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Inquiry on Protecting the Rights of Older Australians from Abuse:

The experiences of older lesbian, gay, bisexual, transgender and intersex (LGBTI) Australians

Thank you for the opportunity to contribute a submission to the ALRC's important inquiry into elder abuse. This submission will focus on issues affecting LGBTI elders.

GRAI was established in 2005 to improve the rights and well-being of older LGBTI people in Western Australia. Our work has included advocacy for law reform which has enhanced the legal rights of LGBTI people in aged care and currently we work to raise awareness of the needs and concerns of LGBTI elders and deliver LGBTI inclusivity training to the aged care sector in WA. We also work within the community to build stronger connectivity with older LGBTI people, with a program that includes social events and information workshops.

Although, over the past few years, social stigma associated with LGBTI status has dramatically reduced – alongside greater legal protections – unfortunately we still witness many examples of systemic, direct and indirect discrimination. Much of this is inadvertent: a result of hetero-normativity embedded in our culture which blinds organisations and individuals to the fact that they are acting in an exclusionary manner. Legal provisions which require compliance to inclusivity standards have been helpful to address this, by often forcing a re-evaluation of long-standing practices and organisational culture.

Despite the general improvement in the social and legal standing of LGBTI people, strong beliefs of the 'wrongness' of diverse sexuality and gender identities still are in evidence, and very real abuses are perpetrated by carers and/or family members who hold these views. An older person frequently takes it as their responsibility to avoid conflict and does so by regular pretence: a suppression or denial of sexual or gender identity which creates stress and loss during an LGBTI elder's life. Not infrequently, this identity loss even extends posthumously with the erasure of identity in funeral arrangements causing distress and disenfranchised grief among LGBTI community friends and relationships.

The continuation of discriminatory practices is exacerbated by the widespread invisibility of older LGBTI people. This cohort has experienced historic alienation having been criminalised, pathologised and vilified, and has learned critical survival techniques of remaining hidden from view to avoid negative or even

dangerous repercussions. This lack of visibility can stymie reform and certainly contributes to the rarity of complaint from LGBTI elders.

GRAI submits the following responses to some of the specific questions posed by the ALRC in the Elder Abuse Issues Paper.

Question 1: To what extent should the following elements, or any others, be taken into account in describing or defining elder abuse?

Elders' rights are almost universally framed with the assumption of an individual perpetrator or 'the person who is the 'abuser''.

This is problematic when discussing LGBTI rights, which have been negated or undermined by systemic abuses. Discriminatory sanctions were applied by the state, by the psychiatric profession and by the church, and the broad reach of this oppression continues to affect present day values. The exclusive 'normalisation' of heterosexuality is endemic, and obscures identification of factors which limit the rights and well-being of LGBTI elders.

GRAI would therefore like to see a broadening of the definition of elder abuse to extend to **systemic abuse**.

Harm or distress. LGBTI elders frequently maintain secrecy over their sexuality or gender identity to many of their associates and/or carers. While this protects them from feared 'negative attention' or reduction in service, it is also a cause of ongoing stress. On the other hand, LGBTI elders who are more 'out', while freed from the anxiety of discovery, are exposed to increased risk of rejection or abuse from co-clients, families or friends, and report a sense of discomfort from untrained care providers.

Intention. Hetero-normativity (the assumption that heterosexuality is 'normal', and consequent lack of consideration of other sexualities/gender identities) has led aged care providers to generally overlook LGBTI issues – especially when combined with ageist erotophobia, in which issues of sexuality and older people are stigmatised. These two factors create a barrier to policy change as ambivalent board and staff members need convincing of the necessity of reform. However, personal prejudice or lack of information should not provide exemption from the law, which should be clear in its expectations of equality in service delivery and the provision of a safe environment.

Families of LGBTI elders are sometimes perpetrators of abuse, sometimes knowingly, because of their disapproval, but sometimes in genuine ignorance if their relative has kept their sexuality/gender identity hidden from them. In the latter case, the law should be flexible, while allowing for remedial action if possible.

Posthumous rights. LGBTI community members who have families who are disrespectful or hostile to their identities are at great risk of having their identities erased upon their death. That this final indignity comes at the end of a life of struggle is especially painful for friends/partners/networks of the deceased.

Legal standing of the dead is harder, but not impossible to establish, and precedents include international debate on posthumous rights with regard to bodily integrity and reproductive rights.[1] GRAI would welcome reform in this area to uphold the rights of LGBTI people to be recognised as 'who they were'.

[1] Kirsten Rabe Smolensky , 2009, Rights of the Dead, Hofstra Law Review, Vol. 37:763 http://law.hofstra.edu/pdf/academics/journals/lawreview/lrv_issues_v37n03_cc4_smolensky_final.pdf

Question 2: What are the key elements of best practice legal responses to elder abuse?

With regards to protecting LGBTI elders from abuse, key elements would include:

- Widespread legal education campaigns
    - to raise awareness of the exclusionary effects of hetero-normativity and its barrier to inclusive health and care services, and
    - to impress upon families/carers that abuse on the basis of sexuality and gender identity is unlawful, and
    - to empower elders who are victims of abuse to seek protection and redress.
- Specially targeted workshops to assist LGBTI communities complete end-of-life documents, including Wills, AHDs, EPAs and EPGs. As LGBTI elders are particularly vulnerable to hostile family, it is important for this cohort to have documented their wishes.
- Readily accessible complaints mechanisms which are clearly identified as LGBTI-friendly, would alleviate concerns that seeking help could 'backfire'.
- Consistent anti-discrimination laws across all states and territories and concomitant licensing obligations for service providers (eg accreditation standards to include LGBTI inclusivity).

Question 3: The ALRC is interested in hearing examples of elder abuse to provide illustrative case studies, including those concerning LGBTI people

The following examples are drawn from people closely known to GRAI.

1. An 85 year old woman is not 'out' to her family or friends for fear she will be ostracised. This means she has no-one with whom she can share stories of her past, or with whom she can be 'her full self'. Although it appears that this loss is 'self-inflicted', it characterises the systemic nature of discrimination, and the need for others (individuals/organisations) to 'come out first' and signal a welcoming stance to LGBTI community.
2. An older gay man in residential aged care is suffering from long term social anxiety problems and severe migraines. He has a lifelong affiliation with a church and fears exclusion should his sexuality be revealed. The (lesbian) nurse matron in his facility slowly gained his trust and put him in touch with an LGBTI-friendly ministry. His health and mental condition is rapidly improving.
3. A niece, who inherited her aunt's house and estate, directed the funeral celebrant to exclude mention of 'the lesbian society' from the eulogy, which had been previously composed in conjunction with her aunt. The booklet accompanying the funeral service also made no mention of her aunt's female partner of 47 years but falsely hinted references to men in her aunt's life.
4. A 60 year old decided to make the transition to the woman she had always felt herself to be. Fortunately she has mostly supportive family, but endures stares and comments almost every time she is in public. She also has to act as an educator in hundreds of interactions each month (social, shops, doctors). Education is sorely needed to alleviate that burden. Legal recourse to the gender reassignment board has been extremely helpful.

Question 4: The ALRC is interested in identifying evidence about elder abuse in Australia. What further research is needed and where are the gaps in the evidence?

Very little research has been conducted into the risks to and needs of LGBTI elders in general, and especially so in rural areas. It should be noted that LGBTI elders often have become so accustomed to the 'status quo' of being a vilified or disrespected minority, that for healthy psychological survival this

experience is simply internalised as 'normal' and rarely identified as 'abuse'. A researcher may consider asking if an elder 'feels free to be themselves' rather than using a stronger term such as 'abuse'.

The often hidden nature of LGBTI elders adds challenge to research in this area. Especially in the case of older lesbians, the researcher needs to be someone they trust or participation will not be forthcoming[2].

Question 11: What evidence exists of elder abuse committed in aged care, including in residential, home and flexible care settings?

In Western Australia, we have not yet had the resources to gather data on LGBTI elder abuse in aged care. However, in 2010, we conducted research in conjunction with Curtin University, on attitudes of residential care providers to LGBTI people and their care needs. The report, *'We don't have any of those people here'*[3], demonstrated that LGBTI residents were largely invisible to the survey respondents. This, combined with a low level of understanding of LGBTI elders' special needs, lead us to conclude that the facilities' capacity to adequately meet the care needs of these elders would be highly compromised.

Research findings included:

- 86% of Facility Survey respondents were unaware of any LGBTI residents within their facility.
- "Your Facility recognises that LGBTI residents have specific needs": only 5% Strongly Agreed; 19% Agreed.
- None had links with LGBTI organisations.
- Low awareness of State and/or Federal legislation re LGBTI people.

We hope that these statistics would be improved were they re-surveyed in 2016. However, over the past 2 years we have been conducting LGBTI inclusivity training in aged care, and from training room interactions conclude that although participants are mostly receptive and sympathetic, understanding about the special needs of LGBTI elders remains patchy.

LGBTI elders or elders with LGBTI friends or family, generally keep their sexuality or gender identities hidden, potentially increasing minority stress for all concerned. This lack of communication leads to poor interpersonal outcomes between clients and service providers, and critical lack of recognition of partners, either through lack of sensitivity or lack of disclosure. Impacts of the lack of partner recognition include distress and sadness at being unable to demonstrate affection and lack of consultation in decision-making, potentially breaching rights.

Lack of responsiveness to the special needs of LGBTI elders also leads to uneven access to services, and LGBTI people often remain reluctant to access necessary care for fear of humiliation or poor treatment. Thus we can see that lack of welcoming, inclusive services, can indirectly result in poorer health outcomes for LGBTI elders through delayed attention[4].

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[2] Westwood, S, 2013, Researching Older Lesbians: Problems and Partial Solutions, *Journal of Lesbian Studies*, 17: 380-392, Routledge, UK

[3] GRAI , 2010, *We don't have any of those people here. Retirement Accommodation and Aged Care Issues for Non-Heterosexual Populations*. Curtin Health Innovation Research Institute, Curtin University, WA

[4] Leonard, W 2002, *What's the difference: Health issues of major concern to gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians*, Ministerial Advisory Committee on Gay and Lesbian Health, Melbourne.

Question 12: What further role should aged care assessment programs play in identifying and responding to people at risk of elder abuse?

If aged care assessors are equipped with specific training on LGBTI history and its impacts, they could be well placed to play a key role identifying abuse of LGBTI elders and respond in a culturally safe manner. Bearing in mind that abuse may be systemic (as described above) assessors should also be prepared to challenge an organisation for its lack of inclusivity.

Working with a cohort who may not necessarily self-identify has its challenges, which are not, however, insurmountable if a culturally sensitive approach is taken. Also, we note that, like many elders, LGBTI elders may be reluctant to report abuse, especially if an emotionally 'needed' relationship is at stake. Assessors' capacity to respond to a potentially abusive situation would be improved if they were confident of being able to refer to a culturally competent mediation or support service.

Question 13: What changes should be made to aged care laws and legal frameworks to improve safeguards against elder abuse arising from decisions made on behalf of a care recipient?

Aged care providers have indicated to us their reliance on prescribed decision-making hierarchies which privilege biological family. This is problematic if a partner is present but not clearly identified, and can disregard 'families of choice' (the LGBTI elders' support network) who may have a closer relationship with and understanding of the needs of the individual concerned. Greater sensitivity to the role of non-family support networks would provide decision-making more closely aligned with the person's wishes.

Self-determination is undermined by the application of Guardianship, the implications of which are often poorly explained. Other options such as supported decision-making[5] are relatively seldom discussed, despite having the potential to avoid legal and social pitfalls of full guardianship. An individual's rights and autonomy would be better protected by legal frameworks which emphasised the benefits of supported decision-making processes and stressed guardianship as a last resort.

A contentious area in residential aged care is the 'rights' of residents who are deemed to have 'lost capacity' to consent to sexual relationships. Generally there are no guidelines for staff or guardians to assess whether the relationship poses a risk to the individual/s concerned and whether or not it is 'consensual'. In the absence of guidelines, rights of privacy are breached (the activity reported to family) and the sexual rights of the concerned individuals are alienated (couples are kept apart or moved to different facilities). Although it is imperative that facilities guard against sexual abuse, not all intimate activity can be placed in this category. A more nuanced approach to 'capacity to consent' needs to be taken, as well as training in the indicators of well-being and ill-being that signal whether a relationship is welcomed.

Taken together, we believe there is need for greater sophistication and flexibility in issues of consent and decision-making.

Question 15: What changes to the requirements concerning quality of care in aged care should be made to improve safeguards against elder abuse?

From an LGBTI elders' perspective, on-going training for cultural sensitivity in aged care is essential. Best Practice Awards for LGBTI inclusive services are encouraging other organisations to follow this lead, but

[5] 'Supported decision making is a recognised alternative to guardianship through which people with disabilities use friends, family members, and professionals to help them understand the situations and choices they face, so that they may make their own decisions without the "need" for a guardian' (Blanck & Martinis, 2015 in 'Capacity and Rights in older people – what is the role of the health professional?', Carmel Peisah, Capacity Australia, UNSW Uni Sydney).

there is still a long way to go before this is the norm in the sector. Stronger provisions within the Standards for Aged Care are needed to ensure the cultural transformations necessary within the aged care sector,

Question 18: What changes to aged care complaints mechanisms should be made to improve responses to elder abuse?

Complaints mechanisms need to be LGBTI-safe, and be clearly labelled as such, in order to gain the confidence of LGBTI consumers. Given the fraught social histories of our LGBTI elders, trust is not readily gained, and a communications strategy to engage with the LGBTI community is necessary.

Question 20: What changes to the role of aged care advocacy services and the community visitors scheme should be made to improve the identification of and responses to elder abuse?

Similarly to Question 18, advocacy services and CVS staff should be well trained in LGBTI inclusive practices, and specific efforts made by these organisations to build relationships with the LGBTI community.

Question 33: What role should public advocates play in investigating and responding to elder abuse?

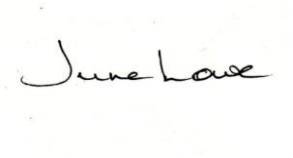
An increased education role by advocacy services could help to clarify the obligations of service providers and carers to uphold the rights of LGBTI elders. Both workshops and factsheets could shed light on some of the 'grey' areas, such as consent.

Question 41: What alternative dispute resolution mechanisms are available to respond to elder abuse? How should they be improved? Is there a need for additional services, and where should they be located?

It is widely suspected that elder abuse is grossly underreported, and with an ageing national demographic this is likely to be an increasing problem. Meanwhile, advocacy services and family mediation services are chronically under resourced, limiting their profile and capacity. An increasingly vulnerable population needs a much more robust advocacy, operating in a variety of ways. It is imperative that advocacy agencies (such as Advocare) and community legal centres be soundly resourced, along with innovative community outreach activities, perhaps including 'roving' advocates located at doctors' clinics, libraries, community centres, multicultural centres, etc., to spread information and support services more widely. Community education including workshops, arts projects and public displays, could also help to empower people to identify and confront elder abuse.

Internalised ageism and homophobia blind many LGBTI elders to their situation, and the pervasiveness of the underpinning social mores blunts the community dismay that should be felt at such widespread social injustice. A concerted effort is needed to promote and support safe ageing environments albeit in the community or in formal care, and we hope this Inquiry by the ALRC will provide a basis for better legal instruments to improve elders' protection and well-being.

Yours sincerely



June Lowe

Chair, GRAI (GLBTI Rights in Ageing Inc)