Family Violence Death Review Committee

He tao huata e taea te karo

Health Quality & Safety Commission New Zealand

Kupu Taurangi Hauora o Aotearoa

Review of Adult Decision-Making Capacity Law
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Review of Adult Decision-Making Capacity Law

Family Violence Death Review Committee

The Family Violence Death Review Committee (the committee) is a statutory committee of the Health Quality & Safety Commission (the Commission) mandated to (1) review and report to the Commission on family violence deaths, with a view to reducing the numbers of family violence deaths, and (2) develop strategic plans and methodologies that are designed to reduce family violence morbidity and mortality.

Committee members are drawn from a wide range of sectors – primarily justice, health, academic research and family violence service non-governmental organisations – and all share an expertise in family violence. The following submissions are based on reviews of family violence homicides undertaken by the committee and the collective personal views and professional experiences of the committee members.

This submission specifically relates to questions 14 and 17 of the Preliminary Issues Paper, respectively:

- Do you think there needs to be safeguards or accountability mechanisms when a person uses an enduring power of attorney (EPoA)? If so, what should they be?
- Do you think there needs to be safeguards or accountability mechanisms to help supporters? If so, what should they be?

At various points in the Preliminary Issues Paper, the authors make reference to Manatū Hauora | Ministry of Health's 'repeal and replace' review of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act). While the authors have chosen to draw parallels with the 'repeal and replace' work to highlight the overlap with adult decision-making, we note that some of the issues raised in the Preliminary Issues Paper will require Manatū Hauora (as well as Te Whatu Ora) to have more nuanced understandings of coercion as it may be enacted in the acceptance or refusal of care and support services offered through the health system. Therefore, it is not sufficient to develop an effective adult decision-making law to address these issues: the resources provided to ensure the effective implementation of such will determine the success (or otherwise) of the exercise currently being undertaken.

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Our submission

The need for safeguards or accountability mechanisms when a person uses an EPoA.

The following has been drawn from the Committee's seventh report, *A Duty to Care | Me manaaki te tangata*.

> One of the key issues in appointing an EPoA is that while they are established when an individual has full capacity, it is rare for anyone to review and oversee an EPoA once the individual had reduced capacity.[1] The risks of abuse of an EPoA increase when the person provided with that responsibility is also named in the individual's will,[2] is the beneficiary of a family trust or holds other legal powers. Purser and colleagues[3] have identified that placing the responsibility on the vulnerable person to report instances of EPoA abuse also exposes them to further abuse through losing accommodation, damaging relationships, losing daily support[4] and threats of institutional care.[5] The in-depth reviews reveal the potential for financial abuse through legal processes has a strong gender element.[6] …
>
> Indeed, such activities may also occur during a relationship and members of the wider family can be involved. Through our in-depth reviews, the Committee identified financially controlling behaviours that limited a person's access to community support services. Service providers endorsed such behaviours because they perceived male family members as entitled to hold the weight of decision-making within the family, while they failed to adequately meet their duty of care obligations.
>
> > *Patient rung in a very distressed [state] stating her mother needed to be in a rest home because she could not look after her anymore. States family never help and no one is listening to her. Discussed with [doctor] who stated brother looked after mother and had power of attorney and did not want mother to go into a rest home. Patient advised she needs to discuss her feelings and thoughts with her family*.[7]
>
> In-depth reviews of death events reveal that assumptions that people have equitable decision-making and caregiving responsibilities are rarely correct. In addition, services apparently fail to appreciate how much distress people are living with before they seek

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[1] Wuth N. 2013. Enduring powers of attorney: with limited remedies – it's time to face the facts! *Elder Law Review* 7.

[2] Caxton Legal Centre Inc. 2007. Submission 112 to the inquiry into older people and the law, Parliament of Australia, House of Representatives Committees. URL: www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=/laca/olderpeople/subs.htm

[3] Purser K, Cockburn T, Cross C, et al. 2018. Alleged financial abuse of those under an enduring power of attorney: an exploratory study. *British Journal of Social Work* 48(4): 887–905.

[4] Gibson SC, Honn Qualls S. 2012. A family systems perspective of elder financial abuse. *Journal of the American Society on Aging* 36(3): 26–9.

[5] Monro R. 2002. Elder abuse and legal remedies: practical realities? *Reform* (81): 42–6.

[6] While this element is particularly relevant to financial abuse of disabled family members, in-depth reviews also found it is evident in relation to intimate partner violence.

[7] Clinical notes, in-depth review, 2021.

> help. Where services minimise, trivialise and do not hear such help-seeking, they do not meet their duty of care.[8]

Within the report, the Committee were also able to identify possible solutions to the problems identified:

> Because of the potential for exploitation when an intimate partner or other family members have financial control, services need to understand a person's life beyond their immediate caregiver. While there is the potential to add safety mechanisms (such as the addition of more than one attorney or the addition of safeguards), the onus is on lawyers to advise about these measures if they are not already in place. Introducing such mechanisms also requires a detailed understanding of points of vulnerability including housing and day-to-day care, as well as of the social, cultural and emotional coping mechanisms available to a person with disabilities and their family or whānau.[9]

In their Preliminary Issues Paper, the authors draw attention to the problems associated with the Family Court and how this can be viewed as a barrier to obtaining further support due to the financial cost of engaging, timeliness of responses and its adversarial nature. We note in response to this point that the Pou Tangata Iwi Leaders Group, in response to a request for submissions to the Family Court (Family Court Associates) Legislation Bill, outlined alternative solutions, drawing on effective work that is being undertaken by the courts in collaboration with iwi and police.[10] The model they proposed allowed for community representation and ensured accessibility for people from a range of cultures. They also centred on an inquisitorial process of resolution, allowing for shared decision-making in the presence of a *full and complete understanding of the context being reviewed*.

Safeguards or accountability mechanisms to help supporters

Information collected by the Committee underscores the importance of providing comprehensive support for people who are looking after disabled or older adults. We note that a large proportion of the intrafamilial homicides captured within our data set are deaths that occur in the context of insufficient or ineffective support services for family or whānau who have provided long-term support. In a number of these cases, the family or whānau have been proactive about approaching services for support with a disabled person but have not been heard or responded to. In 35 percent of intrafamilial homicide events, the offender was found not guilty by reason of insanity, highlighting the need for mental health services to work closely with the families of those who are in need of their services.

As expressed within the introduction of this submission, we do not believe it is sufficient to develop an effective adult decision-making law to address the issues outlined. Resources are required to ensure the effective implementation as intended. For example, the following

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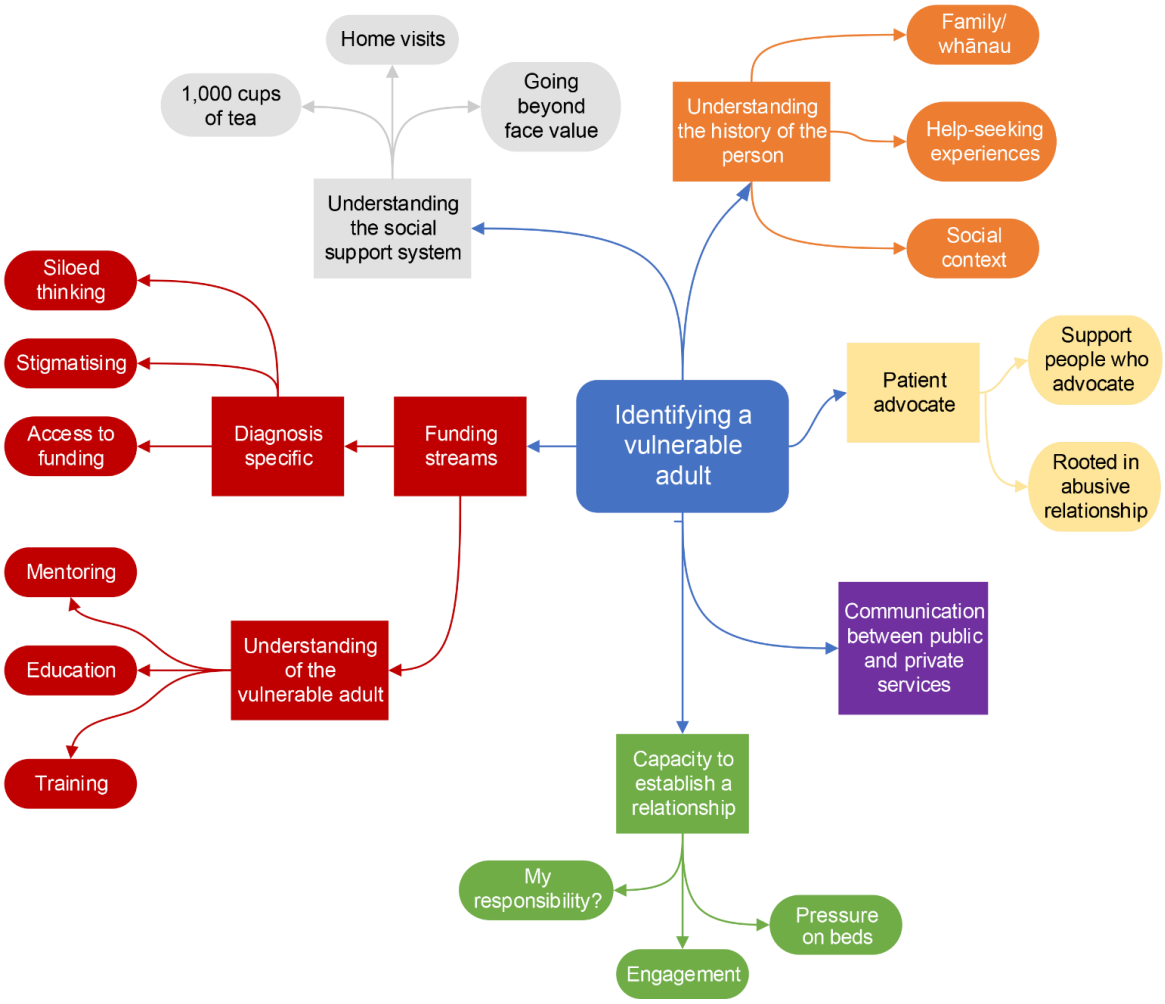
[8] Family Violence Death Review Committee. Seventh Report: A duty to care | Me manaaki te tangata. June 2022. Wellington: Health Quality & Safety Commission (pages 60–62).
[9] Willacy H. 2021. Safeguarding adults. Patient. URL: https://patient.info/doctor/safeguarding-adults-pro (accessed 8 March 2023).
[10] Pou Tangata Iwi Leaders Groups – Te Ora o te Whānau and Justice. Submission to the Justice Select Committee. Family Court (Family Court Associates) Legislation Bill.

graphic from our seventh report illustrates the difficulties associated with identifying vulnerable people within the hospital system and highlights the complex systems that supporters must negotiate to be recognised.



The effective implementation of legislative and policy initiatives requires active consideration of the systems in which they will be embedded. For example, age is a prohibited ground for discrimination according to Aotearoa New Zealand human rights legislation.[11] Equally, the Family Violence Act[12] has provisions directed towards older people. However, neither of these provisions have been sufficiently activated, in part because of insufficient access to

[11] Human Rights Act 1993, s21(1)(i)
[12] Family Violence Act 2018, s11(1)(f)

support and resources for older people, who will be directly impacted by the adult decision-making capacity law.

We draw on kaupapa Māori organisations to provide guidance in a duty-to-care response. In particular, learnings from these organisations highlight:

- Responses to an individual need to occur in relation to the wider family – those who are supporting the family need to focus on the needs of the family rather than service delivery or contracting priorities.
- Holistic worldviews acknowledge the impact of intergenerational trauma and intergenerational behaviour patterns – many who use violence against older people have also been victims of violence in the past but are not seen as victims in their own right. Where ineffective or inadequate responses are provided, intergenerational trauma can be further embedded.
- Organisations need to develop trusting and supportive relationships with families. For example, the organisations stressed the importance of:
  - 'we want to provide help whatever the problem … at the earliest opportunity.'
  - 'The things that people struggle to get early intervention support with, that could be the drivers of the more serious problems' (page 84).[13]

While the onus is on lawyers to provide response and protection for adults in need of support with decision-making, we note that there is limited understanding of the nature and dynamics of family violence as it may present in people with disabilities or the older community. As one of our community representatives noted,

> But in terms of training and development, you know, GPs, **lawyers**, police, mental health workers, midwives and I would say teachers, at any given stage, you can pretty much guarantee that the whānau will have an interaction with one of those professions. And unfortunately, from our experience, they are the least trained on how to understand coercive control (page 65, emphasis added)[14]

[13] Family Violence Death Review Committee June 2022, *op. cit*.
[14] Family Violence Death Review Committee June 2022, *op. cit*.