

Seniors Rights Victoria

Submission to the Royal Commission into
Victoria's Mental Health System

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Executive summary

Since the Royal Commission into Family Violence and the subsequent ambitious and comprehensive reform agenda, the Victorian Government has been playing a leading role in addressing and preventing elder abuse. In order to continue this role, and to properly support the mental health and wellbeing of older people, the Victorian Government needs to apply the same dedication to reforming the mental health system.

The multiple intersections of mental health and elder abuse are complex, including both the mental health of the older person and the mental health of those who perpetrate elder abuse. Reform of the mental health system to better support older people and their families will also play a vital role in preventing and addressing elder abuse, which is a form of family violence.

This submission from Seniors Rights Victoria (SRV), the state-wide elder abuse service, focuses on three aspects of mental health and elder abuse:

1. Poor mental health increasing a person's vulnerability to elder abuse
2. The effect of elder abuse on an older person's mental health
3. The older person as a carer for a family member living with mental illness.

Ageing and gender inequality are considered two of the drivers of elder abuse but research has also identified a number of reinforcing factors that increase the likelihood of elder abuse occurring. As one of these factors is poor mental health (of both the older person and the elder abuse perpetrator) this submission details how the mental health system should be improved to lessen the likelihood of such abuse occurring.

Proper support and treatment for older people with, or at risk of, mental illness makes them less vulnerable to abuse. Mental health for older adults can be improved by addressing loneliness and social isolation, increasing the awareness and diagnosis of depression and anxiety in older adults, ensuring mental health practitioners specialise in the unique circumstances of later life, and ensuring differential diagnosis regarding dementia and depression, which can exhibit some similar symptoms.

The mental health and wellbeing of older people who have experienced elder abuse can be better supported by ensuring adequate ongoing funding of the social work and legal service provided by SRV. Regardless of how strong and resilient they are, people who have experienced elder abuse may be traumatised, stressed and struggling to cope. The Victorian Government has an important role in helping people deal with the consequences of elder abuse, and this includes ensuring mental health care is available and affordable, and that there are dedicated counselling and support group services for people who have experienced elder abuse.

As parents, older people are often placed in a role of responsibility and support for an adult child who is experiencing mental illness. The Victorian mental health system is reliant on family carers to provide housing, living expenses and daily care, yet this is often at great emotional and financial expense for the carer, who is sometimes also at risk of elder abuse. In order to properly support older people who are providing care for family members there needs to be additional service pathways for early access to mental health treatment, universal carer-inclusive practice, and an increased recognition of the potential for elder abuse to occur in family environments where someone is experiencing mental illness.

The following summary of recommendations gives an overview of this submission by Seniors Rights Victoria to the Royal Commission into Victoria's Mental Health System.

Summary of recommendations

1. The Victorian Government should provide funding for group-based interventions that are designed to address social isolation and loneliness in older adults. Group-based interventions would play a role in both preventing and addressing depression.
2. The Victorian Government should ensure continual awareness-raising that depression and anxiety are not a normal part of ageing, and they can be treated.
3. Mental health professionals should be adequately trained in the unique characteristics of later life, and older people seeking mental health support should be enabled to identify the professionals with this expertise.
4. Steps should be taken to improve public understanding and professional diagnosis of mental illness, as distinct from dementia, in an older person.
5. The Victorian Government should continue to support Seniors Rights Victoria to address and prevent elder abuse. In particular, the Government should ensure that SRV is able to provide the necessary social work advocacy to support the mental health and wellbeing of older people who have experienced elder abuse, including those seeking legal redress.
6. The Victorian Government should fund the provision of counselling services specifically for people who have experienced elder abuse, and the evaluation of such counselling services for effectiveness.
7. The Victorian Government should fund the establishment and evaluation of community support groups for people who have experienced elder abuse.
8. The Victorian Government needs to ensure that mental health treatment is available and affordable, and it needs to match the demands of the ageing community.
9. The Victorian Government needs to develop service pathways via which family members can access mental health treatment for someone close to them, including an early intervention mental health outreach team that could be invited into a person's home to encourage mental health help-seeking before a situation reaches crisis point.
10. The Victorian Government needs to ensure that carer-inclusive practice is mandated for all mental health service providers to encourage recognition of the role of carers, and their needs. In turn, carer support services need to be properly funded to ensure they are available and accessible regardless of where the carer resides.
11. The Victorian Government needs to fund family violence (including elder abuse) training for mental health service providers.
12. The Victorian Government needs to ensure that mental health service providers assess the risk of elder abuse when consumers are residing with, or discharged to, ageing parents.
13. The Victorian Government needs to ensure that older adults who become or remain carers of their adult children with mental illness are given adequate support so that abuse is prevented or early intervention occurs.

1 About this submission

1.1 Introduction

The consequences of elder abuse for the individual, the family, and society at large are complex and often severe. Elder abuse can result in family breakdown, poverty, homelessness, financial stress, and poor mental and physical health and wellbeing – all of which are devastating on a personal level and incur great costs to society in the form of social services, law enforcement and health services.

The multiple intersections of mental health and elder abuse are complex, including both the mental health of the older person and the mental health of those who perpetrate elder abuse. Reform of the mental health system to better support older people and their families will also play a vital role in preventing and addressing elder abuse, which is a form of family violence.

This submission focuses on three aspects of mental health and elder abuse:

1. Poor mental health increasing a person's vulnerability to elder abuse
2. The effect of elder abuse on an older person's mental health
3. The older person as a carer for a family member living with mental illness.

In particular, this submission considers the following issues related to the terms of reference for the Royal Commission into Victoria's mental health system:

- Support for older people with poor mental health, particularly related to family violence
- Access to the mental health system
- Pathways between the mental health system and other support services
- Support for and expectations of carers and family members of people with mental illness.

This submission takes as its starting point the experiences of older people who have been clients of Seniors Rights Victoria (SRV). This means they have experienced elder abuse and approached SRV for assistance in addressing the abuse. These client stories are told through direct quotations and through anonymised case studies, where names and identifying details have been changed. The submission also draws on the extensive experience of SRV staff, primarily social work advocates and lawyers who work with older people who have experienced elder abuse. It also draws directly from recommendations made in SRV's 2015 submission to Victoria's next 10-year mental health strategy.

This submission highlights the multifaceted drivers and far-reaching consequences of mental illness. Better prevention of elder abuse through stronger family support services would lead to a decrease in depression and anxiety among older people. In turn, better support for older people experiencing mental illness – including mental illness exacerbated or caused by elder abuse – would make them less vulnerable and more able to address elder abuse.

This submission strongly supports early intervention – rather than a crisis response – to support people who experience mental illness. All too often a crisis point is needed to access mental health services, which is not only detrimental to the person with mental illness but can result in psychological, physical and financial stress and elder abuse for other family members, as well as the need for a police response,

legal services and emergency health service intervention, which each come with increased individual and community cost.

1.2 About Seniors Rights Victoria

Seniors Rights Victoria (SRV) works to prevent elder abuse and safeguard the rights, dignity and independence of older people. SRV operates under the principles of empowerment of older people, working with individuals to increase their degree of self-determination, enabling them to represent their own interests and claim their rights.

Elder abuse is any act which causes harm to an older person and is carried out by someone they know and trust such as a family member or friend. The abuse may be physical, social, financial, psychological or sexual and can include mistreatment and neglect.

SRV is a community legal centre operating a helpline and a lawyer–social worker advice and casework model to support older people who have experienced elder abuse. SRV provides information, advice, education and support to older Victorians, their friends and family members, and service providers, through:

- helpline service including information and referral
- specialist legal services
- social work advocacy, including short-term individual support
- community and professional education.

SRV also has a role in policy and advocacy, capacity building, and working collaboratively with relevant sectors to better identify, address and prevent elder abuse.

Operating since 2008, SRV is funded by the Community Legal Service Program through Victoria Legal Aid and the Victorian Department of Health and Human Services. It is a program of the Council of the Ageing Victoria (COTA Vic) and governed by its board.

2 Elder abuse

2.1 Elder abuse as a form of family violence

The following background information on elder abuse will assist in properly understanding the intersection of the mental health system and elder abuse.

Elder abuse is any form of violence or mistreatment that causes harm to an older person, and occurs within a relationship of trust. Elder abuse can include acts of psychological, financial, physical, social and sexual abuse, as well as neglect. Some older people may describe this type of behaviour as disrespect or mistreatment, rather than abuse or violence. Elder abuse can happen in many contexts, including the home and residential aged care.

As elder abuse most often occurs within the family or a domestic setting, it is recognised as a form of family violence under the *Family Violence Protection Act 2008 (Vic)*. The Victorian Government has also recognised elder abuse as a form of family violence and included it as an area of particular interest within the family violence reforms.

Importantly, elder abuse is often intergenerational and perpetrated by an adult child against their parent. Of the older people who contact Seniors Rights Victoria because they are experiencing abuse, over 90% are being abused by a family member. Two-thirds of these family member perpetrators are sons or daughters of the older person.¹

Some examples of elder abuse include:

- aggressive, threatening and coercive behaviour
- forcing an older person to hand over money or an asset, or misusing their funds
- physical assault
- preventing contact with family and friends
- limiting a person's choices or placing pressure on them regarding decisions they make
- neglecting to provide a person with appropriate health or personal care
- inheritance impatience – the misplaced sense of entitlement to an older person's assets or resources.

Elder abuse does not include disputes over consumer rights or criminal acts by strangers.

2.2 Causes of elder abuse

Social conditions that lead to family violence and elder abuse are sometimes referred to as 'drivers' or 'causes' of violence. There are also reinforcing factors affecting older people and perpetrators of elder abuse, that increase the likelihood of elder abuse occurring. The following information is taken from the Seniors Rights Victoria publication *Elder Abuse as Family Violence* (2018).

2.2.1 Drivers

Ageism, and the way people are treated differently as they age, is a driver of elder abuse. Negative attitudes associated with ageing mean that it can be seen as a time of decline, loss and vulnerability. Ageism results in older people being marginalised and afforded less power and social status. Adult children can feel a sense of entitlement to their parents' finances. When older people are regarded as less valuable, unable to make decisions for themselves and a burden on resources it can result in social and cultural norms where elder abuse is tolerated.

Gender inequality and the imbalance of power between women and men is a driver of family violence. Similar to other forms of family violence, women are more likely to experience elder abuse than men. In addition, some older women experience violence at the hands of their long-term partner or in a new relationship. While women comprise a higher proportion of the older population than men, this alone does not explain the disparity. The intersection of ageism and gender inequality may make older women at higher risk of abuse. However, older men may be less likely to report abuse, and they may also be socially isolated and unaware of the help available to them.²

¹ National Ageing Research Institute in partnership with Seniors Rights Victoria (2015) Profile of elder abuse in Victoria.

² Brian Beach and Sally-Marie Bamford (2014) Isolation: the emerging crisis for older men, Report for Independent Age, UK.

2.2.2 Reinforcing factors

Research has shown that there is a range of factors that can increase an older person's likelihood of experiencing elder abuse, and one of these is poor mental health.³ While these factors do not on their own predict abuse, they can play a role in the frequency or severity of the violence.

Reinforcing factors that may affect an older person and increase the risk of elder abuse include:

- social isolation and a lack of support
- poor physical or mental health
- cognitive impairment, including dementia
- disability or reliance on others for support with daily living
- family conflict
- trauma or past abuse.

Research shows that there is a high prevalence of depression and dementia in people who have experienced elder abuse and neglect though it is not clear whether the presence of dementia or depression might make a person more vulnerable to mistreatment, or whether depression may be caused by mistreatment and dementia symptoms exacerbated.⁴

There is a number of reinforcing factors that can play a role in a person perpetrating elder abuse, including undiagnosed or untreated mental illness. While these factors do not cause a person to become abusive, they can have an influence on the situation.

Reinforcing factors that may affect a person choosing to perpetrate elder abuse include:

- lack of social support
- poor mental health
- dependence on the older person for emotional support, financial help, housing and other assistance
- substance abuse
- caregiver feeling stressed and unsupported.

Poor mental health or mental illness as a reinforcing factor for both the older person and the perpetrator of abuse will be discussed in detail in this submission.

³ Karl Pillemer, David Burnes, Catherine Riffin and Mark S. Lachs (2016) Elder Abuse: Global Situation, Risk Factors, and Prevention Strategies, *Gerontologist*, Vol. 56, No. 2, pp. 194–205.; Ruijia Chen and XinQi Dong (2017) "Risk Factors of Elder Abuse" in XinQi Dong (Ed.) *Elder Abuse: Research, Practice and Policy*, Springer International Publishing, pp. 93–107; Mark Johannesen and Dina LoGiudice (2013) Elder abuse: a systematic review of risk factors in community-dwelling elders, *Age and Ageing*, 42: 292–298.

⁴ Carmel Bitondo Dyer, Valory N. Pavlik, Kathleen Pace Murphy, David J. Hyman (2000) The High Prevalence of Depression and Dementia in Elder Abuse or Neglect, *Journal of the American Geriatrics Society*, Vol 48, Issue 2, 2000.

3 Poor mental health increasing a person's vulnerability to elder abuse

This section speaks to Question 2 and 4:

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

In summary, while older people experience the same risk factors as younger populations regarding mental health, they may also experience additional factors relating to their stage of life, such as being less valued by society, or experiencing a decline in physical and cognitive abilities, without the societal support to respond to these growing needs. Having poor mental health can increase a person's vulnerability to elder abuse, and their ability to cope with its effects.

As a risk factor for both elder abuse and poor mental health, social isolation of older people must be addressed. In addition, there needs to be an increased awareness of the existence of depression and anxiety in older adults, and a willingness to diagnose and treat it with specialist support. Increased efforts need to be made to ensure older people with cognitive difficulties caused by stress, depression and anxiety are not misdiagnosed as having dementia and no capacity for decision-making.

3.1 Mental health of older people

The World Health Organization reports that over 20% of adults aged over 60 have a mental or neurological disorder.⁵ The most common disorders and their approximate prevalence in people over 60 are:

- 7% of people aged over 60 have depression
- 5% of people aged over 60 have dementia
- 3.8% of people aged over 60 have an anxiety disorder
- 1% of people aged over 60 have substance misuse
- One quarter of all deaths from self-harm are from people aged 60 and over.

The Australian Bureau of Statistics report that the prevalence of these disorders in the Australian population might be much higher. It is estimated that 10 per cent of older people (65 years and over) experience depression or feelings of depression and about 11 per cent experience an anxiety-related illness.⁶ While lower than reported levels in the wider population (approximately 13 per cent of people aged 18 years and over are estimated to have depression while close to 15 per cent are estimated to have an anxiety-related condition) this may be affected by lower mental health literacy in older age

⁵ World Health Organization (2017) Mental health of older adults, accessed at <https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults>

⁶ Australian Bureau of Statistics (2018) National health survey - first results: Australia 2017–18 (Catalogue No. 4364.0.55.001), Canberra.

groups. Depression is even more common among people with dementia, with research suggesting the prevalence is 20 to 30 per cent, with people in long-term residential care at increased risk.⁷

Older people experience the same risk factors for poor mental health as younger populations but they may experience additional factors relating to their stage of life. For some older people the compounding impact of traumas and loss throughout a lifetime, coupled with age-related health issues and a loss in functional capability or socioeconomic status, can increase the likelihood of experiencing mental health problems related to psychological distress. Conversely, over the course of a lifetime, many older people have coped with challenges and stressors and built a level of resilience and strength that improves their mental health and their ability to handle further difficulties.

There are some populations of older people who may be at increased risk of depression and anxiety, including:

- older people in residential aged care and hospital
- older people who are carers
- older people with multiple physical limitations
- older people with dementia
- older Indigenous people
- older immigrants
- older women.⁸

Many older people may belong to more than one of these categories, compounding their increased risk.

In Australia, the highest age-specific suicide death rate is for men aged 85 and over and the Australian Institute of Health and Welfare reports that most, but not all, older people who die by suicide have a diagnosable mental disorder at the time of death, most commonly depression.⁹

3.2 Mental illness as a vulnerability to elder abuse

Having poor mental health can make an older person more vulnerable to abuse in a number of ways. Depression and anxiety can affect decision-making and a person's ability to cope with stress, while psychotic illnesses that include hallucinations, delusions and paranoia may make it difficult for a person to cope with daily activities, and may lead to a person having increased care needs.

Both psychotic and mood symptoms of mental illness may put someone in a vulnerable or dependent position where they can be taken advantage of or make poor decisions. For older people, these difficulties may be impacted by age-related illness and disability, as well as financial stresses related to living on a limited income such as the age pension.

⁷ Dementia Australia, Depression and dementia fact sheet. Accessed at <https://www.dementia.org.au/national/support-and-services/carers/behaviour-changes/depression-and-dementia>

⁸ Haralambous, B, Lin, X, Dow, B, Jones, C, Tinney, J and Bryant, C (2009) Depression in older age: a scoping study, Melbourne: National Ageing Research Institute.

⁹ Australian Institute of Health and Welfare 2015. Australia's welfare 2015. Australia's welfare series no. 12. Cat. no. AUS 189. Canberra: AIHW.

As previously discussed, a high proportion of elder abuse is perpetrated by a family member of the older person and it is most often family who are responsible for providing care as a person ages. For these reasons it is not only important to support the mental health needs of older people for their own wellbeing, but also to help safeguard them from elder abuse and its further detrimental consequences.

An older person who is depressed, stressed and anxious may have difficulty with cognitive functioning and this can be mistaken for dementia. In some instances professionals have mistakenly misattributed a decline in cognitive ability to dementia, and ruled that the person no longer has decision-making capacity. A family member or person purporting to be a carer may then strip the person of their autonomy and take control over their life and finances. SRV has been involved in multiple cases where abuse of powers of attorney held by family members has occurred following a misdiagnosis of dementia and a presumed lack of decision-making capacity in older adults.

3.3 Preventing and addressing mental illness in older adults

It is important to prevent and address mental illness in older adults in order to support individual wellbeing and allow people to enjoy and participate fully in life. But it is also important to prevent and address mental illness in order to prevent elder abuse. (Addressing mental illness *caused* by elder abuse will be discussed in more detail in chapter 4.)

3.3.1 Addressing loneliness and social isolation

Major factors affecting the older population are loneliness and social isolation, and these factors also make people more vulnerable to developing depression¹⁰ and to experiencing elder abuse.¹¹

As people age, opportunities for social interaction and meaningful engagement can diminish and as a society we are not very good at recognising or addressing this issue. It is important to note that living alone does not necessarily equate with loneliness, just as living with others (for example, in a residential aged care facility) does not always make for a fulfilling social life. Many daily interactions which previously facilitated a level of participation in society now take place online and without a human element, for example banking and bill paying, shopping, and information seeking. This removal of even inconsequential interactions can increase a person's feeling of disconnection and loneliness.

While many older people have high levels of digital literacy this can be variable and more so than younger generations older people who use social media may be more likely to see it as a complementary but lesser form of interaction than relationships which happen in person. Consequently, online communication and community building may not have the same level of involvement and satisfaction for older generations who spent most of their lives in a pre-digital era.

Addressing social isolation is important in assisting people to maintain good mental health, as well as improving opportunities for people to find and access appropriate mental health treatment. Much has been written about the social isolation of older people, and its effect on mental health and included here as Appendix 1 is *COTA Victoria Working Paper Social Isolation: Its impact on the mental health and wellbeing of older Victorians*.

¹⁰ Jo Moriarty (2005) Update for SCIE best practice guide on assessing the mental health needs of older people, King's College London, Social Care Workforce Research Unit.

¹¹ Seniors Rights Victoria (2018) Elder Abuse as Family Violence.

There is strong evidence to suggest that having a role, good social networks, an adequate income and living in a supportive neighbourhood all contribute to good mental health in later life.¹² Literature reviews regarding the effectiveness of interventions designed to address social isolation and loneliness in older adults suggest that the most effective interventions are group interventions with a focused educational component, and interventions which target specific population groups. Less effective or ineffective interventions are those that only involve indirect contact for the participant or one-on-one interventions conducted in people's own homes.¹³

This indicates that any attempts to improve social connection for older people need to take a community rather than an individual approach, and should be co-designed with older adults, including those in harder to reach populations.

Recommendation: The Victorian Government should provide funding for group-based interventions that are designed to address social isolation and loneliness in older adults. Group-based interventions would play a role in both preventing and addressing depression.

3.3.2 Higher awareness and diagnosis of depression and anxiety in older adults

There has been increased awareness that older people can experience mental illness, however, it often goes unrecognised as it can be seen as a natural part of and response to ageing, or seen as a symptom of a brain condition such as dementia. Hearing, speaking, cognitive or visual impairments may inhibit a person communicating their experience of mental illness, and stigma associated with mental illness, particularly for older adults, may also be a barrier to self-reporting. Other reasons older adults may under-utilise mental health services are a lower mental health literacy in older generations and the tendency for health services to prioritise older people's physical health above their mental health.¹⁴

There needs to be an increased awareness of the existence of mental illness, particularly depression and anxiety, in older adults and a willingness to diagnose and treat it.

Recommendation: The Victorian Government should ensure continual awareness-raising that depression and anxiety are not a normal part of ageing, and they can be treated.

3.3.3 Mental health practitioners specialising in later life

While older people may find appropriate treatment with a range of counsellors, psychologists and psychiatrists, there are not many mental health practitioners who specialise in treating older adults experiencing depression and anxiety (as distinct from psychotic disorders). Older people with depression and anxiety may appreciate treatment by professionals who are well-versed in the stressors that are not unique to but more common in later life, such as multiple and compounding losses, multiple chronic and age-related illnesses, poverty and chronic pain.

Recommendation: Mental health professionals should be adequately trained in the unique characteristics of later life, and older people seeking mental health support should be enabled to identify the professionals with this expertise.

¹² Jo Moriarty (2005) op. cit.

¹³ Anne Pate (2014) COTA Victoria Working Paper Social Isolation: Its impact on the mental health and wellbeing of older Victorians.

¹⁴ Australian Institute for Health and Welfare (2019) Normalising mental illness in older adults is a barrier to care. Accessed at <https://aifs.gov.au/cfca/2019/02/13/normalising-mental-illness-older-adults-barrier-care>.

3.3.4 Misdiagnosis of dementia

There is also scope to improve public and professional understanding and diagnosis of treatable mental illness as distinct from dementia in an older person. As already mentioned in this submission, depression, stress and anxiety may contribute to a decline in an older person's decision-making capacity. A decline in cognitive ability is sometimes attributed to dementia when the cause may in fact be a treatable mental illness. Where a health professional makes a diagnosis of dementia and that the older person does not have decision-making capacity, the older person loses control of aspects of their life to an attorney, guardian or administrator, opening them to abuse. More consideration needs to be given to ensuring that older people experiencing cognitive difficulties due to stress, depression and anxiety are not misdiagnosed with dementia.

Recommendation: Steps should be taken to improve public understanding and professional diagnosis of mental illness, as distinct from dementia, in an older person.

4 The effect of elder abuse on an older person's mental health

This section speaks to Question 2 and 4:

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

In summary, elder abuse has a profoundly negative impact on a person's mental health, causing psychological distress, depression and anxiety, and affecting a person's ability to cope. In order to prevent mental illness in older people caused or exacerbated by elder abuse, it is necessary to prevent and address the underlying elder abuse.

In addition, people who have experienced mental illness caused by family violence, including elder abuse, would likely benefit from interventions and treatment options that directly acknowledge this abuse, such as tailored counselling and community support groups.

The personal story in this section also highlights the need for affordable mental health treatment, particularly for older people on a limited income, or who have been victims of financial abuse. Currently, it is too difficult for older people to access affordable mental health care.

4.1 Consequences of elder abuse

People who have experienced elder abuse have an increased likelihood of experiencing mental illness, and the distress, fear and worry related to the abuse can affect a person's coping and decision-making abilities.

Abuse and mistreatment of any kind can have a profound and detrimental effect on a person. As well as causing feelings of stress and anxiety, elder abuse has been shown to lead to an increased risk of

depression and thoughts of suicide.¹⁵ In addition to the profound negative effects on a person's mental health, elder abuse has been shown to make it more difficult for an older person to cope with age-related illness and disability, often resulting in an increase in ill health, hospital visits, early admittance to residential aged care and early death.¹⁶

Recent research showed elder abuse is a major risk for deteriorations in the mental health of older women.¹⁷ A comprehensive study showed that older women who had high life satisfaction, enthusiasm and energy (described as a stable high mental health trajectory) who then experienced elder abuse, consequently reported a decline in their mental health from which they did not recover. In this instance, elder abuse was measured as (in the prior 12 months) having family members take things without permission, restrict physical freedom and telling the person they are sick or disabled when they are not. With other variables accounted for, this research demonstrated the devastating effect of elder abuse on previously high-functioning women with stable high mental health.

Tricia's story

Tricia's story, told in her own words below, demonstrates the way elder abuse can have a profound effect on a person, and impact every facet of their life. Please note, all names have been changed.

Tricia, 68 years old, has overcome many challenges in her life including the loss of her husband and son, and her own battle with cancer. She attributes her resilience to strong support from her family and friends, particularly her sisters. Tricia has long been supportive of her daughter, Amanda, and Amanda's three children.

“Amanda was married for close to a decade and that ended when she got pregnant and her husband did not want to be a father.”

Amanda was pregnant when she came to live with Tricia in her small unit. She remained there for over five years, having a second child.

“We were a happy little family. I was there when all of them were born; I have been there every day of their lives. You wouldn't believe how close I am to them ... I was the other parent. Amanda and I had our differences in opinion as all mothers and daughters do. She would say, 'I'm right', and I would say, 'I'm right', and somewhere in the middle is the truth. But eventually you get over it, especially when you live together.”

When Amanda's second child was three she and the children moved out. Tricia paid the deposit and first month's rent on a new unit for Amanda, and would often fill the fridge with food and provide items for the grandchildren.

“I didn't want my grandchildren to have my childhood, going from rental property to rental property.”

¹⁵ Chen and Dong (2017) op. cit.

¹⁶ Elizabeth Podnieks and Cynthia Thomas (2017) “The Consequences of Elder Abuse” in Dong (Ed.), 2017, *ibid.*, pp. 109–123; and Ruijia Chen and Xinqi Dong (2017).

¹⁷ Thach Tran, Karin Hammarberg, Joanne Ryan, Judy Lowthian, Rosanne Freak-Poli, Alice Owen, Maggie Kirkman, Andrea Curtis, Heather Rowe, Helen Brown, Stephanie Ward, Carlene Britt & Jane Fisher (2018): Mental health trajectories among women in Australia as they age, *Aging & Mental Health*, DOI: 10.1080/13607863.2018.1474445

Amanda's new partner, Mark, soon moved in and Amanda had a third child. Tricia found she was under a lot of pressure from her daughter to provide ongoing financial support, including a loan to help them buy a new car.

"I never got the money back. My brother-in-law asked Mark, 'When are you going to start paying Tricia back the money?' And he said, 'No, that's a gift, that's Amanda's inheritance.' And I thought, well, I'm not a fighter. And I was already tired and beaten, and I thought I'd just let it go."

When Amanda and Mark were evicted from their property, Tricia suggested they all buy a property together.

"It was an idea I had back when it was just Amanda and her children and I. And I thought we could all live together in a house where there were bedrooms and a house for them and a separate part for me. Because I was sitting there in a unit worth about \$500,000 and my daughter had nothing."

Tricia sold her house and together they bought a property. The agreement was that Tricia would pay the deposit while Amanda and Mark paid the mortgage. Tricia found herself in the position of paying for most of the household expenses, including paying for everyone to go on holiday together. With no help from Amanda and Mark, Tricia turned the garage of the house into a self-sufficient flat for herself but still joined the family for meals.

"My card became an ATM. I lived there for two-and-a-half years. By the end of that time they had me believing I had dementia, that I was bipolar. A key would be taken off my key ring and they'd act as though they had nothing to do with it, but it was the key to the front door of their house, and suddenly I wasn't allowed in there."

Amanda and Mark began to pressure Tricia to pay the mortgage and continued to financially abuse her. They became aggressive and threatening toward her and told her she was unwelcome in their home. The experience has had a huge toll on Tricia's mental health.

"My mental health is terrible at the moment. I have got a body that's like a car that's about to run out of petrol. You know, like a car that shakes and shudders before it stops working? Well, that's my body."

One morning, while caring for her youngest grandchild, Tricia realised she could no longer function.

"I've looked after her every day of her life and it was like second nature to me. But that day it was like she was on red cordial – but it wasn't her, it was me. I couldn't take it. Within ten minutes of my daughter leaving her with me I had to ring up and tell her I couldn't take it anymore. And I was in tears that I couldn't look after my granddaughter, and the way I felt."

Tricia called the CAT team to see if they could help her.

"When I called the CAT team she said – and she was an absolutely beautiful lady – but she said we're absolutely overloaded, we can't come out and see you. If you've got a dog there, pat your dog, have a cup of tea and that will make you feel better."

Later that day Tricia's sister took her into the hospital.

"I went in and my sister sat there for 5 hours with me and the nurse said at Maroondah Hospital they put you in age groups. And my age group, being over 65, she said that all that's upstairs is dementia patients – and that's not you. So really, the public system has nothing for people like me. I was basically sent home."

"The CAT team nurse asked me if I had private health insurance. She said they could ring around the private hospitals and find out who has a bed and they tell me where to go. They found a bed which was the next day, or a day later. And it was scary, to go in there, but good."

"I'd say I had a mental breakdown. Anxiety, depression – I was there for three weeks. I had been bullied for eighteen months."

"The hospital was the best thing that I ever found. The psychiatrist is excellent with medications, getting them spot on, and I have been doing classes for eighteen months there. It started out with relaxation classes, mindfulness, swimming, walking, that kind of thing. And then you went into cognitive behavioural therapy and ACT (acceptance and commitment therapy)."

Tricia is confident that the hospital stay and ongoing support from a psychiatrist was exactly what she needed.

"The classes and seeing the psychiatrist hasn't improved my anxiety and depression, but it helps me deal with it. The aches and pains and headaches and being exhausted are all to do with anxiety and depression: how much they react on the body; how they can give you a racing heart and you can't think straight; how you can get that word that's in your brain, you can spell it, you can see it and you can almost get it to your tongue but it won't come out of your mouth. I thought things like that were something else but it's amazing when you realise how many of these things are related to your mental health."

"I'm 68 now and I was thinking that I must have dementia, and I must have this and that. But I didn't. It's just that my brain was overtaxed with all of these different things that make your body say, 'I can't help anymore'."

When Tricia left hospital she went to stay with her sister.

"I spent three weeks in bed. I couldn't get out of bed. My baby sister, she's wonderful. She would say, 'Come on, we're getting up, we're going for a drive.' I wouldn't want to go. And she'd say, 'Come on, let's go.'"

Tricia decided the only option was to live permanently with her sister and she is now estranged from her daughter and grandchildren.

"I haven't had a house for 18 months now. I have nowhere to go. I live in the back bedroom of my sister's house. I haven't got over it; I'm dealing with it. I'll never be the same. Because of all the things. Losing a husband, losing a son, losing Henry [ex-partner], losing my grandkids – that's a big one."

Tricia sees ongoing mental health support as necessary.

“I will probably see my psychiatrist for the rest of my life. I still have ups and downs. I’ve done all the classes at the hospital twice. Every single class to do with CBT and ACT I’ve done twice because the mental brain is so damaged you can only take in small amounts.”

However, she is very aware that she can only access this support because of her private health insurance. And with the pension as her only income, she can only keep paying the premiums for her insurance because she is living with her sister.

“Because I’m living with my sister I’m paying minimal. And I’m paying this absolutely brilliant psychiatrist \$325 every time I see him. I get \$940 a fortnight but by the time you pay him, pay your health insurance, a bit to run your car around, and a bit to my sister, which is absolutely nothing, there is nothing left. So where people are taking their money and they don’t have private health insurance and they’re in the public system –what help can they get?”

4.2 Supporting the mental health of older people who have experienced elder abuse

As Tricia’s story demonstrates, there are treatments that have supported her to cope with the depression and anxiety caused by elder abuse. These include psychiatric support, medication and a range of group therapies such as meditation and CBT. However, these are not readily available, particularly to those reliant on the public health system, and they are not particular to the experience of elder abuse.

The World Health Organization has noted that people who have experienced elder abuse in domestic settings exhibit higher levels of depression and distress, as well as “feelings of helplessness, alienation, guilt, shame, fear, anxiety, denial and post-traumatic stress.”¹⁸ Seniors Rights Victoria staff state that clients can feel overwhelmed, confused and unable to cope in their usual manner. Pam Morton, previously a lawyer with SRV, observed:

“Elder abuse has crippling implications for victims where the ramifications of disbelief and denial lead to profound changes in confidence and sociability. Older people (particularly women as mothers of adult children) struggle with a sense of failure and shame, and then withdraw from other family members and friends and gradually stop participating in their wider community.

The family home closes down in many ways and becomes a place of retreat and not one of welcome. Others stop visiting to avoid conflict and strife. The older person becomes isolated, lonely and fearful. Taking steps to make changes appear insurmountable, and requires courage that overcomes an almost innate responsibility to protect one’s child.”

4.2.1 Continued funding for Seniors Rights Victoria

The statement above demonstrates the unique characteristics of the psychological distress caused by elder abuse, and indicates the support needed by older people to cope with the stress and trauma of being in an abusive situation.

¹⁸ World Health Organization (2002) World report on violence and health, p. 132-133.

As the state-wide service for addressing and seeking to prevent elder abuse, SRV provides a leading role in serving the community in this area. SRV provides community education to older people about how to safeguard their rights and protect against abuse, as well as providing information to service providers and callers to the elder abuse helpline.

The largest component of SRV's work is to directly support older people who are experiencing elder abuse, through social work advocacy and legal services. This multidisciplinary model of a social worker and lawyer together allows SRV to work with the older person to make the changes they desire to address the abuse. This means the older person is supported by a social worker who takes a holistic view of the older person's needs and circumstances, which is particularly important if the older person needs to take legal action, which can be overwhelming and protracted.

As Tricia's story shows, the older person who has been abused is often experiencing high levels of stress and trauma, which impacts on their physical health, decision-making and their ability to cope. It is imperative for people in this position to have strong, on-going support.

Recommendation: The Victorian Government should continue to support Seniors Rights Victoria to address and prevent elder abuse. In particular, the Government should ensure that SRV is able to provide the necessary social work advocacy to support the mental health and wellbeing of older people who have experienced elder abuse, including those seeking legal redress.

4.2.2 Elder abuse counselling services

As stated in Seniors Rights Victoria 2015 submission to 'Victoria's next 10-year mental health strategy', SRV believes that older people who have experienced abuse would benefit from tailored counselling services that acknowledge the trauma they have experienced and support their ability to cope. These services would have a specialist understanding of elder abuse and therefore be able to communicate with survivors in a meaningful way about their experiences and ongoing needs and hopes for the future.

The dynamics of elder abuse in families is different to that of other forms of family violence such as intimate partner violence. For example, there is often the keen desire of an elder abuse survivor to preserve or re-establish a loving relationship with the perpetrator who is their adult son or daughter. This is quite different to domestic violence situations where indefinite separation of a couple is usually a preferred outcome. It is this kind of understanding of the dynamics of elder abuse that is required in order to provide appropriate support to elder abuse survivors.

While Seniors Rights Victoria is able to provide support through a social work advocacy role while the older person is addressing the abuse, the organisation does not have the capacity to provide ongoing counselling for older people as they recover after the abuse has ceased.

Recommendation: The Victorian Government should fund the provision of counselling services specifically for people who have experienced elder abuse, and the evaluation of such counselling services for effectiveness.

4.2.3 Elder abuse support groups

As Tricia's story demonstrated, group therapies and interventions have been beneficial for her in coping with her situation. These courses were provided through a private hospital and are not particular to the experience of people who have been victims of elder abuse. Contact with others who have had similar experiences might assist older people who are stuck in a pattern of abuse or to recover from their trauma. Support groups enable victims and survivors to share their stories, give and receive peer support, and also reduce social isolation.

Recommendation: The Victorian Government should fund the establishment and evaluation of community support groups for people who have experienced elder abuse.

4.2.4 Affordable mental health care

Tricia was only able to access health care because of her private health insurance. She is only able to pay for her private health insurance and psychiatrist visits because she is paying minimal costs to live with her sister, having lost her home ownership through elder abuse and the resulting family breakdown.

Many older people experience financial stress, including those who can be described as asset rich but income poor as their wealth is tied up in their home. For some older people financial stress might be a continuation from earlier life, for others it is a new experience related to no longer earning an income, a lack of savings or superannuation, illness or family breakdown. The financial stresses of later life can be compounded by age-related concerns and financial elder abuse, as described by Tricia and other SRV clients.

For these reasons it is imperative that mental health treatment is available and affordable to all people, regardless of whether they have private health insurance. Victoria should not be operating a health system that only provides care to those who can afford it.

Recommendation: The Victorian Government needs to ensure that mental health treatment is available and affordable, and it needs to match the demands of the ageing community.

5 Older people as family members and carers

This section speaks to Question 6, 4 and 9:

What are the needs of family members and carers and what can be done better to support them?

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

In summary, while it is not suggested that mental illness causes someone to become a perpetrator of elder abuse, poor mental health is recognised as a reinforcing factor that increases the risk of abuse occurring. Regardless of whether elder abuse occurs, the stressful nature of caring for a family member who has a mental illness can have a detrimental effect on the older person, and they would benefit from increased recognition of this, and further support.

There needs to be better service pathways to enable carers to initiate mental health treatment for family members, carer-inclusive practice by mental service providers to ensure carer needs are being met, and an increased recognition by mental health services of the potential risk of elder abuse occurring within families where ageing parents are providing care to family members with mental illness.

5.1 Mental illness of elder abuse perpetrators

Approximately two-thirds of the abuse experienced by callers to Seniors Rights Victoria is perpetrated by an adult son or daughter of the older person. For this reason SRV is keen for any of the reinforcing factors

that might be affecting this adult child to be addressed so as to prevent elder abuse from occurring. It is not enough to remove the elder abuse perpetrator from the older person’s home, or restrict their interaction through an intervention order, if the reinforcing factors affecting the perpetrator are not properly and sustainably addressed – one of these reinforcing factors is often mental health.

A common scenario seen at SRV is an older person seeking help for an adult child who has returned home (or never left the family home) and who is experiencing mental illness. The mental illness may be undiagnosed or untreated, and may be one of many complex reasons that is leading to the perpetration of emotional, financial and/or physical abuse toward the older person. This is not to suggest that mental illness causes a person to become abusive to others, only that it is one of a range of reinforcing factors that increase the likelihood of intergenerational family violence occurring.

Importantly, the mental illness of the family member is often identified by the older person not because they are seeking a cause of the abuse, but because they are seeking help for their family member. They have often tried many unsuccessful avenues for supporting the family member to seek or maintain mental health treatment, and have turned to SRV as a last resort, recognising that the situation is untenable for all concerned.

According to an analysis of SRV’s Helpline data for a recent two-year period, many of those responsible for physical and psychological elder abuse were identified as having mental health issues. Such perpetrators accounted for 13.2% of all cases. Relevant statistics extracted from the report about SRV’s Helpline data are as follows¹⁹:

	Percentage of perpetrators with mental illness
All types of abuse	13.2
Financial abuse	10
Psychological abuse	18.5
Physical abuse	26.7
Social abuse	15.4
Neglect	16.7

It is important to note that this data is only indicative – mental illness of the perpetrator is reported by clients and not confirmed by any secondary sources. However, it indicates, for example, that in almost 20 percent of cases of psychological abuse and one-quarter of cases of physical abuse, the older person believes mental health support for the perpetrator is needed.

The reality is that for many people with a mental illness, their family often provides support in the shape of accommodation, living expenses, and daily care. There is often the added issue of trying to get the person to engage with mental health services, or dealing with the challenging behaviours that might present. In addition there may be care of other family members, including grandchildren, if the family member experiencing mental illness is not in a position to fill this role.

In many situations this support is provided by an ageing mother or father who feels it is a part of their role as a parent, regardless of the age of the child. The parent–child relationship is unique in its combination of love and responsibility, and wider society failing to provide adequate mental health services too often relies on parental obligation to act as a safety net for people experiencing mental illness. Unfortunately, providing this support can often be detrimental to the older person in many ways.

¹⁹ SRV and NARI (2015) op. cit.

5.2 A mother's story

For over fifty years Mary had been there for her daughter, Leigh, providing support in hundreds of big and little ways. Two years ago, when things once again reached breaking point and it seemed all her options had been exhausted, Mary came to the conclusion that the only way to help Leigh was to let her go. In practice, this meant taking out an intervention order against her daughter so the police could remove Leigh from the house, forcing her into homelessness and hoping that this might bring Leigh closer to receiving the mental health support she needed. It worked, but at great cost to Mary, Leigh, their family, and society at large.

Mary's story, told in her own words below, is representative of many older people who support adult children with mental illness. Stories like Mary's demonstrate that better mental health support and housing options would prevent a number of related issues, including family conflict, elder abuse and heavy tolls on the carer's physical and mental health. Better early intervention, community-based mental health support would also negate the need for, and cost of, crisis-based police responses and legal interventions, while providing more opportunity to maintain family relationships. Please note that all names have been changed.

Mary's story

Leigh first experienced mental illness in the late 1980s when she was in her early twenties. Having moved away from the family home for work and study, she became unwell and returned to living with her mother, Mary.

"She had a nervous breakdown," said Mary. "She wouldn't come out of the bedroom. And I called the CAT team – a friend had passed on their number – and they came to the house and they helped."

The CAT team spent time reassuring Leigh that they were there to support her.

"When they finally got to talk to her they gave her the option of either being hospitalised or being medicated at home. And fortunately, twenty-four hours later, she begrudgingly became medicated at home.

And we got her through that gradually, with their help. They visited a few times, I can't remember how many, but they were accessible and it was a twenty-four-hour service then.

She took probably three or four months before she became really quite normal again, and life went on. She was on medication for about eighteen months, and then she was off the medication but she was fine. Looking back, I would say, probably still fragile, but she coped. She had a job and all that sort of stuff, and she was studying. She's very intelligent, she has a couple of degrees."

Leigh moved out of home and sometime later she met a new partner. They married and Leigh became pregnant.

"Through that period she was showing signs of stress, some odd behaviour. And they sold a house and bought a larger one, which they couldn't really afford, so there were financial stresses as well."

Mary was giving the couple financial help and things settled after the baby was born. But their financial situation and marriage soon deteriorated, and Leigh's partner moved out.

"She just didn't cope. She refused to accept that she was not well. And she [thought that she] certainly didn't need medication. In spite of the fact that when we'd got her through the other thing before and she said she would know – that she would recognise the signals, she would make sure it didn't go any further – but none of that happens of course, it just doesn't happen."

Leigh and her 8-year-old son, Christopher, returned to living with Mary.

"And we got through it. But then she started getting really angry at me, and abusing me, and finances became a problem. Basically I said to her that she either had to go and get medical help or get herself a job to help with the finances, because I'm not particularly wealthy. I was coping, but looking long-term at it, I couldn't do it forever. I guess I'm one of those self-funded retirees who are cash poor and asset rich. My asset is the house, so it's a bind."

The ongoing situation with her daughter took its toll on Mary.

"My health went up and down all through that period. My GP said I needed to go and talk to somebody about myself. But I thought I've coped with a few things throughout my life which had been difficult and I had not had to do that. I felt I had sufficient skill to cope myself and not have to go to somebody else, so I didn't."

Leigh was not contributing to the household costs and was reliant on Mary. Mary's other daughter, Rachel, could see how stressed Mary was and that things needed to change.

"She was becoming quite extravagant in her spending, and I was finding all the financial pressures stressful, and wondering how it was all going to finish. Because I'm 79 now, I'm not going to be around for fifty years to keep it all together."

Friends were saying, you need to do something, you look sick. They could see me ... tightening up, I guess. And not looking good; getting teary. So Rachel finally convinced me we had to do something."

But Leigh refused mental health support. Mary started seeing a counsellor to see if there was anything she could do differently.

"The things she was telling me, nothing worked. It was more about how I could cope with Leigh, rather than how I could cope myself. Everything we talked about for how to deal with Leigh didn't work, and that made me more frustrated."

On a particularly difficult day, Rachel convinced Mary to call the CAT team (crisis assessment and treatment team).

"There had been verbal abuse and Leigh was stamping around, upsetting both Christopher and me. So I called them three times over a period of about three or four weeks. And each time I called

while she was really at me. I knew it was only a matter of time before she actually got physically difficult as well, because the abuse just got longer and bigger and louder.

And I would call the CAT team and I'd get put on hold, and half an hour later somebody would come to the phone:

'What is the situation? Is she hurting herself?'

'No.'

'Is she hurting you?'

'Not really, she's screaming and yelling.'

'Has she settled down?'

'No.'

'Well, we'll call back in an hour and see how things are going.'

And they would or they might not or somebody else might call. The third time they said, 'Well she's not really bad enough for us to come, because she's only yelling.'

So I gave up on the CAT team and started getting desperate because in my mind they had helped me before and that door was now closed. I believe that if I had help then, we could have talked her into taking medication like last time. She was actually worse this time but they don't have the capacity they used to. If somebody could have come who was not within the family I'm sure it would have been a completely different situation."

Mary was not sure where to turn for help. She couldn't convince Leigh to access any mental health support and there was no way of making any assistance come to the house.

"They didn't offer any other options. They just said we can't help, and that was it. They said they can only help if my life, her life or the child's life was directly threatened. She never at any stage was difficult with her son and he is still her shining light. There was never any yelling at him. He was just around but I was still upset because as he grew up he shouldn't have had to hear that, to be around that."

Mary tried different avenues, including a family violence service provider who offered her counselling.

"It didn't help the situation really with my daughter but it did calm me down a bit."

She never contacted the police reasoning that if Leigh's behaviour wasn't bad enough for the CAT team to respond the police response would be similar.

"There didn't seem to be anybody that could help. The counsellor from the family violence service was good. She was a tough little lady and she basically told me this was what I was doing the right way and this was what I was doing that was not sufficient. She said I know exactly what you're feeling and this is how you can cope with it. She was upfront and straight with me and then she went away, she changed jobs. I had two visits with her and then was given this other woman who started soft pedalling everything and was no help at all."

Mary contacted Seniors Rights Victoria after a friend heard about the service on the radio.

“That’s when things actually happened. Because they [SRV] were immediate. They were on the phone, but they were immediate. And they said the things that helped. They were practical and they didn’t mind me bawling. It was extremely tough to make that first call.”

SRV supported Mary to consider her options and the consequences of any decisions that she made. Mary came to see that the only way to keep herself safe and for Leigh to get mental health support was if Leigh was forced to leave Mary’s house and be responsible for herself.

“I couldn’t do anything until I actually accepted the fact that she is an adult and she has to make her own decisions. It’s the old cliché: you can take a horse to water but you cannot make it drink.

“There were several crunch points over the years where if I had been able to get the right kind of help that might have talked her into going onto medication, it would have been fine. But you can’t make people do things. The big difference is between the CAT team coming the first time and not coming the second time. I couldn’t make her get help but if they could have come and spoken to her it might have been different.”

After much consideration and with great reluctance Mary decided to take an intervention order out against Leigh. A lawyer and an advocate from SRV supported Mary through the court process to achieve this.

“If I hadn’t have gone to court and done all that stuff, which is hideous, I don’t know where I’d be. Because she is my daughter and I love her, in spite of it all. I don’t like her very much, but I do love her.

“It wasn’t just my safety and my health, it was my daughter’s. She wasn’t well. I had to do it for her. I know people sometimes do, but you can’t hate your kids, it just doesn’t pay, physically or mentally.”

Once the order was in place, police arrived at Mary’s house to remove Leigh.

“They were amazing – above and beyond what one expects. The young man was brilliant and he said normally they don’t spend any time doing it and just remove them. But he tried to talk her into going carefully and comfortably ...it took him a long time to get her out of the house.”

After that Mary had little idea where Leigh had gone or how she was living. The police officer who had enforced the intervention order saw Leigh one day when he was on patrol and spoke to her. He reported to Mary that Leigh seemed stressed and refused any offers of assistance. One of Mary’s family members managed to stay in occasional contact with Leigh, who was living in her car. When Leigh’s car was written off in an accident (for which she was not at fault), Mary would put money into an account to pay for Leigh to stay in a backpackers’ hostel.

After some time Leigh went into the police station to report a theft of her belongings. The police assessed her mental health and decided she needed to be hospitalised. It was only at this point that Leigh started to receive the mental health support she needed.

“I have no idea what kind of mental health support she was getting. We were not told anything. She went into hospital and we assume she was on medication but we were not told anything. You cannot get information because of the privacy laws. And I accept that totally except when you need it! I supported my daughter for years and when she finally got hospitalised we got no real details.”

Mary was frustrated by the fact that for so long Leigh was treated as Mary’s responsibility and no-one seemed willing to help. But once Leigh was finally receiving support Mary was not seen as integral to Leigh’s recovery, and was not given any information about her daughter. After leaving hospital, Leigh was on an order and instructed to attend the Mental Health Tribunal but she didn’t turn up to the hearing and nothing further was done.

“She was obviously still not well, but the Tribunal just cut her off. We don’t really know any of the details. We weren’t invited, we weren’t told. But they should never have let her go. They could have contacted us. The hospital knew we had been looking after her, they could have asked us for any information they needed that would help her.”

Rachel has since had some limited contact with Leigh’s case worker, who told her that in the weeks leading up to the Tribunal review, Leigh’s treatment order had been formally modified but Leigh refused to comply with the additional requirements. At the Tribunal hearing, which Leigh refused to attend, Leigh’s psychiatrist and case worker both recommended that Leigh not be released from her compulsory treatment order and that the terms of the order should be strengthened.

Rachel was only made aware of the events of the Tribunal after the event when she also learned that in the months prior to the hearing Leigh had only reluctantly connected with her case worker and support services, and was in denial that she was ill and needed mental health support and guidance. Instead she always believed that those around her were the ones who needed help.

The only contact Mary had received from the hospital treating Leigh was at the time of discharge. A hospital social worker phoned Mary and asked if Leigh could come to live with her again.

“I explained that there was a three-year intervention order and she said something like, ‘Well, people change’. In terms of my health – I’m even now starting to shake a bit – but I was back to square one. This woman, her voice was such that, ‘Well you ought to, she’s your daughter.’ She wanted me to take her problem off her plate.”

As far as Mary knows, Leigh is now living in a sharehouse and in regular contact with her son. Mary sees her grandson every second week and relishes the opportunity to just be a grandmother, without all the other pressures and stresses she previously faced. But the situation has taken a toll, both on Mary’s own health and her relationship with her daughter.

“I know she will probably never speak to me again, and I’m coping with that, but there should have been help along the way. But there are so many people in the same boat, or a very similar boat. I doesn’t matter what causes the mental illness.

In the end I took the only action that was available to me. But if the CAT team had come in the first place it would have been different. Leigh was here, Christopher was here, and in the good

moments she was still Leigh. If they had come then and we were able to sort it out over the next six to twelve months, she'd probably still be living with me. Or perhaps still working and all the other stuff.

There might have been other problems to solve but the fact that we had to go down the track that we have gone down means she doesn't see this part of the family as any support at all. In spite of the fact that we are all still sitting here waiting for her to contact us."

5.3 Supporting older people as carers

Mary's story highlights a number of areas where family members – in this case ageing parents – of people with mental illness need to be better supported. This support is necessary to prevent elder abuse, with all of its psychological and financial ramifications, and to ensure that the person with mental illness is receiving the treatment they need at the earliest opportunity.

The mental health system is heavily reliant on the support of family members to provide care to people experiencing mental illness, and this is unlikely to change. However, where elder abuse, or other forms of family violence, are present it is not always possible or desirable for family members to provide this care, and to be putting themselves at risk.

The mental health service system needs to not only acknowledge the importance of family carers but to support them as integral members of the individual's support network and of the system itself. It also needs to assess the risk of family violence and elder abuse occurring and enable the carer to be safe, and the care relationship sustainable.

All too often the person in need of mental health support is considered unreachable, living within a family home and not in a position to seek support for themselves. Due to pressures on the mental health system and limitations of services such as CAT teams, this situation is only breached when the person is deemed at imminent harm to themselves or others. However, the high tolerance for harm and the engulfing sense of responsibility felt by many older parents, means they are often being harmed long before the situation reaches a crisis level that forces a response. Earlier intervention is necessary – for the person with mental illness, the family and the sustainability of the mental health system.

5.3.1 Service pathways for family members to initiate mental health treatment

Mary and Leigh's situation is not unusual. There are many people with mental illness who are isolated in the privacy of a home and who refuse to initiate or engage with services that might be able to support them. This means the burden of their care is placed directly on family members and the toll is often great. Mary's story demonstrates the stress, depression and anxiety caused by her daughter's behaviour, as well as the financial costs. When Leigh had her first experience of mental illness it was Mary who identified it and asked the CAT team to attend and support her daughter. This intervention was successful and, with time, Leigh got better, becoming again an engaged and productive member of society.

Unfortunately when a similar situation occurred thirty years later the results were vastly different. In not recognising that she was experiencing mental illness, Leigh was unable to engage with a mental health service and seek treatment. This meant the only options open to Mary were ones that could be accessed in a moment of crisis – unfortunately, these moments were not of high enough risk to elicit a response as Leigh was not an immediate harm to herself or others.

For her own safety and in the hope that Leigh would be forced into some sort of help-seeking, the only course left to Mary was to seek legal assistance to take out an intervention order against her daughter and have her removed from the family home. While this kept Mary safe from her daughter's abusive behaviour, it brought with it other concerns. Leigh was forced into homelessness and from there a police assessment led to her hospitalisation. In addition, it meant Leigh – due to behaviours related to untreated mental illness – was forced into the legal system. She then faced serious implications if the intervention order was breached, including the possibility of a criminal conviction and record.

Mary strongly believes that if the CAT team had responded and visited the home, Leigh would have received mental health support without becoming homeless, without being hospitalised and without becoming estranged from her mother. This last point is very important – it can be very difficult for family relationships to overcome the stress and conflict of resorting to an intervention order and police enforcement. While Leigh ultimately received the mental health treatment she needed, her relationship with her mother has not recovered. Mary does not know Leigh's whereabouts and has had to accept that she may enjoy a relationship with her daughter again. Earlier intervention would have assisted in retaining this relationship.

Helen's story

Helen, an 80-year-old woman, is concerned for her 50-year-old daughter, Leanne. Leanne had previously been staying with Helen until a particularly violent situation led to Helen calling the police and taking out a limited intervention order to protect herself from Leanne.

Leanne went to live in Helen's vacant rental property and Leanne's brother visits regularly to bring her food. Helen reports that Leanne is isolated and very depressed, and that she seems to have dropped out of society. Leanne is unemployed, has no money and does not receive anything from Centrelink as she chooses not to engage with them. Despite having a serious physical injury she has decided not to see a doctor or take any medications, and she ignores any letters from hospitals or services.

Helen is concerned for her daughter though they currently have no contact. She wishes she had called the CAT team when Leanne was violent rather than the police. Her greatest wish is for her daughter's mental health to be attended to. While Helen knows she could force Leanne to leave she would never do that as Leanne has nowhere to go and would only end up homeless.

Similar to Mary, Helen's story demonstrates an all too common situation where the person requiring mental health treatment is not willing or able to seek it. SRV therefore submits that the Victorian Government prioritises the development of early intervention service pathways via which family members can access mental health treatment for someone close to them who does not acknowledge their illness or is resistant to treatment.

The complexities associated with being an elder abuse victim must be taken into account when designing such pathways. This is because being in a situation of family violence in combination with personal attributes of the victim associated with ageing can make it particularly difficult for older people to know about services and to be able to contact them (in both a physical and psychological sense). It is particularly important that service pathways and interventions exist and can be accessed pre-crisis stage.

The Mental Health Victoria (MHV) submission to this Royal Commission calls for the development of community mental health service hubs, and SRV supports this initiative. MHV suggests that the Victorian Government should work with the Commonwealth Government to develop a new community mental health service model based on the Commonwealth-funded hubs that are part of a national trial. MHV posits that these community hubs would provide integrated care within the community, support for

carers, and multiple access points including drop-in and GP referral. Such hubs would be the ideal point for a mental health outreach team to be located.

Recommendation: The Victorian Government needs to develop service pathways via which family members can access mental health treatment for someone close to them, including an early intervention mental health outreach team that could be invited into a person's home to encourage mental health help-seeking before a situation reaches crisis point.

5.3.2 Better support and communication for carers

A difficult aspect of Mary's situation was the lack of recognition and support she received from the hospital that provided mental health care to Leigh. While Mary was respectful and understanding of privacy laws and the sharing of a person's information, she found it frustrating that she was kept in the dark around Leigh's treatment and discharge. She also felt she was not given the opportunity, as someone who had spent many years in close proximity to and caring for Leigh, to give information and advice (including about earlier treatment) that may have been helpful to the treating team.

While the intervention order would restrict Mary's direct involvement with Leigh, there were other family members including Leigh's sister Rachel who were also in the caring role but who did not receive any information. For example, Rachel, who wanted to support Leigh's treatment, had no knowledge of the Mental Health Tribunal meeting until after the event, so was unable to support Leigh's involvement.

Mental Health Victoria recommends that carer-inclusive practice should be mandated, rather than voluntary, for all services providing mental health treatment. Carer-inclusive practice is based on six partnership standards as outlined in *A practical guide for working with carers of people with a mental illness*.²⁰

The carer-inclusive partnership standards are:

- Carers and the essential role they play are identified at first contact, or as soon as possible thereafter.
- Staff are carer aware and trained in carer engagement strategies.
- Policy and practice protocols regarding confidentiality and sharing of information are in place.
- Defined staff positions are allocated for carers in all service settings.
- A carer introduction to the service and staff is available, with a relevant range of information across the care settings.
- A range of carer support services is available.

Cohealth currently runs a Family Alcohol and Drug Support Program, and most of the clients are older parents who care for and support their adult children experiencing substance and/or mental health issues. Family support workers provide advice and education, referrals to support groups and education programs over the phone or in person in Collingwood and Footscray. Programs of a similar nature should be widely available to support family members, particularly older parents, who are supporting a family member with mental illness.

²⁰ Mind Australia, Helping Minds, Private Mental Health Consumer Carer Network (Australia), Mental Health Carers Arafmi Australia and Mental Health Australia (2016) *A practical guide for working with carers of people with a mental illness*.

Carers Vic provides phone counselling support for anyone who is caring for someone with a mental illness. Additionally, for people residing in some LGAs they provide short-term ongoing support and advocacy, assistance organising respite, support groups, workshops and information. They can refer to other similar organisations for the LGAs they don't cover.

Unfortunately, many people don't know about these support services or don't identify as a 'carer', which means they remain unaware of such services. Carer-inclusive practice would encourage mental health service providers to ensure, as matter of course, that carers and family members of their client have been introduced to appropriate carer support services, such as counselling, support groups or the provision of short-term advocacy.

The wellbeing of people with mental illness is often reliant on care provided by family members and others, and the mental health system could not operate without informal carers. The system needs to properly recognise and support carers to ensure they can continue to provide this support, or assist them in finding alternative means of support for the unwell person.

Recommendation: The Victorian Government needs to ensure that carer-inclusive practice is mandated for all mental health service providers to encourage recognition of the role of carers, and their needs. In turn, carer support services need to be properly funded to ensure they are available and accessible regardless of where the carer resides.

5.3.3 Recognition of potential elder abuse during treatment and discharge

One of the concerning aspects of Mary's story is that when it came time for Leigh to be discharged from receiving mental health treatment, the social worker at the hospital asked Mary if Leigh could live with her. Even when informed of the current intervention order that Mary had against Leigh, the social worker encouraged Mary to still let Leigh live with her.

This is concerning on many levels:

- If Leigh had have been discharged to Mary's care she would have been in breach of the intervention order, which could have serious consequences for Leigh.
- The existence of an intervention order indicates a level of risk for Mary, which the social worker ignored, potentially putting Mary in danger.
- By making the request, the social worker was carrying the unquestioned assumption that Mary was (and always would be) responsible for Leigh and her care.

Even if there was no intervention order, the assumption that Mary should be the one to take responsibility for Leigh is a concerning (but very common) one. There are many situations where an adult without independent housing is expected to live with their parents, and the parents often agree (even to their own detriment) because they don't see any other option and feel a sense of responsibility to their adult child. In practice, the results can be disastrous. If parents are not properly supported in providing care then all parties can find themselves in a difficult, stressed and potentially abusive situation. When public mental health systems discharge adults to return to live in the family home, there needs to be better availability of advice and support for the patient's parents. Should abuse occur, parents need to be able to access supportive interventions by mental health professionals and, if necessary, obtain assistance to accommodate their child elsewhere.

In order to allow the continuation of appropriate treatment, the best opportunity for recovery and to safeguard against risks for carers and family members, there needs to be adequate housing for both recently discharged patients and those with longer term mental illness who are unable to support themselves independently. Poverty, homelessness and housing insecurity all make it more difficult for a person to maintain good mental health and ongoing treatment. It should not be the role of the ageing parent or other family member to alleviate these issues to their own detriment.

Mental Health Victoria suggests that there needs to be improved discharge and transitional supports to ensure continuity of care and links to support services as required (including housing, legal, employment, etc.). The discharge planning should also ensure that the circumstances of other family members are considered, including the risk of elder abuse.

Mental health service providers need better training around family violence, including elder abuse, and the risks that may arise when treating a consumer and/or discharging a consumer to a family home. A proper evaluation should occur during discharge planning to assess the risk to and support needs of the carer, and links to appropriate services should be provided. The needs of the carer, and potential risk of elder abuse, should be revisited often during a person's engagement with a mental health service.

Recommendation: The Victorian Government needs to fund family violence (including elder abuse) training for mental health service providers.

Recommendation: The Victorian Government needs to ensure that mental health service providers assess the risk of elder abuse when consumers are residing with, or discharged to, ageing parents.

Recommendation: The Victorian Government needs to ensure that older adults who become or remain carers of their adult children with mental illness are given adequate support so that abuse is prevented or early intervention occurs.

6 Conclusion

The multiple intersections of mental health and elder abuse are complex. This submission has focused on three intersections of mental health and elder abuse, including situations where poor mental health has increased an older person's vulnerability to elder abuse; the experience of elder abuse has effected an older person's mental health; and issues relating to the older person as a carer for a family member with mental illness.

Seniors Rights Victoria makes a number of recommendations to the Royal Commission for improvements to the Victorian mental health system so it can better support people experiencing mental illness, and their family members, particularly ageing parents.

6.1 Summary of recommendations

Preventing and addressing elder abuse is a key part of the Victorian Government's family violence reforms, and through this submission SRV encourages the continuation of this work. Throughout this report SRV has made a series of recommendations for how the Victorian Government can improve the mental health system to better support the mental health and wellbeing of older Victorians. These include recommendations that aim to better support people who have experienced elder abuse, those

whose mental health may make them more vulnerable to abuse, and those who are providing care for a family member with mental illness.

1. The Victorian Government should provide funding for group-based interventions that are designed to address social isolation and loneliness in older adults. Group-based interventions would play a role in both preventing and addressing depression.
2. The Victorian Government should ensure continual awareness-raising that depression and anxiety are not a normal part of ageing, and they can be treated.
3. Mental health professionals should be adequately trained in the unique characteristics of later life, and older people seeking mental health support should be enabled to identify the professionals with this expertise.
4. Steps should be taken to improve public understanding and professional diagnosis of mental illness, as distinct from dementia, in an older person.
5. The Victorian Government should continue to support Seniors Rights Victoria to address and prevent elder abuse. In particular, the Government should ensure that SRV is able to provide the necessary social work advocacy to support the mental health and wellbeing of older people who have experienced elder abuse, including those seeking legal redress.
6. The Victorian Government should fund the provision of counselling services specifically for people who have experienced elder abuse, and the evaluation of such counselling services for effectiveness.
7. The Victorian Government should fund the establishment and evaluation of community support groups for people who have experienced elder abuse.
8. The Victorian Government needs to ensure that mental health treatment is available and affordable, and it needs to match the demands of the ageing community.
9. The Victorian Government needs to develop of service pathways via which family members can access mental health treatment for someone close to them, including an early intervention mental health outreach team that could be invited into a person's home to encourage mental health help-seeking before a situation reaches crisis point.
10. The Victorian Government needs to ensure that carer-inclusive practice is mandated for all mental health service providers to encourage recognition of the role of carers, and their needs. In turn, carer support services need to be properly funded to ensure they are available and accessible regardless of where the carer resides.
11. The Victorian Government needs to fund family violence (including elder abuse) training for mental health service providers.
12. The Victorian Government needs to ensure that mental health service providers assess the risk of elder abuse when consumers are residing with, or discharged to, ageing parents.
13. The Victorian Government needs to ensure that older adults who become or remain carers of their adult children with mental illness are given adequate support so that abuse is prevented or early intervention occurs.

6.2 References

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7 Appendix

Please see attached for the *COTA Victoria Working Paper Social Isolation: Its impact on the mental health and wellbeing of older Victorians*.