults who have apparent cognitive impairments or mental ill health (OPA 2012a, p. 34)

The creation of the position of Disability Services Commissioner in 2006 was an important development particularly for residents, and families of residents, in supported disability accommodation. The Disability Services Commissioner has investigative powers, but these are largely limited in keeping with the Commissioner’s primary role, which is to be a complaints-based monitor of services provided by ‘disability service providers’ (Disability Act 2006 (Vic), section 16). In
the year to June 2012, the office received 832 ‘new enquiries and complaints’ (Disability Services Commissioner 2012, p. 18).

I do want to note here that the Office of the Disability Services Commissioner has produced some important materials concerning abuse, particularly one recent report on *Safeguarding people’s right to be free from abuse* (Coulson Barr 2012).

The Senior Practitioner is another statutory office in Victoria that was introduced with the passage of the *Disability Act 2006*. Among other roles, the Senior Practitioner has oversight of the use of restrictive interventions by disability service providers. In the year to June 2011 restrictive interventions were used against 1,911 people in Victoria by disability service providers (Senior Practitioner 2012, p. 10).

Other important agencies in Victoria include:

- The Chief Psychiatrist, who monitors psychiatric practice standards, receives reports about the use of restraints and seclusion and investigates consumer complaints.
- The Victorian Ombudsman, who has played an important role in bringing to light wrongs committed against at-risk adults. One important investigation and report in 2011, which emanated from concerns raised by OPA Community Visitors, identified a range of systemic failures and staff wrongdoing after a non-verbal disability services client sustained second-degree burns from being dragged along the floor of his group home (Ombudsman Victoria 2011).
- The Health Services Commissioner, who is empowered to investigate complaints against health service providers.

**Strengths and weaknesses**

The main strengths of Victoria’s adult protection system are:

- the relatively extensive network of government funded or subsidised support services;
- the broad range of independent statutory agencies who provide monitoring functions; and
- the relatively informal and cheap guardianship system, which sees guardianship services provided at no cost to the represented person while administrators are entitled to a fee in the form of a percentage of administered estates.

The main weaknesses include:

- inadequate responses to the experience of violence, abuse, exploitation and neglect by at-risk Victorians;
- an undue reliance on guardianship as a protective mechanism.

I shall look at each of these weaknesses in turn.

Many studies point to the high rate at which people with cognitive impairments and other disabilities are subject to violence, abuse and neglect, and which also point to the inadequacy of current laws and practices in addressing crimes against people with

Significant evidence also points to the prevalence of, and inadequate responses to, financial abuse and exploitation (in addition to the references on this topic at the foot of p. 17, see Victorian Parliament Law Reform Committee 2010, pp. 26-30, 183-223; House of Representatives Standing Committee on Legal and Constitutional Affairs 2007, pp. 15ff).

A clear underlying factor that makes at-risk adults vulnerable to violence, exploitation, abuse and neglect is poverty. A PricewaterhouseCoopers report pointed out in 2011 (p. 11) that:

‘Almost one in two people with a disability in Australia live in or near poverty (45%). This is more than 2.5 times the rate of poverty experienced in the general population and more than double the OECD average of 22% … Australia is by far the worst performer on [the relative poverty risk] indicator, ranking 27th out of 27 OECD countries …’

Given the connection between poverty and disability, it is not surprising to note that another policy area of particular concern to at-risk adults is accommodation. A range of studies has shown the inadequate availability of appropriate accommodation for people with disabilities. Most significant among these in recent times has been the Victorian Parliament Family and Community Development Committee (2009) inquiry into supported accommodation.

When it comes to the investigation of situations of concern, Victoria’s adult protection system has some notable gaps. As mentioned, Victoria’s emergency services tend to play a limited role outside of situations where there is a medical emergency or where there is obvious evidence of a crime having been committed. Other agencies do have investigatory powers, but while in combination these can result in significant positive outcomes, many situations of concern do not automatically come within the purview of any particular agency.

While OPA’s investigatory powers initially appear to be broad-ranging, their effect is far more constrained in practice. As the VLRC has noted (2012, p. 447):

‘While these provisions are expressed broadly, they are limited in their application to circumstances where a guardianship or administration order might be appropriate. Further, the Public Advocate does not have a comprehensive range of powers to carry out these functions.’

While other agencies do have investigative powers, they do not fill this gap. The Victorian Ombudsman’s investigations concentrate on ‘administrative action’ taken by public authorities (Ombudsman Act 1973 Vic, section 13(1)). The Ombudsman is not well suited to the kind of supportive investigation, incorporating referral to support agencies, that may often be required when at-risk adults are concerned.

Meanwhile the Disability Service Commissioner, the Chief Psychiatrist and the Health Services Commissioner all have investigative powers in relation to specified
service provision (disability services, mental health services, health services), and people in receipt of other specified services (for example, aged care) have discrete complaints mechanisms that can be pursued. But none of these statutory officers or agencies have the role of carrying out investigations in the general community about the wellbeing of at-risk adults.

As I mentioned at the start of this chapter, the Aged Care Assessment Service and the Department of Human Services Intake and Response service do conduct investigations in order to determine a person’s eligibility for services. While they also can, and do, make referrals to police where wrongdoing is identified or suspected, their roles are not primarily to investigate wrongdoing or breaches of duty.

As I shall suggest later, there is a strong case to be made for increasing the investigative powers and responsibilities of the Public Advocate to address this shortfall.

When it comes to the use of guardianship as a protective mechanism, the modern guardianship system has always been limited in three ways.

First, the guardianship system’s main protective mechanism is the appointment of substitute decision makers, rather than the direct provision of services (though access to services can be arranged by substitute decision makers).

Second, the system requires the following of a legal process, albeit a free and relatively informal inquisitorial tribunal process rather than a formal adversarial court hearing (though professional administrators are paid a fee from the person’s estate). This inevitably leads to delays, even in urgent cases, and the ‘creeping legalism’ that has been identified in recent years (see VCAT 2009, p. 9) is perhaps inevitable.

Third, since a guardianship order requires transferral of decision-making authority, appointment criteria are necessarily narrow (and becoming narrower). At present in Victoria for a guardianship order to be made, a person needs to have a disability, be unable as a result to make ‘reasonable decisions’, and be in need of a substitute decision maker (see Chesterman 2010c). This can mean that some at-risk individuals without a diagnosed disability are not eligible for a guardianship appointment.

**Four case studies**

The key premise for this report is that a gap exists where some level of investigation is warranted (not just assessment about eligibility for service provision) and where there is an insufficiently pressing medical need or obvious evidence of criminal activity to warrant the involvement of emergency services.

As a way of articulating this gap I will here describe four case scenarios involving four people who have come to the attention of one or more OPA program areas in the recent past. I have drawn on these case studies in my meetings with professionals in the studied jurisdictions, with a view to inquiring how Victoria might improve its ability to respond more effectively to people in the situations of these four individuals.
Case Study 1. Cynthia, a woman without speech who used to reside in an institutional setting, was noticed by staff in her group home to have a swollen and bruised foot. Paramedics attended but Cynthia remained in her home on paracetamol as there was insufficient room for her to be admitted to hospital. When Cynthia was taken to hospital the next day it was discovered that Cynthia’s ankle was broken. Several days later Cynthia was still in pain and she was taken back to hospital, where it was found that Cynthia had breaks in both her legs and it was also identified that Cynthia’s hips had both previously been fractured. After Cynthia’s return home several weeks later, OPA’s volunteer Community Visitors were concerned about the lack of appropriate bedding and other support provided to Cynthia, and were advised that Cynthia had diarrhoea and head lice, in addition to osteoporosis. While immediate steps were then taken to improve Cynthia’s care and support, further inquiries revealed that staff had not followed departmental procedures in responding to Cynthia’s situation. (This case is described in OPA 2012b, p. 7.)

In this case there is no obvious agency that should investigate the treatment of Cynthia. There would have been little benefit to Cynthia were a guardian appointed to make decisions for her. While a complaint could have been lodged with the Disability Services Commissioner in this case, this would have required someone to take that step on Cynthia’s behalf. Likewise a complaint could have been lodged with the Ombudsman, but that office is not well placed to make a referral for immediate service provision.

While the Commissioner and the Ombudsman could clearly call the service provider to account for the mistreatment of Cynthia, this is a case where a role exists for an independent ‘supportive investigator’. The investigator could be alerted to Cynthia’s situation (by a staff member, a fellow resident, or a member of the community) and could then investigate and ensure immediate service provision to Cynthia in addition to making appropriate referrals concerning disciplinary action and possible criminal investigation.

Case Study 2. A caller to OPA’s Advice Service is a staff member with a crisis accommodation provider who is calling about an Indigenous woman in her 30s, Margaret, who has an intellectual disability and who is currently residing at the crisis service. Margaret alleges that she has been sexually assaulted by her parents. While Victoria Police have been notified and the Sexual Offences and Child Abuse Investigation Team has been involved, police have now declined to take further action. The caller is at a loss to know what to do.

This is another case where there is no obvious agency in Victoria to conduct an investigation. An investigator here would need to be empowered both to seek appropriate service provision for Margaret, as well as to make appropriate referrals (including to police) where wrongdoing has been identified.
Case Study 3. Andrew is a man in his early 50s who has a mild intellectual disability. He lives in a private residence which was shared with his mother until her death. Andrew does not shower, and chooses to spend most of the day watching children’s television shows. His only exercise involves going to the shops. His diet consists in the main of bread and potato cakes. His house is approaching a state of severe domestic mess, with bags on the dining room table that appear to have been unopened for years, and his garage is full of toys and newspapers collected over many years. The house is damp and Andrew’s health is poor. Among his health problems, Andrew has a treatable skin condition but he refuses to apply medicinal cream, and nor will he allow others to treat him. While Andrew is not resistant to receiving supports to enable him to stay in his home, he does not keep appointments without support.

Again, in Andrew’s situation there is no obvious agency to be called to investigate. OPA did conduct an investigation into Andrew’s wellbeing when a guardianship application was lodged. Despite the investigator recommending against guardianship, a wide-ranging temporary guardianship order was made by VCAT, with the guardian empowered to make decisions concerning Andrew’s health, accommodation and access to services. This was later extended by a further guardianship order when Andrew’s health deteriorated.

Case Study 4. A woman is accompanied to a bank by her son and one other family member, who withdraw significant amounts from a joint account. The manager of the bank has concerns that the woman is being coerced, but with no evidence of incapacity, and voicing concerns about privacy laws, he is uncertain what he should do. On contacting a professional administrator, who raised the matter with OPA, the manager is advised to conduct an initial inquiry into the woman’s ability to make her own decisions, with advice that an administration application should be lodged if there are concerns.

This case demonstrates again that there is no obvious agency to whom the concerns voiced by the bank manager can be made known. In the absence of clear evidence of financial abuse, a complaint to Victoria Police is unlikely to lead to any action. The case also demonstrates that an application for an administration order can be a very blunt instrument with which to address likely financial abuse. In addition to the delays that inevitably accompany such a course of action, the problems here include the facts that:

- it is not clear who should bear the responsibility for applying for the administration order, and
- an administration order carries no punishment of wrongdoing or standard setting concerning financial abuse.

While an administration application may be the best response at present in Victoria to this scenario, the result may well be that the matter is sent to OPA by VCAT for investigation. A better response might be for the bank manager to be able to speak directly to an investigative body which would be empowered to investigate.

The key questions generated by these case studies are:
• Are reforms needed to empower one or more agencies to conduct meaningful investigations in these scenarios?
• How would investigations in the identified scenarios best be conducted?
• What other outcomes (aside from guardianship and referral to services) might be appropriate?

I have drawn on these case studies in my conversations with experts in the visited jurisdictions, in a bid to identify possible improvements to the current situation in Victoria.
Chapter Three. Notable features of the visited adult protection systems

The aim of this chapter is to examine how aspects of the adult protection systems in the visited jurisdictions might be drawn on to improve Victoria’s offerings in this regard. The aim here is to concentrate on developments in these jurisdictions that differ from what occurs in Victoria, and to consider whether these developments suggest improvements that might be made in Victoria. The aim is not to examine similarities, for instance, in the ways in which agencies in the visited jurisdictions respond when at-risk adults suffer violence, abuse, exploitation or neglect. Indeed in many ways these similarities – for example the roles of emergency services, the provision of disability and aged care support and so on – outweigh the differences.

Washington State, USA

Washington State’s population of 6.9 million people is slightly larger than Victoria’s. The reason for my visit here was because Washington State has a specific Adult Protective Services (APS) program, which operates within its Department of Social and Health Services (within the Aging and Disability Services branch).

Adult Protective Services

APS encourages reports to it of abuse and neglect (as indicated in the image below), and has a range of powers to investigate and respond to notifications.

Image 2. Washington State Department of Social and Health Services
(http://www.dshs.wa.gov/endharm.shtml)
I met with three APS Program Managers; Carol Sloan, Mike Wagner and Vicky Gawlik. APS has jurisdiction to investigate concerns about the wellbeing of adults in a range of settings, including in private residences as well as in supported accommodation settings where an alleged abuser is not associated with the residence (and is not, for instance, a staff member or fellow resident). A specific Residential Care Services Program, also within the Department of Social and Health Services, is responsible for responding to abuse and neglect in care settings (as detailed below).

According to statistics handed to me, in 2012 APS investigated 19,298 allegations in 15,048 cases (some cases have more than one allegation).

The statutory basis for this adult protection scheme (Revised Code of Washington (RCW) 74.34.020 (17)) defines a ‘vulnerable adult’ as someone who is:

(a) Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or
(b) Found incapacitated … or
(c) Who has a developmental disability … or
(d) Admitted to any facility; or
(e) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed … or
(f) Receiving services from an individual provider; or
(g) Who self-directs his or her own care and receives services from a personal aide’.

Washington State has a mixed system of mandatory and ‘permissive’ reporting, meaning some calls to APS are legally required. The Code provides (RCW 74.34.035 (1) and (6)) that ‘mandated reporters’ must, and that ‘[p]ermissive reporters may report to the department … when there is reasonable cause to believe that a vulnerable adult is being or has been abandoned, abused, financially exploited, or neglected’.

The following individuals are included in a list of mandated reporters (RCW 74.34.020 (11)):

‘an employee of the department; law enforcement officer; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner …’

Reports to APS come from a range of people. Some calls come from ordinary members of the public, while others come from police, service professionals and other departmental members.

Departmental investigative powers are outlined (RCW 74.34.067) as follows:

‘(1) Where appropriate, an investigation by the department may include a private interview with the vulnerable adult regarding the alleged abandonment, abuse, financial exploitation, neglect, or self-neglect.

(2) In conducting the investigation, the department shall interview the complainant, unless anonymous, and shall use its best efforts to interview the vulnerable adult or adults harmed, and, consistent with the protection of the vulnerable adult shall
interview facility staff, any available independent sources of relevant information, including if appropriate the family members of the vulnerable adult.’

The ‘End Harm’ number indicated in the image above operates from 8am to 5pm, with messages able to be left. After contact is made with APS, matters are prioritised according to the risk to the person, with responses required within 24 hours, 5 days or 10 days, according to the level of risk.

APS investigators first ensure that the person in question meets the definition of ‘vulnerable adult’ and that the alleged behaviour meets the criteria that warrants their involvement (that is, that there is an apparent case in question of ‘abandonment, abuse, financial exploitation, neglect, or self-neglect’).

If these criteria are met then investigators physically go and ‘eyeball’ the person in question unannounced. They will interview the adult and any alleged perpetrator, collaborating with local law enforcement agencies where necessary (which occurs in around 5 per cent of investigations). APS investigators are instructed to withdraw if they have concerns for their safety.

Investigators then make a finding that the claim is substantiated, unsubstantiated or inconclusive. Statistics provided to me indicate that in 2012 there were 2,060 instances where allegations were substantiated, while in 7,184 cases allegations were found to be unsubstantiated. There were also 4,373 findings that the investigation was inconclusive (and a number of investigations were ongoing).

It is worth making the point that even an ‘inconclusive’ or ‘unsubstantiated’ finding can have an impact on an at-risk adult, with, for instance, other individuals around the person being put on notice that protective services are aware of the person in question. It is also worth noting that the rate of substantiated findings was much higher in cases of self-neglect than in other areas (though questions remain about the impact of substantiations in these cases – as I mention below).

Once an investigation is complete the following responsibility is statutorily placed on the department (RCW 74.34.067 (6)):

‘When the investigation is completed and the department determines that an incident of abandonment, abuse, financial exploitation, neglect, or self-neglect has occurred, the department shall inform the vulnerable adult of their right to refuse protective services, and ensure that, if necessary, appropriate protective services are provided to the vulnerable adult, with the consent of the vulnerable adult.’

Where a matter is substantiated, the focus of APS is on ensuring the safety of the vulnerable adult. APS does not provide case management, but it can link in services to assist the person and organise, for instance, cleaning where a situation is hazardous (in a self-neglect situation). Where the adult has capacity to determine whether they will receive services, then their consent must be obtained for this to happen. Where the person does not have capacity to make this decision, then attempts will be made to link in appropriate services, including assisted accommodation support. Guardianship applications will also be made if this is considered necessary and the ‘least restrictive’ option (the language of ‘least restrictive’ is used in Washington State as it is in Victoria).
Where a substantiation includes a finding of wrongdoing by another person, APS will inform that wrongdoer, who then has the right to challenge the finding. One of the outcomes of such a finding is that the wrongdoer is placed on an ‘Abuse Registry’. This information is then available to people conducting background checks on the person in question, and means that the person will be unable to work in care settings in Washington State where they might have unrestricted access to vulnerable adults. The register was established in 2003 and now has between 3,500 and 4,000 names on it.

Substantiated findings can also lead, where necessary, to the making of a Vulnerable Adult Protection Order, which can include any of the following elements (RCW 74.34.130):

‘(1) Restraining [the] respondent from committing acts of abandonment, abuse, neglect, or financial exploitation against the vulnerable adult;
(2) Excluding the respondent from the vulnerable adult’s residence for a specified period or until further order of the court;
(3) Prohibiting contact with the vulnerable adult by [the] respondent for a specified period or until further order of the court;
(4) Prohibiting the respondent from knowingly coming within, or knowingly remaining within, a specified distance from a specified location;
(5) Requiring an accounting by [the] respondent of the disposition of the vulnerable adult’s income or other resources;
(6) Restraining the transfer of the respondent’s and/or vulnerable adult’s property for a specified period not exceeding ninety days’.

Another outcome of a substantiated finding, where wrongdoing by another individual is identified, is referral to police.

I was interested to ask APS Program Managers whether APS would investigate the types of matters raised in Case Study 2 (Margaret in crisis service alleging sexual assault), Case Study 3 (Andrew in a situation of self-neglect) and Case Study 4 (a woman apparently coerced into withdrawing funds). They confirmed that they would investigate all three matters.

One person I spoke with who has regular interaction with APS is Karin Taifur, a case manager with Evergreen Health’s Geriatric Regional Assessment Team. This small team of around half a dozen core staff is funded by King County and provides crisis mental health and other services. The team regularly conducts evaluations in situations similar to Case Study 3 (Andrew in a situation of self-neglect), and will connect a person to appropriate services where the person is willing for this to occur. Unsurprisingly, a person’s wealth will significantly affect the kinds of services they can receive, though Medicaid funded programs are available (Medicaid is a state-managed program, as opposed to Medicare, which is federally run). The team also regularly prepares supporting materials for guardianship applications.
Evergreen Health’s Geriatric Regional Assessment Team regularly receives requests from APS to conduct evaluations, and also regularly refers matters to APS when the team’s work reveals situations which warrant or indeed require APS attention (the team is a mandated reporter).

I was able to glean a lot of frank information about the operation of Washington State’s APS from the people I spoke to (including those people mentioned above as well as the individuals mentioned in ensuing sections).

APS is by no means a perfect system, and several interviewees pointed to some limitations in its operation. These included concerns that:

- APS can be too rule-bound, in not investigating matters that fall just outside its investigations criteria (e.g. a person doesn’t meet the definition of ‘vulnerable adult’);
- Its investigations, especially in financial exploitation cases, could be more thorough, which would make subsequent police investigations and prosecutions easier to undertake;
- It doesn’t have sufficient resources to arrange case management and emergency support where, for instance, neglect is identified;
- In situations of self-neglect, a substantiated finding by APS will not necessarily lead to any further activity to support the person.

My interviews in Washington State have led me to the view that it is a significant challenge to ask an investigator on any given day to be able to examine situations of violence, exploitation, abuse and neglect. While APS does not have specialist investigators, it would make sense to me, as it does to several people I interviewed, to have investigators who specialise in one of three fields:

- Self neglect
- Financial exploitation
- Other criminal victimisation.

While some investigations clearly involve more than one of these areas, each does require a particular skill set and approach. I will return to this in the concluding chapter.

**Residential Care Services**

Residential Care Services is another branch within Washington State’s Department of Social and Health Services, and it has responsibility for licensing residential service providers. As Dreyfus (2010, p. 12) notes, the Resident and Client Protection Program, that forms part of Residential Care Services, has investigative powers in relation to:

‘… individuals alleged to have abused, abandoned, neglected, exploited, and financially exploited a resident or client in the following programs:

- Nursing homes
- Boarding homes
- Adult family homes
- Intermediate care facilities … and
An ‘adult family home’ is defined (RCW 70.128.010) as
‘a residential home in which a person or persons provide personal care, special care, room, and board to more than one but not more than six adults who are not related by blood or marriage to the person or persons providing the services.’

While I was advised that in general there is underreporting of abuse and mistreatment of vulnerable adults in care settings, the work of the Resident and Client Protection Program was praised. Case Study 1 (abuse and neglect of Cynthia in a group home) is clearly one that this program would investigate.

Washington State also has a Medicaid Fraud Control Unit within the office of the State Attorney General, which prosecutes cases of mistreatment, abuse and neglect that occur in long-term care facilities. I met Assistant Attorney General Eileen Alexander, who works in the Unit. Despite its name, the Unit’s jurisdiction extends beyond Medicaid-funded matters to include mistreatment that occurs in Medicaid eligible services. The Unit investigates criminal mistreatment, which includes neglect and financial abuse, and referrals to it routinely come from Residential Care Services (within the DSHS). The Unit’s jurisdiction overlaps with that of other agencies, particularly the law enforcement arms of the State’s various counties, and regular liaison between the agencies is required. Some counties are particularly good in investigating violence, abuse and neglect, and King County (which incorporates Seattle) is suggested to be one of the better ones.

Case Study 1 (abuse and neglect of Cynthia) was confirmed with me to be a scenario that the Unit could investigate.

It is worth noting that Washington State also has a Long-Term Care Ombudsman (2013), who has jurisdiction to receive complaints in relation to care provided in nursing homes, supported living facilities and ‘adult family homes’.

**Policing and prosecuting cases of elder abuse**

Seattle’s Police Department has a particular unit devoted to detection of, and prosecution in, elder abuse cases. I met with Detective Pamela St John, who works in the Seattle Police Department’s Elder Abuse Unit. The Seattle Police Department is only one of King County’s police departments, though it is unusually skilled in the area of elder abuse. (Seattle’s population of 630,000 makes up a little under one-tenth of Washington State’s population.)

The Seattle Police Department’s website contains the following information on elder and vulnerable adult abuse.
Most of the Seattle Police Department’s investigations concerning elder or vulnerable adult abuse originate in referrals from the State’s APS. Around 900 referrals originate in this way each year, with less than 100 per year coming from Residential Care Services and likewise less than 100 per year coming from other sources (including matters directly reported to police by members of the public).

I was particularly interested to speak to Detective St John about financial abuse investigations. The Seattle Police Department’s website contains the following on this topic (see over).
Detective St John is one of two Seattle detectives who investigate financial abuse of vulnerable adults, which accounts for around 40 per cent of referrals to police concerning vulnerable adults. Investigations involve meeting alleged victims, obtaining records (by search warrant if necessary), and can involve accounts being frozen or, in rare cases, seized. Around 10 per cent of investigations result in matters being forwarded for prosecution.

While the Seattle Police Department’s focus on financial abuse involves only two officers, this can have a significant impact on public perceptions of wrongdoing. Given the scale of the problem in Victoria (and Australia), such a development would clearly be worth trialling.

I also spoke with two Senior Deputy Prosecuting Attorneys in King County’s Elder Abuse Project, Page Ulrey and Kathy Van Olst. Prosecutorial referrals come to King County prosecutors from all of the county’s police departments (Seattle Police Department is just one of these, albeit the biggest one and the one best able to investigate financial exploitation of vulnerable adults). The Elder Abuse Project has its origins in a federal grant awarded to King County over ten years ago that saw a range of professionals trained in recognising and investigating financial exploitation. While that grant has since expired, its effect is ongoing. The project led to the creation of two specific prosecutorial positions in the county (and it also explains Seattle Police Department’s expertise in this area).

The Elder Abuse Project draws on the work now of three people, who are responsible for between 75 and 100 prosecutions per year of financial exploitation of vulnerable adults. Two typical scenarios which are the subject of prosecutions are:
• An adult child with a gambling or other addiction who financially exploits a parent who has a mild cognitive impairment;
• A caregiver who financial exploits a person in their care.

The gap in Victoria’s adult protection system that Case Study 4 sought to demonstrate (suspicions about a woman being coerced to withdraw money from a joint account) is one I raised with Detective St John and with the two prosecutors whom I met. I was advised that the Seattle Police Department would investigate a case like that, and that the prosecutors would prosecute, and indeed have prosecuted, in cases like that. The tack taken by a prosecutor in such a case would depend on the capacity of the woman in that scenario to make decisions concerning her financial activity (it was pointed out to me that even if the woman in question technically had capacity to make decisions here, a criminal prosecution for undue influence or breach of fiduciary duty could still ensue).

A further point raised with me by Detective St John and by the Elder Abuse Project prosecutors is the need for advocacy support for victims when elder abuse criminal investigations and prosecutions are underway. The Seattle Police Department is rare among police departments in King County, and indeed in Washington State, in having the services of one advocate, who is heavily called upon.

A final point to note here is that financial institutions in Washington State are legislatively required (RCW 74.34.220) to provide training on financial exploitation. This is something several of the people I met considered to be very important to the State’s ability to tackle the financial exploitation of vulnerable adults.

**Guardianship**

Under Washington State’s guardianship laws a range of individuals and organisations can be given financial and personal decision-making powers over ‘incapacitated’ adults. The statutory basis for guardianship appointments in Washington State (RCW 11.88.010) is as follows:

‘(1) The superior court of each county shall have power to appoint guardians for the persons and/or estates of incapacitated persons …

(a) For purposes of this chapter, a person may be deemed incapacitated as to person when the superior court determines the individual has a significant risk of personal harm based upon a demonstrated inability to adequately provide for nutrition, health, housing, or physical safety.

(b) For purposes of this chapter, a person may be deemed incapacitated as to the person’s estate when the superior court determines the individual is at significant risk of financial harm based upon a demonstrated inability to adequately manage property or financial affairs.

(c) A determination of incapacity is a legal not a medical decision, based upon a demonstration of management insufficiencies over time in the area of person or estate. Age, eccentricity, poverty, or medical diagnosis alone shall not be sufficient to justify a finding of incapacity.’
I met with Shirley Bondon, Manager of Court Access Programs, Office of Public Guardianship. There are over 20,000 active guardianship cases in Washington State, with almost all of these being ‘private’ cases in which the guardian is an individual (typically a family member) or one of the thousands of professional guardians who are paid for their work (often from the estate of the person they are representing). Most guardianship orders are plenary rather than limited.

The Office of Public Guardianship oversees only a very limited ‘public’ guardianship program, with a small number of guardianship cases funded by the State. These are all contracted out to professional guardians who have been certified after completing training and meeting other eligibility criteria (including credit and criminal record checks). Since the program began in 2008, there have been only a small number of public guardianship cases (around 120), and future budgetary commitment to the work of the Office is uncertain.

Similar to the situation in Victoria, three typical categories of public guardianship cases in Washington State include:

- Elderly people with dementia who have no family support;
- Adults aged between 18 and 40 with a developmental disability whose parents are unable to continue caring for them;
- Adults with a mental illness.

My interviews in Washington State pointed to a number of challenges that confront the guardianship system there. These include:

- The expense and adversarial nature of the court process required before an order is made;
- The skill level of guardians themselves and their reported reluctance to seek and act on the wishes of the people who are subject to guardianship orders;
- The State’s preference for plenary rather than limited guardianship orders;
- The small role, and uncertain future, of public guardianship.

Mental health

In this brief overview of Washington State’s adult protection system I haven’t focussed on points of similarity with Victoria. Included among these similarities is Washington State’s mental health legislation (contained in RCW 71.05.150 and passim), which permits involuntary detention and treatment where a person with a ‘mental disorder’ shows ‘a likelihood of serious harm’. While this legislation and its application have not been the subject of my research, it clearly forms part of the adult protection framework in Washington State.

Observations and conclusions

Four matters routinely mentioned by professionals with whom I spoke in Washington State, which are common among professionals in this field throughout the world, are:

- The need for adequate resources to be available if investigations into the wellbeing of at-risk adults are to be both informative and therapeutic;
• The difficulties that confront successful prosecutions in situations of neglect (which require evidence both that a duty of care exists and that such a duty has been breached by a particular individual or organisation);
• The challenge presented to any protective system by situations of self-neglect, where resources are not readily available to assist, and where people may also be unwilling to receive services; and
• The difficulties involved in investigating and prosecuting where victims are unable to speak (a situation, one of my interviewees noted, which exists in every murder inquiry).

With those limitations in mind, the strengths of the system in Washington State are clear:
• The state’s adult protection laws are extensive and impressive – the fact that they don’t simply focus on people with disabilities gives them greater general standard setting ability and relevance (not to mention international human rights law compliance);
• The existence of one contact point where abuse and neglect can be reported (in addition to contact points for emergency services) provides certainty and encourages the involvement in adult protection of general members of the public;
• The ‘mandated reporter’ status of health and welfare professionals (among others) means that matters that arise in a variety of settings must be channelled through APS, which limits the chance that people will ‘slip through the cracks’;
• The range of agencies that exist with sometimes overlapping investigative roles is a strength, given that a multifaceted approach is needed in a robust adult protection system (this approach in Washington State incorporates activities ranging from prosecution for criminal breaches to advocacy for improved service provision); and
• The ability and willingness of state and county law enforcement agencies to address financial abuse is significant, and the Seattle Police Department’s and King County’s prosecutorial activities here are particularly impressive.

In conducting my meetings in Washington State, I was also struck by how crucial it is for the various professionals involved in the State’s adult protection system to understand, and respect, the roles played by other professionals and their organisations in the system. I’ll return to this matter at the end of this report.

One final point that is worthy of mention is admittedly anecdotal, but nevertheless seems important. In simply walking around Seattle, a city with a population of under one million people, I was bewildered to see the many dozens of people (I would say over 100) who were homeless, begging and/or in quite florid states of mental illness. This sheer number of apparently at-risk adults was not apparent in my visits to the other cities of Edinburgh, London and Halifax (and nor is it the case in my experience of any Australian capital city). While I have certainly seen people begging in all of these places, it was the number of clearly at-risk adults in Seattle that was striking. If, as I discuss later, any adult protection system is only as good as the social services able to be delivered under it, then it would seem wrong not to include this observation.
Nova Scotia, Canada

Nova Scotia is a province on Canada’s south-east coast with a population of around 945,000. Nova Scotia’s adult protection regime consists of a number of familiar agencies and strategies, in addition to which are some local variations and new initiatives.

It is important at the outset to note that Nova Scotia has particular regulatory and response mechanisms in place for people who are residing in supported accommodation settings, which are governed by the Protection for Persons in Care Act. My focus will not be on protection responses concerning people in these settings, though I will refer briefly again to this topic when discussing the case scenarios.

Adult protection

A specific adult protection scheme, which does not yet incorporate protection from financial abuse, exists in Nova Scotia that incorporates a range of legal and practice responses, as the following images from Nova Scotia government websites demonstrate.

Image 5. Nova Scotia ‘Continuing Care Programs’
(http://www.gov.ns.ca/health/ccs/adult_protection.asp)
I met with Judy Taylor, Nova Scotia’s Adult Protection Coordinator, and our meeting was also attended via teleconference by Suzanne Brake, Newfoundland’s Adult Protection Coordinator, and Kelly Cooper, Adult Protection Coordinator for the Yukon. While my focus here will be on Nova Scotia, it was good to hear from other provincial adult protection coordinators, and their involvement in this meeting informs some of what follows.

The legislative basis for Nova Scotia’s adult protection regime is the Adult Protection Act, which defines (section 3(b)) an ‘adult in need of protection’ as:

- an adult who, in the premises where he resides,
  - (i) is a victim of physical abuse, sexual abuse, mental cruelty or a combination thereof, is incapable of protecting himself therefrom by reason of physical disability or mental infirmity, and refuses, delays or is unable to make provision for his protection therefrom, or
  - (ii) is not receiving adequate care and attention, is incapable of caring adequately for himself by reason of physical disability or mental infirmity, and refuses, delays or is unable to make provision for his adequate care and attention’.

The Act permits the making of a range of protective orders. These can be made by the Nova Scotia Supreme Court (Family Division) in Cape Breton and Halifax, and
elsewhere in the province by the Family Court (Nova Scotia Department of Health and Wellness, 2011a, par. 2.9).

The *Adult Protection Act* provides for the following orders to be made.

**Entry order**
Section 8(2) ‘Where the adult who is being assessed refuses to consent to the assessment or a member of the family of the adult or any person having care or control of the adult interferes with or obstructs the assessment in any way, the Minister may apply to the court for an order authorizing the entry into any building or place by a peace officer, the Minister, a qualified medical practitioner or any person named in the order for the purpose of making the assessment’.

**Assessment Order**
Section 9(1) ‘Where … the Minister is satisfied that there are reasonable and probable grounds to believe a person is an adult in need of protection, he may apply to a court for an order declaring the person to be an adult in need of protection and, where applicable, a protective intervention order …’

**Protective Orders**
Section 9(3) ‘Where the court finds, upon the hearing of the application, that a person is an adult in need of protection and either
- (a) is not mentally competent to decide whether or not to accept the assistance of the Minister; or
- (b) is refusing the assistance by reason of duress,
the court shall so declare and may, where it appears to the court to be in the best interest of that person,
- (c) make an order authorizing the Minister to provide the adult with services, including placement in a facility approved by the Minister, which will enhance the ability of the adult to care and fend adequately for himself or which will protect the adult from abuse or neglect;
- (d) make a protective intervention order directed to any person who, in the opinion of the court, is a source of danger to the adult in need of protection
  - (i) requiring that person to leave the premises where the adult in need of protection resides unless that person is the owner or lessee of the premises,
  - (ii) prohibiting or limiting that person from contact or association with the adult in need of protection,
  - (iii) requiring that person to pay maintenance for the adult in need of protection in the same manner and to the same extent as that person could be required to pay pursuant to the *Family Maintenance Act*.’

**Removal orders**
Section 10(1) ‘Where … the Minister is satisfied that there are reasonable and probable grounds to believe that
- (a) the life of a person is in danger;
- (b) the person is an adult in need of protection; and
- (c) the person is not mentally competent to decide whether or not to accept the assistance of the Minister or is refusing the assistance by reason of duress,
the Minister may authorize the immediate removal of the person to such place as the Minister considers fit and proper for the protection of the person and the preservation of his life, and a person so authorized may take reasonable measures to remove the person whose life is in danger.’
These provisions have been interpreted in the key Adult Protection Policy Manual in the following way (Nova Scotia Department of Health and Wellness, 2011a, par. 6.11):

‘There are four different court applications which can be made under the Adult Protection Act:
1. Section 8- Order for Entry. This order allows Adult Protection workers, police and other health professionals to gain entry into a client’s home to conduct an assessment ...
2. Section 9- declaring that an adult is in need of protection and if found in need of protection, authorizing the Minister to refer the adult to services which will meet his or her protection needs ...
3. Section 9- requesting a protective intervention order against an individual who is a source of danger or significant risk to the adult in need of protection. This order limits the access that the individual has with the adult in need of protection ...
4. Section 10- removing an adult in need of protection from his or her premises if he or she is in danger or living at extremely high risk ’

The Act thus gives broad powers to the Minister to conduct investigations and order service delivery.

The adult protection system in Nova Scotia does not yet extend to situations of financial abuse (Nova Scotia Department of Health and Wellness, 2011b). An amendment to the adult protection legislation has been passed but not yet proclaimed which incorporates into the legislation protection from ‘financial abuse’ for people aged 65 or older who have ‘a permanent mental incapacity’ (Adult Protection Act (amended) 2013, section 1). At present people with concerns about financial exploitation or abuse of at-risk adults are referred to Nova Scotia police.

Operationally, the adult protection system in Nova Scotia works as follows. As indicated in Image 5 above, Nova Scotia has a single entry-point telephone number through which concerns can be raised about at-risk adults. The line is open from 8.30am to 4.30pm seven days a week, with people encouraged to contact emergency services if calls need to be made outside these hours. When a call comes in it is assigned to one of 17 adult protection workers who will usually call back on the same day (within the hour in emergency situations). The adult protection staff tend to have social work backgrounds, and many come with experience of having worked in the child protection system.

There are on average around 1,300 referrals to Adult Protection Services each year. At the intake and inquiry stage a person whose situation warrants an assessment will be met by the worker who then develops a ‘care plan’ and, where it is required, organises a referral for particular services or indeed an accommodation placement.

Where necessary a court order of the kind indicated above will be sought directing the provision of services or authorising the accommodation decision. I met with one Supreme Court Judge, Justice Mona Lynch, who has made protection orders, but is only called on to do so less than once a month. I also met with legal academic Assistant Professor Sheila Wildeman, whose research interests have included adult protection and mental health laws.
In essence the term that best describes the adult protection system in Nova Scotia is ‘coordination’, with the delegates of the Minister empowered to direct service provision, or make accommodation decisions, where the person in question meets the threshold criteria. In practice the differences between this system and the guardianship system as it operates in Victoria are less pronounced than I first imagined they would be. In both cases substitute decisions are in effect being made with the wellbeing of the person in question in mind. There are, however, some clear differences.

One clear point of difference is the single entry point through which concerns can be raised. For the guardianship process to be instigated in Victoria someone must apply to VCAT. In Nova Scotia a telephone call is all that is required to instigate the adult protection system’s response. Court-made protection orders are only necessary where there is objection to the proposed service or other response that has been recommended by the relevant adult protection worker. Here it is important to note that section 7 of the Adult Protection Act provides that:

‘Where, after an assessment, the Minister is satisfied that a person is an adult in need of protection, the Minister shall assist the person, if the person is willing to accept the assistance, in obtaining services which will enhance the ability of the person to care and fend adequately for himself or will protect the person from abuse or neglect.’

Another point of difference sees the adult protection worker in Nova Scotia with the power, at least technically, to ‘direct’ services (rather than just request them). While in practice the efforts to link a person to appropriate services are described by practitioners in terms of ‘collaboration’, the difference has the potential to be important in particularly difficult situations.

A further point of difference, which is related to the ease with which concerns can be raised with adult protection workers, is the encouragement that the system in Nova Scotia gives to citizens to report situations of concern. Indeed, rather than being simply encouraged to report situations of concern, the Adult Protection Act actually creates a ‘failure to report’ offence, holding that:

Section 5 (1) ‘Every person who has information, whether or not it is confidential or privileged, indicating that an adult is in need of protection shall report that information to the Minister.’

Section 16 (1) ‘Every person who has information, whether or not it is confidential or privileged, indicating that an adult is in need of protection and who fails to report that information to the Minister is guilty of an offence under this Act.’

In my meeting with three provincial adult protection coordinators I raised the four case scenarios described in Chapter Two. I asked whether they would be the subject of investigations if similar situations were brought to the attention of their adult protection systems. In Nova Scotia, Case Study 1 (Cynthia in a group home) would be referred for investigation under the Protection for Persons in Care Act, which, as I indicated at the start of this section, operates in parallel with the adult protection system. A person reporting Case Study 4 (apparent financial exploitation) would be encouraged to report it to police (though after the proclamation of the amendments to the Adult Protection Act, such situations will be investigated by adult protection workers). Case Study 2 (Margaret in crisis accommodation) and Case Study 3 (self-neglect of Andrew) would be investigated. (The adult protection coordinators from
Newfoundland and the Yukon indicated that all four case studies could be the subject of investigations in their adult protection systems.)

It is important to be sanguine about the framework and operations of adult protection in Nova Scotia. One comment made to me was that the adult protection system is only as good as the social services that lie behind it. In an era of state withdrawal from service provision, this can be particularly problematic. Sometimes this withdrawal is justified, I was informed, to allow greater room for individual autonomy, though clearly cost-saving is one aspect of this.

Another danger with any adult protection system is that it may, in the public’s eyes, cause people increasingly to believe that adult protection is the role of government, rather than the role of society. Providing people with a number to call may, according to this argument, lead callers to believe they are absolved of any further responsibility once a call has been made. I do not, however, consider this to be a strong argument against improving adult protection practices, nor a strong argument against providing a central contact point through which concerns can be lodged.

**Guardianship**

While Nova Scotia’s guardianship legislation was reviewed in 1995 by the Law Reform Commission of Nova Scotia, the relevant guardianship legislation remains the *Incompetent Persons Act 1989*. According to the Act an ‘incompetent person’ is defined (section 2) to include adults who are ‘incapable from infirmity of mind of managing [their] own affairs’. If the Nova Scotia Supreme Court is satisfied ‘that the person in question is incapable of taking care of himself’ then the Court can ‘appoint a guardian of his person and estate’ (section 3(3)).

In Nova Scotia personal or lifestyle decisions can be made by private appointed guardians. Meanwhile private individuals and trustee companies can be appointed as guardian of a person’s estate, with similar substitute financial decision-making powers to those held by administrators in Victoria.

Nova Scotia has no public guardian, only a Public Trustee. The Public Trustee can be appointed as ‘guardian of the estate’ of a person who is deemed unable to make their own decisions (Nova Scotia Public Trustee 2013).

Interestingly, the Public Trustee also has many of the powers often held by guardians in Victoria, including last-resort authority to consent to: medical treatment; admission to nursing care; and the receipt of services in the home (Nova Scotia Public Trustee 2013). In a significant difference to the power of guardians in Victoria, the Public Trustee in Nova Scotia is also the last-resort substitute decision maker for an adult’s involuntary psychiatric treatment.

These powers, which can be exercised by the Public Trustee where an adult lacks capacity to make his or her own decision and where no higher-ranked substitute decision maker is available, are contained in the:

- *Hospitals Act* (section 9);
- *Personal Directives Act* (section 14), which, despite its name, enables substitute ‘health-care decisions, a decision to accept an offer of placement in
Chesterman – Churchill Fellowship report

a continuing-care home and home-care services decisions’ to be made where a valid directive has not been made; and the

- *Involuntary Psychiatric Treatment Act*, which is currently under review (section 38).

These Acts list a hierarchy of substitute decision makers, akin to Victoria’s person responsible hierarchy, with the Public Trustee the final decision maker. The Public Trustee’s role here, thus, is automatic and does not require court or tribunal appointment.

I met with Anne Erly, the Health Care Decisions Coordinator at the office of the Public Trustee. In the last financial year 22 per cent of ‘health care’ referrals involved medical treatment decisions under the *Hospitals Act*, 11 per cent involved involuntary psychiatric decisions (including consent for treatment under Community Treatment Orders), and 67 per cent of referrals involved decisions under the *Personal Directives Act*.

The ‘health care’ powers of the Public Trustee are akin to guardianship powers routinely exercised by OPA, except that OPA does not make psychiatric treatment decisions (and I am informed that many psychiatric patients for whom the Public Trustee is substitute decision maker look to the Public Trustee’s office to play a greater role in their affairs than it is able to play).

One key operational difference between the Public Trustee’s ‘health care’ role and OPA’s role as guardian is that the appointment of the Public Trustee as substitute decision maker is automatic. OPA’s appointment as guardian requires a tribunal order. (OPA’s role as registry for section 42K (medical treatment) notices under the *Guardianship and Administration Act*, where a person responsible is not available, is in some ways comparable here, but this is not technically a substitute consent process, rather a process of registration in the absence of consent.)

Another point to be made here is that the Public Trustee’s health powers are clearly constrained to decisions that need to be made. While this apparently is a source of frustration for some clients and carers, who would like the office’s role to be more expansive, this is clearly consistent with modern human rights norms. (While guardianship orders in Victoria can limit the authority of a guardian to a particular decision that needs to be made, this is not a routine practice.)

Nova Scotia thus has in place an adult protection system which enables a number of protective actions to be taken, and also authorises the Public Trustee to make certain ‘protective’ substitute decisions, including some accommodation decisions. There might thus be said to exist two pathways by which steps can be taken to protect an adult at risk in the community.

**Financial abuse**

When it comes to the protection of a person’s finances the *Adult Protection Act* (sections 9 and 13) actually authorises the Public Trustee to be notified of protective orders and to act to protect the person’s financial wellbeing.
Having made that point, the Office of the Public Trustee does not consider that it has a role in investigating the alleged financial abuse of someone who is not a client (Nova Scotia Public Trustee 2013). While Case Study 4 (apparent financial exploitation) is a situation where the Public Trustee could become involved as ‘guardian of the estate’, I am advised that there would be no automatic police referral in that kind of situation.

As mentioned earlier, a new provision has been passed that will bring ‘financial abuse’ cases into the adult protection system, though this is not yet operational. Practices in Nova Scotia concerning financial exploitation will presumably change quite significantly when the new provision is proclaimed.

**Mental health**

As mentioned earlier, Nova Scotia’s principal mental health law, the *Involuntary Psychiatric Treatment Act 2005*, is currently under review. This Act (section 17) permits involuntary admission to a mental health facility of a person with ‘a mental disorder’ who is at risk to themselves or others and who ‘as a result of the mental disorder … does not have the capacity to make admission and treatment decisions’. The Act enables (section 38) treatment to be authorised by a substitute decision maker and also (section 47) enables Community Treatment Orders to be made, under which people can reside in the community so long as they take medication.

One clear difference with this legislation to the situation in Victoria is the hierarchy of automatic substitute psychiatric treatment decision makers which, as I mentioned earlier, includes the Public Trustee (and this list of decision makers is relevant for every psychiatric treatment decision of an involuntary patient, since decision-making incapacity is one of the criteria for detention). In Victoria this power lies with the authorised psychiatrist.

Among the concerns expressed to me about Nova Scotia’s mental health legislation and mental health practices was the view that insufficient weight is given to the ‘pre-incapacity’ treatment choices that patients may have expressed.

Another more practical criticism that was expressed concerned the difficulty with which the small number of provincial psychiatrists are able to monitor people on community treatment orders, which is resulting in a number of people in this situation coming to the attention of the adult protection system.

**Observations and conclusions**

Many of the challenges facing service professionals in the adult protection sphere in Nova Scotia are similar to those that confront professionals in this sphere in Victoria. These include:

- the need for more resources, or system capacity, to enable appropriate service delivery, including crisis accommodation and care;
- the difficulty of finding enough physicians to conduct capacity assessments;
Chesterman – Churchill Fellowship report

- the difficulty of finding appropriate accommodation settings in which people with acquired brain injuries can reside;
- the challenges presented by cases of self-neglect (including where services are being refused).

Having made those points, some clear strengths of the system in Nova Scotia include:
- the single entry point through which concerns about the wellbeing of at-risk adults can be raised;
- the encouragement, and indeed requirement, of citizens to report situations of concern;
- the broad suite of powers that enable adult protection workers to investigate and offer service and accommodation responses where a need is identified.
Scotland, United Kingdom

With 5.2 million people, Scotland’s population is slightly smaller than Victoria’s (at 5.6 million). The main reason for my visit to Scotland was to examine the operation of its relatively recent adult protection legislation, and to see whether Victoria might learn from Scotland’s experiences in this field.

Adult protection

In Scotland the enactment of the *Adult Support and Protection (Scotland) Act 2007* marked a significant moment in the history of that country’s attempt to improve the protection of at-risk adults.

That Act (section 3(1)) states that:

> “Adults at risk” are adults who—
> (a) are unable to safeguard their own well-being, property, rights or other interests,
> (b) are at risk of harm, and
> (c) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.’

The Act places an onus on local councils (section 4) to:

> ‘make inquiries about a person’s well-being, property or financial affairs if it knows or believes—
> (a) that the person is an adult at risk, and
> (b) that it might need to intervene (by performing functions under this Part or otherwise) in order to protect the person’s well-being, property or financial affairs.’

The Act (section 7) also empowers council officers to undertake investigations, including in private homes:

> ‘A council officer may enter any place for the purpose of enabling or assisting a council conducting inquiries under section 4 to decide whether it needs to do anything (by performing functions under this Part or otherwise) in order to protect an adult at risk from harm.’

The Act also provides for the undertaking of medical examinations (section 9) and examinations of records (section 10).

The Act also creates a suite of protective orders that enable protective mechanisms to be put in place. These consist of:

- Assessment orders (section 11), under which the sheriff orders the removal of a person from the visit site for the purpose of medical or other examination;
- Removal orders (section 14), which last for up to 7 days and enable a person to be removed from a situation of harm; and
- Banning orders (section 19), which enable the sheriff to ban identified individuals from being in particular locations.
While as the Act’s main role is protective, it does recognise the ability of individuals to object to the placing of protective orders over them. In so doing, it makes an important contribution to the ‘autonomy versus protection’ debate that surrounds any adult protection scheme. Section 35 provides that:

‘(1) The sheriff must not make a protection order if the sheriff knows that the affected adult at risk has refused to consent to the granting of the order.

(2) A person must not take any action for the purposes of carrying out or enforcing a protection order if the person knows that the affected adult at risk has refused to consent to the action.

(3) Despite subsections (1) and (2), a refusal to consent may be ignored if the sheriff or person reasonably believes—

(a) that the affected adult at risk has been unduly pressurised to refuse consent, and
(b) that there are no steps which could reasonably be taken with the adult’s consent which would protect the adult from the harm which the order or action is intended to prevent.

(4) An adult at risk may be considered to have been unduly pressurised to refuse to consent to the granting of an order or the taking of an action if it appears—

(a) that harm which the order or action is intended to prevent is being, or is likely to be, inflicted by a person in whom the adult at risk has confidence and trust, and
(b) that the adult at risk would consent if the adult did not have confidence and trust in that person.’

The Act (section 42) obliges local councils to establish Adult Protection Committees, which review the workings of a range of public bodies in the area, and the Committees must allow (section 44) for representation from a range of public bodies, including the Public Guardian, the Mental Welfare Commission and the Care Commission.

Adult Protection Committees are required (section 46) to report every two years on their operations. In the 2010 to 2012 period, inconsistent data collection and reporting by the 29 Scottish Adult Protection Committees means that it is not possible to know the total number of protection orders and investigations carried out throughout Scotland. One Scotland-wide summary report noted that 1,650 investigations had been conducted in this period, and 137 protection orders made, but these were said very much to be incomplete figures. Better, and more collatable, data from Adult Protection Committees has been sought for future reporting periods (see Ekosgen 2012).

During my trip to Scotland I met with a range of professionals whose frank discussions assisted enormously with my understanding of this protection system.

I met with Joanne Boyle, who works with the Scottish government on adult support and protection (in the Mental Health and Protection of Rights Division). I was also fortunate enough to attend an adult protection conference at the University of Stirling on 25 June 2013, which was attended by 140 adult protection professionals, including those working in the social work, health, mental health, and emergency services fields.
(many of whom are employed at local council level). On the day of the conference, and at a dinner the evening beforehand, I met and spoke with a number of conference attendees and presenters, who included: Paul Comley, National Adult Protection Coordinator, WithScotland; Beth Smith, Director, WithScotland; Pene Rowe, Highland Child and Adult Protection Development Officer; Kate Gibb, Lead Officer, Child and Adult Protection, Shetland; and Max Barnett, Chair, Shetland Adult Protection Committee. The analysis below draws on these discussions, and also on presentations I heard at the conference.

During my trip to Scotland I also met with other professionals involved in the disability and mental health sectors. I met Richard Hamer, Director of External Affairs, and Charlie McMillan, Director of Services and Development, at Capability Scotland. Capability Scotland is a large provider of a range of disability services, including accommodation, education and day services, with a decades-long history of providing services to people with cerebral palsy, whose degrees of disability range from mild to profound. I also met Tony Jevon, Social Work Officer at the Mental Welfare Commission, and I will briefly describe the work of the Commission in a following section.

The commentary that follows draws on discussions I had with all of these individuals.

One of the significant attributes of Scotland’s adult protection system is its encouragement of members of the public to identify at-risk adults, and the responsibility it places on officials at local councils to inquire about, and take steps to protect, any at-risk adults. An example of the public campaign that has accompanied the legislation is the video available on the principal ‘act against harm’ website, the link to which is displayed below.

**Image 7. Scotland’s Act Against Harm**
(http://www.actagainstharm.org/)
This campaign was successful initially in raising awareness, though I am advised its effect has waned significantly in the time since its launch.

People wishing to report situations of harm are guided to local council websites and contact details. Indeed when I asked people who they would call if they identified a person needing assistance, they nominated the social work department of the local council.

Local government websites contain details about reporting harm. For instance, the Edinburgh Council website contains the following:


While the enactment of specific legislation in 2007 was a significant step, the adult protection system in Scotland cannot be understood simply by reading existing laws and policies. Scotland has a long history of active local council involvement in citizen well-being, and the adult protection initiatives of the past six years are best understood as crafting a new layer of oversight and coordination onto this long history of active local social welfare involvement in the lives of at-risk citizens.

It is telling that the 29 Adult Protection Committees (technically there are 32 actual committees, but some work collaboratively and there are 29 Committee chairs) are organised locally and draw on the expertise of a range of local service personnel, including law enforcement, emergency services, health and social services personnel.

The organisation WithScotland, which organised the adult protection conference that I attended, has been engaged by the Scottish government to coordinate the adult
protection work being carried out throughout the country. WithScotland is a small organisation of less than 10 staff, which is based at the University of Stirling and which has a background in child protection. WithScotland’s adult protection work is funded by the Scottish government and is led by Paul Comley, the Adult Protection Coordinator, who seeks to integrate the range of activities occurring at local levels and also works to get the Adult Protection Committees throughout the country functioning collaboratively. The coordination activity undertaken by WithScotland thus seeks to draw local expertise together to understand the national adult protection situation – what is working well and what isn’t – and at the same time seeks to ensure that the local committees are implementing the government’s protection goals (Scotland government 2013), which are concerned with:

1. Adults at risk of Financial Harm
2. Adult Support & Protection in Care Home settings
3. Adult Support & Protection in [Accident and Emergency] settings
4. Services Users and Carers Involvement in Adult Support & Protection
5. National Data Collection’.

While the recent adult protection initiatives have seen the Scottish government articulate and promote key national priorities, the word that to my mind best sums up this recent work is ‘collaboration’. One phrase which was repeated in different ways many times at the adult protection conference was ‘it’s all about partnerships’. The main role of the Adult Protection Committees is to bring together key service professionals and coordinate local efforts. The role of WithScotland at a national level is to coordinate the work of all the Committees and draw out significant themes.

While for reasons mentioned earlier reliable national data is not available (and developments here are sought under one of the five national priority goals), it is interesting to note that the following trends have been apparent to professionals in the field (and are widely accepted to be accurate) in the five years since the protection scheme has been operational:

- there has been relatively low usage of protection orders;
- referrals to the adult protection system from members of the public and from health service personnel have been relatively few in number;
- there has been a high volume of referrals from police, which has now levelled off somewhat;
- there has been a surprising volume of referrals that have involved self-harm or self-neglect (including drug and alcohol abuse).

The low uptake of orders is not necessarily a problem, in the view of some experts. They point to the existence of the orders, even if they are not actually sought in particular cases, as being ‘one of the tools in the toolbox’ that ensures staff get access to at-risk adults when concerns are raised.

The low level of referrals from health service staff is suggested to relate to a number of possible factors, including: simple lack of knowledge of the framework; concerns about confidentiality; and concerns that referrals might jeopardise existing professional relationships.

The low rate of referrals from members of the general public is attributed to a lack of knowledge of the system. It is interesting to note that while the ‘act against harm’
campaign was successful in raising awareness, that awareness diminished once the campaign intensity was reduced. Suggestions are now being made that the campaign may have been too broad (in targeting a broad gamut of situations of concern) and that a new campaign should focus on particular aspects of adult protection, such as protection from financial abuse. (On this score it is worth noting briefly that one ‘industry’ development on this topic has been praised, namely the work of the Scottish Business Resilience Centre).

A general concern raised with me about the Scottish adult protection system is that it is not clear that the excellent and far-reaching protection legislation is matched in practice, in particular in the current era of extensive cutbacks to social services. The ‘practice’ being referred to is the provision of social services to at-risk adults. As one person commented to me, it is difficult to know how much protection is going on. This confirms in my mind a perhaps obvious but important finding from visiting other jurisdictions: that adult protection systems are only ever as good as the resultant social services that are able to be provided.

The level of bureaucracy involved in the Scottish protection system was also occasionally queried, especially in a time of welfare reform.

It is important to note that the framework for the general adult ‘protection’ system in Scotland involves not only the named protection legislation, but also Scotland’s guardianship (or ‘incapacity’) legislation and its mental health legislation. In turning now to those topics, one positive comment made to me about the protection legislation is that it ensures that people are able to be protected if they would otherwise fall between gaps that exist in these other protective regimes.

**Guardianship**

I met with Scotland’s Public Guardian, Sandra McDonald, and was interested to discuss the interplay between guardianship and adult protection services. Guardianship orders in Scotland are made by the Sheriffs’ Court under the *Adults with Incapacity (Scotland) Act* (section 58) where:

‘(a) the adult is incapable in relation to decisions about, or of acting to safeguard or promote his interests in, his property, financial affairs or personal welfare, and is likely to continue to be so incapable; and

(b) no other means provided by or under this Act would be sufficient to enable the adult’s interests in his property, financial affairs or personal welfare to be safeguarded or promoted.’

Guardianship orders in Scotland are similar to Victorian guardianship orders and can enable people to be appointed as financial and property and/or personal welfare decision makers. Ordinarily guardians are individuals, however in the case of personal welfare appointments, the Chief Social Work Officer of the relevant local authority can be appointed (who usually then delegates this role to a council social worker). While the Office of the Public Guardian supervises financial guardians, local authorities are responsible for supervising personal welfare guardians (Office of the Public Guardian Scotland 2013a).
It is important to note that, as is the case in all the visited jurisdictions, there is a charge associated with guardianship applications and orders, though these can be reduced or waived in certain circumstances.

Intervention orders can also be made in Scotland, and these differ somewhat from intervention orders as that term is understood in Victoria. In Scotland an intervention order can be used to make a particular financial or personal welfare decision. The Office of the Public Guardian (Scotland) describes the distinction between intervention orders and guardianship orders in this way (2013b):

‘An intervention order can cover more than one aspect of the adult’s property, financial affairs and/or personal welfare. There is no fixed period for the appointment as it will last until the intervener has concluded the matters authorised by the court. An intervention order would normally be suitable when dealing with issues where the outcome can be predicted. A guardianship order on the other hand would be more appropriate where ongoing management of the adult’s affairs is required. This may be a financial or property transaction, such as signing a legal document on behalf of the adult or a personal welfare matter such as arranging for the adult to attend a medical appointment.’

As indicated above, the main role of the Office of the Public Guardian in Scotland is to oversee substitute decision makers with property and/or financial powers. The Office (2013c):

- Monitors financial guardians and financial interveners;
- Provides education about powers of attorney, guardianship, accessing funds of adults without capacity, and related matters;
- Hosts a register of all post-2001 continuing powers of attorney; and
- Investigates situations of possible financial abuse.

The Office of the Public Guardian currently registers around 50,000 continuing powers of attorney per year. These continuing powers of attorney, which can cover medical, financial and personal welfare decisions, must be registered if substitute decisions for a person without capacity are to be valid. (Around 30 per cent of these are now registered digitally.) Once a power of attorney is registered a certificate of registration and a sealed copy of the document are returned. Production of the original document is then used as proof of authenticity. Banks and hospitals do not have access to the register to determine whether a power of attorney is legitimate (this has been proposed in Victoria). While the Office of the Public Guardian monitors financial guardians, it only monitors powers of attorney, beyond the registration stage, where concerns are raised.

The Office of the Public Guardian conducts around 200 investigations each year on financial matters. As the Office notes in one of its fact sheets (2013d), the investigators may:

- Provide advice
- Freeze bank accounts
- Recommend an application be made for financial guardianship
- Apply to the sheriff for supervision or removal of a substitute decision maker
- Refer the matter to police.
While the Office of the Public Guardian is unable to seek repayment of misused funds, this is something that financial guardians can undertake.

There are clear overlaps between the guardianship and adult protection systems in Scotland. While local authorities can and do investigate concerns raised about a range of activities, including financial exploitation, the Office of the Public Guardian also has a role in financial exploitation matters, particularly when a person who fits the definition of an ‘adult with incapacity’ has a continuing power of attorney. While the protection legislation applies to people defined as ‘at-risk’, as noted above the Office of the Public Guardian operates under the Adults with Incapacity Act, whose definition of its target population (‘adults with incapacity’) is narrower. This is one of the reasons why referrals of situations of concern are often made by the Office of the Public Guardian to local authorities, but rarely the other way around. Referrals by the Office of the Public Guardian will occur when a person may not meet the incapacity criteria, but may meet the ‘at-risk’ criteria.

To illustrate this, my discussions with various professionals about Case Study 4 from Chapter Two (possible financial exploitation) suggest the outcome in Scotland would likely be a referral to the appropriate local authority, meaning a council social worker would investigate. If there happened to be a power of attorney involved (which there wasn’t in that particular case study), and the person in question met the ‘incapacity’ criteria, then the Office of the Public Guardian would investigate (and could go so far as to freeze the account and seek appointment of a financial guardian if that were warranted).

The overlap between the Office of the Public Guardian and the adult protection system is difficult for each to negotiate, partly because of the different statutory terms under which each operates. Another factor here too is the nationwide jurisdiction of the Office of the Public Guardian and the local focus of adult protection. This is demonstrated by the fact that the Office of the Public Guardian has a standing place on the 29 Adult Protection Committees, and yet does not have the capacity to attend all these local meetings (and so only attends when it specifically needs to do so). This obviously inhibits the ability of the different spheres to work cooperatively with one another.

**Mental health**

Individuals in Scotland can be detained under the Mental Health (Care and Treatment) (Scotland) Act (section 44 and passim) if they have a ‘mental disorder’ which significantly impairs their ‘ability to make decisions about the provision of medical treatment’, and if they would be a danger to themselves or others if they were not detained. I won’t here discuss the various stages and review timelines under which orders can be made (which happen to be very similar to the ones likely to be adopted soon in Victoria).
The Mental Welfare Commission for Scotland has a range of functions that make it comparable to Victoria’s Office of the Public Advocate (OPA). The Commission (2013a) has a key advice and education role concerning two important pieces of legislation, which are discussed below. The Commission (2013b) also visits people with mental illnesses and cognitive impairments in a range of settings.

The Commission (2013c) monitors the Mental Health (Care and Treatment) (Scotland) Act and welfare provisions in the Adults with Incapacity (Scotland) Act, and must be advised when:

- a person has been:
  - detained under the Mental Health Act
  - detained without the consent of a mental health officer
  - placed under a compulsory treatment order
  - given care and treatment that is not in line with his or her advance statement

or if:

- a compulsory treatment order has been changed in an important way
- a welfare guardian has been appointed to make decisions on another person’s behalf.

The Mental Welfare Commission also conducts investigations when a person with a mental illness or learning disability is not receiving appropriate care.
The Commission (2013d) describes its investigations in this way:

‘We review individual case notes. We will ask for copies of all relevant health and social care files. Our review of files may be supplemented with correspondence with the professionals responsible for the person’s care and treatment. If the causes are not clear, or if there are conflicting views of what happened we might decide to conduct recorded interviews with the people involved. A Commission practitioner will also talk to the person, or people, concerned and/or family and carers to find out their views on what went wrong.’

This power to investigate, I was advised, is used judiciously, so that only a small number of full inquiries are undertaken in any one year. Typically local reviews will be sought and further activity from the Commission will follow if those local reviews generate concerns. The criteria for undertaking a full Commission investigation will not involve simply the seriousness of the harm in question, but the capacity for an investigation to achieve significant practice reform.

Following an investigation the Commission (2013d) will:

‘put together a picture of what happened, suggest where things went wrong and make recommendations for change. A report will be published and sent to the organisations that we think need to review and respond to our recommendations.’

The discretion exercised by the Commission about which matters to investigate struck me as potentially significant for OPA, were OPA to receive a broader statutory investigation power. This could mean, for instance, that so long as an individual’s ongoing safety is not in jeopardy, OPA might choose only to conduct a ‘full investigation’ into a matter if the matter was very serious and if the investigation had the potential to lead to service improvement.

**Care Inspectorate**

One important regulatory agency in Scotland is the Care Inspectorate (2013). The inspectorate regulates and inspects ‘care services’ in Scotland, and this includes many of the residential settings where at-risk adults reside. Concerns come to the Inspectorate in a range of ways, including from staff at care services and from members of the public. While there were some criticisms of the Inspectorate that suggested it is unduly ‘rule-bound’ in what it chooses to investigate, and that it doesn’t probe deeply enough sometimes into the particular living conditions of some people in supported accommodation, the Inspectorate is clearly one important avenue through which concerns can be raised about the well-being of at-risk adults. Were Case Study 1 from Chapter Two (abuse in a group home) to occur in Scotland, the Care Inspectorate would be able to investigate.

**Observations and conclusions**

Of all the jurisdictions I visited, Scotland provides the most robust, engaged and complete general system of adult protection. Yet it is something of a mistake to view this general system of adult protection through the prism of Scotland’s quite recent adult protection legislation and policy framework. Scotland has a long and impressive history of social care provision through local councils, and the adult protection
initiatives of recent years have very much been crafted onto, and rely almost entirely on, this impressive social care practice at council level.

By way of illustration, it is widely accepted that all of the case scenarios raised in Chapter Two could have been investigated by existing agencies or council social welfare workers prior to the adoption of the current protection legislation. At the same time, investigators examining situations like those discussed in the scenarios, particularly Case Study 4 (likely financial exploitation) and Case Study 3 (self-neglect), have far greater coercive powers now, following the legislation’s enactment, that can be drawn upon in ascertaining whether protective actions might be warranted.

Scotland’s strong history of social service provision is recognised by those involved in key adult protection agencies. As one of the Adult Protection Convenors commented at the adult protection conference I attended in Stirling, all the adult protection in the world will be meaningless if you do not have committed caring staff on the ground.

As I mentioned earlier, the key phrase the surrounds adult protection work in Scotland is ‘collaboration’. The striking amount of administrative effort that goes into ensuring local collaboration would appear quite odd and bureaucratic, were it not for the rich history of social care provision in Scotland that continues today, even at a time of significant welfare reform.

In contemplating the relevance to Victoria of Scotland’s experience of adult protection, it is obvious that there is no sense in replicating Scotland’s adult protection framework if there does not exist the same social care history, experience and practice that is crucial to its operation. And Victoria’s social care operations are different. While some services are provided at the local level, local councils in Victoria are less involved in social care provision, and less autonomous in their ability to determine local service priorities, than is the case in Scotland. Victorians have state and federal agencies that play significant roles in either delivering social care programs, or determining the conditions on which such programs are delivered. This would make replication of the locally-based Scottish Adult Protection Committees unwise.

There are, however, three key lessons that Victoria can learn from the adult protection system in Scotland:

- The importance of drawing together a wide range of professional staff to have regular discussions about adult protection;
- The need to inform and remind the public that everyone has a role to play in recognising and responding to situations where at-risk adults are in situations of concern;
- The central place played by service delivery in any adult protection system.
England, United Kingdom

England, with a population of 53 million, has not had the same degree of legislatively-backed ‘adult protection’ policy focus as Scotland, although the local authority focus there of most social care investigations and delivery is very similar to the situation in Scotland. In both jurisdictions the most important agencies in adult protection are the local authorities, with whom concerns about the well-being of individuals are typically raised, and which are responsible for organising most social care delivery.

The development by the Department of Health (UK) of ‘No Secrets’ in 2000 was a significant moment in the history of adult protection. The principal publication was subtitled ‘Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse’, and this document contained and defined a collaborative ‘multi-agency’ approach to adult safeguarding.

Adult protection developments since 2000 throughout England (and arguably throughout the United Kingdom) have drawn to varying degrees on this significant policy development (and on a revision in 2009 of ‘No Secrets’).

England’s legislative framework for protecting at-risk adults does not include an equivalent of Scotland’s protection legislation, and instead consists largely of two important pieces of legislation, concerning mental capacity and mental health, to which I’ll turn in a moment.

It is worth noting at the outset that while England’s Mental Capacity Act is considered to be very progressive, England’s mental health legislation is able to be applied very broadly. The Mental Health Act permits detention and treatment of people with a ‘mental disorder’, which is defined (section 1) to refer to ‘any disorder or disability of the mind’. This definition is far broader than that in place in Victoria. While the English Act does not apply generally to people with a ‘learning disability’ (defined in section 1 to mean ‘a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning’), it does apply to such people (section 1) where the learning disability ‘is associated with abnormally aggressive or seriously irresponsible conduct’.

My reason for visiting England was to examine the way a number of protection agencies operate in the absence of any overarching protection legislation. In addition to meeting the various people identified in the sections that follow, I also met with representatives from two advocacy organisations.

I met with Gary FitzGerald, CEO of Action on Elder Abuse, a prominent systemic advocate on elder abuse. I also spoke with Maggie Evans, the organisation’s Marketing and Support Manager. This small organisation, with half a dozen staff, devotes itself to the topic of elder abuse throughout the United Kingdom, so its officers are well placed to examine jurisdictional differences between, for example, Scotland and England.

I also met with Sue Bott, the Director of Policy, Services and Development at Disability Rights UK, an advocacy organisation with around 25 employees. The key priorities for Disability Rights UK concern: ‘independent living’, particularly the
ability of people with disabilities to be in control of their finance and lives; and ‘getting on’, namely the ability of people with disabilities to attain employment and generally to get on with life.

I draw on information provided by Sue, Gary and Maggie, in addition to that provided by others I met in London, in the sections that follow.

There have been some significant adult protection developments in England that warrant attention. One of the most significant has emanated from an agency I visited, the Social Care Institute for Excellence.

**Social Care Institute for Excellence**

The Social Care Institute for Excellence is a charity independent of government which works with social services throughout the United Kingdom. It gathers together information and research on social care related matters and seeks (SCIE 2013) to ‘translate that knowledge into practical resources, learning materials and services including training and consultancy’. I met with Patricia Kearney, the Director of Innovation and Development at the SCIE.

SCIE is a leading provider of important resources for the social services sector, and in particular has produced excellent materials concerning the prevention of, and responses to, the abuse of at-risk adults. SCIE offers significant resources under the banner of ‘Adult safeguarding’, as is indicated on its website from which an extract appears below.

SCIE was responsible (2011) for the production of ‘Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse’.

**Image 11. Social Care Institute for Excellence Protection Guideline**

This is an important document that has two particularly salient parts for the purposes of this report. The first concerns alert raising (pp. 55ff) and the second concerns the conduct of investigations (from p. 83). While I won’t explore these aspects in depth here, they are useful reference points for future policy development.

The ‘Protecting adults at risk’ policy points to the important role of individuals known as ‘Safeguarding Adults Managers’ (or SAMs). As the guide specifies (p. 26):

> ‘The lead coordinating role in relation to individual cases is taken by senior staff of the local authority adult social care, the integrated/joint health and social care team, centralised Safeguarding Adults team or [Community Mental Health Teams] who are designated SAMs. A SAM must be informed of any safeguarding concern arising in any organisation and has overall responsibility for coordinating the Safeguarding Adults process.

The SAM has overall responsibility to ensure that:

- the action being taken by organisations is coordinated and monitored
- the adult at risk is involved in all decisions that affect their daily life
- those who need to know are kept informed
- a decision is made in consultation with other relevant organisations to instigate the Safeguarding Adults process
- a multi-agency strategy meeting or discussion is held to determine how the Safeguarding Adults process will be conducted, who will conduct an investigation and to ensure decisions are recorded and copied to relevant organisations
the response of the organisations involved in the Safeguarding Adults process is coordinated. The aim is to agree that where indicated a joint investigation will take place with agreement to share information in line with the information-sharing protocol
• a multi-agency case conference is convened and chaired and a record made of the decisions and circulated to all relevant organisations
• a protection plan is agreed with the adult at risk if they have mental capacity to participate in this, or in the best interests of the person if they have been assessed not to have mental capacity
• any safeguarding documentation is completed including monitoring information.’

Among other things, the SAM is responsible for receiving the investigation report and for organising coordinated follow-up (p. 87).

One of the important contributions this policy makes concerns the need for lines of responsibility to be clear when investigations are conducted. This is particularly important in an area like adult protection, where the jurisdictions of a range of authorities can often overlap.

**Local authorities**

As indicated earlier, local authorities are key agencies in adult protection in England, as they are in Scotland. I visited one local authority, the Hackney Borough in London, and spoke with Mental Capacity/DoLS Lead Officer Martin Sexton.

The City of London has joined with the Borough of Hackney in creating the City of London and Hackney Safeguarding Adults Board, and has adopted the London multi-agency safeguarding policy discussed above. The aim of the partnership (City of London 2012) is to ‘embody a London wide approach that will bring more cohesion to the way in which the protection of vulnerable adults is dealt with in London.’

The City of London and Hackney Safeguarding Adults Board (Borough of Hackney 2013) has:

‘implemented a local protocol in line with the London multi-agency policy and procedures. This [is] a seven stage process for handling safeguarding cases. The stages are –

• Stage 1 – Alert
• Stage 2 – Referral
• Stage 3 - Strategy Meeting/Discussion
• Stage 4 – Investigation
• Stage 5 - Case Conference and Protection Plan
• Stage 6 - Review of Protection Plan
• Stage 7 - Closing the Safeguarding Adults Process’.

While responsibility for implementing the shared policy approach falls to the individual local authority, the combined board has adopted a number of practice guidelines and template documents that are publicly available.

I was advised that the Borough of Hackney, which is a relatively disadvantaged community with a population of just under 250,000, received 675 safeguarding
referrals in the year 2012/13, of which 225 proceeded to investigation. Referrals come from a range of sources, though there have been very low referral rates from members of the general public. It is mostly professionals who are making referrals, including police, housing support workers, and health service staff, among others.

When a referral is made, the safeguarding team follows the stages outlined above, with priority placed on responding to any immediate risks to the person. The appointment of a Safeguarding Adults Manager is a key step, which identifies one individual who has the role of bringing together often a coordinated response to a situation of risk.

I was interested to see how the case scenarios mentioned in Chapter Two would be handled under this framework.

The situation of self-neglect (Case Study 3), interestingly, would probably not be viewed as a safeguarding matter and so would not be subject to the above framework. The person in that situation, however, would still be offered a social care response (just not one under the safeguarding framework). The other three scenarios would trigger the safeguarding processes were alerts about them raised in the Borough of Hackney, including the situation of apparent financial abuse.

**Care Quality Commission**

In England the Care Quality Commission (2013) has a role to ‘make sure hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high-quality care, and we encourage them to make improvements.’ The Commission has been criticised in recent times for being unable meaningfully to investigate standards breaches or to enforce adverse findings, and there is currently a significant amount of controversy over its role. I won’t discuss the Commission’s regulatory role any further here, suffice it to say it does have a safeguarding role in relation to ‘care homes’ and ‘care services’, and is one key agency to which complaints about abuse or neglect in these settings can be made.

It is worth commenting here too that there have been a number of high profile scandals involving institutional care in the recent past in England, including at the Winterbourne View hospital and more recently in aged care accommodation.

**Guardianship**

Guardianship in England is governed by different legislation to that in force in Scotland. In England the Court of Protection makes guardianship appointments (the term ‘deputies’ is used in preference to ‘guardians’) under the Mental Capacity Act (there is also scope for guardianship to be exercised under some parts of the English mental health legislation). The Mental Capacity Act (section 16) provides that:

‘(1) This section applies if a person (“P”) lacks capacity in relation to a matter or matters concerning —

(a) P’s personal welfare, or
(b) P’s property and affairs.

(2) The court may —
(a) by making an order, make the decision or decisions on P’s behalf in relation to the matter or matters, or
(b) appoint a person (a “deputy”) to make decisions on P’s behalf in relation to the matter or matters.’

The Act makes it clear that guardianship is to be used as sparingly as possible. The Act (section 16(4)) states that ‘a decision by the court is to be preferred to the appointment of a deputy’. Where a deputy is, however, appointed, the Court must ensure that ‘the powers conferred on a deputy’ are ‘as limited in scope and duration as is reasonably practicable in the circumstances’. Deputies can be individuals or, where property appointments are concerned, trust corporations (section 19).

Capacity is defined in the following way. The Act (section 2) provides that:
‘a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain’.

A person is considered (section 3) ‘unable to make a decision for himself’ if the person is unable:
(a) to understand the information relevant to the decision,
(b) to retain that information,
(c) to use or weigh that information as part of the process of making the decision, or
(d) to communicate his decision’.

The Court has power (section 49) to call for reports from local authorities, the Public Guardian and official Court of Protection Visitors.

I met with Denzil Lush, a Senior Judge on the Court of Protection. I was interested to learn that over 94 per cent of applications to the court are in relation to financial matters. Interesting also was the information that where health and welfare matters are before the Court, the Court has increasingly been making particular orders in preference to the appointment of deputies (as section 16(4) requires). In 2012, for instance, I was provided with statistics that show there were 835 ‘health and welfare orders’ made and only 101 appointments of ‘health and welfare deputies’.

This practice reinforces a view expressed succinctly in a 2010 Court of Protection case to which I was alerted by Justice Lush. In the case (G v E [2010] EWHC 2512 (COP), par 57), Justice Baker outlined the limited role that the Mental Capacity Act allows for guardianship:
‘The [Mental Capacity] Act and Code are … constructed on the basis that the vast majority of decisions concerning incapacitated adults are taken informally and collaboratively by individuals or groups of people consulting and working together. It is emphatically not part of the scheme underpinning the Act that there should be one individual who as a matter of course is given a special legal status to make decisions about incapacitated persons. Experience has shown that working together is the best policy to ensure that incapacitated adults such as E receive the highest quality of care.’
Also important in this respect is Section 5 of the Act, which protects a care provider from liability where they reasonably believe that the adult in question ‘lacks capacity in relation to the matter’ and where they reasonably believe ‘that it will be in [the person’s] best interests’ for ‘an act in connection with the care or treatment of’ the person to take place. This section was raised with me in three separate meetings in London to explain why safeguarding situations often would not require guardianship applications.

The Office of the Public Guardian (OPG) has particular responsibilities in relation to guardianship, and concerning the operation and registration of lasting powers of attorney (so-called ‘enduring powers of attorney’ can no longer be created but can still be registered; they have been replaced by ‘lasting powers of attorney’).

I met with three staff members at the Office of the Public Guardian: Alan Eccles, Chief Executive and Public Guardian; Angela Johnson, Head of Practice and Compliance; and Kit Collingwood. Much of the information in this section is drawn from information provided by them.

The statutory basis for the OPG’s work is contained in the Mental Capacity Act, which provides (section 58(1)) that:

‘The Public Guardian has the following functions—

a. establishing and maintaining a register of lasting powers of attorney,

b. establishing and maintaining a register of orders appointing deputies,

c. supervising deputies appointed by the court,

d. directing a Court of Protection Visitor to visit—

(i) a donee of a lasting power of attorney,

(ii) a deputy appointed by the court, or

(iii) the person granting the power of attorney or for whom the deputy is appointed (“P”),

and to make a report to the Public Guardian on such matters as he may direct,

e. receiving security which the court requires a person to give for the discharge of his functions,

f. receiving reports from donees of lasting powers of attorney and deputies appointed by the court,

g. reporting to the court on such matters relating to proceedings under this Act as the court requires,

h. dealing with representations (including complaints) about the way in which a donee of a lasting power of attorney or a deputy appointed by the court is exercising his powers,

i. publishing, in any manner the Public Guardian thinks appropriate, any information he thinks appropriate about the discharge of his functions.’

The OPG (2012, p. 6) describes its principal functions in this way:

‘The OPG’s core functions are to:

• register Lasting Powers of Attorney (LPAs) and Enduring Powers of Attorney (EPAs);

• supervise Deputies appointed by the Court of Protection;

• maintain the registers of Deputies, LPAs and EPAs and respond to requests to search the registers; and

• investigate complaints, or allegations of abuse, made against Deputies or Attorneys acting under registered powers.’
In the year to June 2012 OPG (2012, p. 8) received 218,000 applications to register lasting powers of attorney and enduring powers of attorney. England’s population of 53 million people is roughly ten times that of Scotland (and of Victoria). Applications to register lasting powers of attorney rose, I was advised, in the year to June 2013 to 245,569. It is worth noting that it now costs £130 to register a lasting power, and that the OPG operates on a full ‘cost recovery’ basis (meaning it does not draw for its operation on public funds).

The Office also supervises the work of deputies, with now around 45,000 deputies on its database. Most of these are financial deputies, with around 600 health and welfare deputies on its records.

The OPG is empowered to conduct investigations, and makes specific mention on its website of the abuse of vulnerable adults (below).

Image 12. Office of the Public Guardian

In 2011-2012 OPG completed 451 ‘investigations and supervision cases’, and noted in its annual report (OPG 2012, p. 17) that most of these related to ‘allegations of financial abuse’. I was advised that, in the year to June 2013, 665 full investigations were conducted. While the number of referrals about property and finance far
outweigh those in relation to health and welfare matters, concerns in the latter

category have risen in recent times.

Concerns about the activities of deputies and attorneys routinely come to the OPG
from a range of sources, which include: members of the public, relatives, banks, other
statutory bodies, and care providers. The Office has a dedicated whistle-blowing
hotline, but will also often internally escalate matters of its own accord as a result of
internal checking and the routine review of the work of deputies and attorneys.

Investigations utilise a range of mechanisms, which can include on-site visits
(including by Court of Protection visitors) and liaison with other relevant statutory
agencies.

The Office is legislatively constrained in its ability to safeguard vulnerable individuals
in some key ways. First, the Office can only investigate activities of deputies and
attorneys and cannot, for instance, examine abuse of vulnerable people by third
parties.

A further constraint on the work of the Office relates to situations where a person may
be being abused by an attorney under an enduring instrument but where the person in
question still has capacity to make their own decisions. This situation can occur when
a financial enduring instrument has been signed, as this will become operational
immediately – prior to a loss of capacity – unless the donor specifies otherwise. In
cases such as this the person may be vulnerable, and may be being abused by their
attorney, but there is little the Office, or the Court of Protection, can do, other than
refer the concern to a local authority and seek assistance for the person under the local
authority’s safeguarding scheme.

These constraints mean that many referrals to the OPG are not able to be investigated.
The policy view has been taken, however, that it is better to encourage professionals
and the general public to raise concerns with the Office, and perhaps have these
concerns referred to other agencies, rather than not have the concerns raised at all.

In terms of outcomes from investigations, the OPG reported (2012, p. 17) that in the
year to June 2012:

‘Outcomes from investigations include[d]:

• 94 Public Guardian applications to the Court of Protection to discharge Deputies
  or to revoke an EPA/LPA
• 5 other types of Court application, for example, to freeze bank accounts or to
  obtain an Order directing the Deputy/Attorney to account to the Public Guardian
• 74 cases where the investigation found no evidence that the Deputy/Attorney
  was acting inappropriately
• 34 cases where the supervision level of the Deputy was decreased
• 2 cases where the Public Guardian has written a formal instruction to
  Deputies/Attorneys to comply with the requirements of their role or face further
  action.’

Similarly, in the year to June 2013, I was advised that the most common outcome was
for an application to be made to the Court of Protection to discharge deputies or to
revoke enduring instruments.
Observations and conclusions

One of the key catchcries at the moment in social care in England, I am informed, is ‘integration’, with integration between health and social care high on the government’s agenda. One observation I would make about the situation in England is that the key role of local authorities in investigating the well-being of at-risk adults ensures that integration is more in existence there than many might realise.

In England there are certainly parameters beyond which social care responses are unable to be provided to at-risk adults by some agencies. For instance, the point was made by several people that the lack of evidence of a person’s incapacity will prevent a range of agencies (including the Office of the Public Guardian and the Court of Protection) from being able to take protective actions, even if a person is clearly vulnerable. In Scotland this gap is addressed by the adult protection legislation, which enables protective actions to be taken even if the person does not satisfy, for instance, the guardianship capacity criteria.

But it is worth noting that some of the key gaps I have identified in other jurisdictions are not so apparent in England (or indeed in Scotland). This includes situations where, for instance, an arm’s length adult protection service investigates but is not able to secure the provision of services (either because it is not empowered to direct their provision or because resource constraints mean that the service is simply not available).

Indeed the greater degree of ‘integration’ that generally exists in England (and in Scotland) than in the other visited jurisdictions was clear from my discussions with various professionals in the United Kingdom about the case scenarios discussed in Chapter Two. While certain criteria obviously must apply before safeguarding processes are ‘triggered’, at no stage was I confronted with the response that the relevant local authority ‘cannot deal with those situations’. The response was more along the lines that steps could be taken to ascertain how the person might be assisted, even if the matter might not technically be a ‘safeguarding’ one.

Having made that point, the safeguarding of vulnerable adults is one social care priority area in England, for which there exists a clear social care ‘safeguarding’ framework (even if there is yet to be legislative backing for this scheme). One of the challenges confronting adult protection in England is the willingness of local authorities to see people in certain situations as coming within the framework’s remit. Indeed, I raised the four case scenarios from Chapter Two with people I met in London and was informed by one knowledgeable professional that the key challenge in ensuring an adequate response to the individuals at the centre of two of those scenarios – Case Studies 3 (self-neglect) and 4 (apparent financial abuse) – was for their predicaments to be identified as situations of abuse. Once that happens, the safeguarding principles should apply. The fact that this is a challenge was confirmed when I encountered different views, in speaking to various professionals in London, about whether the situation of self-neglect described in Case Study 3 was one that should trigger a safeguarding response.
This is one challenge that can be addressed by legislation (though legislation, of course, cannot then ensure appropriate service delivery). Another limitation that can be addressed by legislation concerns the ability of investigators to get access to at-risk adults when concerns about them have been raised. The lack of overarching protection legislation in England does make it more difficult for those enquiring into the well-being of individuals to get appropriate access to them. This is different in Scotland, where the protection legislation enables local authorities, if necessary, to draw on coercive powers to get access to at-risk adults. Even if those coercive powers are rarely utilised – as appears to be the case in Scotland – their existence does embolden local authorities in their willingness to investigate, and no doubt encourages those involved in any investigation to comply and provide access to the person in question.

Legislative developments are occurring in the field of adult protection in England. An adult care bill is currently before parliament and it would, if enacted, give some legislative backing to the safeguarding policies and practices that exist in various parts of England (and would require, for instance, the creation of local safeguarding boards throughout the country). While this would clarify the legal parameters of safeguarding policies, the bill is still the subject of debate, and I am advised that the enacted legislation is likely to be much narrower, and less interventionist, than the protection legislation in place in Scotland.

As mentioned earlier, one of the strengths of the situation in England (as it is in Scotland) is that local authorities, which are central to determining how and when social services are provided, are often the key investigating agencies when concerns about at-risk adults are raised. One drawback from this is that it can result in uneven investigation practices and uneven social care service delivery responses throughout the country. The unevenness throughout the country of the social care provided by local authorities was indeed a news item during my time in England.

Another drawback exists when it is the local authority itself which may be responsible for service failure, or worse, in which case an obvious conflict of interest arises should that local authority also be charged with investigating the situation.

A third concern raised with me about local authority safeguarding processes was whether local authorities had the skills necessary to investigate what are often complex matters.

Regardless of one’s views about the costs and benefits of replicating England’s locally-based safeguarding system in Victoria, it would frankly not be feasible to do this in a jurisdiction like Victoria where social and health services are organised and delivered by a range of federal, state and local council service professionals.

In addition, there are some advantages to identifying a central (rather than local) contact point where concerns can be registered, and from which appropriate referrals can be made to a range of professionals including police, health and disability support services. In Victoria this central contact point would sensibly exist at state, rather than at federal or local level (given that police, health and disability support are largely organised by, and provided by, the states and territories). This is why I will argue shortly for an expansion of OPA’s power to investigate situations of concern.
But there are some lessons to be learnt from the situation in England that can be applied to improve protection practices in Victoria. These include:

- The low usage of guardianship appointments to ensure the protection of at-risk adults and the clear statutory and policy encouragement against such appointments;
- The need to ensure that social care investigators are in close contact with service providers and are able to seek the provision of such services when this is appropriate;
- The need to identify one individual as having responsibility for any particular investigation;
- The need to provide investigators with clear policy frameworks and reporting procedures; and
- The need to ensure that individual safety remains the central point of concern of any adult protection scheme, so that any lead investigator is not unduly constrained by inflexible program criteria in achieving that goal.
Chapter Four. Current reform initiatives in Victoria

Although there are significant gaps, Victoria does have an evolved array of laws and practices that operate to provide considerable protection for at-risk adults. Given this, social policy reform in this area is most sensibly geared towards improving and building on what is already there, rather than imagining the creation of a new system of adult protection. In addition, reform is most likely to happen if it complements, and is consistent with, current reform developments.

With this in mind, this chapter charts the most significant current reform initiatives in Victoria, and this will inform the recommendations made in the final chapter.

A number of important developments at the state, national and international levels have occurred in the recent past that impact directly or indirectly on the way in which services and protective mechanisms are applied to at-risk Victorian adults.

A range of state and federal social policy initiatives have recently occurred that affect the provision of services to, and protection of, at-risk adults. These have been concentrated around the following topics:
- disability-focussed strategies and plans;
- guardianship and related substitute decision making reform (including reform of mental health laws and laws governing enduring powers of attorney);
- elder abuse;
- anti-violence strategies in relation particularly to women and children.

Disability reform

Reform of disability policies has been informed by the acknowledgement that Australia rates poorly in international terms when comparisons are made between the wellbeing of people with disabilities as against the wellbeing of those without disabilities (PricewaterhouseCoopers 2011).

The key reform philosophy in Victoria and indeed Australia is one that is shared in many jurisdictions throughout the world: disability expenditure needs to be determined wherever possible by consumer choices.

In Victoria, this approach has been labelled ‘self-directed planning and support’, with an increasing number of ‘individual support packages’ available to individuals who qualify for disability funding. This approach remains embedded in the Victorian State Disability Plan 2013-2016. As one Department of Human Services information sheet (2012) stated:

‘The provision of disability services in Victoria is based on a self-directed planning and support approach. This approach includes:
- planning that is directed by the person to the greatest extent possible
- individually tailored and flexible supports based on the needs expressed by the person and
• a focus on community participation and strengthening informal supports.
Individual Support Packages are a key way in which this approach is realised for people with a disability.’

At federal level, DisabilityCare (the new National Disability Insurance Scheme) promises to be the most significant social policy reform since the introduction of universal health insurance. The new scheme could involve a near doubling on current combined state and federal disability funding, if the recommendations of the Productivity Commission (2011, vol. 2, p. 781) are fully implemented.

DisabilityCare, which in July 2013 began to operate in its launch phase (including in the Barwon region in Victoria), is also based on a self-directed planning, or market/purchaser model. In calling for the scheme to be established, the Productivity Commission (2011, vol 1. p. 30) proposed ‘an “individual choice” model, in which people with a disability (or their guardians) could choose how much control they wanted to exercise’.

Some important questions remain about:
• the extent to which adults with cognitive impairments will make, or be supported to make, their own purchasing decisions; and
• when it will be appropriate for such decisions to be made on participants’ behalf by informal substitute decision makers or formally appointed substitute decision makers (including by nominees).

Questions also exist about how the new scheme will ensure the maintenance and improvement of existing safeguards. While current state and territory safeguards will continue to apply for now, this is a complex matter when one considers that the federal government is likely over time to increase its regulatory involvement in a field historically regulated by the states and territories, and when one considers the likely influx of new service providers and new service models.

Guardianship and powers of attorney

Victoria is currently in the process of reforming its laws in three key substitute decision making areas. In 2010 the Victorian Parliament Law Reform Committee produced the report on its Inquiry into Powers of Attorney. The report made 90 recommendations which included proposals on how Enduring Powers of Guardianship and Enduring Powers of Attorney (Financial) might better protect the wellbeing of adults with cognitive impairments and be less easily used as instruments of abuse.


The final report (2012) made 440 recommendations for reform to Victoria’s guardianship system, among which are a number of reform proposals that are germane
to this report (most of which have been strongly supported by OPA). These include proposals:

- to tighten Victoria’s guardianship eligibility criteria, with one notable exception concerning long-term carers of people with profound disabilities (Recommendations 174 and 176);
- to legislate to create personal and tribunal initiated supported decision-making arrangements (Recommendations 32 and 35);
- to set up a pilot supported decision-making program at OPA (Recommendation 62);
- to provide a new medical treatment decision-making regime in relation to adults who are unable to make their own medical treatment decisions (Chapter 13);
- to create a new civil wrong under which it would be ‘unlawful for a person with responsibility to care for a person with impaired decision-making ability because of a disability to abuse, neglect or exploit that person’ (Recommendation 305).
- to create an online register for personal appointment instruments as well as of VCAT appointments (Recommendation 259). This complements an important recommendation (Recommendation 66) from the 2010 Victorian Parliament Law Reform Committee report on powers of attorney.

One key set of recommendations concerns OPA’s power to conduct investigations.

OPA’s current powers of investigation under the Guardianship and Administration Act 1986 (section 16(1)(h)) are quite limited, with the Public Advocate able to ‘investigate any complaint or allegation that a person is under inappropriate guardianship or is being exploited or abused or in need of guardianship’. The apparently broad power is more limited than it appears. As mentioned earlier, the VLRC noted (2012, p. 447) that OPA’s powers here ‘are limited in their application to circumstances where a guardianship or administration order might be appropriate’ with OPA not having ‘a comprehensive range of powers to carry out these functions.’ Thus in practice this has limited OPA’s investigation powers to situations where complaints are made about the well-being of people who have guardians or who ought to have guardians appointed.

Similar to the situation in Victoria, the Office of the Public Advocate in Western Australia (OPA (WA)) has the power under the Guardianship and Administration Act 1990 (WA, section 97(1)(c)):

‘to investigate any complaint or allegation that a person is in need of a guardian or administrator, or is under an inappropriate guardianship or administration order ...’

Unlike in Victoria, this power has been exercised by OPA (WA) to investigate ‘matters referred by the community, about a person of concern’. In 2011/12, 142 matters of this nature were investigated, most of which involved investigating ‘whether the person of concern required a guardian or administrator, or was under an inappropriate order’ (OPA (WA) 2012, p. 18). Although a similar power is utilised more extensively in Western Australia to incorporate ‘community-referred’ investigations, the same constraints exist in Western Australia as in Victoria, with OPA (WA) (2012, p. 18) noting that:

72
‘The legislation does not provide the Public Advocate with the power to demand information from parties and this can constrain some investigations in which claims of financial or other forms of abuse ... cannot be substantiated.’

The guardian of last resort in Queensland does have broader investigative powers than OPA (Victoria). The Adult Guardian in Queensland, under the Guardianship and Administration Act 2000 (Qld, section 180), has broad power to:

‘... investigate any complaint or allegation that an adult with impaired capacity for a matter—
(a) is being or has been neglected, exploited or abused; or
(b) has inappropriate or inadequate decision-making arrangements.’

The Office of the Adult Guardian undertook new investigations in 151 matters in the year to June 2011, with about half of the 203 investigations that were finalised that year concerning alleged financial abuse or the risk of this occurring (Office of the Adult Guardian 2011, p. 16).

While the information from Queensland is clearly instructive, the granting to OPA of a comparable power to that which is possessed by the Adult Guardian in Queensland may translate into different investigation characteristics and practices. The complaints-based nature of the power means investigation trends will largely follow community expectations of the role of the responsible agency. In Queensland, there are clearly high expectations around the Adult Guardian’s regulation of enduring instruments, with almost half of the investigations finalised in the year to June 2011 concerning allegations of ‘abuse or exploitation by an attorney acting under an enduring document’ (Office of the Adult Guardian 2011, p. 16).

While OPA also has a high profile for its work in educating the public about enduring instruments, it has also had a very prominent role in recent years advocating for greater protection for at-risk adults from physical neglect and exploitation. In part this is due to the fact that such matters are routinely highlighted by OPA’s Community Visitors program, particularly when the program’s annual report is tabled in parliament (the Community Visitor program in Queensland operates separately from the Office of the Adult Guardian). In part it is also a result of the research conducted by OPA and the media presence on this topic of the Public Advocate.

Moreover, as will be discussed shortly, OPA is advocating for an ‘own motion’ investigation power, which would enable it to identify investigation priorities more readily than is possible with a complaints-based power. The would also mean the investigation trends reported by the Adult Guardian in Queensland may not be a reliable guide to likely trends in Victoria.

OPA has actively sought to play a greater investigatory role in relation to the abuse, neglect and exploitation of at-risk adults (OPA 2010, p. 27; OPA 2011, p. 43). The VLRC has agreed that this should occur, recommending in its Guardianship Final Report (2012) that:

‘328. Under new guardianship legislation, the Public Advocate should have the function of receiving and investigating complaints in relation to:
(a) the abuse, neglect or exploitation of people with impaired decision-making ability due to a disability …’
329. New guardianship legislation should provide where the Public Advocate believes that an investigation is warranted she should be able to conduct an investigation on her own motion in relation to:
(a) the abuse, neglect or exploitation of people with impaired decision-making ability due to a disability …’

Mental health

Victoria’s Mental Health Act 1986 has been subject to government review and new legislation will shortly be introduced into parliament. Involuntary treatment will continue to be permitted under the proposed new legislation, although there will be tighter eligibility criteria and shorter review times. A range of new offices are also proposed, including a Mental Health Tribunal to replace the Mental Health Review Board, and a Mental Health Complaints Commissioner. In addition, it is proposed that mental health patients will have a greater say in relation to their own medical treatment, even when they are detained on an involuntary basis (Department of Health 2012a).

Elder abuse

Though the term ‘elder abuse’ dates back decades, significant policy attention has been devoted to this topic in recent years. In 2009 the Victorian government adopted a new prevention strategy under the banner ‘With respect to age – 2009. Victorian government practice guidelines for health services and community agencies for the prevention of elder abuse’. These guidelines (p. 4) adopted as a definition of ‘elder abuse’: ‘Any act occurring within a relationship where there is an implication of trust, which results in harm to an older person.’ The Victorian government also had a role as partner in the creation of Seniors Rights Victoria, whose brief includes the provision of advice and casework services.

More recently the Department of Health (2012b) has created new ‘Elder abuse prevention and response guidelines for action 2012-2014’ (part of the ‘Health priorities framework 2012-2022’), in the creation of which I, on behalf of OPA, had an advisory role.

In addition to raising the profile of elder abuse, which incorporates financial and other forms of abuse, these initiatives have sought to locate in a range of existing and new agencies responsibility for identifying and acting upon situations of abuse. In sum, these initiatives recognise that older Victorians are particularly vulnerable to harms – including at the hands of family members – and that existing prevention and response strategies have been piecemeal and insufficient.

It is worth noting too that South Australia’s Office of the Public Advocate (2011a and 2011b) has produced two reports that call for renewed gap-closing and whole-of government activity in this area.
In further activity in this field the Victorian Parliament Family and Community Development Committee conducted an *Inquiry into opportunities for participation of Victorian seniors* (2012). This report, among other things, sought the development and implementation of an elder abuse awareness campaign (Recommendation 4.2) and the appointment of a ‘Commissioner for Older People’ (Recommendation 3.6), who would create and implement ‘a whole of government strategy that effectively fosters participation of older people in Victoria’. The Victorian government responded to this inquiry and announced (2013, p. 6) that it:

> ‘will appoint a Ministerial Advisory Committee for Senior Victorians, chaired by a Commissioner for Senior Victorians, with responsibility for the development of an older persons action plan, bringing together in one document the full range of strategies and actions underway to address the participation of the older population and coordinating the plan across government.’

I’ll return to this later in the report.

**Anti-violence**

Social policy attempts to curb violence in Victoria, including against at-risk adults, have in recent years included ‘A right to safety and justice: Strategic framework to guide continuing family violence reform in Victoria 2010-2020’ and ‘A right to respect: Victoria’s plan to prevent violence against women 2010-2020’.

OPA’s work on violence (Dillon 2010) led to an inquiry by the Victorian Parliament Law Reform Committee (2013) into ‘access to and interaction with the justice system by people with an intellectual disability and their families and carers’. In its 47 recommendations that committee called for the Victorian government to consider a range of reforms, including improved police education, wider accommodation availability, and improved mechanisms for gathering evidence and using evidence in trials. One of OPA’s key volunteer programs, the Independent Third Person program, was a central feature of the report, with the Committee calling (Recommendation 17) for its wider promotion. A minority of committee members (2013, p. 372) sought improved resourcing of this program.

OPA, in conjunction with Women with Disabilities Victoria and the Domestic Violence Resource Centre Victoria, is conducting a large study of violence against women with disabilities, under the heading ‘Voices against Violence’. An initial finding is that nearly half of 100 female guardianship clients at OPA had experienced violence, a figure which itself is almost certainly a conservative estimate, since some violence will not have been recorded (see McGuire 2013).

A similar project currently underway nationally is entitled ‘Stop the Silence Stop the Violence’ (2013). This project, which is coordinated by Women with Disabilities Australia and People with Disability Australia, aims to gather evidence to promote and advocate for reforms to improve the well-being of girls and women with disabilities who are at risk of violence.

A number of organisations have been developing their own programs and resources in a bid to address violence against at-risk adults.
OPA (2013) has taken a leading role in developing a multi-agency guide to responding to violence, which we have labelled IGUANA (Interagency Guideline for Addressing Violence, Neglect and Abuse). The idea for the guideline arose following concerns at OPA about the treatment of people with cognitive impairments and mental illnesses when suspicions or allegations exist that they have been abused or exploited.

OPA then developed a draft guideline, which drew on a range of comparable guidelines in Australia and indeed in other western democracies. It took as its starting point a seven-point checklist recently developed by OPA in conjunction with the Department of Human Services, which guides responses once the Public Advocate notifies the Department of concerns that have arisen through OPA’s volunteer Community Visitors scheme (disability stream). At the time of its launch in May 2013, a total of 28 organisations (including service providers and advocacy groups) had endorsed IGUANA.

**Image 13. Office of the Public Advocate ‘IGUANA’ guideline**
(www.publicadvocate.vic.gov.au)

Other important anti-violence initiatives in Victoria include the ‘Making Rights Reality’ program, which is operated by the Springvale Monash Legal Service and the South Eastern Centre Against Sexual Assault (SECASA 2013). This program assists
people with cognitive impairments to negotiate the criminal justice system, and to receive appropriate support, following sexual assault.
Chapter Five. Conclusions and reform recommendations

While Victoria does not have a named ‘adult protection’ system as such, our combined disability and aged care approach does provide protection for at-risk adults in a way comparable to that provided in the visited jurisdictions of Washington State, Nova Scotia, Scotland and England. While Victoria’s system does not require, in my view, any wholesale overhaul, there are some significant changes that could be made that would improve our protection of at-risk adults. In this chapter I make six recommendations in that regard, all of which would be relatively easy and inexpensive to introduce.

It is worth at the outset discussing what this report does not recommend. I do not, for instance, recommend the creation of a new adult protection services division within the Department of Human Services. While adult protection services operate well in some of the visited jurisdictions, many of their roles are already exercised by existing Victorian offices and agencies. To create a new entity within the Victorian bureaucracy would come at considerable and unnecessary expense, and would risk losing some of the positive aspects of Victoria’s safeguarding system, including the corporate knowledge that is held by agencies which have exercised protective functions for some time.

It is also worth pointing out that I do not here make recommendations in relation to people involved in the mental health system. In the main this is because new mental health legislation is about to be introduced into parliament. This new legislation will obviously need to be monitored to ensure that its protective application does not inhibit the human rights of the people subject to it.

This report has not concentrated on staff training, though this is clearly integral to any well-functioning adult protection scheme. As indicated in Chapter Four, a number of developments in Victoria are mirroring important safeguarding developments in the United Kingdom, including the adoption of a multi-agency abuse response guideline. Clearly there is a need for response training and guidance, which ideally should take place in the context of holistic training on assisting people to achieve their goals rather than focussing solely on reacting to and responding to problems that arise.

My visits to Washington State, Nova Scotia, Scotland and England have provided me with knowledge of a range of ideas and strategies that can be drawn upon to suggest reforms to existing agencies and practices in Victoria, and to complement and support current reform initiatives that are underway here.

In short, the areas in which Victoria can improve include the following. We should:

- ensure police have the expertise to investigate and prosecute situations of concern where it is likely a crime has been committed, with improvements particularly needed in the area of financial abuse;
- establish a clear non-police contact point through which members of the public and service professionals can raise concerns about the well-being of at-risk adults;
• entrust a government or semi-government agency with clear authority to investigate situations of concern, including in private residences as well as in supported accommodation, utilising a supportive intervention approach;
• enable Victorian courts and tribunals to make a wider range of protective orders than the current suite of orders that are available;
• ensure that the various agencies involved in adult protection regularly liaise with one another away from the intensity of interactions on particular cases.

Policing and prosecuting

Victoria Police is and should remain the central point of contact where crime is suspected. Indeed one of the dangers of empowering other agencies to investigate situations of at-risk adults is that crimes against people with disabilities, for instance, might become viewed as less problematic than crimes against others. This is one reason why appropriate referrals to Victoria Police by non-police investigators will continue to be important.

When it comes to current policing of crimes against at-risk adults, it is clear that financial abuse is one area in need of improvement. Currently, in the absence of significant evidence of criminality, one typical response to a situation of suspected financial abuse is to seek the appointment of an administrator. The main problem here is not so much the law, which already criminalises theft, but its enforcement.

Having said that, many financial abuse cases are very complex and involve minimal evidence of wrongdoing, making the proposed civil wrong recommended by the VLRC (2012) and the recommendations from the Victorian Parliament Law Reform Committee in its powers of attorney inquiry (2010) worth considering.

While the next section advocates a broadening of the power of OPA to investigate such matters, it is also clear that key criminal justice agencies could take a stronger role in relation to investigating and prosecuting individuals who have engaged in crimes against at-risk groups, including those engaged in elder abuse crimes. In this regard these agencies, particularly Victoria Police and the Victorian Office of Public Prosecutions, could draw on the experiences of the Seattle Police Department and of the King County (Washington State) prosecutors whom I met.

Recommendation 1. Victoria Police and the Victorian Office of Public Prosecutions should be encouraged to examine and replicate the work of the Seattle Police Department and King County prosecutors in investigating and prosecuting individuals involved in crimes against at-risk adults.
Investigation powers of statutory agencies

Victoria currently does have reasonably good investigation and reporting strategies for at-risk adults who live in a range of supported accommodation settings. However, one area where Victoria can clearly improve concerns the situation of at-risk adults in the general community.

Recognition of this ‘investigation gap’ leads one to consider a number of possible reforms to existing agencies that have investigative roles.

The Disability Services Commissioner (DSC) facilitates and works to resolve complaints involving services provided by disability service providers. While this is an important role, it would be a substantial reform to ask the DSC to investigate the situation of at-risk adults in the community.

Nor is the Ombudsman the authority to fill this gap. The Ombudsman has power to investigate the misuse of public funds and the inappropriate activities of public authorities. Enabling the Ombudsman to investigate community referrals about situations that may not currently involve public agencies or the misuse of public funds would not be consistent with the Ombudsman’s core roles. Moreover, investigations here will often involve direct referrals to support and other services, which the Ombudsman is not well placed to facilitate.

Nor is the Health Services Commissioner the person to fill this gap, save for situations where there is problem with delivery, or non-delivery, of a health service.

The best available option, and the preferred one, would be to extend the power of OPA to investigate situations of concern. As discussed in Chapters Two and Four, OPA’s powers to conduct investigations are limited at present to situations of guardianship and potential guardianship, and the VLRC has recommended this be changed. OPA is already on record as supporting this recommendation, and I here endorse it again.

One possibility might be to mirror the division that exists in many of the visited jurisdictions, and have one pathway for raising concerns about people in supported accommodation settings, with another pathway for reporting concerns about people in the general community (including in private homes). However, in Victoria a range of agencies already have roles in relation to particular supported settings. For instance the DSC’s jurisdiction concerns services provided by disability service providers, and the federally-regulated aged-care sector has its own complaints-based system. OPA’s investigatory power could be limited to settings outside of these (and would thus include private homes as well as boarding houses and supported residential services).

But for there to be complementary protective provisions across all settings, this option would need to be accompanied by changes to the investigation powers and practices of existing agencies (especially those with more of a complaints-resolution focus than a protective-investigative role). This is doubly complex when one considers that this kind of reform in the aged-care sector would likely require federal legislation.
A far simpler option, and the preferred one, is to give OPA the power as recommended by the VLRC, and allow institutional protocols to guide decisions about investigations in settings where multiple agencies have roles. Many of the visited jurisdictions have protective agencies whose roles overlap to some extent, and this can work well so long as there exist appropriate protocols and so long as there is institutional and interpersonal respect for the role of each agency (on this point, see further Recommendation 6).

It is also worth commenting that the reason why OPA is the appropriate agency to broaden its powers of investigation concerns the fact that OPA is able to utilise a supportive intervention approach in conducting its investigations. In other words, this means that OPA investigators will see it as key to their role not only to report on what they have found, but to make immediate support referrals as soon as they begin investigating. This is very much in line with the approach in the best of the visited jurisdictions, particularly Scotland.

One important side effect of broadening OPA’s investigation powers will be the social capital one of providing members of the general community with a place where they can register concerns about people in their own communities, which will encourage people to have a heightened awareness of people at risk in their communities.

While the broadening out of OPA’s investigation role will require some additional resources, a considerable proportion of this increase would be met by lower use of the guardianship system, which is addressed later in this chapter.

**Recommendation 2.** The Victorian parliament should grant the Public Advocate the broader investigation power as recommended by the Victorian Law Reform Commission. This would enable the Office of the Public Advocate to investigate (following a complaint or on its own motion) ‘the abuse, neglect or exploitation of people with impaired decision-making ability’.

Should OPA be granted this investigative power, it would be essential for OPA to then arrange for protocols to be developed and signed with key agencies to whom, and from whom, referrals would regularly be made. These agencies will include key ones in the disability and criminal justice fields. In addition, as mentioned in Chapter Four, Victoria is soon to have a new Commissioner for Senior Victorians, whose role will be to ensure the coordination of government activities concerning older Victorians. Given the prevalence and under-investigation of elder abuse, there is a clear need for the new Commissioner to work closely with OPA when it comes to preventing and investigating elder abuse.

**Recommendation 3.** In order properly to exercise a broader investigation power, the Office of the Public Advocate should develop protocols, or amend existing protocols, between it and: Victoria Police; the Department of Human Services; the Department of Health; the Victorian Civil and Administrative Tribunal; the Disability Services Commissioner; State Trustees Ltd; Seniors Rights Victoria; the new Commissioner for Senior Victorians; and other relevant agencies.

In considering how a broader investigation power would be exercised, it is important to remember one clear message from a number of professionals with whom I have
spoken. Investigations concerning at-risk adults can be broken-up into three reasonably specialised areas:

- situations of neglect (including self-neglect);
- financial abuse; and
- non-financial crimes (including violence and abuse).

While sometimes cases involve more than one of these categories, it would be worth OPA considering (were it to gain a broader power of investigation) the creation of three specialist teams to ensure that the organisation as a whole has the appropriate skill sets to investigate cases in these sometimes quite disparate areas.

A further point on the implications of this research for OPA’s operations is the possibility that OPA might reconsider the longer-term relevance of its current mission and statutory mandate. While the current mission is ‘to protect and promote the rights of people with disability’, society has increasingly come to the view that not all people with disability need protection, and that not all adults who need protection have a recognised disability (for instance, some people who are addicted to gambling or alcohol are at risk but may not have a recognised disability). One possibility is that OPA might consider limiting its mandate to protecting and promoting the rights of ‘at-risk adults’. The term ‘at-risk adults’ could be defined to include ‘people whose cognitive impairment, mental illness, communication disability or other trait put them at greater risk of harm than other adults.’

OPA does occasionally play a role in relation to children (e.g. the Baby D Family Court case), and the Victorian government is currently considering a recommendation to enable VCAT to make guardianship orders for people aged 16 years and older. Those factors would clearly need to be borne in mind were OPA to consider in the longer term advocating for statutory reform to see its mission changed.

Protective orders

One of the most striking differences between the situation in Victoria and that in place in Washington State, Nova Scotia and Scotland is the limited range of protection orders available here. Where judicial intervention is warranted here, then guardianship orders and intervention orders tend to be the key protective mechanisms. While other protective orders are possible (including in the fields of involuntary mental health treatment, criminal justice, civil detention and public health – see Chesterman 2012), guardianship and intervention orders are the key protective orders available for adults who are at-risk in the community (but who are not in a state of mental health crisis).

In Victoria guardianship orders would be the only likely protective orders that would be made in relation to the four people involved in the case studies in Chapter Two (in Case Study 4 – possible financial exploitation – that ‘guardianship’ order would be an administration order).

After visiting the public guardians and their equivalents in each of the jurisdictions to which I travelled, I am convinced that Victoria’s practice of public guardianship is probably among the best in the world. OPA clearly positions itself as a human rights organisation, and it treats public guardianship as a protective responsibility that
demands significant time and energy of those delegated to perform the role of guardian. I am equally of the view that Victoria relies too heavily on guardianship as a mechanism by which at-risk adults are sought to be protected.

There are now well documented problems with using guardianship as a catch-all protective mechanism. As already noted, the VLRC has called for guardianship criteria generally to be limited to situations of absolute need (with one exception) and has proposed that supported decision-making orders should be utilised where feasible instead (which OPA has supported and which I again support below).

OPA has argued (2011, pp. 19-20) that guardianship criteria should be more tightly limited than currently they are, to enable appointments only where decisions need to be made or where serious risks exist. The VLRC recommended limiting guardianship orders to situations in which (2012, recommendation 172):

‘the person … has decision-making incapacity caused by that person’s disability [and] … has decision-making incapacity in relation to the matters for which the appointment is sought.’

The Commission did, however, also recommend (2012, Recommendation 176) that long-term informal decision makers be able to be appointed as guardians and administrators for people with profound disabilities in the absence of current need. OPA has opposed this recommendation for several reasons, including the fact that it is almost certainly inconsistent with the Convention on the Rights of Persons with Disabilities.

There are a range of reasons why expanded guardianship is not an appropriate response to the problems articulated in this report, foremost among which is the fact that a broadening out of guardianship would likely contravene the Convention on the Rights of Persons with Disabilities.

In addition, as OPA has previously argued (2010, p. 6):

‘There is a pressing need for greater policy focus on adult vulnerability, and the broadening out of guardianship to cover such situations would often be unhelpful and even problematic. As the [2009] Annual Report of the South Australian Office of the Public Advocate notes, the problems with using guardianship in this way are that:

- guardianship is reactive and its use here would not lead to adequate resourcing of prevention strategies;
- guardianship would cause undue concentration to be placed on individuals who may be suffering from abuse at the hands of others;
- guardianship will not immediately lead to the taking of sometimes simple service system measures that may improve a person’s quality of life; and
- the use of guardianship generally risks turning adult protection into something that is “seen as someone else’s responsibility”.

Victoria is fortunate to have an accessible tribunal system in place rather than utilising the more formal, and expensive, court-based systems involved in the visited jurisdictions.'
If Victoria is to make less use of guardianship, there will need to be alternative options available, with due process safeguards embedded, when some degree of compulsion is required to ensure the protection of an individual.

Drawing together the range of such options I have examined in Washington State, Nova Scotia, Scotland and England, the key powers that are needed here are:

- orders enabling entry and assessment;
- removal and placement orders;
- provision of service orders; and
- banning orders.

While some of these powers are already vested in VCAT and in a range of Victorian courts (e.g. Family Violence Intervention Orders and Personal Safety Intervention Orders) I would propose that such powers be specifically vested in VCAT in relation to at-risk adults.

Recommendation 4. The Victorian Parliament should grant the Victorian Civil and Administrative Tribunal the power to make a wide range of orders in relation to at-risk adults, as alternatives to guardianship orders, including:

- entry and assessment orders;
- removal and placement orders;
- service provision orders;
- banning orders; and
- supported decision-making orders.

Public awareness campaign

A key element of a thorough adult protection system is encouragement for all members of society to take an interest in the wellbeing of their fellow citizens. To this end, a public education campaign would need to accompany any adoption of the above recommendations, particularly the recommendation concerning OPA’s powers of investigation (Recommendation 2). I was particularly impressed with parts of Scotland’s ‘act against harm’ campaign, and consider that elements of it warrant replication here. In addition, the significance of a single entry or contact point for situations of concern, as exists in Washington State and Nova Scotia, is also worthy of replication. This entry point does not need to be accessible at all times, and should be available during business hours. People needing to call outside these times should be encouraged to contact emergency services. The following recommendation is contingent upon Recommendation 2 being adopted.

Recommendation 5. The Office of the Public Advocate should develop a public education campaign modelled on Scotland’s ‘act against harm’ campaign that is centred on a stand-alone website that:

- describes, and gives examples of, situations of concern; and that
- provides the general public and service professionals with one contact telephone number, operational during business hours, through which concerns about the well-being of at-risk adults can be registered.
Keeping adult protection on the agenda

For me the most striking finding from the project is how important it is that the various institutions involved in adult protection understand and respect each other’s roles and are willing to collaborate with one another. This gives rise to a positive protection culture that ensures, for instance, that individuals who are at risk of falling through gaps which inevitably become evident in any protection system, are picked up somewhere along the line and are not left to become unwitting victims of demarcation disputes.

It is salutary to think that it is a relatively small number of people who work in the various protective agencies in any one jurisdiction, and it is clear to me how important it is that they communicate regularly with one another. Indeed, while there is both a cause and effect element to this, the better functioning systems tend to see this happen routinely. While this happens to some extent in Victoria, the breadth of agencies in regular contact with one another could be extended.

Even when I visited organisations with similar roles to OPA – such as the health decisions arm of the Public Trustee in Nova Scotia or the public guardians in Scotland and England – I found that there is a remarkable degree of jurisdictional variability. In part this is obviously explained by the particular powers that each organisation holds, but in part there is a ‘gap-filling’ element at play that leads organisations to play roles simply because a need is identified and because no-one else is operating in that space.

With all of this in mind, OPA has a clear potential role to play to assist those agencies involved in adult protection to better coordinate their activities and to learn from each other. The point made in a number of meetings was that where individuals can put a face to a name in other agencies, better referrals are more likely to happen, and unduly ‘rule bound’ reasons for not liaising are less likely to happen. In addition, relatively small initiatives that can spring from cross-agency liaison can have significant longer-term impact. The example that comes to mind here is the grant received by King County in Washington State to train professionals about financial exploitation, which now sees police officers and prosecutors devoted to this area. The hosting by OPA of a roundtable meeting would be a good place for this kind of discussion to occur.

Recommendation 6. The Office of the Public Advocate should host an Adult Protection Roundtable in 2014, with representatives from key agencies invited to discuss the protection of at-risk adults.

This roundtable might have as its key themes:
- policing and prosecuting crimes against at-risk adults;
- investigations by statutory agencies;
- protective orders; and
- public awareness.

The roundtable might pay particular attention to the three quite different situations which can confront at-risk adults, namely:
- neglect (including self-neglect);
- financial abuse; and
• other forms of violence and abuse.

The agencies invited to take part in the roundtable should include the following: Office of the Disability Services Commissioner, Victoria Legal Aid, Victoria Police, Office of Public Prosecutions, Ombudsman Victoria, State Trustees Ltd, National Disability Services, Council on the Ageing, Seniors Rights Victoria, the Victorian Civil and Administrative Tribunal, the Department of Human Services, the Department of Health, and the Department of Justice. I would be very pleased to hear from other agencies that would like to take part.
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