COMMONWEALTH OF AUSTRALIA

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SENATE

STANDING COMMITTEE ON COMMUNITY AFFAIRS

Reference: Aged Care Amendment (Security and Protection) Bill 2007

THURSDAY, 1 MARCH 2007

CANBERRA

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SENATE STANDING COMMITTEE ON

COMMUNITY AFFAIRS

Thursday, 1 March 2007

Members: Senator Humphries *(Chair)*, Senator Moore *(Deputy Chair)*, Senators Adams, Allison, Carol Brown, Fierravanti-Wells, Patterson and Polley

Participating members: Senators Allison, Barnett, Bartlett, Bernardi, Mark Bishop, Boswell, Bob Brown, George Campbell, Carr, Chapman, Crossin, Eggleston, Chris Evans, Faulkner, Ferguson, Ferris, Fielding, Forshaw, Heffernan, Hogg, Hurley, Hutchins, Joyce, Kirk, Lightfoot, Ludwig, Lundy, Marshall, Mason, McEwen, McGauran, McLucas, Milne, Nash, Nettle, O'Brien, Parry, Payne, Robert Ray, Siewert, Stephens, Stott Despoja, Watson, Webber, Wong and Wortley

Senators in attendance: Senators Humphries, McLucas, Moore, Patterson and Polley

Terms of reference for the inquiry:

To inquire into and report on:

Aged Care Amendment (Security and Protection) Bill 2007

WITNESSES

Committee met at 3.33 pm

HEATHCOTE, Mrs Bettine Garth, Chair, National Policy Council, COTA Over 50s

REEVE, Ms Patricia D, Executive Director, Policy, COTA Over 50s

RICHARDS, Ms Gayle Maria, National Policy Officer, COTA Over 50s

AIVALIOTIS, Mr Steven, Senior Advocate, Elder Rights Advocacy

LYTTLE, Ms Mary, Chief Executive Officer, Elder Rights Advocacy

CHAIR (Senator Humphries)—Good afternoon. I am pleased to declare open this public meeting of the Senate Standing Committee on Community Affairs, and I welcome representatives who have come to provide us with evidence in this inquiry into the Aged Care Amendment (Security and Protection) Bill 2007. I welcome particularly here representatives from Elder Rights Advocacy and the COTA Over 50s alliance. Thank you all for being here today.

Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you, I understand. We have submissions from both groups, and we thank you for those. We also unfortunately have a tight time frame this afternoon, so we want to move through as quickly as we can. I suggest that, if each of the groups would like to make an opening statement, hopefully running for no more than seven or eight minutes, we can then move on to ask you some questions. I invite Elder Rights Advocacy to kick off this afternoon.

Ms Lyttle—Thank you very much for the opportunity to speak to the committee today. Our day-to-day role is working as advocates supporting the right of older people using aged-care services in Victoria, as part of the national program. As part of this role, we support people to have their complaints addressed either by the facility directly or through the complaints resolution scheme as it currently exists. So we therefore have quite a deal to do with that.

I would like to say at the outset that we do welcome the measures that are in place and proposed in the bill and commend the minister for the initiative that has been taken to this stage. We would like, of course, to see this initiative extended to community care programs of the Commonwealth and the government, rather than simply residential care. We have a couple of concerns that we would like to reflect on. One is to do with the types of complaints accepted and how they are then dealt with and also the weight that will be given to information provided by complainants. That has been an issue, which we are happy to talk about more later.

We believe all complaints should be accepted as a standard, and the investigation process, importantly, should be able to accept the prima facie evidence of family members and others bringing complaints forward. We also believe that complaints about psychological abuse and neglect should be the subject of compulsory reporting to the department for action and investigation, and we do not think that residents with dementia should be denied their rights by a system of exemptions, when a serious injury may have occurred. We believe that these matters should also be reportable, at least to the department, for investigation.

The investigation process for complaints overall we think needs to be very open and responsive to consumers and their families. Importantly, it should deal with complaints promptly—those have been issues we have heard of in the past, about time taken—and, also importantly, provide detailed information about the result of the complaints and the action taken. It is not clear to us at the moment as to how much information on compliance action taken on a matter, in the future, would be relayed to the complainant. At the moment, any compliance action taken is not reported—not able to be reported—to the complainant. So we are just not clear where that is going in the future process.

Again, we would come back to that issue of the information provided by the complainants and the weight that is given. We think this is quite appropriate, particularly in the light of the changes, I guess, that have been put in place by the government, which we are not critiquing. But, in relation to people paying more for their aged-care services, providers relay this to us as people being more demanding. We would see it as people having different expectations because they are users and they are paying their way a lot more. But, as part of that, I think they increasingly will not accept anything less than a very robust complaints system that is very responsive to them. That is certainly our view of people whom we get involved with.

We also have a side issue. We do not often like to think we, as advocates, look after ourselves, but now and again we do. There are some whistleblower protections for staff so people can feel comfortable about speaking up, which is fantastic. There are times—there have been in the past—when people may relay something initially to an advocate because they have been speaking to us about something else. We notice that there is no

protection for us in the legislation around even some qualified privilege for defamation. We realise the hiring and firing parts of the protection are related to staff directly. As a funded program we understand we are going to have obligations to report certain things that will be in the new guidelines. That is, again, fair enough. It would be helpful if we had that protection.

We have in the past been threatened with legal action for simply assisting people to use the complaints process as it exists now and we have had to report that to our own professional indemnity insurers. Nothing has occurred from that but we have been threatened. I am just saying that on a couple of occasions we have been threatened with that simply for assisting people to use the process of speaking up and presenting their submissions to a committee. We thought it was a good opportunity to raise the matter now. As I said, the protections for the workforce are very good.

Overall we believe that the measures are good. We have a problem, though, in that we have not seen the principles. We work with those things and the Aged Care Act each and every day. We have well-thumbed copies. We are very boring—we read these at night on occasion to assist our clients. We would like to see the rest of the detail—the devil is always in the detail. We hope it is not; we hope that some of the measures that people are suggesting can be included in the principles to make this very workable. Thank you.

CHAIR—Thank you, Ms Lyttle. Mr Aivaliotis, do you wish to say anything at this stage?

Mr Aivaliotis—No.

CHAIR—Mrs Heathcote, I invite you to make a statement on behalf of COTA.

Mrs Heathcote—Good afternoon, Senator Humphries, and members of the committee. It is often said that you can judge a country by the way it treats its older people. Successive governments have been too long in addressing the issues of abuse of older people in our Australian community, although its existence has been raised by many for a considerable length of time. COTA Over 50s has participated in government consultations on the issues covered in the current bill, including police checks and compulsory reporting of incidents occurring in residential aged care facilities. We believe that the pragmatic and workable legislation that has resulted should be supported.

Measures such as police checks on all staff and the drafting of this legislation to support implementation of, for example, compulsory reporting of physical and sexual assault and protection of staff who report incidents send a clear message to approved providers, the staff as well as the residents and their families, that these forms of abuse will no longer be tolerated by the community.

Whilst over the last 12 months this government has instigated a variety of measures to combat the more serious forms of abuse—serious physical and sexual assault in aged-care services—it marks only the beginning, if as a country we mean to stamp out all forms of abuse. Within the broader community, underlying issues of ageism and negative age stereotyping that give rise to discrimination and abuse need to be addressed. This will require significant public awareness campaigns and national strategies to ensure that age discrimination legislation is effective and is used by older people. Financial abuse is considered to be both the most prevalent form of abuse and the most difficult to eradicate. Thank you.

CHAIR—Thank you very much. Do the other members from COTA wish to make a statement at this stage?

Ms Reeve—No.

Ms Richards—No.

CHAIR—Thank you very much to all of you for those opening statements, and thank you for keeping them succinct. I assume that you are all aware that in the attachment to the department's submission to this inquiry—I think that is available on the website now, and there are copies over here—there are guidelines which the department has drafted with respect to the way in which the act will work. These are not the same as the principles, I understand, but they seem to give flesh to what is going to be behind the principles. Have any of you had a chance to look at those guidelines at this stage?

Ms Reeve—No.

Ms Lyttle—No.

CHAIR—Okay. That is all right. It seems to me that some of the questions that have been raised in both of your submissions might be answered by those guidelines. You might care to have a look at them and see if there are other issues arising out of that that you would like to address to the committee and perhaps come back to us with a written statement of some sort on that front.

Can I pick up on an issue that Ms Lyttle raised about the reporting arrangements. Certainly in the submissions we have received we have noticed a variety of positions on reporting requirements. On the one hand we have had comments like the one that you made today that all incidents need to be reported, particularly if they involve people with, say, dementia, even if it is only to the department. We have had others at the other end of the spectrum say that people should have the right not to have an incident reported—that if they wish not to proceed with the matter they should have the right as a resident to say, 'No, I don't want that to be taken any further.' There are obviously a variety of views coming through in the submissions. Can you give us a principle you believe should govern our deliberations on this? How should we opt in that spectrum for a particular position that satisfactorily addresses both the rights of older people in those settings and the need to make sure that there is a transparency about the process of bringing those complaints to the public eye, where that is appropriate?

Ms Lyttle—I guess we have accepted—that is probably implied—that the reportable environment will be in place about serious issues. It is then a matter of which incidents and which types of things. If you do accept that reporting serious matters such as sexual and physical assaults is a given, our view then is: why would you leave out people with dementia who have had something perpetrated upon them? The exemption, as we understand it, is to do with if there is already an identified cognitive impairment—this is an explanation that we have had—and that a behaviour plan is in place—

CHAIR—Could I interrupt you there. My understanding of the way the act is meant to work is that the exemption for people with a mental impairment is in respect of the perpetrator rather than the victim. If the perpetrator has a mental impairment, then there is discretion in some circumstances not to go to the police.

Ms Lyttle—Yes, okay.

CHAIR—If the victim is the only party with a mental impairment then certainly, as I understand it, there is a requirement for the police to be notified.

Ms Lyttle—Yes, okay. It is a matter then of: can one party have supposedly informed intent to do this—is that right?—and to have some cognition around it?

CHAIR—Yes.

Ms Lyttle—In our experience family members have still wanted some of those incidents reported, because they have not felt that the provider has dealt with this appropriately to keep their family member safe. I have certainly had instances where both parties have had some level of cognitive impairment, but the family have wanted this looked at by someone other than the facility. A couple of those have been very serious issues.

Senator MOORE—The family of the victim?

Ms Lyttle—Yes. Do you want to talk a bit more about things you have come across?

Mr Aivaliotis—Our understanding of the reading of the proposed legislation is that if the perpetrator has a cognitive impairment, discretion is there whether it is referred on. If there is an incident and there is a behaviour management plan that is organised and set up, and then there are multiple incidents after that, we would say, 'Under those circumstances of behaviour management planning, is it working?' and the department needs to be aware that we have an issue of concern here. It should be reportable under those circumstances to the department that we have a problem.

Ms Lyttle—We are not saying that it should all be reported to the police necessarily, but the department or someone outside the system ought to be looking to see what is being done to keep people safe. The underlying thing is that you are looking for safe care for people who should not be at risk of abuse. Now, how do we do that?

CHAIR—Turning to COTA, it seems to me from your submission that you are sort of at the other end of this spectrum. You say in your submission that there ought to be the discretion for a resident—or their family—who has been assaulted and who does not wish to press charges to have their wishes taken into account and respected and, presumably, for the matter not to be reported. Is that what you would say?

Ms Reeve—Yes. Our concern is that people—and I am not talking about people suffering from dementia or others not able to act in their own best interest—living in residential care should not, by virtue of living in residential care, have fewer rights than those of us in the rest of the community. So, unless there was a fear that the person was under duress, they should have that option considered. I think we might have finished up at the same point that Elder Rights did on the previous issue, but we certainly would not expect to be reporting to the police actions of people who are cognitively impaired. We would expect that the arrangements for people who

may be violent or prone to assault other residents should be carefully monitored and that we should all ensure that these arrangements are appropriate. We do not think it is appropriate that police reporting is the way to go for dealing with such issues. In relation to the earlier issue of people who may not wish to report—there may be issues of family visiting et cetera such that people, in the interests of family relations, want to take a different stance—we think they should be listened to.

CHAIR—Can I take it that both groups agree that there should be a separation of circumstances where it is appropriate to inform the police and circumstances where perhaps only the department needs to be advised, so not necessarily the police as well.

Ms Reeve—Yes.

Ms Lyttle—Yes.

CHAIR—And the role of the families or the individuals who have been assaulted is important for determining which of those steps is taken?

Ms Reeve—Amongst other things.

Ms Lyttle—There could be a situation, as I understand it, where the police have been involved and then say to the person or the family, 'Do you wish to press charges? Who is going forward with it?' That is the point where you again get a choice. It has been reported, because we are required to report it. The police can then take it further—so what will the role of the police be around the particular incident?

CHAIR—My understanding is that the question of pressing charges and the question of reporting to the police are two different stages. It is compulsory to report but it is not compulsory for that report to lead to a charge being laid, if the person concerned does not wish to take it that far. That is my understanding, but we will clarify that with the department when they come.

Ms Lyttle—That is my understanding too. It comes back to Patricia's point: at that point, people who are able can retain the capacity to say, 'No, do not take it any further'—but at least the police have come to this point and investigated.

Mr Aivaliotis—Or they can say, 'I will not be involved in any further proceedings.' Some residents whom I have been involved with have said that. They say: 'This has happened to me. The police are aware, but I don't want any further part in the whole process.' And the police have respected that and have not interviewed them any further, or they have stopped the interviewing process.

Ms Lyttle—Again, people need to know their rights. We have raised that in our submission—that if it is a competent resident they have the rights that anyone has under police interviewing. They need to know about that.

Senator McLUCAS—I want to pick up on the question of the right not to report. Can you give the committee an understanding of on what basis people do not want to progress with a matter? What are the reasons residents give you for saying, 'I don't want to progress this any further'?

Mr Aivaliotis—As an example, in one case that I was involved in, the resident said that it was because it was a long process: the amount of interviews, what they had to do. Other significant factors were that other people would find out and that the resident had to still live there. We were having a conversation, just prior to the hearing starting, about the unfamiliarity of the police intervention—will they come in uniform, will they enter the facility, will people look at the police coming in to talk to them, what is the context, what will happen to them under those circumstances? It varies from person to person, but the main issue has been that it will take too long so they are not interested in taking it any further—that they have made the statement they needed to make.

Senator McLUCAS—And that is sufficient for the victim to find a sense of closure?

Mr Aivaliotis—Yes, in that instance. The two people I was involved with said that, yes, the authorities were aware of it and that was enough.

Senator McLUCAS—You cannot extrapolate policy from individual issues, but I was just interested to understand why people do not want to do that.

Ms Lyttle—And their safety was assured.

Mr Aivaliotis—Yes, the providers had implemented strategies to ensure that the circumstances that brought on the issues were not to be repeated. They ensured that it would not be repeated, with particular measures.

Senator McLUCAS—I would like to go to the issue of no whistleblower protection for an advocate. I think you raise a very important point, which certainly has not come across my desk, so I am pleased you did. Have you raised that with the department?

Ms Lyttle—Not specifically. We have only put it into the submission, mostly because of time I guess.

Senator McLUCAS—We might talk about time later.

Ms Lyttle—We will not talk about that; that is fine. I am not criticising.

Senator McLUCAS—You are quite welcome to.

Ms Lyttle—In fact, I did not even put it into the submission. We did this in a fairly tearing hurry, and then we began thinking, 'Gosh, where are we in something like that?' Given that we had had a couple of situations, we thought this would be the opportunity to get it in.

Senator McLUCAS—Are you suggesting that whistleblower protection should be provided to funded advocacy organisations?

Ms Lyttle—Yes.

Senator McLUCAS—What about family advocates?

Ms Lyttle—Where families sit in this is another matter. I guess it is a matter of how you put that in the legislation. If that can be got in, that is excellent. If there is protection for anybody who reports in good faith, then why not extend it to them also?

Senator McLUCAS—You spoke of a number of threatened legal actions that your organisation has experienced. Is that an experience shared by other advocacy organisations that you are aware of?

Ms Lyttle—I believe a couple of them may have, but I have to say it is not common; it has not happened to us too often. It has been in more recent years—I have been in this job since advocacy started—particularly when homes have had sanctions. There has been an environment where providers have thought that we were being too open with information or assisting people too much and various things like that. I guess they have tried to push the whistleblower, which is what we sometimes are in that environment in helping people. That is where it has come up.

I think it has come up in more recent days—and this is purely speculation—because we are entering a more sophisticated environment in which much more is at stake for a provider's reputation, with a more commercial environment. So, increasingly, we find ourselves facing lawyers in situations with providers, because they take advice at that level. We are out there as advocates, waving the flag and assisting people, with very little protection, if you like—apart from our professional indemnity insurance.

Mr Aivaliotis—There have been instances where other family members have witnessed incidents of abuse and they have raised that with the family of the other resident involved. The provider has asked, 'Who told you?' and the ongoing issue in that instance was that if they raised it again they would sue them for slander because they did not have proof—even though the family member actually saw the assault take place. So we would say to the committee that, on top of advocates having consideration about whistleblowers, family members who are acting in good faith should be considered.

Senator McLUCAS—Thank you for raising that with us. We will raise it with the department. Did COTA want to comment?

Ms Reeve—We support the view that family members and visitors to institutions who, in good faith, report something ought to be protected however they can be.

Senator McLUCAS—During the inquiry into aged care that we did some years ago, the issue of retribution was raised by family advocates, but I think the threat of legal action is a new issue for this committee, and we appreciate you raising it. Mrs Heathcote, you said there should be police checks on all staff and you emphasised the word 'all'. As I understand it, the legislation requires checks for persons who will have unsupervised contact with a resident. Are you slightly disagreeing with the scope of the legislation?

Mrs Heathcote—No.

Senator McLUCAS—I have misunderstood you then. Ms Lyttle, you talked about the weight given to complaints and you said you would like to expand on that. Could you do that, please?

Ms Lyttle—I think we can both talk about instances where that has happened. With the way things may be dealt with currently—and all we can go with is the current system—family members are not always writing

things down, taking notes and documenting what happens. Sometimes they are; sometimes for all sorts of reasons they may make notes about what is occurring, particularly if they start to have a problem with the care. They may remind themselves with notes on what occurred, what time they put in a complaint or things that happened. But we have found it can be very hard for their information about what occurred and the subsequent complaint to be heard with the same weight when the provider then responds and says, 'Well, we've documented what is happening for this person. It's in the care plan that's written up.' The provider may have quite a pile of documentation; it is part of their obligations. That then makes the family member's account of what happened perhaps less believable. We would like to see what they are saying as prima facie evidence and have often described it that way to the department. To be fair, in some instances in the process we have managed to get things taken up that had been rejected as a complaint. We have helped them to reframe information they had against the standards—and that is part of the support we can offer, because we understand the system—or to flesh out the detail of any evidence they have, so that there is a bit more to be explored in what occurred.

Senator McLUCAS—These are complaints that are taken through the complaints resolution scheme?

Ms Lyttle—Through the current system, yes. It is sometimes just too easy, I think, for the provider to reply with a lot of documentation and detail, and the family member's information and evidence gets lost in that.

Senator McLUCAS—Do you think, then, that the shift from a scheme based on the principle of resolution to a system where the office will investigate will assist that process?

Ms Lyttle—If what the family member or complainant provides is also seen as evidence. How that is seen is crucial, really. Is that the experience you have had, Steve?

Mr Aivaliotis—It is about what information is available from the complainant to be handed over to the formal complaints resolution scheme to investigate. As Mary was saying, the level of evidence that they are able to provide is limited in certain circumstances to, for instance, some documentary evidence or dates. In certain circumstances that is not sufficient to warrant the acceptance of a complaint. These family members sometimes do not have the capacity to gather more evidence. Yes, there are certain family members who say, 'We'll set up video surveillance if that is what you want us to do,' which is a bit extreme. However, short of that, they are saying, 'What else can we possibly do? We only visit certain hours of the day. This is what we have observed; this is our evidence.' As I say, in certain circumstances that is just not enough; it is not accepted.

Senator McLUCAS—I do not know that the change from resolution to investigation will necessarily affect your concern, but I think it is important that you have put it on the record.

Senator MOORE—I have only two questions. The first is a straight one about what role you had in the consultation around the development of this legislation. Because both organisations are so active in the industry and, in particular, with residents and families, I want to get on record what role you had in the consultation process.

Ms Lyttle—None.

Senator MOORE—That is short.

Ms Lyttle—Not any formal thing.

Ms Reeve—As members of the Aged Care Advisory Committee, we have been involved in discussions the minister had with that committee.

Senator MOORE—You are unaware of any other process?

Ms Reeve—No.

Mrs Heathcote—Anecdotal evidence to us and an involvement with the equivalent organisation in Western Australia have been used as the basis for much of our information.

Senator MOORE—We have been talking about this kind of thing for a long time. A question I want to follow up on is the education process. Your submissions talked about the important element of making sure that everybody knows their rights and understands how the system operates. Do you have any idea how that can be done? I do not know whether $1 million is enough, but that is the big question in terms of setting up structures with the best will in the world but then ensuring that people understand them, that people are comfortable with them and that people know how to use them. Do you have any suggestions? You may want

to take that on notice and think about it and then come back to us on it. For the sake of this inquiry, I would be interested in whether you have any comment to make.

Ms Reeve—There is a base level at which we would want to see the government develop material for consumers. We would expect that providers would provide that material to residents and their families and that other groups, such as ours, the advocacy services and seniors information services, would make it available to any of their inquirers. Hopefully, the government would also do some broader public awareness campaign on these issues. As well as legislation, we know that we need to have a cultural change to bring about these sorts of changes.

Senator MOORE—Sure. Have you any ideas on how you would engage the institutions, their staff members and, in particular, police in the process? Chair, this is a supplementary of the original question. It is not a new one; it is all part of the same thing.

Ms Lyttle—Police are a challenge. We have not tried educating police. So I have to say that I am unsure about that one. In Victoria, there has been some involvement of the police and people with designated responsibility in that area implementing the code of practice guidelines. We are starting to get that through. But we still hear, as I heard last week, of someone calling a police station about a matter to report and not getting a very good response and then having to pursue it by asking to speak to the senior sergeant et cetera. So I think there is quite an educative role around that.

Some parallels to this can be found in the domestic violence area to say very similar things. 'What does "no" mean?' and all of those sorts of programs have gone out to say to people: 'Don't just walk away.' As police, they know that they have to deal with it. We have developed some information as part of our own education program for residents, families and staff, and we will continue to do that, and we would be happy to do more of it. As Patricia said, COTA and other carer associations could provide information to people. So there are a range of already known measures, from the information leaflet to residents and families that says, 'These are the new measures to keep people safe,' through to a broader public awareness campaign about what the government sees as acceptable, which can start to talk about what this means.

Mrs Heathcote—In Western Australia, a group of organisations get together to talk about this issue. Represented on that group are people from the police force who have taken it upon themselves to go out and educate other police throughout Western Australia on the issue. That is one way of spreading the word that, when the police do get involved, they need to be aware of the sensitivities that are involved and that, in some instances, this sort of abuse is different from other abuse.

Senator MOORE—If anyone has any ideas on information for community awareness programs, could they please let us know. I am sure the department has some ideas. We can have inches of this paper; but, unless people get the process of awareness right, it is worthless. Mrs Heathcote, you mentioned Western Australia and an organisation that has a cross-consultative or interagency process. Is that a state based organisation?

Mrs Heathcote—Yes, it is.

Senator MOORE—Are you aware of any other states that have something like that?

Mrs Heathcote—I am not aware.

Ms Richards—New South Wales does. They are a similar group to ours in terms of education. I am not sure whether they disseminate information to police in particular, but they try to raise awareness within the general community and with particular people.

Ms Reeve—I think there are a number of initiatives—I know those in Victoria best—looking at issues of abuse of older people more generally. This would fit in as one component, and that is where we are beginning to see cross-agency work.

Ms Lyttle—The advisory group to the minister has been established again to meet in March. It is a cross-disciplinary group, with police involved as well.

Senator MOORE—Is that a state advisory group?

Ms Lyttle—Yes. It is Victoria's abuse prevention strategy in the community.

Ms Reeve—I will follow up with our other members, because I think there are others.

Ms Lyttle—Our colleagues in advocacy programs in Western Australia and South Australia get state government money to run abuse prevention programs in the community. There is an abuse prevention hotline in Queensland. So there are two or three things in that area.

CHAIR—We thank you very much for the evidence that you have given to us this afternoon. It has been very useful. I repeat the invitation for you to come back to us in the next week or so if you have any further comments to make on the guidelines, which you can find in the Department of Health and Ageing submission on the website.

Ms Lyttle—Thank you.

[4.13 pm]

McMILLAN, Mr Derek Allan, Group Executive, Retirement Living Services, Australian Unity

MEAD, Mr Rohan William, Group Managing Director, Australian Unity

CHAIR—Welcome. Thank you for appearing before the committee. Information on parliamentary privilege and the protection of witnesses has been provided to you. Thank you for your submission and for supplying it in a short space of time. Before we ask you questions on your submission, I invite you to make a short opening statement.

Mr Mead—I thank the committee for the invitation to talk about the important matters touched on by the **Error! No document variable supplied.**. I would like to elaborate on a few points in our submission. Australian Unity has been providing aged care and retirement living services to older Australians for 45 years—a significant part of our 165-year history as a mutual organisation. We believe that we are successful in the sector because of our reputation as a values based company. Our philosophy is that we are providing a home environment for each and every individual whom we look after, and we have a responsibility to make that home environment as secure and safe as possible. We would like our residents not only to be safe but to feel safe—to feel that their entire wellbeing is important to our organisation and that they live in a caring, transparent and accountable environment.

Our organisation is interested more generally in the formulation of wellbeing in the Australian community as well as in our retirement and aged care operations. For example, we are the founder and publisher of the Australian Unity wellbeing index. In these particular operations, our care model revolves around identifying resident needs on each of the seven internationally recognised wellbeing domains: future security, standard of living, health, personal relationships, safety, achievements in life and community connection. We applaud the intention of this bill to protect residents against any possibility of an inadequate response to—or worse, a cover-up of—a known or suspected incidence of abuse. We believe that compulsory reporting of elder abuse is a necessary step to help the community at large feel that the security and welfare of older people is of primary importance to their service providers and obviously all Australians.

In some ways, Australian Unity's existing policies go further than this bill in the scope of abuse considered. We currently require staff to directly report to their facility manager if they suspect or have been told about a possible instance of elder abuse. Our definition of elder abuse includes physical abuse, psychological or emotional abuse, sexual abuse, financial exploitation or abuse as well as neglect. Once that report is made, our policy requires the instigation of a thorough investigation, part of which involves informing the older person of their right to an independent advocate and their right to confidentiality. We believe compulsory notification requirements of the bill can be accommodated within our existing policy on notifications.

There has been some discussion about whether elder abuse is a symptom of training issues or workplace shortages. It is our policy to attempt always to recruit staff in our businesses in line with our company's values—values that include customer driven integrity, community, our people, those sorts of things. We believe that staff who are aligned with positive values such as these will not consider harming an older person in any way. We believe that this approach provides the best protection to residents with regard to stresses that can arise in any workplace, and particularly in the care of the elderly and infirm.

Further, it is our practice to provide an employee assistance program which allows staff members to obtain counselling and support to address any stresses they might be experiencing, including those external to the workplace. We are preparing to fully train staff in the new legislation. We are preparing to update our induction program for staff in this area of our business. The obligations under this act, should it pass, will be an integral part of that program.

I would like to take a moment to comment on the specifics of the bill. The draft legislation requires us to report to both the secretary and the police an allegation of abuse or a suspicion that there has been an incidence of abuse. In making the following comments, I reiterate and underline that we are firm believers in transparency and accountability. However, we do feel that the draft bill does not allow for some of the complications of daily care of older Australians. In some instances of alleged abuse, the need to report the allegation to police would be clear. But in other instances this may not be so and could result in the unnecessary involvement of police in incidents that could stem from mental incoherence of an older person suffering from dementia, for example.

We note the Australian and New Zealand Society for Geriatric Medicine made reference to the potential frequency of these situations in its submission to your committee. Having good relations with our local police officers is also an important part of the management of our facilities. We would regret any situation where those officers felt we were burdening them with some baseless allegations, as we would be required to do under the proposed law. We made an early proposal to deal with this potential problem area in our written submission. Today, with the benefit of further research and consultation, we would like to amend our suggestion slightly.

The draft bill requires a provider to report an allegation of abuse. It seems to imply that this reporting is necessary regardless of whether there is any considered likelihood of substantiation of that allegation. We submit that the draft bill should be amended so that a provider be compelled to report an allegation only where there is reasonable grounds to suspect that the information indicates a reportable assault has occurred. We note that such a reasonable grounds standard is already represented in the legislation as it relates to the protection of a person who discloses an allegation of suspected abuse. We believe the legislation would be more consistent if that standard also applied in relation to a provider's compulsory reporting obligations.

However, we would say additionally, as an approved provider, that we should fully support the mandated recording of all allegations, even when there are no reasonable grounds to suspect a reportable assault. We would, if legislators choose to adopt such a course, expect that such records would be open for review at any time by the department. We think that that combination of reporting obligations and recording obligations would be a more appropriate legislative setting for this complex area.

We wish also to note the needs of residents, as the other witnesses have already discussed today. As I have explained, our current policy in relation to elder abuse recognises the right for any competent older person to request or consider confidentiality and privacy in relation to the reporting of abuse. Unfortunately, this bill does not extend that right, and instead removes it from the older person. Should we discover ourselves, as operators and providers, in a position where a resident asks us not to report an offence we will find ourselves with competing pressures that will require careful management. We believe such situations could be handled in conjunction with police, particularly those trained in dealing with victims of domestic violence or sexual assault.

We appreciate your attention to these concerns and others we have raised in our submission. We trust they have been somewhat useful to your investigation of these important matters. My colleague and I would be pleased to answer any questions.

Senator McLUCAS—I want to go to the question of your proposed amendment. It would require that, if an allegation is made of serious assault or sexual abuse, you would then add on 'with reasonable grounds does require reporting'.

Mr Mead—Would require.

Senator McLUCAS—Who would do the assessment to ascertain the 'reasonable grounds'? Walk me through a practical example, if you would.

Mr Mead—I might ask my colleague to further elaborate on the day-to-day experience, but it would obviously be the staff of the provider in situ. They are the people in contact with the event in question. Inevitably, judgments occur at the coalface.

I would preface comments on this area by reminding us all that these facilities are people's homes. What is more, they are shared homes. The blunt instrument of legislation in this area can potentially produce undesired effects. Our recommendation would be that there would be a parallel set of obligations—one based on reasonable grounds and one entirely mandatory, no matter the reason; one reporting and one recording—so that, if there were any suspicion that a provider were not using their judgment appropriately in relation to the reporting of reasonably based allegations, there could be a documentary record open to investigation such that appropriate regulatory and compliance steps could be taken. That would be a general comment.

Senator McLUCAS—Before we go on, could you also have the requirement that all allegations, whether they be on reasonable grounds or not, be reported to the department within 24 hours?

Mr Mead—It would be fair to say that it is true that the area of our concern here is perhaps at its highest in relation to the compulsory reporting to the police because of the potential for residents to be uncomfortable in certain circumstances with that mandated step. We would agree that there is probably a further nuance here between reporting to the police and reporting to the department. Nevertheless, in all, we would still submit that it is appropriate in the context of people's homes that this judgment be left to the best efforts of well-

intentioned staff to try and manage in the best way possible. That is the substance of our submission. But we acknowledge the gradation that you identify.

Mr McMillan—Perhaps I can illustrate our point by talking through a specific example. Our current policy would dictate that the facility manager or one key personnel member would be the responsible officer to investigate that initial allegation. That investigation would look for reasonable grounds based on physical evidence. There would be interviews with the victim, other staff and other residents. There would be observations from other staff members. Those could be in relation to residents, the victim and the alleged perpetrator, whether they are staff members or not. It would also look at whether the resident's behaviour had changed. Those would be the types of investigations that a manager would undertake to assess whether there was reasonable ground for suspicion. We think that that policy works well at the moment with our current elder abuse framework. We would recommend that as quite a reasonable methodology for assessing the intent of this bill.

Senator McLUCAS—And your staff are currently trained to do that?

Mr McMillan—That is right. Our key personnel at each site and our village managers, with their experience, knowledge and responsibility, are trained to assess those situations.

Senator McLUCAS—You also make the comment in your submission about the requirement to report within 24 hours and the difficulties that that poses for an event that may occur on a weekend. Can you walk us through the practicalities of that?

Mr McMillan—It is not so much the difficulty of reporting to the police, but it is difficult to report to the department. The department is open nine to five, Monday to Friday, while our business is a 24-hour, seven day a week business.

Senator McLUCAS—We might raise that with the department. We might get a hotline. It has been put in other submissions that there is a potential conflict with the principles of the act in the compulsory reporting of abuse and the issue of the right not to report if a resident expresses that right. Have you looked at that in terms of a legal construct? Do you think that there is potentially a conflict in the act, given that the act is premised on the rights of the residents?

Mr McMillan—There are clearly some categories here involving the cognitive position of the residents. Leaving those issues aside for a second, the situation is that this bill removes a right that is currently available to all other adults in Australia. That is an issue that we would definitely ask the committee to reflect on. The spectrum of potential complexity here is enormous. The very legitimate right of residents to make an assessment about their own privacy and confidentiality has to be borne carefully in mind.

It seems to me that elder abuse of the type that we are discussing here today falls into four categories, and they relate to the perpetrator. There would be concerns about the staff of any operator, fellow residents, strangers and family. I am sure that the committee would fully understand that there are complex issues in all of those categories. We fully support the laudable public policy intentions of this bill but we would suggest that there should be appropriate consideration given to the right to privacy and confidentiality in this complex area.

Senator McLUCAS—If there is time at the end, I might come back and we can talk further on that. Thank you.

Senator PATTERSON—I am a bit confused about what happens to the rights of the person who has had the accusation made against them. Not everyone who is old is nice. They may be set against a particular staff member or somebody else. How do you protect the privacy of the other person? They are accused. The accuser is protected in your system. I do not quite understand how that would work if it were a vexatious accusation. And that can happen.

Mr McMillan—We believe that having reasonable grounds before reporting can address some of those issues. If there is a proper investigation conducted—and that may be within half an hour or an hour of the allegation—then the vexatious claims are limited.

Senator PATTERSON—But you do not make the law for the best nursing homes; you make them, sadly, for the lowest common denominator. A good nursing home might undertake that investigation immediately. But for one that does not want to be criticised and is reluctant to admit that there is something going on in their nursing home, wouldn't that be a way for them to cop out of it? You have to think about some of the worst ones that you have ever seen. There are some around. We try to make sure that they are not like that, but some

of them deteriorate. You are assuming that they all act in good faith in carrying out an investigation within a certain time. Put your nasty hats on and think about it.

Mr Mead—We are exceedingly aware of the types of circumstances that you describe. It would seem to us to be regrettable that in attempting to address those issues we penalise the amenity of many thousands of Australians who do not live in such facilities and who may find, for example, under the currently proposed wording of the bill, uniformed police officers attending routinely in ways that disturb harmony or alarm members. For example, a baseless allegation could be made by someone with some cognitive impairment. If we admit that example of a baseless allegation, the situation would be that the machinery of this act would require the involvement of the police. There are very legitimate concerns to be balanced against the equally legitimate concern that you raise.

Senator PATTERSON—If you were to adopt this thing that you are suggesting, could a facility that fails be then subject to the more stringent approach? You would have a second level. I do not know how you would do it or how it would be written. But it seems to me that you have to protect those people who are in a facility, such as an aged care facility, that isn't all hunky-dory.

Mr Mead—Certainly. Without the benefit of extensive consultation, my instincts say that we would support a tiered process of the application of mandated reporting. For example, it may be that the type of regime we have recommended obtained for all except in circumstances where the department determined that a different regime should apply. Perhaps that is one route through this particular set of issues.

Senator PATTERSON—If you had failed a number of accreditation points, for example, that could be a measure. There might be other ways of doing it; I am just trying to think of a way. I am a bit anxious about your solution because it is being taken from a position of goodwill and good intent. We will mull over that, I suppose.

Senator MOORE—How many complaints did you have last year?

Mr McMillan—Serious complaints?

Senator MOORE—Yes.

Mr McMillan—We had none last year and one the year before.

Senator MOORE—You are a very large organisation and the evidence that you have given is based on that experience. I think that is important to put on record in terms of the process. I asked my question about information and awareness campaigns. You expressed that you already have an operating system in your organisation and you described it to us. Can you suggest how we could learn from that in terms of ensuring that residents, families, staff members, visitors and police all understand their rights in the process? How can it be done?

Mr McMillan—Our current approach is to tackle this at what we would call induction or admission to the facility.

Senator MOORE—That is for the family and the resident?

Mr McMillan—That is for the family and the resident. Then, if there is a complaint, we would discuss their rights with them at the time of the complaint. As to further education, I think it is quite complex. I do not have a strong view on how we could extend that beyond our current staff and resident base into the broader community.

Mr Mead—For example, I think we would not resist a degree of greater formalisation of our current practices. If you were to generalise such practices—for example, the provision of information to all relevant family members at induction or admission, or a set of other potential information provision procedures at critical points in a resident's care—I would have thought that, when multiplied by the community of residents, their families and staff, would go a significant way to achieving some of the critical awareness that you may be concerned with.

Senator MOORE—Currently at airports you have to have a special card to be allowed into parts of airports. There is a special card; I forget—and I should not forget, but I have forgotten—what it is called. It has been contentious. Anyone who is allowed to go into special parts of airports has to have training and awareness about what they are doing and about what rights they have there. They have to sign their lives away and actually apply to get this card to allow them to be in the area. I understand fully what the rights are for people who are staff members of your organisation, but, for people who come on campus—and I use the term

campus because it is a generally used one—for things such as entertainment, maintenance or any of those other things—people you do not control—how do you actually get their rights and responsibilities to them?

Mr Mead—Again, this is a fraught area when we are seeking to achieve a home environment. So some of the people that you would be potentially—

Senator MOORE—Screening.

Mr Mead—involving in this mechanism might be volunteers, they may be family members. Could I tell you one story of two residents in a facility of ours. Let's call them John and Jane. Four months or so after purchasing a retirement village unit—a separate discussion from the one we are having today—at one of our joint facilities, Jane had a fall that had some serious complications and led to some issues to do with cognitive impairment. She had that fall at home in a private home environment and so on. Jane, it so happened in this case, transferred to the adjacent and included aged care facility within the general community. John is able to drop in and out to visit Jane. We would do everything that we could to facilitate the ready access. I could describe any number of other instances, Senator, which we are talking about involving ourselves in in quite formal ways. So certainly there are remaining tortuous issues here.

Senator MOORE—Yes. I think the impact of the legislation is going to evolve as it goes through, but it is interesting. I just wanted to get your comments on record. Thank you.

CHAIR—I will start by asking you to tease out the model that you are talking about here as the alternative to the one that is in the legislation. Say you have a complaint by a person with dementia in a home that they had been assaulted by a staff member. The management of the home investigate and come to the conclusion that the claim is without foundation. That is recorded but not reported to the police. Who sees the recording of those incidents, if anybody?

Mr Mead—We would submit that those be generally available to the department on whatever basis the department required.

CHAIR—So you could be required, say, to submit those every six months or every year to the department.

Mr Mead—Whatever appropriate processes the department determined.

CHAIR—What if a family member of the demented person says, 'We're not satisfied. We believe this should be reported.' What would happen then?

Mr McMillan—Our general principle is open dialogue with the family members of the resident. Most likely we would have discussed that allegation with the family members to let them know that they had made that allegation and we had investigated the complaint and found that it was baseless. If in fact they then wanted us to report it, I would think that we would then report it.

Mr Mead—Absolutely.

CHAIR—I am not asking what you would do. I am asking what the rule should be. Let's just take the case Senator Patterson was raising of the less than ethical home. They may not want to report these instances. What should the law require where a provider decides they do not believe the matter needs to be reported but the family member, for argument's sake, does?

Mr McMillan—I will respond to that firstly in the inverse. One of the challenges that we are wrestling with with this bill at the moment is the implications for our procedures come 1 April if it is to be assessed. One of those is: what do we do with the staff? If there is an allegation that needs to be reported, it will then be investigated, so should we then suspend that staff member? That then has a potential impact on staffing ratios, agency staff, quality of care as well as the rights of treating that staff member fairly, particularly if we believe that the allegation is baseless. But then can we not suspend that staff member if we are pending an investigation from the department?

CHAIR—It is a good question, but in a sense a separate one from the one that I am asking. What is the right of the person or their family to have a matter reported if the people operating the home do not want to report?

Mr Mead—There is only one answer here: the incident must be reported. If there is a competent person who is insisting on further investigation, it would be undesirable that that did not get reported.

CHAIR—That sounds like a reasonable position to take. You suggest in your submission that the principles in the legislation, I presume as modified—as you have suggested it should be modified—should apply to other residential facilities like boarding houses and retirement villages. I cannot quite see these arrangements

working in the context of, for example, a retirement village. With aged-care facilities of the kind that this bill covers, we are talking about generally fairly vulnerable people, often frail, who are being provided with day-to-day services by staff. In a retirement village people may have relatively little interaction with staff, and they are often fairly independent, by definition, to be able to live in a semi-autonomous setting. As an operator, you do not have the same obligations towards those people to watch out for their interaction with other people that you do for a person in a nursing home. Wouldn't you need some fairly extensive changes to these arrangements if they were to apply to people in retirement villages?

Mr McMillan—Perhaps it was slightly clumsily worded, but we were particularly focusing on those residents who receive, say, CAPs packages or additional care services that are government funded services. The bill as it stands does not apply to those residents and yet they are equally as vulnerable as, perhaps even more vulnerable than, residents in a residential aged-care facility. So it is really about whether we can make this bill more inclusive to capture all older persons—

Mr Mead—Who are recipients of assisted living.

Mr McMillan—who are recipients of care services, yes.

CHAIR—You suggest that there should be counselling and support offered to victims at the earliest possible time. Do you see that as the obligation of the providers of the services, or of the Commonwealth government, or of whom?

Mr McMillan—We would see it as our obligation to arrange those services. There is a range of government funded services that we would access, but in the first instance we would see it as our obligation to arrange those services.

CHAIR—You suggest training for the police in the way they enter homes and so forth. You would understand the difficulty in the Commonwealth imposing training regimes on state police forces, but perhaps some arrangements can be made in that regard. I think that has covered my issues. Are there any further questions?

Senator McLUCAS—Our committee is reporting on 9 March, the legislation has to pass through the parliament, and we have not yet seen the regulations. Practically, how do you start on 1 April?

Mr McMillan—Yes, I would have to say that the timetable is very tight for us because of the shiftwork nature of the staff, and recognising as well that staff do not necessarily always work full-time. For example, in a facility where there are 50 full-time equivalents there may be 120 staff members. I suppose that is why we are turning our minds to how we can modify the policies and procedures so that we have those clear before 1 April. But we certainly would appreciate some additional time if that were possible in order not only to crystallise our policies but also to then roll out the training to the staff. It could take a week to do that—to capture all of the staff.

Senator McLUCAS—A week?

Mr McMillan—Yes.

Senator McLUCAS—Providing you have prepared the training?

Mr McMillan—Yes.

Mr Mead—After preparation.

Mr McMillan—In terms of the implementation.

Senator McLUCAS—After preparation of the training?

Mr McMillan—Yes, just to implement it; just to pick up everybody's shifts.

Senator McLUCAS—We might take that recommendation on board as well. Thank you very much for your time.

CHAIR—Thank you for your appearance today. If you have any further comments based on the guidelines published in the submission of the Department of Health and Ageing—they flesh out what the principles will ultimately say—you might care to make some further comments in writing to the committee.

[4.50 pm]

KELLY, Ms Laura, National Policy Officer, Liquor, Hospitality and Miscellaneous Union

Evidence was taken via teleconference—

CHAIR—Welcome. Have you had information on parliamentary privilege and the protection of witnesses provided to you?

Ms Kelly—Yes, I have.

CHAIR—We have the submission that you provided to the committee, and we thank you for providing that in a fairly short space of time. Would you like to start with a short opening statement? We will then proceed to ask you some questions.

Ms Kelly—Has everyone had a chance to look through the submission?

CHAIR—I think you should assume that we all have read your submission.

Ms Kelly—Fabulous. I will highlight the key points for us. They are staff training and staff ratios, as I am not quite sure how you would implement a reporting system where there are inadequate staff to act as reporters. We hope protections for whistleblowers, which are outlined in the act, can be tightened, particularly given the current industrial environment. We have had a couple of members complain about having hours reduced, and a staff member was recently fired in SA after reporting alleged abuse. We hope to have the language around victimisation tightened to include any kind of change of hours or established work tasks. We also have concerns about the complaints infrastructure for the Aged Care Commissioner. We are a bit concerned that it will not be established as independent from the Department of Health and Ageing.

I think a lot of people would see requirements for staff training surrounding the introduction of a new reporting regime as an implementation issue, but, because the success of the entire regime is going to pivot on staff training, we think it is important enough to have a statement to the effect that the Commonwealth will support training across the board and that staff will not be obligated to bear the costs. There are a couple of references in the submission about the complexity of detecting symptoms of abuse, and without sufficient training PCAs working understaffed are not going to have a lot of time to detect complex symptoms.

CHAIR—Thank you. You may or may not have seen the guidelines which have now been made available with the submission of the Department of Health and Ageing, which fleshes out some of the issues that are raised in your submission. Have you had a chance to look at those guidelines as yet?

Ms Kelly—No. I could not find them at all when I was trying to prepare the submission, and there was such a tight time frame in which to contact the department for information. It was difficult. When I looked through, making the submission, it said that responsibility for introducing the guidelines rested with the minister after the act was introduced. Have they now been released?

CHAIR—The principles have not but the guidelines, which seem to cover much of the same ground, have been. I invite you to have a look at the guidelines that are part of the submission of the Department of Health and Ageing and, if there are issues arising from that that you would like to comment on further, to come back to the committee and make a supplementary submission, perhaps in the next week, in order for us to take on board any issues.

Ms Kelly—That would be great.

CHAIR—You talk about the need for training of staff working with residents with dementia, for example, to ensure that they understand how to recognise incidents of abuse and so forth. Who do you see having the responsibility for providing that training—government or providers?

Ms Kelly—I think that, if there is going to be consistency nationally, the responsibility needs to rest with government, probably in consultation with organisations like Alzheimers Australia.

CHAIR—So they should fund it and provide it or set standards that require it to be offered by the providers?

Ms Kelly—Ideally, certificate III would be a minimum mandatory qualification for aged-care workers. I think that a high percentage of personal carers have a certificate III. I probably should have included that mandatory reporting should be part of basic introductory training. I think that that should be provided at the cost of the government, considering the low wages and skills shortage in the sector.

CHAIR—You go on to say that the Aged Care Commissioner office should be separate from the Department of Health and Ageing so as to give it the capacity to operate independently. You would appreciate that there are lots of agencies which benefit from a level of independence but of course, on such occasions, it comes at a certain cost. When you separate the structures, you have to duplicate some of the overheads and other activities which therefore increases the cost of the mechanism. To justify the separation, can you suggest any problems in terms of lack of independence with the present complaints mechanism that your union has encountered that might lead us to the view that we need to have that independence that is not there at the moment?

Ms Kelly—In terms of the present complaints mechanism, the investigation rate of complaints varies extremely significantly between states. In Queensland every complaint is investigated, but there are other states where there is just a small percentage of complaints investigation. I do not have the figures on me now. I think it needs to be looked at nationally. Also, a lot of the information comes through providers. When the commissioner is internal to the department, it seems that the perception of independence, for staff who are aware of the links between providers and the department, is what creates a lot of the difficulty around reporting. I think staff would be more inclined to report if there was not an investigation body that had say over their future employment or reinstatement internal to the department which funds and audits their provider.

CHAIR—Are you aware of cases or potential cases at the moment where staff have felt reluctant to complain because of the lack of independence in the present structure?

Ms Kelly—Yes. It is a really difficult thing to assess and have tangible evidence of, to be honest. The case in South Australia remains one where staff have been completely reluctant to report, and the person that encouraged reporting was fired. We ran a campaign to try to get her reinstated. I am not sure of the outcome of that at present. Most of our concerns probably centre around workloads and training. That is not to say that if something were internal to the department it could not be done well, but, when you start to get into the mind frame of lowering overhead costs, it is not a culture that creates independence, investment in training and communication to encourage reporting when people are vulnerable. It may be expensive but I think that, when the safety of elderly people is involved and people's jobs are on the line, it is important to invest the money.

CHAIR—Thank you for that. I have one last question: the guidelines preserve the capacity for people to make complaints—and this obviously would include complaints against staff members—anonymously. Does your union have a view about the notion of anonymous complaints against, say, people working in the aged-care sector?

Ms Kelly—Yes, it is our view that you have to be able to make the complaint anonymously so it reduces the chance of victimisation. Our concern about investigation of complaints centres around staff training on how to perceive potential abuse and form a complaint but also the training required of the investigators. You mentioned that a lot of my concerns were addressed in the guidelines. Do the guidelines state specifically the type of training investigators should have and the time frame for complaints investigation?

CHAIR—I have to confess to not having read the guidelines from beginning to end, but I suspect that at least some of those things are not in there.

Ms Kelly—That is fairly crucial. If there were an investigation body that did not have psychologists trained in detecting signs of abuse, specialists in dementia, specific training in both aged care and signs of violence, then it would be concerning. What did the participants think about the suggestions about workloads and staffing ratios? Do people think it is possible to have a reporting system where there might be one staff member alone overnight or—

CHAIR—I am not sure of the answer to your question, but it is probably not a matter that we can have a dialogue about at the moment. We might proceed to have other questions by other committee members at this point.

Senator McLUCAS—I will start with that question about staffing; it has been raised by a number of submitters. In fact I think one of the submissions goes as far as to say that the regime will not deliver any further protection for older people who live in residential aged care unless we have more staff to deliver it. Your submission is very clear. What evidence do you have to support the need for increased staffing levels?

Ms Kelly—That is a really hard question. We have done a paper on existing staffing levels, and I guess a call for improved research on that would be fabulous. The National Institute of Labour Studies survey describes itself as a census in the industry. I do not have the figures handy on the number of facilities they

surveyed, but the survey results are skewed towards community rather than private providers and did not give a complete picture of staffing ratios across the sector.

Senator McLUCAS—Maybe, Ms Kelly, you could direct us to that report. I think I know the one you were referring to. We will be able to have a look at your proposal. It is somewhat outside the scope of this particular legislation, but the fact that a number of submissions go to the question of the numbers of staff that should be required in aged care is worth thinking about.

Ms Kelly—Yes. It is an implementation issue that does not fit neatly into legislation around mandatory reporting, but it is an on-the-ground issue such that if you do not get it right a technical regime for reporting will become completely useless. On the ground you have to have the time. From what I can see, having done policy consultations, the carers I am speaking to barely have the time to complete basic care tasks. We did a recent survey in WA and found that high percentages of carers, around 60 per cent, were saying that they did not have time to complete basic care tasks, were struggling to do so in one shift space and were working overtime to do so. If that is the case, there is not a lot of time for personal interaction between residents and carers, and that is when issues like abuse are going to be detected.

Senator McLUCAS—Going to the timetable that we are marching along to in very quick time, this committee is to report by 9 March. You may have heard that I previously asked a similar question to Australian Unity. We report on 9 March. The legislation has to pass the parliament. The regulations have to be first of all seen and then passed, and we are meant to start on 1 April. My question goes to training. In a practical sense, is that a reasonable time frame?

Ms Kelly—Absolutely not. There was a view to having the legislation up and running by April. That is correct, is it not?

Senator McLUCAS—Yes, the legislation says that it will commence on 1 April.

Ms Kelly—Yes. Every staff member in the sector would need to be trained and will therefore be legally obligated to report from April. Logistically, I do not know how that is feasible. I think that is a view that is fairly common amongst both the unions and the providers in the sector. It was raised at the National Aged Care Alliance meeting a few weeks ago in Melbourne.

Senator McLUCAS—I need to correct the record. We are reporting on 14 March, not 9 March; I apologise. I might leave it there. Thank you very much for your submission. I know everyone has had to pull them together in very quick time.

Ms Kelly—Yes, I apologise. It is rather embarrassing. I have been flat out, and I pulled it together very quickly and did not include a lot of ratio figures. I will have a look at the guidelines, see how specific they are around training and make a further submission.

Senator McLUCAS—We appreciate your submission. Thank you.

Senator MOORE—I have two questions. One is to do with training. It is my understanding that staff can currently access training—there is training available currently in some places—on these issues of elder abuse but it is not available everywhere, it is not regulated and not everybody gets the chance to do it. Are you aware of or have you been told by your members of their experiences of any similar training of this nature?

Ms Kelly—I am not, to be honest. I did not have time to do the consultation with members.

Senator MOORE—I was just wondering whether you had any feedback. My understanding of the legislation is that it regulates practice that should already be in place—that there is already awareness of issues to do with people having poor treatment and that staff members across the board in some places already have training. I will ask elsewhere. My second question is on awareness and how you inform all the people who will be part of this mandatory process of their rights and whether you have any ideas about the mandatory element of reporting. From your point of view, as an opinion, how do you ensure that people are aware of their rights and feel confident in taking up their rights?

Ms Kelly—I think for that to happen there would need to be a culture of care that, from what I have experienced, just does not exist in Australian aged care. From what I have seen, there are no mandatory minimum qualifications. You have a decline of nurses in the sector and an increase in PCAs who are paid a minimum of $15 an hour and are rushed off their feet. The findings of the NILS survey, which interviewed 6,000 care staff, were that only 18 per cent of residential care staff felt they had enough time to care for residents. If you do not have enough time to complete basic care tasks and you are paid $15 an hour—and,

anecdotally, members tell us that it is common to be left alone overnight to care for 50 residents—in that situation there is no-one to report on carers.

In an ANU study by Dr Tony Schumacher Jones, 80 per cent of PCAs reported being given work that was impossible to finish in one shift. This paints a picture of a fairly under-resourced sector. You need to respect the role of care workers and have mandatory training with nationally consistent standards, fair remuneration and training that is not rushed through for the sake of political expediency to ensure that people feel safe reporting. Again, they now know there is a complaints mechanism that has already had a number of problems raised about it and which is going to operate internally to the department that funds facilities. I do not hold a lot of hope for it functioning well to address the difficulties of elder abuse in the short term.

Senator MOORE—A point was raised in previous evidence about the sheer mechanics of how you handle a complaint based system. If a complaint has been made and it is going through the process, from a staff point of view—I know that you have a couple of different perspectives, but I am asking about your point of view as an organisation that represents staff members—should a staff member be suspended? What process should be put in place at that stage?

You may want to take that question on notice and think about it and other areas. It is about a mechanical aspect of the implementation of a new system. Each organisation that I am aware of has its own guidelines now, but once we translate to a nationally determined process we are going to have to be aware of this stuff. I know this is another piece of work for you, but it would be useful if you could respond to this question on notice in the future.

Ms Kelly—We have not yet developed a formal policy position. It is a really difficult situation in which to balance and respect each party's rights. We would be inclined from initial consultations to suggest that there could be something in between suspending someone and leaving them on their normal care tasks. There are alternative forms of work that can be found—again, it comes down to staffing ratios—and additional forms of supervision that could be offered. I will take that question away and come back with a more thorough answer.

Senator McLUCAS—We will raise with the department your point about people not necessarily being terminated but having their hours cut.

Ms Kelly—That would be much appreciated.

Senator McLUCAS—The way I read the bill, I think the issue is covered—but I am not a lawyer.

CHAIR—Ms Kelly, if you have any further comments you want to make on the guidelines, please feel free to do so. If possible, we would like to see those comments within the next week because we have a reporting deadline to make. Thank you for your evidence today.

[5.14 pm]

MUNDY, Mr Gregory Philip, Chief Executive Officer, Aged and Community Services Australia

YOUNG, Mr Rod, Chief Executive Officer, Aged Care Association Australia

CHAIR—Welcome. I think I have seen both of you at Senate committees at various stages, so I think you know the rules about parliamentary privilege and the protection of witnesses. Senator Adams asked me to apologise to both organisations for her inability to be here today. She has a clashing commitment and was not able to make it. But there are plenty of other senators around the table to ask you some questions. Before we do that, though, I invite each of you to make a short opening statement, perhaps starting with Mr Mundy.

Mr Mundy—We have been involved in consultation with the Department of Health and Ageing and in fact the minister on the development of the range of measures to respond to elder abuse, so we have been party to previous discussions up to this point. Nonetheless, we do have some comments on the draft bill, because there is always a level of detail which cannot be picked up in advance. We support the bill. We think it is required as a response to the issue of elder abuse.

We do support the direction of the changes for the Aged Care Commissioner. There is a large volume of cases that cannot be dealt with by a dispute resolution mechanism—they are not capable of resolution—and this bill recognises that fact. The investigatory powers, I think, may well prove to clear up a lot of things that otherwise are not capable of closure, so we support that. We will have a very close interest in the development of the principles that will govern the exercise of those investigatory powers, which are not yet on the table, and the guidelines that are in the submission from the Department of Health and Ageing do not yet go to that level of detail. So that is something that we would flag that will be of quite a lot of interest to us following passage of the bill.

We also support the role of the Aged Care Commissioner being able to investigate the actions of the Aged Care Standards and Accreditation Agency. We think that represents a more even-handed approach. There is not anyone really charged with that remit systematically at present, and we think that fills a gap that gives a bit more symmetry to the regulatory regime.

In terms of the compulsory reporting regime, we are certainly appreciative of the fact that provision has been made for exceptions to the requirement to compulsorily report incidents of abuse to the department and the police. We are concerned that those may need some greater clarification. What, for example, will count as a mental impairment, and who is empowered to determine that you have one? Our feeling is that that is a relatively narrow form of exception that may not in fact do the entire work that it is required to do to avoid taking things to the police and the department that are not capable of being dealt with by those parties.

We do have another concern which has been raised in some of the development of the bill to this point—that is, the proposed act appears to require our members to report suspected or alleged incidents of abuse regardless of whether the alleged victim of that abuse consents to having that abuse reported and, in fact, in the face of their refusal to have such abuse reported to anyone. Someone gave me a very sharp example of that very recently—on Sunday, in fact: a case where a female resident had been assaulted by her daughter. It was a technical assault. It would probably be in scope for what is in the draft bill. But the resident absolutely did not want that incident reported to the police. Yes, it was an assault, but, no, they did not want it reported.

It seems to me that there is a risk here—that we risk treating older people like children and denying them rights that we would actually give to any other competent adults. I recognise that that is not an easy thing to deal with, but it does trouble me that we are giving older people fewer rights than we would to anyone else, simply because they are residents in residential care. I think that is a difficult thing to do. We are actually denying people rights that other citizens would have.

There are some other things which we have highlighted in our submission, which perhaps are matters of detail. As you have certainly read the submission, I will not go into them unless you have questions. We have received some advice since we prepared the submission, on the weekend, from our lawyers, who have made some technical points that they think are not clear to them as lawyers, which I can run through very quickly. It will not take terribly long.

They make the point that the phrase ‘unreasonable use of force’ may well encompass both criminal and non-criminal conduct as an expression, and why would you report non-criminal conduct to the police? So that was a suggestion of something that required clarification from their point of view.

They make the point, which I think is a good point, that the whistleblower protection provisions do not actually extend to anyone other than staff members, so they do not apply to residents, to family members or to visitors, and yet any one of those people might be the person who identifies something that needs to be reported, and they possibly would warrant some protection too. I think that is a very good point. They make some technical points about what happens with incidents that happen before the legislation is enacted—are they still capable of being reported once the legislation comes in? That raises the legal point of potential double jeopardy. It is a good point, I think.

Both the legislation and the explanatory memorandum appear to say that an allegation must be reported whether it is based on reasonable grounds or not, but suspicions have to be on reasonable grounds. They query, 'Why wouldn't the same test of reasonableness apply both to allegations and to suspicions?' That may be an interpretation that follows from the way those sentences have been constructed, but they say that it appears that there is a different standard for allegations and suspicions, and in fact both should be based on reasonable grounds.

Another point that they have raised is that the definition of a reportable assault is not limited to assaults which take place at the residential care facility. In circumstances where residents might leave the facility to do something else, maybe this is an issue that needs to be picked up in either the principles or the guidelines. It is not clear where the legal responsibility starts and finishes. They are still residents of the facility, but they may in fact suffer some incident when they are visiting their GP, visiting a hospital or simply at the shops.

One of the things that we are concerned with, and it should be something that is the subject of the principles made under the act, is that we do have sufficient attention to principles of natural justice and due process in the operations of all of these provisions, including those that apply to the commissioner. There are some questions of detail that we would have: does that extend to allowing people legal representation or not? There are arguments either way, but it does need to be clear whether that is or is not intended in those operations.

It is also observed that the notice of required actions will also need some definition as to whether they are intended to extend to punitive sanctions or compensatory payments, which have been the subject of adverse findings from the Administrative Appeals Tribunal in the past. In our view, it would be safer if they did not, but it is something that is not precisely specified in the bill as it is currently drafted. The other issue, I think, that does need some clarification—

Senator MOORE—I am a little unclear. That is quite a specialised point about the penalties and the effect with the AAT. Could you just go through that last sentence again, so I can get that last issue clear.

Mr Mundy—Under the legislation, the department can issue a notice of required action on the approved provider. It is not clear to us or to our lawyers exactly what can come under a notice of required action. If it includes sanctions, or if it includes compensatory payments—I think it probably should not, but it is not clear to me or from the bill that it does not—in the past the AAT have said, 'No, that's too broad.' Maybe they would just say that again, but it might be better to define that before it gets out there.

Senator MOORE—Thank you.

Mr Mundy—The last point I will make is that there might need to be some greater clarity about who is or is not a staff member. We have put a lot of attention to that in getting to this point, but we think the whistleblower provisions, for example, would be difficult to apply to the staff of contractors, who are only under our members' supervision for the time they are working for us. When they go back and work for Acme Agency, they are working for someone else, and we actually have no control over what might happen once they are not on our particular contract.

There is also a little bit of ambiguity about when a staff member becomes the approved provider. Approved providers and staff members are distinguished for this purpose for one set of reasons, but in fact a staff member can actually be the approved provider in other parts of the Aged Care Act. So, again, it may be something that could be effectively dealt with in the principles, or it may be that it is a false distinction, but it is not quite clear where one starts and one finishes.

That is probably sufficient by way of introductory remarks. I am sorry to bring in new material, but, as has been acknowledged, the time lines have been relatively truncated. You can deal with things when you get them and not before.

CHAIR—That is fine. Thank you, Mr Mundy. Mr Young?

Mr Young—We are substantially supportive of the legislation, particularly in the context of endeavours to maintain and improve community confidence in the security of residents. We have certainly been an organisation that has been asking government to change the complaints resolution scheme. In the context of creating a new structure, we are quite pleased that, from the start-up date, the existing scheme is being done away with to provide a lot more investigative capacities to the department because it does substantially improve and, in our opinion, create a level of procedural fairness that does not really exist in the current scheme and allows for matters to be dealt with rather more expeditiously by the department than what we currently have. I will leave my comments there and answer questions from senators. Other issues are obviously addressed within the report, but we have generally been supportive. We have raised a number of issues in our submission that we would be happy to address or comment on further if you wish.

CHAIR—Thank you very much for that.

Senator McLUCAS—I will go to the question of the time frame. We have talked with a number of witnesses to date about that. We report on 14 March, the bill has to pass the Senate and we have to see the principles, and we are meant to start on 1 April.

Mr Young—We put in our submission that we think 1 April is a very difficult start-up time frame. Given the timelines that you just outlined, the ability of the department to be able to put guidelines out to the industry cannot be any earlier than the date on which the legislation is passed by both houses. On current timelines, it is fairly likely that the bill will be passed and granted by the start-up date of 1 April. We cannot see any reason, particularly given that aged-care providers are in the process of getting the new procedures in place and obtaining police checks for new and existing staff, why we could not set a start-up date for this component two months hence, which was our suggestion in our submission.

Senator McLUCAS—Mr Mundy, would you like to comment on that?

Mr Mundy—I do not think there is any way it can happen on 1 April, to be quite honest. Sometimes things officially happen on a date but in practice happen on some subsequent date. That could also happen here. There are quite a lot of steps before the finalisation of the legislation which is yet to occur. Presumably the bill will be passed before the House rises, but I guess we cannot assume that. I think it is just too short a period of time. Some of the things could happen on 1 April, but I think getting the people apprised of and trained in their new responsibilities would take longer than that.

Senator McLUCAS—In terms of the training, Australian Unity suggested they would need a full week. My view of Australian Unity then is that they must be very good at training!

Mr Mundy—I understood their response to mean that, once they had developed all the materials and organised the training, it would take a whole week to get every member of their staff through the training. But there is a lot of lead time before that and presumably some follow-up afterwards to make sure that it has been effective, I would have said it would take more like eight weeks to do all of that and to do it thoroughly. People want to get on with this, but you cannot do the impossible.

Senator McLUCAS—What is happening on the ground now with the development of those training materials?

Mr Mundy—A variety of things are occurring. There has been some effort made by the industry to develop general materials on the issue of elder abuse. My own organisation has produced a brochure, for example, for use by staff which we did at our own expense. We ran off 200,000 of those which are virtually all gone because they proved to be quite popular.

Senator MOORE—When was that done?

Mr Mundy—Late last year.

Senator McLUCAS—So beforehand?

Mr Mundy—It is called 'How to recognise and address elder abuse'. It is really an orientation tool for staff, because if elder abuse were obvious we would not have a problem. It is because it is insidious that we have to put some effort into training staff to look out for the signs, I guess. We have also produced some other resources of a general nature. What is required with this bill is quite specific information, briefing and training on how to follow these new procedural requirements and that is a different order of training. It needs proper materials developed: 'If you see this you must do that. This is your obligation under the act.' That could, in the fullness of time, be integrated into existing induction training of staff, existing in-service training of staff. The certificate III in aged care is part of the community services training package which is currently under review

and it is the sort of thing that you would expect to be picked up by that review and incorporated in the specification, but that will not result in upgraded training courses until well into 2008. So it is a much longer timeline. In the fullness of time it will be. The units currently have existing requirements. But we will need something in advance of that so people are familiar with these new procedures.

Senator McLUCAS—Did you have any comments, Mr Young?

Mr Young—I agree with Mr Mundy. It is going to take a considerable amount of implementation, policy and HR function, reintegration and education for staff. That is not going to be a slow process but it is going to take time. Probably the most important thing for providers is re-educating their staff on their HR policies and procedures, who the reporting lines are required to be compliant with and who the stand-in staff member is in various circumstances so that it is quite specific to staffers what their responsibilities are and to whom and what sort of time frame they have to respond in.

Mr Mundy—If I could add to my answer, I would say it is weeks, not months. I am not making an open-ended sort of claim that we need an infinite amount of time in which to do it. It is doable but it will take a matter of several weeks. One of the reasons I say that is that many organisations already have procedures in place, but what they will need to do is to check that what they have always been doing actually complies with the act. That is the first step. If the answer to that is yes to 100 per cent, they might be able to stop there; but if the answer is, 'It does to 80 per cent but we need to change these new things,' that seems to me like a matter of several weeks work to do it properly.

Senator McLUCAS—What role should the department play in the development of that training material?

Mr Young—I am not sure the department should do a great deal more than providing the guidelines that will then be used by industry organisations like ours, other training companies, VET training et cetera into other programs as was touched on earlier.

Senator McLUCAS—Mr Young, I thought you were going to request some money to assist in rolling out the training! I have got one other issue. The question of when a provider can use their discretion not to report a reportable incident, let us call it, because the alleged perpetrator has a mental impairment has been raised with me by providers. It is on the basis that the provider can use that discretion because they have a diagnosed mental impairment according to the proposed act. It has been put to me that that is often not the case in a technical sense, that they will not have had a medical diagnosis of their impairment that sits on their medical record.

Mr Young—Can I answer your question to start with. I have been wont to use my own mother's experience in discussing this on a number of occasions to date, so I might as well continue with my dear mother as an example. My mother is in care. She was diagnosed with dementia some years ago. My understanding of that part of the legislation—but we may need to clarify this when it is included and then develop it further in the principles—is that the diagnosis could be from a GP or a geriatrician; if the staff in the facility itself made a diagnosis, that would meet—

Senator McLUCAS—Staff can as well?

Mr Young—Staff within facilities do already provide clear definitions of behavioural difficulties in some circumstances. A GP might do it. Usually staff, having made a determination or an assessment of that nature, would ask a GP to verify it—or, if available, a geriatrician. That would then lead to an amendment to the care plan for that individual which would have a behavioural modification component or management component. My understanding is that the resident would be somebody who has been diagnosed through one of those processes and that that has then led to a behaviour management component within the resident's care plan.

Going back to my mother as an example, my mother has been both the perpetrator, I must unfortunately admit, of an assault on another resident and the recipient of such conduct, neither of which were done in anger. It was purely management issues. The facilities, the moment these things happened, rang me and discussed the issue, and we called in a GP or a geriatrician or whatever was appropriate. But neither instance was a situation in which I would, for the life of me, consider it appropriate to have the police involved, because (a) she would not be able to tell them, the next day, anything about the event in either instance and (b) it would have been totally inappropriate for it to have been turned into a criminal investigation by police. Both matters, using that as an example, were handled directly by staff. They were treated as a clinical issue and they were converted into changed medication in one instance and behaviour management in the other, for the other resident who perpetrated the incident on my mother.

So there is clearly a need to be able to manage that sort of situation in a clinical response, in a behaviour management response, whilst at the same time having facilities being responsible. If it is a matter of a serious assault, as we do in the main now—and I do not pretend we are perfect in that—the providers would report it to the police and to the department.

Senator McLUCAS—I suppose the point I was getting to was the diagnosis of the mental impairment. You are of the view that that diagnosis is not necessarily a direct clinical diagnosis that would appear in the person's GP records as opposed to—

Mr Young—If it is done by the GP, yes.

Senator McLUCAS—in the care plan.

Mr Young—Yes. If it is done by the GP, you will have some diagnosis. If it is done by the geriatrician, it is the same. If the nursing staff in the facility do it then there will be a series of documents, either assessment tools or observation tools, which will go into the clinical notes for that resident. So yes, there will be clear documentary evidence of an assessment and a diagnosis having been made through one of those channels.

Senator McLUCAS—Thank you; you have cleared that up for me. Thank you very much.

CHAIR—Senator Moore, do you have questions?

Senator MOORE—Mr Young, how would the issues you just described be affected by the current legislation, from your reading of it?

Mr Young—I guess it just brings into sharper focus the issue of being aware and making a clear management decision—are we talking about the same issue we have just been discussing?

Senator MOORE—Yes. I am very interested in bringing the legislation to bear on incidents we know of.

Mr Young—I think it brings into sharper focus the fact that you must be very aware that you are making a management decision about this resident and how their behaviour will be managed more appropriately in the future. And, if it goes beyond that, then we have the requirement of the legislation to report through the two channels that we are required to.

Senator MOORE—From your reading of the proposed legislation and the guidelines—we are waiting for the principles—do you think that those cases you just explained would be subject to compulsory reporting?

Mr Young—My belief is no, they would not, not for the sort of example I just gave of my own mother, because that is the way I think they should be treated.

Senator MOORE—How they should be treated?

Mr Young—That is the way they should be treated in this new system, under this new legislation. What we are also trying to avoid is having every incident reported into the system because then basically things that should be investigated would get covered with the volume of material reported.

Senator MOORE—I am not clear, Mr Young. In exactly the cases that you just explained, I am not clear from what I have read of the legislation and the guidelines whether or not they would have to be reported. That is the lack of clarity that I personally have at the moment. We will take it up with the department. But I think your issue has really raised that uncertainty for me, just having knowledge of it; instead of talking about theory all the time, that is a real case. We will ask the department about it. It would be very useful to know how that would operate.

That leads to my next question to both of you. These issues about security and safety have been talked about for a long time. The minister has now brought forward legislation to respond to that. You have both raised a number of points in your submissions and in your evidence today that you think require more definition or clarity before you are absolutely comfortable with them. Up till now, what process has there been for you to raise that with the department?

Mr Mundy—We had a series of meetings—I think it was four—of the Aged Care Advisory Committee during the course of 2006. The minister himself attended most, if not all, of those. We have had extensive discussions with a wide range of stakeholders representing the medical people, the nurses, the providers, consumer groups and so on. That has been a productive process and it was an effective consultation process in many respects.

I think it is fair to say that the very clause we are talking about, on allowing exceptions to the compulsory reporting of incidents, came about as a result of input from that committee. I cannot speak for what was in

people's minds, but certainly I think committee members would agree that it was the result of their raising the issue and of their advocacy for having an exception to having to report absolutely everything. In that respect it was a very effective consultation process. But because the legislation is very complicated and because the act that it is amending is very complicated, every time we take a step forward a whole new set of questions is revealed, because you have just moved down one layer of detail. That is a familiar experience with changes to the Aged Care Act.

Of course, once the bill is in the House it gets opened up to a much wider group of people to have a look at it with fresh eyes—people who have not been down the developmental path and who can see it and say, 'Well, you might have thought you were following this particular train of thought but to us it looks quite different.' When the bill becomes an act, those are the people who will be subject to it, not those who have been involved in the detailed development. So we have fresh input with fresh eyes because it has been exposed through being a bill in the House, which is a good process.

Having this inquiry into it is also a good process, because it is a very complex area that involves a delicate balancing of different rights, responsibilities and duties. I think it is very appropriate to proceed cautiously to make sure that, in pursuit of one objective, which is the safety and protection of older people, we do not compromise a whole lot of other objectives which on other days we would hold equally dear.

Senator MOORE—That is a common theme of so many of the submissions: how you actually achieve that balance. Mr Mundy, have you provided the specific points you raised earlier in verbal evidence, in terms of your legal advice and so on, to the department?

Mr Mundy—I got it at 9.30 last night, so the short answer is no. But I can do.

Senator MOORE—From our perspective, they are the kinds of details people are trying to work their way through in a genuine attempt to get the best legislation.

Mr Mundy—Yes, I think these are the sorts of things that legislation drafters would quite appreciate, because they enable them to say, 'Yes, we've covered that; you haven't understood it,' or, 'No, we haven't.' I am quite happy to provide these to the department.

Senator McLUCAS—And to the committee as well.

Senator MOORE—Yes, it is a double whammy: getting it there and then the process in getting the detail right. Often the aims and expectations are generally accepted and it is a matter of getting the detail right. Mr Young, what is your perspective in terms of the process? So many say, 'We accept and welcome the legislation, we respect the desired outcomes, but—' Have you raised the kinds of issues you have raised in your submission with the department in a consultative program up until now?

Mr Young—Yes, but I would reiterate what Mr Mundy said. There have been four industry-wide consultative meetings and then further meetings with the department on detail since those, over the last 12 months. I think that has been most useful in raising the issues and raising the concerns of various stakeholders, and in a number of us changing our opinions as that process has gone on.

Senator MOORE—Which is how it operates. Have you raised the particular things you raised in your submission directly with the department?

Mr Young—Yes, I think they have been raised—that is, other than things like the dual continuation of the scheme, which has not been raised previously because it was not until we saw this that we realised there would be a continuation of both, and there are things like the timetable that we are now facing. It is a matter that has only been raised now because we are getting so close to implementation date and we are concerned, and the process in train now with providers about police checks is starting to bunch up in the same time frame.

Senator MOORE—In the interests of time—it is right on time now—is it possible for either of you gentleman to give us your thoughts about what form of information campaign you think would be most effective in ensuring that all the people who will be caught by this legislation know their rights and will be able to access them? I know that there are many forms of information about knowing your rights already. You brought out your document on your induction process; if we can get a copy of that, it would be very useful—you can send it to us later. To help us ensure that the people at whom this legislation is directed—

Mr Young—Do you mean for staff, residents, relatives or everyone?

Senator MOORE—Everyone. From your perspective, certainly, I am sure you are struggling with how everybody understands it. In your case in particular, you have your staff training, as Senator McLucas has

worked through. I am more interested in how families, residents, visitors and everybody that comes into your ambit understand what their responsibilities are.

Mr Young—I think there is already a fairly comprehensive system—and we cannot ignore what is already in place—

Senator MOORE—Certainly.

Mr Young—of distribution of information to residents, their families and friends et cetera about the complaints resolution scheme as it currently stands: the numbers you can ring, the fact that it is available, the fact that if you are not satisfied locally you can make a complaint about the service, care or whatever might be irking you at the time. I do not think it is as large a task as you might be imagining, because those systems and information services are already there. There is a fairly wide—

Senator MOORE—Are you absolutely confident that everybody understands and uses that? That is my question.

Mr Young—I do not think that you can be confident that everybody understands.

Senator MOORE—That is right.

Mr Young—That is impossible in any system where we have half a million people.

Senator MOORE—In terms of the introduction of this legislation—and we have been told it is about meeting a need that has been identified—the core element is going to be whether people understand the process and use it. I have seen what you have now. I have seen the complaints information line. But I am interested to hear from the people who are in the industry what can be done better to ensure that these changes and the reason for these changes are understood. If you could get that for me, that would be useful. Mr Mundy, if you could do the same, that would be very useful.

Mr Mundy—I have made a note. In fact, there are people other than ourselves that we should ask about those sorts of things. One of the lessons I think that everyone has learned about preparing information products is that there is no substitute for asking the people for whom they are designed in person what it is they need to know and how they need to know it. We can certainly put in a supplementary submission on that point.

Senator MOORE—Thank you.

CHAIR—I have been listening to what you have had to say about the need for the reporting regime to be more flexible about when incidents are reported. I take the point that you have made about cases like the demented parent who makes complaints that really you do not want followed up at all with the police force. I make a general observation: I am sure there would be countless incidents where a lack of mandatory reporting would be quite appropriate in all the circumstances. It is probably also true to say that the general public would have a greater focus on that hopefully very small end of the market where you find people behaving quite unethically in the aged care sector—you might call them the kerosene bath type of operators—and the community is galvanised by outrage that those things are allowed to happen.

It would be cold comfort to the minister of the day in those circumstances in which an incident of abuse arises which has not been reported by virtue of the fact that we have softened the rules on compulsory reporting to accommodate the things that you have been talking about for him or her to be able to say: 'There are thousands of cases in which this reporting does not need to occur. It is just unfortunate that Mrs Jones in this particular nursing home has ended up having her complaints ignored because the operator was unscrupulous about these things.' I suppose I am asking you this: how do you think we can realistically deal with those sorts of incidents—those sorts of extreme cases—if we relax the rules for reporting in the way that you have been suggesting?

Mr Mundy—I will respond to that. I have a view about how it can be done in a way that strikes a different balance between the respective rights of residents and those of organisations, including the department and the minister. The lack of reporting of an incident should not be taken to imply a lack of action on the incident. If there are behavioural incidents that occur that are in the scope of this, it would certainly be our expectation that there would be a requirement for them to be logged and recorded in a resident's file. There should not be a non-recording of them. Those records are the very sorts of things that the Aged Care Standards and Accreditation Agency looks at to make sure that people have appropriate care regimes in place.

My perspective on this issue is that we need to not compromise the care of our residents—and I am putting a very harsh construction on this—in order to protect either bureaucratic or political reputation. We should place the residents' care needs at the top of our hierarchy of needs, and while things like protecting a minister

from the sorts of complaints that you outlined is not a trivial concern, in my view it should come behind or after providing the best possible care to the resident. I concede that there is a balance that needs to be struck. We would not suggest that not reporting something compulsorily does not mean to say that there will be incidents that should be reported and it certainly does not mean that all incidents should not be recorded such that they are available for scrutiny by external bodies in the normal fashion. I would not like to see us introduce something that compromised the rights of residents in order to protect either the department or ministers. That would be putting things in the wrong order.

Mr Young—Going back to my example, I would like to add that both instances that I used as examples were reported to me as the family representative and to the GP, and behavioural management activity occurred. My question is: of what earthly benefit would bringing the police in be in that situation? I do not for a moment suggest that we should not contact the police if it is a serious matter. If there is an issue regarding sexual conduct, bringing the police in should be automatic, in my opinion. But where it is assault of a minor nature then it is a matter that needs to have some management discretion at the local level, because those are the people who are handling it. If you say that every incident is going to come out of our hands and we will be compulsorily required to report this to the police and to the department, then what is likely to happen is that everything will be reported, which will create a huge backlog of reports to the police that will not get investigated. When we have serious matters that require police intervention, they are likely to treat us as a sheep in wolf's clothing, so to speak, and ignore the event. We need to have that balance. These are the people who are providing the care. They understand the behaviour. If they have made a judgment call that has been proved to be wrong, provided that they have recorded the event as Mr Mundy has said, then their consultation with a GP or whatever action they have taken to manage the conduct will form part of the documentary evidence, and that is the important thing. The obligation on us should be that once it goes beyond a certain level it becomes then a reportable event.

Mr Mundy—Adding to what Mr Young has just said, we have lots of other checks and balances built into this bill. It is not just the reporting that would expose abuse. There are also the new complaints procedures and the protections for staff from nuisance complaints. There are lots of other things that help reduce the risk that bad behaviour would be covered up. There is probably enough without having the absolute automatic reporting of everything to people who are not really in a position to do much about it.

CHAIR—Okay. Earlier today, some other witnesses suggested some modifications to the regime that is in the legislation. Australian Unity, for example—I am not sure if you were here when they were giving their evidence—

Mr Mundy—Not for that bit.

CHAIR—suggested that there should be a discretion for a provider not to report a complaint or an incident to the police where they felt that it was trivial and could not be substantiated, as long as a family member were advised of the incident; and, if they believed it should be investigated, then it would automatically go on to the police. Would you support that suggestion?

Mr Mundy—What I had in mind with my last comment was that they can certainly take action through the complaints process. You could short-circuit that and say they should have a right to require it in any event. The only complicating factor there would be that you might have instances where a family member wants it reported but the resident does not. In my view, that is actually not a conflict because, provided they are mentally competent, it is actually the victim's rights that again have to sit at the apex of that hierarchy. But I think a modification to the legislation along those lines would be quite constructive. I think we need to leave the care issues as much as we can within the realm of care and the judicial issues as much as possible outside of that.

Mr Young—There is one further issue on top of that that I think we need to bear in mind, because we do end up in this situation on a fairly regular basis, and that is where you have two family members instructing the facility to do two different things. It is fine if there is someone with the full power of attorney, as in my case—I have that, but my siblings' wishes are always taken into account. But we do end up quite regularly with families instructing the facility to do different things and nobody has ultimate power of attorney in respect of that person's interests.

CHAIR—I would suggest that, if we were going to modify the present compulsory reporting arrangements in every instance, it would be wise to take the position that anybody who legitimately had an interest in that person's welfare, anybody who wanted the matter to be pursued with the police, ought to have that matter

taken forward. It would be very dangerous to say, 'Well, it's a question of what the preponderant opinion is,' or whatever.

Mr Mundy—In fact, they may have that right in any event—of a direct report to the police. Irrespective of what we put in the bill, they could perhaps report it directly anyway. I suspect they could. But I think it would be a useful amendment; it goes in the sort of direction that we think is appropriate.

CHAIR—There are certain processes protected by the legislation where the provider makes the complaint. I have another question for you, Mr Young. You are suggesting a modification of the reporting arrangements with respect to staff of a provider. You point out that the legislation currently provides that an employee can notify the approved provider, one of their key personnel, another person authorised to receive complaints or the secretary of the department. You are suggesting that that should be modified to take into account the provider's own hierarchy of complaints. I see your point, but is it not possible we might end up with delayed reporting in those circumstances, where, say, the provider says, 'You must tell the manager of the facility,' and the manager of the facility is not around, and the—

Mr Young—That is possible, Senator, but potentially—thinking about the consequences of how the legislation is worded at the moment—a staff member could simply go straight to the secretary, and the approved provider, key personnel and/or the reporting person to whom, according to the policy procedures in that facility, the employee should have reported to would be just ignored or bypassed. I am not sure how I would respond to a situation where a staff member did that without going through the channels. If the staff member goes through the channels and no action is taken, it is a different matter. But it leaves it open to the absolute discretion of the employee to decide where they will report to, and I think that is what I have difficulty with. There should be a requirement with an escalation and, if there is no action or the employee is dissatisfied with the steps that have been taken by the approved provider, key personnel, reporting line supervisor, whoever it might be, then there might be that recourse for the staff member of going further up the line. But at the moment it is absolutely at the discretion of the employee to determine where they will report. If an employee determined to go straight to the secretary, we would end up with the secretary coming back and saying to the approved provider or key personnel, 'We have this report; what's going on?' That might put the approved provider or key personnel in a very difficult position.

CHAIR—Is it reasonable, though, putting the case of the secretary to one side, that anybody in the organisation listed in that clause ought to be able to be advised of this to make sure that the report goes in promptly?

Mr Young—Yes, I am just suggesting that it should, however, be in ascending order rather than just being open-ended and that you can report to whom you wish at any point of time. It should, in the first instance, follow the policy processes of the organisation as to who the persons you should report to are. If that does not escalate to some result, then the other alternative could be available to the employee. All I am pointing out is that the way I read the legislation at the moment it simply leaves it at the discretion of the employee to say to whom they will report the incident. I do not think that is good management of issues like that, if employees can just report willy-nilly without any recognition of the processes within the facility.

Mr Mundy—If I could just add to that reply, one of the resources that we have developed and made available—it is on our website—is the set of draft policies and procedures initially developed by the Benevolent Society of New South Wales. There is also some other material we have gathered from Good Practice and other organisations. They are the sorts of tools that people can use to develop their own organisational policies and procedures around these very measures. They were done before the bill was available, so they will need to incorporate those requirements.

One of the things they recommend to staff is, if you see something that is untoward, report it to your supervisor on the grounds that that is a straightforward, common-sense, immediately understandable thing to do. But, if you cannot report it to your supervisor for various reasons, including that it might be about them, then you should take it somewhere else. So the straightforward response is the one that you lead with in training people—report it to your supervisor if you see something that is dodgy—but, if you cannot or you are not comfortable doing that, then there are all these other avenues that are available to you.

CHAIR—Thank you very much for your time today and for the evidence you provided in your submissions and before the committee. If you have any other comments you want to make to the committee, could we ask for them to be made as promptly as possible so that we can build that in, if necessary, to our report. I am thinking particularly of the guidelines, which I understand you may not have seen or read in detail. You might have some comments to make on those.

[6.03 pm]

FORD, Dr Peter William, Chair, Committee for Care of Older People, Australian Medical Association

YATES, Dr Mark, President, Australian Medical Association, Victoria

CHAIR—Welcome. Do you have any additional information you wish to add at this point?

Dr Ford—I am also a general practitioner in Adelaide and have a wide range of residential aged care patients.

Dr Yates—I am also on the care of older persons committee for the federal AMA. I am a geriatrician at Ballarat Health Services. I am director of subacute medicine. Ballarat Health Services is one of the largest state funded providers of residential aged care. There are 550 residential aged care beds there. Obviously, as a geriatrician, this is an area of considerable concern.

CHAIR—Thank you. We have your submission. You have been provided with information on parliamentary privilege and the protection of witnesses, I understand. Would you like to make a short opening statement before we ask you some questions about your submission?

Dr Ford—Thank you, Chair and Senators, for the opportunity to be present today. There are many aspects of this matter that we could comment on but we have restricted ourselves to an immediate and particular problem. We have no problem with there being no discretion in reporting abuse by healthcare workers of residents. We see that as the primary objective of this legislation, so we have no problem with that. In fact we advocate that and we have advocated that with the minister from the beginning of this matter. However, there should be discretion not to report incidents of resident-on-resident and resident-on-staff abuse at all levels of assault in the residential aged-care sector. I will explain why.

The number of people with some level of cognitive impairment in residential aged care is not limited. On average, about 75 per cent of residents in this sector have some level of cognitive impairment and, quite frankly, the capacity of some of the others is questionable. The number is not well defined in the residential aged-care sector, as cognitive impairment may not be evident when the person is admitted, in their initial medical assessments, and changes in their condition may evolve over time and so, at a given time of consideration, their prior diagnosis may not have been recorded.

Because the number of residents with some form of cognitive impairment in the residential aged-care sector is so large, any compulsion to report to police or the department will dilute resources and divert them from being directed to where the expectation of duty of care is highest—and that is the duty of care that the carers have in this setting. That is where the public and we all expect the greatest outcome.

That does not mean that resident-on-resident and resident-on-staff abuse is insignificant. But the emphasis should be on developing behavioural management strategies to account for those situations. It should be compulsory to record all episodes of inter-resident and resident-on-staff abuse as part of a risk management strategy. I heard the previous speakers referring to that and I will not go on at length on that. But we see that as being an in-house process where a log of incidents would be maintained and that log would be accessible to inspectors. We know that this program will facilitate random inspections specifically for the purpose of assessing abuse in the setting.

There should always remain, though, the discretion to report in any instance. In the case of resident-on-resident abuse, there is still always the capacity to report that to police, in the event that the provider sees that as appropriate. And we would like to emphasise that, in all of these programs, there is a need to allocate appropriate resources to facilitate adequate educational and management programs that minimise all abuse in this setting. So far, we have not been acquainted specifically with a level of detail that would allow us to scrutinise what is proposed here, but we would really like to see an extension of educational and support processes around this legislation.

It is of great concern to us at present that we see de-skilling of staff in the sector. There is a lack of emphasis on registered nurses. We know of instances where one registered nurse is in charge of a setting where there are 100 residents and, frankly, they do not have the capacity to provide adequate supervision. So we would see this as extremely important in rolling out this form of legislation. Thank you.

CHAIR—Do you wish to add any comments, Dr Yates?

Dr Yates—No, I think that what Peter said summarises it. I think what we are asking for is something fairly simple though fundamental. The legislation should focus on issues where the duty of care is highest, and that is the duty of care of healthcare providers—be they personal care attendants or other health professionals—to residents in the residential aged-care sector. That should be the focus of the legislation. And I fear that the legislative power and effect will be diluted in an environment where we set grey and undefined boundaries around what may or may not be reported.

It is well known that cognitive impairment is very difficult sometimes to define. Capacity to make decisions about what is right and wrong is not unilaterally determined by cognitive impairment; it is determined by the event itself. So, you can draw quite clearly distinct and unambiguous lines of responsibility in relation to the responsibility of the health professionals and personal carers and volunteers; whereas I think you start drawing very grey lines of who should and should not be reported about in a compulsory manner when you start looking at resident-to-resident or resident-to-staff issues of abuse. I think that is fairly clear-cut and I can elaborate on that further if needed.

CHAIR—Thank you both for your opening comments. As you probably gather, the committee has spent quite a lot of time this afternoon looking at the nature of the reporting regime and attempting to determine whether it strikes the right balance. The comments you have just made about the appropriateness of an expanded discretion have certainly been made by a number of other witnesses. I put to you, though, that in many respects, as to the comments I made before, the system is characterised in the public mind in such instances by the slowest soldier in the army rather than the average or the best soldier in the army—that is, the provider that is cutting corners or has poor supervision or, for whatever reason, is not meeting high standards. In an instance where abuse is not reported in those circumstances because a discretion is exercised, there will understandably be quite strong public anger and concern arguably about the fact that there has been a relaxation of the reporting requirements that lets that kind of provider get away with not making sure that these things are reported. How do we create a system where those sorts of people, those sorts of operators, are actually dealt with?

Dr Ford—I think you have raised a couple of issues there. At the outset we are advocating reporting. The question is the mechanism or the process. In addition to that there is the issue of defining assault. We see these as quite difficult. From the point of view of people who function and work in this area, we see that this could potentially bring the system down. Say you have a situation where the police are mandated basically to attend every incident and, let us face it, sexual assault, for example, can be seen as minor from some points of view—inappropriate handling in some way. Say a demented person touches somebody else inappropriately—if that happened in another setting, that would be seen as assault. That sort of thing happens daily in this sort of setting. People get into the wrong bed and all sorts of things happen. So we are advocating that those incidents be reported but that it is handled by a different route, that it is handled by an internal mechanism that is transparent, available for people to peruse and the authorities to peruse and that it be open to dispute and, in the event that somebody wishes to take it further, there is always that opportunity. So it is not that we are advocating no attention to this problem; it is just the mechanism by which it is pursued.

Dr Yates—I think the question is often around risk management, and the risks are not only present because of an episode of abuse; there is also risk inherent in the way in which that abuse is addressed. Certainly there is considerable risk, I would have thought, with the concept that a man with significant dementia gets taken away by police for discussion on the basis that an episode was reported. Talking about the lowest common denominator effect, I think there is considerable risk of that event occurring as well in a system as it emerges, particularly as there is going to be a very steep learning curve at the transitional phase. I think in that setting I would advocate that the lowest risk or the best management of risk is to target the events where the public have a very high expectation of duty of care—that is, between a personal care attendant or a healthcare worker in a residential care setting and a resident.

There are understandings, despite anxieties that might be expressed, about the difficulties faced when you have multiple people—75 per cent of residents in the residential aged care sector—with cognitive impairment and how they interact. There is an allowance for a certain degree of variation from the norms of interaction, and to that you have to add that, in fact, we have a public that has a difficulty in understanding relationship formation in older people. So we have to deal with all of that, and I think that, certainly, both at a provider level and at a healthcare deliverer level, there can be quite significant misunderstandings about the way that persons with dementia may act both towards them as healthcare providers and towards others. I would be very concerned about the rights of the person with dementia, who might not present with the nicest characteristics of dementia—maybe with calling out or with personal hygiene problems.

The second question was: if there is an abuse by a person with dementia of either another person with dementia or a personal carer, what happens to that person? If that could be proved, is that an avenue for exit from that residential care-providing environment? I think that there are real issues with addressing those sorts of problems where we might actually confuse what is a very clear message to the public that there will be protection for residents from people with high degrees of duty of care—that is, those employed to look after them—compared to the sorts of interactions that really should be addressed at a risk-management, internal, adverse event type reporting methodology in the residential care sector around inter-resident and resident-to-staff member abuse.

While I can understand the anxieties and the need to try to address this—and why the legislation perhaps in the end got drafted as it did—I still think the error in the drafting is that the lines of ambiguity are too broad at the discretionary point to say, 'Has this bit of abuse occurred because someone has cognitive impairment or not?' An example where it even becomes more confusing is the small percentage of people without cognitive impairment in the residential care setting who can at times be very frustrated by constant visits from other residents. The residential care provider should have a mechanism to manage that, and I think that is the thing that we need to be targeting. But at some point that person might just get frustrated enough to shut the door very quickly, for instance. If that were to cause that person with dementia to topple over and fracture their hip, is that abuse? Would that or should that be reported to the police? Or should that be addressed at an internal level? That is a very severe and, obviously, incredibly unfortunate outcome for the person with dementia, but I am not sure that bringing in a police officer to ask the person who does not have cognitive impairment why they shut the door so hard is really going to help us address issues of risk for the person with dementia.

CHAIR—You assessed a classification of different types of assaulters engendering discretion or not. Where would you place assaults by visitors or family members of residents in that system?

Dr Yates—I think that any assault on a resident in the residential aged care sector, be that by a family member or not, should be non-discretionary. That is the clear line we are drawing: we are saying that assault of a resident is a significant issue. Obviously, families have particular relationships—

CHAIR—Sorry, earlier Dr Ford suggested that a resident-on-resident assault should not have to be reported; there was a discretion about that. Can I be clear: are you saying it should or should not be subject to discretion?

Dr Ford—That is subject to discretion in our view, yes.

CHAIR—Do you agree with that?

Dr Yates—You said 'family member on resident'.

CHAIR—Yes, but you went on to say that the reporting of any assault on a resident should be non-discretionary.

Dr Yates—By someone who is not a resident—and that is the point.

CHAIR—That has answered my question. Thank you.

Senator McLUCAS—Dr Ford, you talked about getting to the point where the system might collapse because we have so much reporting occurring. From your practice, what sorts of numbers are we talking about? Let us break them into categories: resident-on-resident events and other events. I think everyone agrees on 'other events'. We do not have a question about that. They have to be reported. That is clear. What sorts of numbers are we talking about in a proportionate sense?

Dr Ford—To give you some perspective: my practice, which incorporates half-a-dozen doctors, would probably handle 250 patients in a setting. I think that there is the highest level of confidence with regard to staff performance in this area. We see that as the most serious perpetration. I have seen probably a handful of situations in, say, the last 10 years. One was of a sexual nature; the others were rough handling kinds of situations. With respect to resident versus resident, it is almost a daily occurrence. It is happening constantly, quite frankly, so you would have the police there every day in many places. Any institution with 100 patients is probably going to require attendance by the police, depending on how you define assault. I think that is a delicate matter. It is difficult. If the staff or the providers take a defensive approach to this and basically see that they cannot define it and will report everything, then it could become unworkable and the element that we wish to really pursue would fail to be addressed.

Senator McLUCAS—Out of those daily events, if we subdivide them into events that are perpetrated by a person with dementia and events like Dr Yates talked about, where a person is exasperated, which would be a reportable offence under the way the bill is drafted, what sorts of numbers are we talking about?

Dr Ford—I suppose, by definition, 75 to 80 per cent have dementia.

Senator McLUCAS—Of course.

Dr Ford—So it would be the other 20 per cent or so, and of those it is an occasional occurrence. The point Dr Yates was making is that the repercussions of pursuing this and imposing some kind of reaction could be devastating. With regard to taking somebody away, when will they be taken away—in the middle of the night? How will it function? We have all seen situations where perhaps the police may not be acquainted with this sector and may not know how to handle these people. What will their destiny be? I suppose that is at the very nub of the issue with both demented and non-demented perpetrators.

Senator McLUCAS—I would imagine that most of the perpetrators would be residents with dementia.

Dr Ford—Yes—absolutely.

Senator McLUCAS—Are we worrying too much about a quite small number of people who do not have dementia who will be caught in this, doing something for which there is no discretion?

Dr Yates—I certainly agree. We are talking about potentially only 25 per cent of the entire resident population who may not have cognitive impairment and therefore would be caught by the current wording of the bill if they were involved in some sort of abuse. These people are in their home; this is where they have actually chosen to live, because they have signed a consent form. They would have chosen that because they are cognitively alert. So I am not sure what would happen in a setting where they had a reason to be cross or angry.

The other thing is that, knowing that these people are all frail—you have to remember that the average length of life in a nursing home is one year, and 40 per cent of people in nursing homes die in the first six months—you do not know whether they had a delirium at the time they got punchy. They might have been deemed as cognitively normal but then got a urinary tract infection, developed a delirium and got punchy. How do we find that in relation to 'cognitively impaired'?

Then there is the population that acquires new Alzheimer's disease, having been a resident in a residential care environment for many years. They can shift from high to low without ACAS assessment. They move along the line and get gradually more forgetful, but nobody has really recorded it and they are picked up as non cognitively impaired. I think for 25 per cent of the total potential population, we should be leaving people who are resident in the residential-care sector alone in relation to this legislation, except that there should be a requirement for providers to internally record all events of this sort and have a management strategy attached to it. That could either be in standard 1, around improving care, or in standard 2, around behaviour management. There are already accreditation guidelines which could be tweaked by the agency in order to address that very readily.

I would be absolutely stunned if you found a residential provider who never had any—just because they are not recording it—and, as far as I am concerned, they would be out. You would expect the other population to have increasing levels of reporting over the next two years. Finally, it should stabilise and then we should see the strategies work. That is how I would manage active abuse by a resident, but any abuse of a resident by someone external who is not a resident should clearly have the effects of this legislation fully applied.

Senator McLUCAS—As a halfway measure, instead of just recording all episodes where residents have abused residents and only being compelled to report when nonresidents have abused residents, where a resident does not have a diagnosis of mental impairment—and I want to get to that in a minute too—would it be suitable to require that you must record them, as you are suggesting, but must also report that to the department? I am looking for a community safeguard—a community surety—that would give comfort that these 'bad nursing home people' are not just 'getting away with it'.

Dr Ford—I think I heard you correctly. You need to bear in mind, as Dr Yates was just saying, that the diagnosis may not be entirely evident.

Senator McLUCAS—Can we keep that separate, because I do want to travel across that.

Dr Ford—Assuming that we apply this to nursing home residents across the board, I do not think we would have a problem with that being reported out of the facility and into the department, but I think it has been flagged in earlier discussions that the department have some concerns about how they would fit into the

mechanism. From my point of view, I see that as quite a reasonable approach. Maybe there will be excess reporting initially—I suspect that there would be—and one would need the resources to deal with it. But I see that in contradistinction to reporting it to the police, which I see as perhaps extreme in this component. Again, we do support the thrust of this bill, but we have a reservation that this will bring it down and that it just will not function.

Senator McLUCAS—I want to quickly go to an issue that I think might be quite significant. My understanding from reading the legislation is that discretion can be applied if there is an existing diagnosis of mental impairment. I will talk with the department about what that really means and the existing technical diagnosis of 'mental impairment'. I spoke earlier to Mr Mundy and Mr Young. They were of the view that if the care plan reflected that the person had dementia, that would be an existing diagnosis of mental impairment and therefore discretion could be applied. Do you have a view on what those words really mean?

Dr Ford—There is a formal definition of dementia, but it is a process of degree. Somebody could have a lesser or more major degree of dementia. Again, I can only emphasise that at the time of admission, for many, the diagnosis is not evident. When somebody is placed in a nursing home, they may become disorientated and things that were not previously evident may become evident. Their behaviour may become entirely abnormal. They would then be in a situation in which they have entered a nursing home and their care plan is there. So, at the time of admission, they perpetrate this misdemeanour but they fall outside the boundary of the protection that you are indicating.

Dr Yates—Dementia is very well described. It is any memory problem plus an abnormality in one of the four thinking domains that is a change from the person's premorbid state—that is all dementia is. It does not indicate severity, and you do not actually get any functional assessment. I diagnosed someone with dementia in my specialist memory service. They are still driving their car and they are looking after their grandchildren. There are patients I see who are diagnosed with dementia who would be managed within the Home and Community Care services, HACC, or in a residential care setting, and they would say that there is nothing wrong with them.

There are no physical stigmata for dementia. You do not have a raised arm or a limp or anything like that. It is all degrees, and if you live in an environment in which dementia is unbelievably common—in other words, 75 per cent of your population have it—you actually only say that someone has dementia when it is barn door obvious. Unless these people have received a formal diagnosis—whether through being seen by their doctor, a specialist or the aged care assessment service, which still needs a specialist—then I do not think you could ever possibly know.

I have also seen people with delirium in an acute hospital setting who have been labelled as dementia sufferers get shunted across into the residential aged-care sector, and that label sticks. When their delirium has gone, they do not have any dementia at all. They never did have dementia, but they still get labelled as dementia sufferers because there is this diagnostic uncertainty. There is no blood test for dementia. You cannot take their blood pressure and say that they have dementia. So I do not have any confidence in the diagnosis based on a care plan. It is a functional presentation.

If you have such impairment of cognitive function that you have clear and obvious functional disability—in other words, you need assistance with eating; you get disoriented every night; you need to be directed to the toilet—yes, you have dementia and that is barn door obvious. But I reckon that if you did a survey and looked at care plans which mentioned dementia, you would probably see it in about 50 per cent of your population and not 75 per cent, because there is a whole 15 per cent that really is not seen terribly well. They do have cognitive impairment, and they may be sufficiently impaired to not necessarily have capacity around what they may choose and not choose to do.

So the issue I still have with this whole issue of involving residents as a target for the legislation is that we are going to capture people who have not been diagnosed accurately and therefore get caught up in a process which requires them to have considerable capacity in order to address that on the basis of civil rights—to be able to stand up and be not held guilty until proven otherwise. They have to be able to fight for themselves in that environment, and I do not believe that they can possibly have the capacity to do that. So I think we have to have a different mechanism for anything that involves the resident as the active abuser. If you need to find the active abuser, you have to have another strategy.

Whether you go down a line where it has to be an internal reporting mechanism and a risk management strategy beside that, and that is something that is analysed and reviewed through the agency or through Health, I do not mind. Does it go to the department? You can do that. That puts the department, I have to say, at some

risk, because if they are holding information about a potential abuse and they do not do anything about it, I do not know what happens there. I am sure you will ask the department and speak to them about that.

That is my issue. I just think that, if the legislation cornered it for that population, the public would understand why that is, so long as there was the methodology to say that we expect providers to do what they are already expected to do—that is, to improve their care provision for people with dementia. I guess I have the pleasure of sitting on the minister's national dementia task force. There are 9,000 personal care workers who are going to be involved in the process of being trained in dementia care. One would expect that, at least through some of the other strategies there, one could value add some of that stuff addressing this issue of behavioural change.

Senator McLUCAS—I would like to share with you your view that the public would understand, Dr Yates. I do not know that the public understand dementia. I do not think we do enough in explaining what it is like.

Dr Yates—That is the little piece of work that we are still trying to do. The communication strategy isn't quite apt.

Senator McLUCAS—Thank you very much for your evidence. It has been terrific.

CHAIR—I have one last question on behalf Senator Moore. Supposing we had an instance where, under your test, there ought to be reporting of a resident-on-staff alleged assault. The resident, who is not demented, says to the operator or the provider, 'I don't want to take this any further.' What is your view about what happens in those circumstances?

Dr Ford—I am not entirely clear about the proposition. Are you saying resident-on-staff?

CHAIR—I beg your pardon—staff-on-resident.

Dr Yates—And the resident says, 'Don't take it any further'?

CHAIR—That is right.

Dr Yates—Too bad. This is not an issue for that person alone. That is an indication of risk to everybody else in that residential care service and anywhere else that that casual worker might be working. The other thing I would have to say is that residents are sometimes frightened in that environment. They fear being thrown out. They fear not receiving the services. If you cannot walk and you are dependent on the people around you to stand you up so that you are not wet that day, it is very tough. I think that, irrespective of that, it will have to be worked through with the resident. Even if they have cognitive impairment, you would have to work through it with them, because it still has to addressed. I do not think you can allow a situation where there has been a clear episode of abuse and the resident says, 'Don't take it any further,' because the alleged perpetrator of that abuse is a risk for everybody else in the residential care centre.

CHAIR—Would that apply in a case of, say, resident-on-resident assault where the operator or the provider decides that they will report and the police have been called in?

Dr Ford—I think the proprietor should have the prerogative of reporting. We would not like to see that door closed. As we have said from the outset, defining every incident becomes incredibly difficult. Let us say it was a resident-on-resident assault that had a very major repercussion, such as some terrible sexual assault or some terrible physical injury, and it has been a repeated episode in some way. Perhaps that person should be incarcerated. The proprietor might see that as an appropriate incident to be reported to the police. Again, could I emphasise here that we have concerns as to the destiny of people who may be demented and who perpetrate some inappropriate act, because it is not really clear to us from the bill as to how they will be managed. Will they be expelled? We are concerned that proprietors may have the opportunity to too readily expel people who have behaved inappropriately. Already there is some cherry-picking around the selection of residents. We have concerns that people who, in their demented state, perpetrate some inappropriate act may not have anywhere to go.

CHAIR—I thank you both for your evidence today, and I thank the AMA for its written submission to the committee.

Dr Yates—Thank you again for the opportunity.

[6.40 pm]

Scheetz, Ms Carolyn, Assistant Secretary, Compliance Branch, Office of Aged Care Quality and Compliance, Department of Health and Ageing

Smith, Ms Carolyn, First Assistant Secretary, Office of Aged Care Quality and Compliance, Department of Health and Ageing

Stuart, Mr Andrew, First Assistant Secretary, Ageing and Aged Care, Department of Health and Ageing

CHAIR—Welcome. I think you are all experienced in the giving of parliamentary evidence and know about the rules—in particular, the committee not asking you to give opinions on matters of policy, although we can ask you questions that explore the explanations of policy and when and how policies were adopted. We have the submission that the department has prepared. Thank you for that. Can I express my appreciation for the fact that some of you have been here all afternoon to listen to the evidence. It makes it easier for us to then ask you about some of that evidence. So thank you for making yourselves available for that purpose, which will make the committee's work a bit easier this afternoon. Do you want to make an opening statement before we ask you questions about the evidence we have heard today?

Ms Smith—Yes.

CHAIR—Please proceed.

Ms Smith—The department would like to thank the senators for the opportunity to appear today at the public hearing of the Senate Community Affairs Committee inquiry into the Aged Care Amendment (Security and Protection) Bill 2007. I intend to make a very short opening statement to allow maximum time for us to respond to any issues the committee may have.

The department has read and considered each of the submissions made by other stakeholders to the committee and would be happy to discuss the issues raised with the committee. I am pleased to note that the submissions are broadly supportive of the legislation, both the underlying policy and the proposed means by which to implement the policy. This level of support is in part a result of the extensive consultation that has informed the development of the legislation.

The department is very grateful for the input that has been provided by stakeholders. However, as acknowledged by stakeholders, this is a very complex and sensitive area which requires the cooperative effort of the government, the industry and the community.

The legislation represents the government's commitment to increasing protections for care recipients, which, with the supporting measures already in place, will increase the overall quality of care delivered in Australian government subsided aged care services.

In the absence of the investigation principles, which cannot be finalised until the bill has been passed, the department has developed an explanatory guide to the legislation, which explains the proposed content of the principles. As you have noted before, this was included with the department's submission. It is available on the department's website, and it has also been widely circulated.

The level of interest and response from the sector is encouraging and their views will assist the department in finalising the detailed principles and operating procedures. Decisions on the detailed arrangements will also be informed by the input through this parliamentary process. In closing, I again thank the committee for the opportunity to appear and welcome any questions or comments you may have.

CHAIR—Thank you. We might proceed thematically to explore some of the issues that have been raised in the hearings today. Do you want to kick-off, Senator McLucas?

Senator McLUCAS—Chair, we can do it two ways. I have a number of issues that have come up through the evidence today that are hopefully quick issues. There is the issue of resident-on-resident activity. I want to go to the costing and to the question of time—not how much we have got, but when it is going to happen.

CHAIR—Implementation timing.

Senator McLUCAS—Yes. I am in your hands.

CHAIR—Why don't you run through some of those individual issues and we will get them out of the way.

Senator McLUCAS—Okay. A solicitor, Mr Herd, has put in a submission talking about the question of retrospectivity. He is saying it is retrospective law and we should not, on principle, make retrospective law. Is that an issue that you have had a look at and is it possible for us to get a response to that?

Ms Smith—The department does not believe this is retrospective law. It is a bit difficult to tell from his submission exactly why he believes it is retrospective, because it is a very brief submission. I can only assume that it may relate to the compulsory reporting requirement. The bill requires that if an issue comes to the provider's attention after 1 April, which is the proposed commencement date, then that must be reported.

CHAIR—But an incident might have occurred 10 years in the past.

Ms Smith—The incident may have occurred on 30 March and it comes to the provider's attention on 1 April. Because the bill is imposing a reporting obligation, there is a reporting obligation on the provider once they become aware of the incident.

Senator McLUCAS—That clarifies that well. With the current diagnosis of mental impairment, how will that work? It is a very key question. The approved provider will have discretion if there is a current diagnosis of mental impairment. How can that be put into effect?

Ms Smith—In entering an aged care facility and being assessed for what level of care the resident needs there is an assessment made of the resident's physical needs, their emotional and cognitive state, what care they will need and what care needs they will need met. So it is our expectation that that diagnosis will be recorded on the resident's care plan.

Senator McLUCAS—Let us take the case of my grandmother, who entered residential aged care eight and some years ago with no mental impairment at all. On her passing she had quite significant dementia. She would not have had on her admission sheet a current diagnosis of mental impairment. So how in that instance does the approved provider have a document which could be looked at in a legal sense that is a current diagnosis of mental impairment?

Ms Smith—Without wanting to comment on your grandmother's case, because I am certainly not qualified to do so, we would certainly imagine and expect that a care recipient's needs will change over time. Their physical frailty may change and may increase, and their cognitive capacity may decrease over time. They will be being seen by a medical professional on a regular basis to assess the needs that that resident has. So I do not see that a care plan is a static document. Indeed it should not be a static document. It should be updated as the care recipient's needs change over time.

Senator McLUCAS—That gets to the real nub of it. Does the current diagnosis have to be made by a medical practitioner?

Ms Smith—It is our expectation it will be made by a medical professional.

Senator McLUCAS—What is a medical professional then? Is a nurse a medical professional?

Ms Smith—Our expectation is that it would be a GP or some other gerontologist.

Senator PATTERSON—I am sorry but gerontologists are not medically trained. Geriatricians are.

Ms Smith—Sorry. I mean geriatrician.

Senator PATTERSON—You are talking about medically qualified people in terms of having a medical degree; is that what you are talking about?

Ms Smith—Yes, that is what we are talking about.

Senator McLUCAS—When a resident sees a general practitioner, that relationship is between the resident and the general practitioner; the GP will carry the case notes. What right does the approved provider have to get the GP to tell them that one of the residents has a mental impairment?

Ms Smith—I think that increasingly there is multidisciplinary care planning that is actually occurring.

Senator McLUCAS—Increasingly there is, but we all bemoan the fact that it is not happening enough. I am concerned that this is a very significant point. The basis on which discretion can or cannot be applied is very grey. There is no right for the approved provider to have the case notes of the GP. The GP could quite rightly refuse to give those notes to them because I think that would break the confidentiality arrangement between the GP and their patient. But this ability for discretion to be applied is contingent on a current diagnosis of mental impairment. I cannot see how that is going to happen on a routine enough basis to sit on a care plan, register or something in that facility.

Ms Scheetz—I think our view is that if somebody has a mental impairment which would preclude them from being responsible for their actions that would be clearly understood by the provider. It would be on their care records and they would be under some sort of treatment or care for that condition.

Senator McLUCAS—This could be a point of law. Under the way the legislation is currently drafted, if someone does not refer an incident to the police and a complaint is made by the victim's family, for example, the question will be whether the person has a diagnosis of mental impairment. It sounds very vague as to whether or not there will be a document that the approved provider can use to say, 'There's their diagnosis of mental impairment.' It sounds very vague to me.

Ms Smith—We believe that if the approved provider is to be currently caring for that person, managing their behaviour appropriately and looking after their care needs, then it would be very difficult for them to be doing that under their existing responsibilities if they did not have a diagnosis in place.

Senator McLUCAS—I think you heard Dr Yates a moment ago talking about the difficulty of diagnosis. I am now concerned that we are putting approved providers into a difficult position in a legal sense about whether they can or cannot apply their discretion because they will not have that diagnosis—whatever it is and whoever owns it.

Mr Stuart—I think that the incentive in this case is in the correct direction—that is, to have medical input into the diagnosis and care plan of the resident—for a number of reasons. This legislation obviously helps you to manage resident-on-resident abuse within a care paradigm rather than within a legal and police paradigm. In this measure there is a measure of incentive for the provider to engage with the medical community in understanding the care needs of their clients and planning for them.

Senator McLUCAS—I understand that.

Mr Stuart—I think that is very common.

Senator McLUCAS—I agree.

Mr Stuart—Increasingly, as we move towards the implementation of the aged-care funding instrument, which will have specific funding levels relating to dementia, that will be recognised through the funding instrument as well. I think both of those things together really move us in the right direction.

CHAIR—Can I just interpose here? I just need to clarify something. Which clause of the bill contains the discretion? I am just trying to find what it actually says.

Senator McLUCAS—Mr Maskell-Knight would have just rattled off that number.

Ms Smith—If you look at 63-1AA, subsection (2) has the requirement to report, and subsection (3) says:

Subsection (2) does not apply in the circumstances (if any) specified in the Accountability Principles …

The exemption will then be in the accountability principles. That has been outlined in the department's explanatory guide. In view of the sensitivity and complexity of this issue, it was seen to be more appropriate to put the exemption in the principles because there may be a need to look at that over time and amend it.

CHAIR—Given the complexity of the problems that Senator McLucas is raising, and they seem to be quite real, we have a bit of room to play with the principles as to how we actually define the way that exemption works. Is that right?

Ms Smith—Yes. One of the key issues for consultation has been how you handle resident-upon-resident abuse within this framework. It has been one of the most difficult issues to work through. The industry certainly raised their very strong concerns about how workable it would be if these issues were all captured within the reporting framework. The view was very strongly put, as Mr Stuart has outlined, that these issues were more appropriately dealt with within a care paradigm than a criminal paradigm. However, there was never a suggestion put to us from the industry that a resident who was in full control of their mental faculties and who engaged in a potentially criminal act should not have that behaviour assessed by the police as the authorities best placed to determine whether criminal behaviour had occurred.

Senator McLUCAS—So the AMA did not raise with you the matters that they have just raised here?

Mr Stuart—Not in terms of a complete exemption of resident-on-resident abuse; in terms of context: there are all kinds of people living in residential aged care. There are 170,000 people every night in residential aged care. They consist of a complete slice of the human community in Australia. There are people there that have been in the past perpetrators of very serious crimes. There are people there who are bullies. There are people there who are predators. There have been also, in the past, for people who have worked in aged care for a long

time, some really very grievous examples of resident-on-resident abuse. So it did not seem to us, in advising the government on this, that it was defensible to have a blanket exemption for all residents.

Senator McLUCAS—Mr Stuart, I think you were here when I was talking with the AMA to try and understand what number of people we are talking about. We are talking about resident-on-resident activity. If you remove those people who do have—however it is going to be found—a current diagnosis of mental impairment, what is the frequency of events in those 170,000 people where there is resident-on-resident or resident-on-staff abuse that is perpetrated by a person who does not have a mental impairment?

Ms Smith—I do not think we have data on that to enable us to give you an accurate answer. I do not think it is as simple as saying that 75 per cent to 80 per cent of the resident population has dementia, because I suspect, though I have not got the data to prove this, that more of the incidents would be perpetrated by people with dementia.

Senator McLUCAS—I agree, but are we talking about 20 incidents a year or 1,000? To make a judgement on how big the hammer has got to be, I think that we have got to have some understanding of the scope of what we are talking about.

Mr Stuart—In the consultations with the industry, they were most keen not to have police turn up to interview people with dementia, either perpetrator or victim, perhaps neither of whom could remember or explain what they had done or what had happened to them. We understand that argument.

When it comes to the other residents, there is not data collection of incidents of this kind and there never has been. Just to respond again to Senator Humphries's question, I think an important reason for having these arrangements in the disallowable instrument is that we expect we are going to learn a great deal about this in the initial year or two. We are asking providers to keep registers of information and we are going to be asking the accreditation agency to make sure those registers are kept. I think we will all be a lot wiser in a year or two.

Senator McLUCAS—Okay; I am happy with that. Australian Unity put up a proposal that discretion could be applied to all resident-perpetrated activity, and then it was somewhat amended by the AMA's proposal. So, instead of compulsory reporting of all incidents of abuse perpetrated by a person who did not have a mental impairment, everything would go to the police; but, if it was a resident who was the perpetrator, the AMA was saying, 'Well, maybe if you just record all that and then it could be open to the department.' Then there was a suggestion of compulsory reporting to the department rather than to the police. Was that an option that was canvassed, teased out or thought through by the department, and what is your view on it?

Ms Smith—With the compulsory reporting, we have a dual reporting requirement: one is to the police and one is to the department. The purpose of the police involvement is to assess whether criminal activity has occurred and if charges need to be laid. The police are the best and most appropriate authorities to make that judgement. The purpose of reporting to the department is for us to consider whether the approved provider has actually met its responsibilities under the aged-care legislation. Our concern if you were to require reporting to only the department is that you would be involving the department in assessments of potential criminal behaviour, which we do not believe is appropriate.

CHAIR—I understand the point that you are making there, but look at it from another point of view—and I will cite a member of my family here. My mother spent a number of years in an aged-care facility before she died and she was demented for the last three or four years of her life. On every occasion that I visited her, she told me about how she had been in some way attacked by the staff of the facility, and the staff told me that she made that complaint every day. I did not ask, but I got the impression that this was a problem that was shared by a number of other residents in the facility. Now, how would the New South Wales Police in that part of Sydney respond if they had five, six, seven calls a day in relation to one facility which was mandatorily reporting allegations of assault by one or more residents of that facility? We would get to the stage very quickly where the police—who, after all, are state police forces, not Commonwealth forces—would simply say: 'This is out of control. We can't respond to these. We simply haven't got the resources to chase up cases which transparently, in the majority of circumstances, are without foundation?'

Ms Smith—I think that is why we did think very carefully about how this would apply and believed that an exemption for resident-upon-resident assault where the perpetrator has dementia was an appropriate response. In relation to the other issue, the department has done a number of things to establish a very good working relationship with the police services in each state and territory. We already have in most cases existing relationships and MOUs between our state offices and the police services. In light of both the police checks

requirement, which has just come in, and the compulsory reporting requirement, which is about to come in, we have been renewing that contact and looking at how we can work more closely together. The other thing that was announced as part of the government's dementia initiative in last year's budget was that we have allocated money for training police about dementia so that they better understand the nature of the disease and how to deal with people who suffer from it.

CHAIR—The discretion will not apply where the allegation is made about a staff member committing an assault. I suspect that there would have been a number of such cases every day in this facility. It seems to me that even when you have trained—

Ms Smith—It is difficult to have a starting assumption that it is not true, because you could then get some very serious things swept under the carpet. That is why this area is so difficult.

Mr Stuart—The legislation covers situations where there is a suspicion that an assault has taken place. There is a first line of commonsense that prevails at the level of the home. The other thing which is important—

CHAIR—That is not quite what I understand the legislation to say.

Senator McLUCAS—Is it a suspicion or an allegation?

CHAIR—It is an allegation or a suspicion on reasonable grounds. In my mother's case, every allegation she made against a staff member would have to be reported to the police under this arrangement.

Mr Stuart—I was also going to point out that the police have discretion. Listening to my colleagues from the AMA, the kind of mental picture I got was that there would be an allegation, there would be a call to the police and the police would arrive in the paddy wagon ready to interview and arrest. They can take some evidence over the phone and the aged-care home can provide a context for the report, and then the police have discretion as to how they deal with the complaint.

Senator PATTERSON—What consultation did you have with the police forces in the various states? Have you consulted them about how they see this working?

Ms Smith—As I indicated earlier, we consulted with the police last year in the development phase, and we are also in the process of arranging further discussions with each of the state police services.

Senator PATTERSON—I am talking about now the legislation is in this shape. What discussions have you had with the various police forces as to how this is going to be implemented?

Ms Smith—I would have to take on notice the exact dates and times of those discussions, but discussions have occurred and are continuing.

Senator PATTERSON—Hang on: you said that they occurred in the development of it. What about now that the legislation is in—

Ms Smith—There were discussions last year in the development phase and at—

Senator PATTERSON—That is right; I understand that; you said that to me just a minute ago.

Ms Smith—the moment each of our state offices is meeting with their relevant police force contacts at a local level.

Senator PATTERSON—Why didn't that happen before the legislation was tabled?

Mr Stuart—It did.

Ms Smith—There was discussion last year, and that discussion is continuing.

Senator PATTERSON—I have heard that. Once the legislation was in a form that could be discussed with the relevant state police forces, why wasn't there discussion with them about the workability of it before we saw it?

Ms Smith—The view that we took was that there needed to be ongoing discussion with them, both at a policy level and then as it got more fleshed out. Once the—

Senator PATTERSON—But we do not know whether they think it is workable or not.

CHAIR—Let Ms Smith finish. I want to hear the full answer.

Ms Smith—We thought that once the legislation had sufficient detail we would then have the detailed operational discussions about how that would work.

Senator PATTERSON—You are asking the parliament to pass legislation, and we do not know what the police force feedback has been as to how this will work. What I am saying is that it seems a bit back to front to me.

Ms Smith—In previous discussions that we had with the police in the development of this, the clear view expressed to us by some of the state police—and I say 'some' because I am aware of only some of the discussions—was that they were equipped to determine criminality of issues. Their view was that these things should be reported to the police.

Senator PATTERSON—Were they aware that there could be hundreds of these in Victoria or New South Wales—especially the large states?

Ms Scheetz—The evidence from the AMA was that the majority of cases relate to resident-on-resident assault with people with dementia. Under our legislation they are exempt. So we would hope that the number of cases would not be that big.

Senator McLUCAS—But we do not know, do we? We really do not know. There was also Senator Humphries's comment that with a person alleging an abuse, even though they have dementia, under this legislation it must be reported.

Ms Smith—I think we also need to reflect on what is happening currently. A lot of providers already have protocols and procedures in place. They are already reporting to the police and to the department if these issues occur. Our state officers already have good working relationships with their local police services. They have MOUs about how they will work together. So there is an existing relationship that we are building on through this process.

Senator PATTERSON—And if I report an event to the police, who is to blame if it is not followed up? The state police force? The Commonwealth? The provider?

Ms Smith—If you are a provider who has reported to the police, you have met your obligation. If you have reported to the police and the department, you have met your obligation under these amendments.

Senator PATTERSON—Have the police got an obligation?

Ms Smith—I think they have an existing obligation to respond to issues that are reported to them.

CHAIR—It seems to me there is a danger that we may end up, when this regime is in place, with a situation where, every day, thousands of phone calls are being made by providers across Australia, reporting cases of alleged abuse to their local police station and where thousands of those calls are basically just being logged and not acted upon by the police because they cannot cope with that volume of such complaints. So we would end up with a regime which is, on paper, an advance towards compulsory reporting but which does not become, in fact, a regime of compulsory investigation.

Mr Stuart—We did consider that issue as part of the development of this policy. In the policy spectrum, at one end there is no requirement for reporting of resident-on-resident abuse. We have knowledge about some very serious things that do occur in aged care homes. There are people who feel bullied and persecuted by other residents. We have had very significant and serious events in nursing homes, at the hands of residents. At the other end of the spectrum is complete reporting of everything. We have tried to find a way through the middle, difficult though that is. I am not certain that there is a better place between those extremes than the one that is being put forward.

Senator PATTERSON—I had quite an interesting discussion, about a year and a half ago, with one of the state ministers responsible for child welfare. They had got to a point where every issue was reported, and his concern was that, as a result of this, you ended up with a situation—and this is what I think Senator Humphries is saying—where you could not see the wood for the trees, where there was so much noise that there was no signal. They had so many reports that people were swamped and overwhelmed, and the really serious cases did not come to the top because of the mandatory reporting of child abuse. So if a neighbour who was vexatious complained, and kept complaining, all those complaints got recorded. He was quite concerned about that. It was an interesting discussion; we were talking about child welfare—child welfare was in my portfolio—and that possibility had not occurred to me.

I am just worried that a similar thing could happen in this case. We could be taking a lesson from that—and often the lessons from early development do fit in adulthood and later adulthood. Are we going to have the same swamping effect and are people therefore not going to respond because 'wolf' has been cried so many times? I think that is what we are trying to get at: how do you get the really serious cases to float up to the top?

Ms Scheetz—We were very aware of that. It was certainly raised at the Aged Care Advisory Committee meetings that we did not want to replicate some of the problems that had occurred in the childcare arena. So reportable assault is defined as the serious sorts of assaults. We are talking about unlawful sexual contact and unreasonable use of force. We are hoping that definition will mean that the cases that are reported are the ones we would want the police to be involved in.

CHAIR—But it is any allegation that has to be reported. So there might be no foundation whatsoever but it has to be reported to the police under this arrangement. I think it is true to say that every witness who has come before us today has argued for some relaxation of that mandatory reporting regime.

Ms Scheetz—Compulsory. It is a very important differentiation.

CHAIR—Sorry, a compulsory reporting regime. Mr Stuart, you asked about alternative models. Some were put forward and one of those was that you must always report allegations of staff-on-resident assaults but that, in the case of resident-on-resident assaults, a discretion ought to exist for them to be logged and for the log to be submitted on a regular basis to the department. They are all recorded but police are only called in (a) when the provider feels that is an appropriate outcome or (b) when the allegation is of an assault by a staff member on a resident. Do you have a view on whether that may be a suitable model?

Mr Stuart—That is roughly where we are in relation to residents with dementia.

CHAIR—Yes, but only residents with dementia who assault—and putting aside the issue that Senator McLucas raised about the difficulty of defining what exactly that means. If it is the case that 95 per cent of the allegations raised in a given year relate to residents with dementia on other residents then we probably do not have a problem. If in fact the allegations are against staff members or they do not involve people with dementia as the perpetrators then we have a major problem in terms of the volume of such cases.

Mr Stuart—Certainly the providers that we have been consulting with were very keen to address the issue of residents with dementia, and saw that as being the key risk area for the kinds of issues that had arisen in the childcare area—not so much with other kinds of residents in aged-care homes. We feel as though we have thought about that issue and responded to it in this way.

Senator McLUCAS—That still goes to the point that we do not know how many events occur that are perpetrated by a person without dementia. It is difficult for me to make a judgement about whether or not the AMA's proposal is reasonable. I am not saying that if there are only 10 then it is not too bad—if there is one, it is terrible; that is a conviction—but if we are talking about a very small number of events then I think we might have the balance a bit out of kilter. I just do not know, because we do not have the data. Without the data, how do you make the judgement?

Ms Scheetz—I think the concern is that we will not have the data until this regime comes into place, because we are not getting the reports. So the data is not available.

Ms Smith—That is the conundrum we face.

Mr Stuart—I reiterate that, in our discussions, the provider organisations have been most concerned about the dementia issue, and I think we have responded to that in the kind of way that Senator Humphries has outlined.

Senator McLUCAS—Except where the victim is a person with dementia. I do not know that that is covered off yet. The LHMU raised the issue, in supporting the whistleblower protection for termination of employment, that they are concerned that victimisation might be having hours cut or having conditions reduced in some way. It is 5.2 in their submission. Could you take that on notice and respond to that concern, please?

Ms Smith—Certainly.

Senator McLUCAS—Thank you. Mr Mundy from ACSA raised a series of questions that his legal advisers had put to him. I wonder if you could take those on notice as well and respond to each of those concerns.

Ms Smith—Yes. Because certainly we had not heard those concerns before today.

Senator McLUCAS—As he said, he got them last night at 9.30, which brings me to the question of timing. It is true to say that the bill says this will be implemented on 1 April. Is it still the intention of the government to have this bill and the regulations in operation on 1 April?

Ms Smith—The government announced 1 April as the start date and the department has been working very hard to achieve that date.

Senator McLUCAS—I understand you have been working very hard.

Ms Smith—That is the current position.

Senator McLUCAS—I would be asking you for an opinion if you thought you could achieve that 1 April set-up, and that would be inappropriate. We will let that one hang. The other significant issue is the right not to report. A number of witnesses have talked about the fact that residents who have no mental impairment should have the right not to report. In fact it has been put to us that the act would be in conflict with itself, given the rights based fundamentals that the Aged Care Act 1997 is based on. Have you taken any legal advice about whether or not the compulsion to report may contravene a resident's rights?

Ms Smith—We have not had formal legal advice on that issue, but I suppose the policy judgement that the department has taken is that in this area you are looking at the rights of an individual and balancing that against the rights of others. The gentlemen from the AMA were very clear on the fact that if you gave people a right not to report, you are potentially putting others at risk if that behaviour or perpetrator is not dealt with.

Senator McLUCAS—That right exists in the community. I am not saying I share the view. I am actually grappling philosophically with this question myself. But at the moment a victim of an assault or sexual abuse who lives in the community has a right not to report that. That is a human right that they carry. This legislation will remove that right for people who live in residential aged care who have no mental impairment. That is the point that COTA and the advocacy group made.

Ms Smith—We are aware of those issues and the concerns. In the end you have to distinguish that a residential aged care facility is a confined facility in which people are living in a group environment and that therefore poses different issues than living in the broader community in terms of the relative risk, I suppose, to others by your own behaviour.

Ms Scheetz—The person has the opportunity to exercise those rights in their dealings with the police. If they do not want the police to continue investigation or they do not want charges to be laid, they can have that discussion with the police.

Senator McLUCAS—I do not know whether you heard the evidence from the advocacy group, but I asked them why people do not want to report. It is to do with people knowing something about them, the police having to come, privacy and all those things. People weigh up that decision. It is a fraught question, but the evidence has been strong.

Mr Stuart—We have attended mostly to the responsibilities of the aged-care provider, in doing this legislation. The responsibility to report lies with the provider. The provider is responsible for the wellbeing and safety of the residents in their care. I think that is the best answer I can give.

Senator McLUCAS—Ms Smith, you said that you had not taken full legal advice on whether the right not to report contravenes the fundamental principles of the act. Have you taken some advice on that?

Ms Smith—Obviously, as we developed the legislation we considered how these provisions would interact with the Aged Care Act. But we have not commissioned a considered legal opinion on the issues that have been raised in the submissions. We only saw the submissions in the last couple of days.

Senator McLUCAS—But the question of the right not to report goes through all your consultations.

Ms Smith—Yes. It is a question that has been considered and carefully thought about, but we have not formally commissioned legal advice.

Mr Stuart—As a general observation, the lawyers who draft legislation for us always look at whether there are conflicts in legislation and they raise that for us if there are significant conflicts. They did not do so in this case.

Senator McLUCAS—I want to go to the question of costs. The explanatory memorandum makes the baldest and most useless statements about the financial impact of this measure. My criticism goes to the minister because he signed off on it. But to say that the new initiatives implemented through this bill are part of $90.2 million over four years aimed at further safeguarding older people in Australian government subsidised aged care gives the community no understanding at all of what they are signing off on. In fact, it gives us no information about what this is going to cost. We have a story about $90.2 million and we have the minister talking about $100 million. I would like to have a complete breakdown of the costs of the

implementation of this bill, as a financial impact statement should in fact say, and a full breakdown of the total costs of the measure and where they would be able to be identified in the budget. Your submission gives some reference to costs, but I am afraid it is very unsatisfactory.

Ms Smith—This measure is in the portfolio additional estimates.

Senator McLUCAS—It is not broken down to the level that we should expect.

Ms Smith—No, but I am just indicating where this measure was. In the budget this year there was an additional $8.6 million for the agency spot checks and police checks. So the figure of $100 million is the $90.2 million plus that $8.6 million.

Mr Stuart—We would be happy to take the additional detail question on notice.

Ms Smith—There was some information on costs in our submission to the inquiry too.

Senator McLUCAS—I found it unsatisfactory. In what time frame would I be able to get the full breakdown of the costs?

Ms Smith—By early next week.

Senator McLUCAS—That would be fabulous. Thank you very much. Ms Smith, you said at the beginning that the regulations cannot be finalised until the bill is passed. Why is that? I agree that they cannot be finalised, but why could we not have had draft regulations?

Ms Smith—There was a sequential issue about the timing of this whole process. You have to get the details of the bill settled to a large degree before you can draft the principles that underpin it. The drafting instructions for the principles are with the Office of Legislative Drafting and Publishing and we hope to have a draft very shortly.

Senator McLUCAS—So essentially you are telling me there was not enough time from the completion of the drafting of the bill to allow the drafting of the principles so that they could be promulgated in draft form?

Ms Smith—We could not settle our drafting instructions until the shape of the bill was relatively clear.

Senator McLUCAS—When was the bill completed?

Ms Smith—The bill was introduced into the House—

Senator McLUCAS—No, that was not the question. When was the bill finished being drafted?

Ms Smith—It was finalised in January.

Senator McLUCAS—In January? When you say that the regulations cannot be finalised until the bill is passed, that is technically correct. But if you take, for example, the private health insurance bill, we have the regulations in a draft form. Admittedly they were provided on the day we were inquiring into them, and they are about two inches thick, but you cannot say that they cannot be provided in a draft form prior to the bill being passed. I think it is accurate to say that, isn't it?

Mr Stuart—It is in part a matter of the allocation of drafting resources. There is always a lot of call on the drafting resources and we are not in charge of those. So they prioritise work depending on the progress with the bill.

Senator McLUCAS—But the bill was only completed in January. Even if you had absolute top priority, there would have been no way that you would have had regulations ready from then on.

The point I am making is the timing question. I think every witness has complained about the time that they have had to provide submissions. Nearly every witness has been embarrassed about the quality of their submission because of the time frame that we are under because of the timetable that the Senate has imposed. We will talk as a committee about whether or not we are going to recommend an extension of time for implementation—

Senator PATTERSON—I want to add something here. I can understand some of your frustration, but let me just say this. I have been around the traps a while—a long while. In opposition, we would often get a bill on a Friday or Thursday and the following Friday we would have a hearing—more often than not, a one-day hearing—and that was the way it was run. It would go to the party-room meeting on a Tuesday and we would have the hearing on the Friday. So I think that you are being a little disingenuous by indicating what you did about the time frame. I know it is tight, but legislation is always tight, and we have to try and meet the deadline. People say—and I did not say anything when the witnesses were here—'I did not have time to

prepare it,' but we would often call a witness on a Tuesday or a Wednesday and ask them to give evidence on a Friday; we would do that more often than not. So let us just get the history in place.

Having said that, I do have a couple of concerns about this. I really would like to know what the police forces think about the legislation and whether they can implement it. But I think to labour the point about it being speedy is a bit rich.

CHAIR—We are running of time so let us—

Senator McLUCAS—When the minister rings me and asks me to treat it as non-controversial because we have a need to get this going, I think we have a problem, given what we have revealed today. This is not non-controversial legislation.

Ms Smith, I will go back to your point that the department does not want to make a judgement about whether or not a matter should be referred to the police. Doesn't the legislation allow the approved provider to make that decision? I can understand that the department does not want to hold information and that they have to make a judgement about whether or not that should be sent to the police, but the legislation does say to the approved provider that they can make a judgement about whether this issue should be referred to the police.

Ms Smith—I think that is an existing responsibility they have. The approved provider is caring on a daily basis for a number of people and there will be incidents occurring in their facility that may or may not require reporting to police. They currently have to make that judgement—

Senator McLUCAS—But now there is a legal responsibility if they do not.

Ms Smith—and the department's judgement has been that, as the provider of the care, they are much better placed to make that judgement than the department several steps removed.

Senator McLUCAS—I certainly agree with you, but I am wondering about the legal responsibility on the approved provider to make that judgement for people who have dementia. I think it is interesting that the department does not want to have that responsibility but we let people who are approved providers have that responsibility. It is an interesting ethical issue.

Ms Smith—This is a very challenging area.

Senator McLUCAS—I agree. It has challenged me as well.

CHAIR—We have a couple of matters to place on notice with you and I will run through them quickly. If you have a one- or two-sentence response now I am happy to hear it but otherwise please take these things on notice. These points were raised in other submissions. Elders Rights Advocacy asked:

Is there a role for the Commissioner in promoting the complaints process to care recipients and the community, and reporting publicly on the outcomes?

I would like to have an answer to that question.

Ms Smith—We can outline the role of the department versus the role of the commissioner. I think that might be helpful.

CHAIR—That would be good. Thank you. Australian Unity pointed out that the requirement under section 63-1AA is for incidents to be reported to a police officer and the secretary within 24 hours. As I recall, it can be either to a police officer or the secretary.

Ms Smith—No, to both.

CHAIR—Sorry, you are right; it is both. And they pointed that if this occurs on a weekend it is very hard to do that.

Ms Smith—First, let me indicate that the secretary is not personally going to be taking all of these calls. If you are familiar with the Aged Care Act, you will know that the secretary holds a range of powers under the act and they are delegated to relevant departmental officers. We will have an arrangement where those calls can be taken on a weekend.

CHAIR—There was another question from Australian Unity about the way employees were defined and whether that covered health professionals such as GPs and other allied health professionals—podiatrists for example—who might be visiting the facility. Were they caught by these provisions? What about contractors such as gardeners who might work for a particular provider? What are their obligations, if any, under the provisions for employees in section 63?

Ms Smith—Yes.

CHAIR—There was a question raised by Aged and Community Services Australia about the issue of the complainant and the party complained about receiving information about the investigation. Is there a process for feeding back to them progress or outcomes with respect to the investigation? And, lastly, does the Aged Care Commissioner have the capacity to investigate the behaviour of the Aged Care Standards and Accreditation Agency as part of their brief?

Ms Smith—In relation to that last issue, yes, they do, and that is reflected in the legislation. In relation to the issues about feedback to the complainant and the approved provider, that will be specified in the investigation principles. There is an overview of those in the explanatory guide, and it is certainly the intention that there will be feedback throughout the process to the approved provider and the complainant. What we have to be mindful of at times is the nature of the relationship between the complainant and a particular care recipient, and sometimes if there is not a direct relationship the department is inhibited from giving full information if that would breach the person's privacy. But within those constraints we would certainly aim to give as much information as possible throughout the process.

CHAIR—Lastly, there were the issues raised by Aged and Community Services Australia that their lawyers had alerted them to in the last 48 hours.

Senator McLUCAS—Yes, I have put that on notice.

CHAIR—You've covered that? Okay. Does anyone have any further questions?

Senator McLUCAS—Yes, just to put on notice—and it will possibly come through the full financial explanation of where this money is. A lot of the witnesses have talked about the need for an education campaign. Quite separate from the staff training issue, people need to know their rights as any of the players in the whole story. Could you explain what the department is proposing to do around that question?

Ms Smith—There is money allocated as part of this measure to provide that sort of information, and we can detail how that will work and what the plans are.

Senator McLUCAS—And the time frame for that as well, please.

Ms Smith—Yes.

Senator McLUCAS—Thanks. Can I just make the comment that my criticism of the time frame for implementation is not directed at department officials; it is very much directed at the minister. I think that his political needs are overriding the development of good legislation. I understand that staff have worked extremely hard to fit in with that.

CHAIR—I have one other question for you to take on notice, please. ERA, Elder Rights Advocacy, raised the question of whether advocates for people in aged-care accommodation would be protected by the whistleblower provisions. My reading of it is that they are not. If a person conveys to an advocate their concern about a case of abuse and that advocate then goes back into the system and makes representations on their behalf, will they be covered by the legislation and protected under the provisions that protect whistleblowers? If you could take that question on notice as well.

Ms Smith—We will take that on notice.

CHAIR—That's great. I thank you for staying for so long, taking so many issues on notice and for providing so much information to the committee. I appreciate that we all have better things to do than sit here at eight o'clock on a Thursday evening at the end of a sitting period, but we really appreciate the time that you have given the committee. That concludes this public hearing. I thank the committee staff and Hansard staff for their time.

Committee adjourned at 7.43 pm