CASA House Centre Against Sexual Assault

SUBMISSION TO VICTORIAN GOVERNMENT

INQUIRY INTO ELDER ABUSE PREVENTION –
COMMUNITY EDUCATION AND STRENGTHENING SERVICE RESPONSES FOR VICTORIA

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CASA House is a department of the Royal Women's Hospital which cares for the health of women and newborn babies and responds to the social and cultural diversity of all the communities we serve. Our role extends beyond the provision of clinical services to advocating changes that will improve women's health and well being. Amongst RWH strategic goals are

- Leadership in women's health advocacy and the promotion of a social model of women's health care, *and*
- Responding to the diversity of our community and engaging with our stakeholders.

In recognition of the key role which RWH can play in identifying and working to prevent all forms of violence against women we are in the process of developing clinical practice guidelines and a program of training and education for all staff. The aims are to ensure practice sensitive to the impact of violence, to create a safe environment for women to disclose their experiences of violence and to provide appropriate support, information and referrals.

CASA House has contact with thousands of victim/survivors of sexual assault each year. These contacts are made through

- calls to the counselling and support telephone line,
- provision of crisis intervention and care at the time of immediate crisis following sexual assault, and
- provision of ongoing support, counselling and advocacy to victim/survivors of recent and past sexual assault.

Responses to the Consultation Paper

QUESTION 1 - PREVENTING ELDER ABUSE – COMMUNITY EDUCATION AND AWARENESS

a) Comments about the strategies proposed in the Consultation Paper, and how to implement them.

1. The Consultation Paper (page 5) asserts that 'studies show that there is minimal difference in the rates of abuse between men and women'. The only study cited is Curtin University of Technology's Elder Abuse in Western Australia (2002). Amongst those findings (on pages 3 and 16) it is recorded that there is a **markedly higher rate of abuse amongst females**. This distortion of Curtin's gendered findings about the prevalence and incidence of violence and abuse experienced by older people made by authors of the Consultation Paper crucially undermines the objectives of the Paper and the Victorian Government. It casts considerable doubt on the credibility of the Paper. It undermines and conceals the experience of older women and also invalidates many of the strategies proposed. Currently there are no population studies in Australia that compare rates of violence experienced by women and men across their lives. The Australian Bureau of Statistics will have data to contribute to this discussion after it analyses the findings of the Personal Safety Survey to be conducted between August and November 2005.

2. In the Consultation Paper and in 'With Respect to Age', violence perpetrated against older people is defined by the situation or context within which it occurs – the family or an institution such as residential facility. This implies that there is something inherent about the situation, context or relationship that evokes, provokes, explains and justifies the violence and abuse. This approach to understanding violence conceals the fact that violence and abuse are deliberate acts of power and control most often perpetrated by men. The failure of the document to identify a perpetrator fundamentally undermines any prevention strategy. The 'situations' and 'relationships' identified are regular components of people's lives, are usually valued by our society and individuals themselves and are, at the very least for some, unavoidable.

3. Although the paper acknowledges that violence, including elder abuse, is **mostly perpetrated by men against women**, the strategies fail to follow through with this fact in mind. There is an ample body of work exposing the inadequacy of 'elder abuse' approaches for the very reason that they fail to consider the differential experiences and impacts of violence upon older women and men (Mears, 1997; Duncan 2002). Policies, guidelines and strategies that ignore current and rigorously achieved evidence are likely to fail to achieve the elimination of violence, including elder abuse. Our concerns are twofold: firstly that older women will remain at risk of violence, and secondly that individuals and services that are responsible for supporting older women when they disclose or allude to experiences of violence will fail to recognise the signs or know how to respond appropriately.

4. In recommending that older women and men identify their **risk of experiencing violence and abuse** the Paper implies that potential victims can prevent violence and abuse happening to them. Specifically that suggests that they can and should do something to stop offenders from being violent.

    - This replicates equally flawed campaigns to prevent violence that are directed at women of all ages and exhort potential victims to assess their risk of experiencing violence and take preventative action. Such campaigns misapply the practice of 'risk assessment' used in health promotion models where target groups e.g. smokers have some level of agency and choice about their own actions and choices. Logically, in the case of violence and abuse 'risk' of violence relates to the likelihood of (usually) men to perpetrate.

    - All available evidence shows that perpetrators of violence are overwhelmingly those women, and in this case older women and men, know and trust (as the Consultation Paper says). They are generally very ordinary people, and rarely are violent and abusive in front of witnesses. They usually **escalate their use of violence over time and use multiple forms of abuse** to maintain control over the victim/survivor. Victims do not cause offenders to be violent and therefore cannot prevent them from being violent.

    - Prevalence and incidence of relationship and family **violence against women of all ages is high** (D'Arcy, 1999; Mazza, Dennerstein and Ryan, 1996; Mouzos and Makkai, 2004; Parker, 1999; Vic Health, 2004; Wilke and Vinton, 2005; WHO, 2002). Also, recent research notes that older women experience violence at similar rates to younger women (Mouton and others, 2004). It is alarming and disingenuous that the Consultation Paper declares that older men and women experience violence and abuse at similar rates, for example the Curtin study (2002).

    - In summary experiences of violence and abuse are, although of epidemic proportions, **not predictable** and therefore may not be anticipated. For these reasons individuals are unable to assess their own chances of experiencing violence.

5. **Empowerment** models for potential victims have not nor could be used to establish safety from abuse. They are effective however, in working towards recovery with victim/survivors of violence and abuse.

6. **Risk**, in relation to violence, must be related to determining risk of those likely to offend. And the best evidence for that is gender and prior use of violence.

7. Strategies in the Consultation Paper replicate what is being done elsewhere in regard to 'elder abuse'. They generally ignore, and therefore mininise older

women's experience of violence across the life span and the consequent health and emotional impacts. This despite **ample contemporary research**, for example done on behalf of the Commonwealth Government's Partnership's Against Domestic Violence, Elder (2000) and Duncan (2002) in Victoria, and Mears and Sargent (2002) in NSW. VicHealth (2004) identifies intimate partner violence has a greater impact on the health of Victorian women under the age of 45 than any other risk factor. These impacts on the health carried into older age can be expected to contribute to increased vulnerability of older women, and therefore their likelihood of experiencing violence.

8. Strategies have been drawn together without reference to **agencies currently delivering services**, including documented examples, to older women who are victim/survivors of violence and abuse, including centres against sexual assault and domestic violence services. Given that the State Government funds most of these agencies it is an amazing oversight to ignore resources and expertise developed through the State's involvement and at its cost.

9. **Mediation** is not an appropriate way to prevent or respond to violence. Parties are not equal where one is a victim of the other party's violence.

b) What other strategies could be added?

- Definition of 'elder abuse' must be expressed as the experience of violence perpetrated by another person, usually a man, usually known and trusted. Women usually experience multiple forms of violence concurrently from the perpetrator. Definitions must **identify and attribute agency to perpetrators**, only on that basis can community prevention strategies be appropriately directed. This approach is also very important in enhancing possibilities for **disclosure and recovery**.

- Emphasise elder abuse in the **context of lifetime experience of violence** and impacts of violence. Put simply past experience of violence may contribute to fear and vulnerability to and exacerbate the impacts of current violent and abusive behaviour. Experiences of abuse of older persons will usually vary for women and men. Women often experience many forms of violence throughout their lives and identify that emotional and psychological abuse have as profound and ongoing impacts as physical, sexual or other forms of abuse.

- Aged care agencies etc. should **collaborate** with agencies already providing services to victim/survivors of violence.

- Strengthen, with funding and other resources, **agencies already providing services to victim/survivors of violence.**

- The ‘case’ language used in the Consultation Paper dehumanises victims and perpetrators of violence, and undermines aims for ‘integrated’ responses. Wording throughout should read ‘**victim/survivors of elder abuse’** instead of ‘case’ or cases’.

- Support and lead the community to work against violence.

c) Examples of good practice of awareness raising activities about prevention.

- In relation to **anti violence strategies or campaigns** there have been very few conducted, and these have been very difficult to evaluate because they are addressing large scale, deep social and individual change in behaviour and attitude.

d) Strategies to ensure that the interests of special needs groups are met. (Special needs groups include Indigenous people, people of cultural and linguistic diversity).

- **Sincere, genuine and broad** community consultation conducted by people the communities trust, and then decisions made consistent with community advice.

- A **range of flexible models** are required, NOT one size fits all.

- **Access and equity** must be core principles for agencies providing services to victims/survivors. Strategies must include training for health professionals providing services to these, and emerging communities.

- For example, responsibility for information sessions and education about both preventing elder abuse and supporting Indigenous victim/survivors appropriately should lie with **Aboriginal controlled services**.

- **Interpreters** should be used to enable individuals and communities to express their opinions and preferences.

- **Culturally and linguistically diverse communities** should be targetted and the means provided to make information and resources accessible.

- **Older women with disabilities** should be provided with information in a range of modalities that they identify as needed. This is important for elderly women where disability may develop as a part of, or overlap with ageing.

e) What we currently do

- respond to, support, and advocate for victim/survivors of violence of all ages
- participate in public inquiries and law reform
- conduct community and professional education and training
- initiate and participate in campaigns to end violence

and what else could we do?

- more with more funding

QUESTION 2 – ELDER ABUSE PREVENTION – STRENGTHENING SERVICE RESPONSES

a) Comments on the above service models and how to implement them.

- Integrated responses have potential to assist victim/survivors and hold perpetrators of elder abuse accountable. It is imperative that older people are provided with accurate information and support to be able to advocate for themselves, or to instruct others to advocate on their behalf, about their choices.
- There is limited evidence that offender/abuser programs achieve positive changes. Should they be conducted it is very important that the stories of victim/survivors be presented to those participants so that they hear about the impacts of their violence on victims. It is also critical that the safety of victim/survivors is the highest priority.

b) What other strategies could be added?

c) Some examples of interagency cooperation in which this agency participates.

- Joint training with Domestic Violence and Incest Resource Centre (DVIRC)for community workers and professionals – 'Working with Older Women: Responding to Past and Current Violence'
- Joint training with DVIRC on the same subject to City of Yarra team leaders in the Home & Community Services Department

d) Strategies to ensure that the interests of special needs groups are met? (Special needs groups include Indigenous people, people of cultural and linguistic diversity).

- As above for previous section

e) For your organisation or sector to address the issues raised, what:
- do you currently do?- could you do?

- As above for previous section

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