



Background and context

Overview

The purpose of this guide is to:

- outline the Victorian Government response to the abuse of older people who live in their home, in the community
- provide practical guidance for health and community service workers to develop agency policies and procedures to respond and act on suspicion or allegation of elder abuse
- support the development and review of interagency protocols that enable cooperation in responding to elder abuse
- provide a range of resources that assist and reinforce the development of policies, procedures and protocols
- strengthen the capacity of health services and community service organisations to respond with confidence to prevent, and to address, elder abuse as required.

This guide targets workers supporting older people in:

- health services, such as:
 - hospitals, including emergency departments
 - rehabilitation services
 - subacute services
 - nursing and allied health services provided in the home and other settings
 - community health services
- community agencies, such as:
 - local government
 - not-for-profit organisations and private organisations involved in providing home and community care (HACC)
- providers of:
 - Community Aged Care Packages (CACPs)
 - Extended Aged Care at Home (EACH) packages
 - Extended Aged Care at Home Dementia (EACHD) packages
 - respite services
 - mental health services for older people
 - community legal aid services
 - family violence support services
 - Aboriginal services
 - services supporting people from culturally and linguistically diverse backgrounds.

1.1 The policy approach—empowering older people

A Fairer Victoria¹ is the Victorian Government's social policy action plan presenting key principles and initiatives that support social sustainability. A Fairer Victoria focuses on the needs of disadvantaged community members, including families, children, older Victorians, Aboriginal Victorians, people with a disability and people with mental health issues.

In that policy context, the Victorian Government response to the prevention of abuse of older people report, *Supporting the Safety and Dignity of Senior Victorians* (June 2006), addresses prevention, awareness-raising and service response at the individual, organisation and community levels. The approach is a combination of service responses and legal interventions which protect the independence, dignity and safety of senior Victorians. These include support from health services and community agencies, criminal and civil justice remedies, and complaint and compliance mechanisms.

The Victorian Government's approach is based on empowering older people, consistent with the universal human right to live life free from violence and abuse. It also reflects a commitment to support the safety, security and dignity of all older people in our community.² The *Charter of Human Rights and Responsibilities Act 2006* came into effect on January 2008, making it the first charter of human rights enacted by an Australian state.³

The empowerment model is underpinned by values reflected in policies and practice that support self-determination, informed choice and the ability of adults to make their own decisions. This approach also extends to the protections under the *Guardianship and Administration Act 1986* for older people who lack capacity.

An adult protective and mandatory reporting approach is not supported by the Victorian Government, senior Victorians and industry stakeholders. Other Australian states and territories have developed empowerment approaches, as has the World Health Organization (WHO).

Whole-of-government family violence reform has also been a key strategy of A Fairer Victoria, with key objectives of increasing safety and accountability. Intimate partner violence is the leading contributor to the health burden of women. Family violence reform resources have also been targeted to increasing mainstream system capacity to respond to diverse communities, including Indigenous communities, women with disabilities and women from CALD backgrounds.

¹ *A Fairer Victoria, Creating Opportunity and Addressing Disadvantage 2005–06 and 2007*. For further information refer to: www.dvc.vic.gov.au/web14/dvc/dvcmain.nsf/allDocs/RWPBA66A032F874AC59CA2572D00026A891?OpenDocument

² United Nations Organization, 1948, *Declaration of Human Rights*, Geneva.

³ Victorian Charter of Human Rights and Responsibilities Act 2006. For further information refer to: www.justice.victoria.gov.au/humanrights/

1.1.1 Key principles underpinning the implementation of the Victorian Government Elder Abuse Prevention Strategy

Competence	All adults are considered competent to make informed decisions unless demonstrated otherwise.
Self-determination	With appropriate information and support, individuals should be encouraged to make their own decisions.
Appropriate protection	Where a person is not competent to make their own decisions, it may be necessary to appoint a guardian or administrator. If a person is represented, their wishes should still be taken into account as far as possible.
Best interests	The interests of an older person's safety and wellbeing are paramount. Even when they are unable to make all decisions themselves, their views should be taken into account.
Importance of relationships	All responses to allegations of abuse should be respectful of the existing relationships that are considered important to an older person.
Collaborative responses	Effective prevention and response requires a collaborative approach which recognises the complexity of the issue and the skills and experience of appropriate services.
Community responsibility	The most effective response is achieved when agencies work collaboratively and in partnership with the community.

The Victorian Government approach is driven by informed examination of the shortcomings and strengths of our current systems, rather than from a crisis approach. The philosophy of empowerment involves listening to older people—it is an active process. Older people should be provided with the best available information to assist them to make decisions about their lives, including information about the services they can access, should they require them.

1.2 The nature and definition of abuse

Elder abuse was recognised in the 1980s as an under-reported form of societal violence, similar to child abuse in terms of having unrefined methods to detect and modify the abuse. Currently, there is no systematic collection of statistics or prevalence studies (that is, the total number of ongoing cases in the population at a point in time). However, some Australian studies estimate that prevalence ranges from below 1 per cent to 5 per cent.⁴ Results of different studies vary, depending on the methodology and definitions used, but evidence suggests that abuse of older people is much more common than societies admit. Much of the problem is hidden, and data is not collected in a consistent manner.

While the population is growing older and living longer, this does not mean that people are exposed to abusive circumstances that they would not have encountered when younger. The difference is that with advancing age may

⁴ Boldy D, Horner B, Crouchley K, Davey M, Boylen S, 2005, *Addressing elder abuse: West Australian case study*, *Australasian Journal on Ageing* 24(1): 3–8.

come new vulnerabilities—not always associated with frailty. Some correlates of ageing may create a life pattern not as robust and as capable of managing life issues and new experiences, whether chosen or imposed, including:

- shrinking social and friendship networks
- reduced access to information
- capacity to keep up to date with changes
- loss of economic power.

When choosing an age to define ‘older’ for the purposes of this issue, 65 years is commonly used, but most people do not experience vulnerabilities at that stage in their life.

The Commonwealth Government uses population estimates for the general population aged 70 years or over, plus Aboriginal Australians⁵ aged 50 years and over, when planning services for older people. The *Commonwealth Government Aged Care Act 1997* recognises the implications of differences in health status and life expectancies between the Aboriginal population and general population.

Other countries, and some international bodies, use 60 years. The age chosen is influenced by cultural context and life course.

For the purposes of identifying and defining abuse of older people, the focus should be on the effects on the older person, rather than the intention of the perpetrator.

1.2.1 Victorian Government definition of elder abuse

The report of the Elder Abuse Prevention project, *Strengthening Victoria’s Response to Elder Abuse* (December 2005), defines abuse as:

Any act occurring within a relationship where there is an implication of trust, which results in harm to an older person.

This definition is consistent with Australian and international agreement about what constitutes abuse of older people and defines a relationship where trust is the sole connection. It excludes relationships that, for example, are based on the exchange of money for services.

For information on types of abuse (financial, physical, sexual, psychological or emotional, social and neglect) and suggested identifying behaviours and signs, refer to [Section 2: Types of abuse and risk factors](#).

Abuse is typically carried out by someone close to an older person with whom they have a relationship implying trust, including family members or friends. Often an older person is dependent on the perpetrator, for example, where an older person is frail or incompetent and the perpetrator is the principal carer. Mental incompetence (for example, dementia), physical frailty or economic circumstances may force an older person to depend on another for housing. However, dependence is not a defining characteristic of abuse—the older person might not be dependent, and may actually be supporting the perpetrator.

Sometimes abuse is the continuation of long-standing patterns of physical or emotional abuse within a family. It could also be the result of stressful situations, such as changes in living arrangements and personal relationships which occur when the care needs of an older person change due to increasing frailty. Abuse can also be the result of the personal characteristics and life course of the perpetrator, such as substance abuse or financial dependency.

Abuse may occur as a result of ignorance or negligence—or it may be deliberate. Some forms of abuse are criminal acts, for example, physical and sexual abuse. Other types, such as financial misappropriation, may not

⁵Department of Health and Aged Care (DHAC), 2001, *Aged Care in Australia*, Canberra

reach the level of criminality, but may require redress through guardianship or civil proceedings ([Section 8: Case studies](#) contains some examples).

The range of acts or omissions that constitute abuse occur along a continuum: at one end, harm results from a poor understanding of an older person's needs; at the other, harm results from aggression and serious physical assault. In different circumstances, different sorts of interventions are required.

The underlying principle of empowerment on which the Victorian Government response to abuse for people living in the community is based focuses on 'strengthening the arm' or capacity of an older person to say and act on what they want to happen and when.

1.3 Abusive relationships other than those based on trust

People generally recognise abuse, but often choose to excuse it due to surrounding circumstances. Paying attention to the different contexts in which incidents of abuse occurs can be more useful than merely defining the nature of the abuse, such as physical, psychological, sexual, neglect or financial.

1.3.1 Consumer-based circumstances

These occur when money is exchanged for a service, and are based on commercial relationships, for example: financial planners, accountants, tradespeople, hairdressers.

Consumer Affairs Victoria (CAV, refer to [7.2.3 The Victorian Department of Justice](#)) provides consumer protection for Victorians regarding products and services. CAV advises on consumers' rights and responsibilities and who to contact when dealing with businesses and buying products in Victoria, for example:

- buying and selling cars and property
- renting a house, flat or building
- managing credit and debt
- shopping over the Internet
- fundraising
- current consumer scams and how to avoid them.

1.3.2 Professional misconduct

Where concern exists about how health or community care professionals conduct themselves in general, including suspicion of or alleged abuse, courses of intervention include lodging a complaint with:

- the organisation employing the worker
- the Health Services Commissioner
- the Medical Board
- the Nurses Board of Victoria
- other appropriate regulatory authorities.

For example, the Nurses Board of Victoria has power, under the *Health Professions Registration Act 2005*, to investigate complaints about professional misconduct.

Professional misconduct includes:

- unprofessional conduct of a health practitioner, where the conduct involves a substantial or consistent failure to reach or maintain a reasonable standard of competence and diligence

- conduct that violates or falls short of, to a substantial degree, the standard of professional conduct observed by members of the profession of good repute or competency
- conduct of a health practitioner, whether occurring in connection with the practice of the health practitioner's health profession or occurring otherwise than in connection with the practice of a health profession, that would, if established, justify a finding that the practitioner is not of good character or is otherwise not a fit and proper person to engage in the practice of that health profession.

'Professional performance' means the knowledge, skill or care possessed and applied by a registered health practitioner in the provision of regulated health services. A 'professional standards panel' is one established by a responsible board under Schedule 2 of the Act. 'Proprietary interest' means a legal or beneficial interest, and includes a proprietary interest as a sole proprietor, partner, director, member or shareholder of a company or as the trustee or beneficiary of a trust.

Such misconduct can be reported to appropriate professional regulatory bodies, the Health Services Commissioner or, in some cases, the relevant government department.

The Nurses Board of Victoria also has the power to investigate complaints of 'unprofessional conduct' within the meaning of Section 3(1) of the Health Professions Registration Act.

Alleged criminal activity should be reported directly to the police.

If harm is suffered, an older person may have remedies under common law, such as an action for negligence or breach of contract.

1.3.3 Harassment and criminal acts

Such acts by strangers are excluded from the definition of elder abuse due to the absence of a trusting relationship, and are more appropriately classified as criminal activity.

1.3.4 Self-neglect or self-mistreatment

Behaviours identified as self-neglect or self-mistreatment would not align with the definition of elder abuse, nor the context, as defined in this guide.

Such behaviours might be better managed through the broader health system, the police or local municipal council, depending on the circumstances. For example, if self-neglect occurs in which a competent person insists on living in unhygienic conditions, the situation could be addressed as a nuisance under the *Health Act 1958*.⁶ However, the nuisance provisions in the Health Act only enable action to be taken with respect to a person who has a nuisance emanating from their property that poses a risk to the health of their neighbours. In this instance, the local municipal council may be the first point of contact.

Self-neglect or self-mistreatment of an individual may co-exist with abuse associated with a relationship between that individual and a trusted person.

1.3.5 Residential aged care services (RACS)

Older people may also be susceptible to abuse in residential aged care or similar settings, which could be evidenced in physical, financial, sexual, psychological, emotional or neglectful behaviours similar to community settings.

Policy and practice regarding preventing abuse of older people in community and residential aged care settings are quite similar. However, abuse that occurs in a residential aged care setting might better be characterised as a 'failure of care' on the part of the provider, who has the responsibility to ensure that residents are protected from abuse.

⁶ Refer to Part 3 of the Health Act. The Health Act will be replaced by the *Public Health and Wellbeing Act* on 1 January 2010.

The Commonwealth Government, as the funder and regulator of residential and community aged care services under the Aged Care Act 1997, introduced major safeguards against abuse. Refer to [7.2.4 The Commonwealth Department of Health and Ageing](#) for further information.

1.4 Additional considerations

1.4.1 Abuse of older Aboriginal people

Abuse in context

Those who work in the field and work in Aboriginal communities will be familiar with the increasing incidence of abuse. Many Aboriginal people have either personally experienced abuse or violence, or know someone who has.

Statistics on abuse or violence in Aboriginal communities points to an increase in incidence. However, becoming more familiar with the factors contributing to this increase should strengthen understanding of how better to improve the situation.

One factor alone cannot be singled out as causing abuse in Aboriginal families; rather, a multitude of interrelated factors are attributable. A useful way of understanding these factors is by categorising them into two groups:

Group 1 factors include:

Colonisation; policies and practices; dispossession of land and traditional cultural dislocation; inherited grief and trauma; dislocation of families through child removal policies; the impact of institutionalism; the breakdown of community kinship systems and Aboriginal lore, including the adaptation and change of gender roles.

Group 2 factors include:

Marginalisation as a minority; society attitudes in general and stereotyping; direct and indirect racism; economic exclusion; unemployment; welfare dependency; past history of abuse; entrenched poverty; destructive coping behaviours; addictions; alcohol and drug abuse; health and mental health issues; low self-esteem and a sense of powerlessness.⁷

Group 2 factors can be caused or compounded by Group 1 factors. The interplay of these factors in individual families' experiences of abuse can be exceedingly complex.

Addressing abuse of older Aboriginal people

The combination of the above factors impacts on older Aboriginal people considerably, particularly the responsibility for a variety of roles to meet the expectations of their community. For example, many older Aboriginal people provide multiple caring roles, including kinship care. This may involve caring for children removed from parents due to abuse and neglect and then cared for by family, rather than by a foster carer unrelated or unknown to them. These multiple roles may expose older Aboriginal people to broader potential abuse from within their community.

⁷ Cripps, K, 2006, *Indigenous Family Violence: From Emergency Measures to Committed Long-Term Action*. An early draft of this paper was presented 29 November 2006 as part of the Robert Riley Memorial Lecture Series, Curtin University. For further information refer to: dbs.ilectures.curtin.edu.au/ilectures/ilectures.lasso?ut=856. Dr Kylie Cripps is an Aboriginal academic, currently a CIPHER post-doctoral research fellow at the Onemda VicHealth Koori Health Unit, University of Melbourne.

Heightened interventions have led to increased scrutiny of Aboriginal people, perhaps contributing to instability within families. Many feel disempowered in their roles, because traditionally, family structures were safe and secure. Western law and the struggle to live in two societies continue to affect Aboriginal people.⁸

In the context of Aboriginal culture, the term ‘older’ and ‘elder’ are often used interchangeably. In the context of abuse of older Aboriginal people, the term ‘recognised elders and respected community representatives’ could be used, because age alone does not necessarily bring with it recognition as an elder. Some Aboriginal communities will have few recognised elders; in other instances Aboriginal people above a certain age will refer to themselves as elders.

When discussing or negotiating with Aboriginal communities it is important to recognise and involve elders and respected community members as well as communicate with Aboriginal community organisations. This will vary between communities, and might involve, for example, making contact with the Aboriginal Housing Board of Victoria to assist with disseminating written information. Workers should select an Aboriginal organisation whose purpose aligns with the assistance sought. Relevant Aboriginal organisations include local Aboriginal community-controlled organisations or Aboriginal peak bodies, such as the Victorian Aboriginal Community Controlled Health Organisation (VACCHO). For further information refer to [7.1.16 Victorian Aboriginal services](#).

Aboriginal people may also receive service support from generic or Koori-specific organisations. Much will depend on the choice of an older person and the circumstances they experience.

Current government strategies addressing Victorian Aboriginal communities, older people and abuse

In 2002 the Victorian Government released a framework made up of three stages to develop and implement an Indigenous Family Violence Strategy (IFVS)⁹ for Victoria:

- Stage 1 established an Indigenous-led taskforce to advise government how to address family violence within Indigenous communities effectively (the final report was released in 2003).
- Stage 2 was the government’s response to the recommendations of the taskforce (2004), which established an Indigenous Family Violence Partnership Forum in April 2005.
- Stage 3 involved the development and implementation of a ten-year plan to address family violence in Indigenous communities, which was launched in June 2008.

The Indigenous community and the Victorian Government recently agreed on a ten-year plan (Stage 3, above), called Strong Culture, Strong Peoples, Strong Families—Towards a Safer Future for Indigenous Families and Communities, to address Indigenous family violence. The plan is the culmination of a community-led process, supported by government and overseen by the Indigenous Family Violence Partnership Forum. The plan outlines agreed strategies and actions for both government and community to prevent and eliminate family violence in Indigenous communities.

Indigenous community members provided extensive input into the development of the plan under the leadership and guidance of Indigenous Family Violence Regional Action Groups (refer to [7.1.16 Victorian Aboriginal services](#)). These groups have a lead role in strengthening community leadership and driving local action to educate, prevent, reduce and respond to family violence in the Indigenous community.

These groups are an inclusive mechanism for the Victorian Indigenous community to develop local responses to family violence matters, ensuring they are responsive and culturally relevant to indigenous individuals, families and communities.¹⁰

⁸ Report on the findings of the *Department of Human Services The Koori Alcohol and Drug Plan 2003–2004*.

⁹ Refer to: www.office-for-children.victoria.gov.au/family-violence-sexual-assault/indigenous

¹⁰ For further information refer to: www1.dvc.vic.gov.au/aav/

The Department of Human Services report *Improving the way we work with Aboriginal organisations*¹¹ aims to strengthen outcomes for Aboriginal Victorians by supporting the capacity of Aboriginal community-controlled organisations (ACCO).

The Home and Community Care (HACC) Victorian Indigenous Committee for Aged Care and Disability (VICACD) vision is to improve the wellbeing and quality of life of Aboriginal elders, carers and people with a disability living in Victoria. VICACD represents the needs of Aboriginal people and agencies in Victoria on aged care and disability issues.

The Department of Human Services, Aged Care Branch, has developed a Strengthening Home and Community Care (HACC) in Aboriginal Communities strategy (January 2008), which responds to several projects and reports commissioned by the department from 2002 to 2006. The project aims to enhance the capacity of HACC-funded Aboriginal organisations to provide services to Aboriginal aged and disabled people and their carers.

This strategy takes into consideration the principles of the Cultural Respect Framework (Australian Health Ministers Advisory Council, 2004, *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–09*, Department of Health, South Australia).

The document *Improving the Lives of Indigenous Victorians: Victorian Indigenous Affairs Framework* aims to ensure Aboriginal people receive the best possible services into the future (refer to the *Project Report*, April 2007¹²). The report highlights the scope, depth and breadth of issues facing this sector on a range of fronts. This project reflects a partnership between key Aboriginal peak and statewide bodies and Commonwealth and Victorian State Government departments.

In May 2008 the Department of Human Services released an updated and more targeted Aboriginal Services Plan (January 2008 to December 2010), replacing the 2004 version.¹³ This new plan is more specific, and highlights areas to improve outcomes and help bridge the life expectancy gap between Aboriginal and non-Aboriginal people and improve the quality of life for Aboriginal people in Victoria.

Addressing the abuse of older Aboriginal people lies in the context of existing strategies, networks and structures which engage older Aboriginal people and Aboriginal communities in Victoria.

1.4.2 Abuse of older people with culturally and linguistically diverse backgrounds

Cultural factors influence how all forms of abuse are viewed, and specific strategies and responses to elder abuse should address such differences.

Being culturally informed and providing sensitive support is an integral component of service provision. It is important that workers provide support with an understanding of culture beyond their country of origin. For example, the perpetrator's refusal to allow workers who speak the older person's language from communicating with them in their preferred (or only) language may be a factor contributing to ongoing abuse. Such isolation can prevent an older person from making disclosures to outside supports, and their only opportunity to communicate without being overheard by the perpetrator may be during personal care activities.

Not having access to workers who can identify with an older person's background (particularly language) can result in minimal understanding of the cultural context of some language or actions that may consequently be deemed insignificant. For example, if a worker commented, 'That person is nervous' in an Anglo-Australian context, there would generally be no cause for immediate concern. However, such a statement made about an elderly Polish person may be cause for concern, because many in the Polish community use the term

¹¹ For further information refer to: www.health.vic.gov.au/koori/improveorg.htm

¹² For further information refer to: www.health.vic.gov.au/koori/posfuturereport.pdf

¹³ For further information refer to: www.dhs.vic.gov.au/pdpd/koori/index.htm

‘nervous’ or ‘nervousness’ to refer to aspects of mental health issues—from mild depression through to someone experiencing a major psychotic episode.

Knowledge of particular cultural barriers faced by older people is important, particularly in the context of safety planning. Prior experience with authorities, such as police, the court system or any type of regime may impact on an older person’s likelihood of accessing these options to enhance their safety.

Victorian Government policy states that, when working with people from a CALD background who do not speak English well, workers should use a professionally qualified interpreter. Friends or family members should not be used as interpreters.

Department of Human Services-funded agencies and services have access to language services (refer to www.dhs.victoria.gov.au/multicultural/ for additional policy information). Staff in all agencies should be familiar with their agency practice regarding accessing language services.

Preventing an older person with a CALD background from having contact with members of their language and/or cultural group can be a form of abuse resulting in physical, mental and social isolation, and can increase the level of dependence on the carer.

What Anglo-Australians consider inappropriate or abusive may not be considered so in other cultural groups, particularly when it comes to financial management.

Ethno-specific service providers can be consulted by mainstream providers to provide cultural advice on a range of factors and assist with contextual understanding of different communities. This approach contributes to informed and effective response and support.

1.4.3 Gender and diversity considerations

A Fairer Victoria (2007)¹⁴ outlines and builds on the Victorian Government’s commitment to ensuring fair and accessible services for all Victorians with a focus on disadvantage and inequality.

Victoria’s Integrated Health Promotion Framework¹⁵ recognises differences in gender and culture beliefs, and that gender relations and cultural values and practices are central to how health beliefs and behaviours are developed and carried out.

A shift has occurred away from treating women and men as respective homogeneous groups. We now look at how sex and gender interact with other social determinants, such as socio-economic status, Aboriginal origin, age, disability, cultural and linguistic diversity, geographic location, sexual orientation and gender identity.

The Victorian Women’s Health and Wellbeing Strategy Stage 2, 2006–2010 (VWHWS) developed a gender and diversity lens aimed at Department of Human Services policy makers and workers in funded agencies. This was designed to assist with considering the gender implications of their work, which will have beneficial outcomes for both women and men.

The principles underpinning the Victorian Government’s Family Violence Reform include recognition that:

Responses to family violence must recognise and address the power imbalance and gender inequality between those using violence (predominantly men) and those experiencing violence (predominantly women and children).

¹⁴ A Fairer Victoria, 2008, For further information refer to: www.dvc.vic.gov.au/web14/dvc/dvcmain.nsf/allDocs/RWPBA66A032F874AC59CA2572D00026A891?OpenDocument

¹⁵ Department of Human Services, 2003, *Integrated health promotion: A practice guide for health providers*: www.health.victoria.gov.au/healthpromotion/what_is/index.htm

Family violence affects the entire community and occurs right across society, regardless of location, socio-economic and health status, age, culture, gender, sexual identity, ability, ethnicity or religion; therefore, responses must take into account the needs and experiences of people from diverse backgrounds and communities.

Sex and gender are not mutually exclusive concepts. Gender should sometimes be considered outside the traditional concepts of masculinity and femininity. For example, some people born intersex may not have a clear biological sex distinction, and transgendered people may experience an inner sense of gender that is different from their sex.

Responses to the impacts of gender and health require different strategies for women and men, and these will be influenced by a range of cultural, social and economic factors. For example, gender can influence:

- decision making
- access to resources
- the organisation of family life and care responsibilities
- division of paid and unpaid labour
- economic status
- educational background
- experiences of abuse or violence.¹⁶

¹⁶ Women's Health Victoria: *Why Women's Health?* www.whv.org.au/health_policy/gender.htm#why