Integrated Model of Care for Responding to Suspected Elder Abuse (IMOC) (Elder Abuse Liaison Officer component)
Submission: 'Review of Family Violence Information Sharing & Risk Management'

Background:
The Victorian Government's 'Integrated Model of Care for Responding to Suspected Elder Abuse (IMoC)' project was implemented across Health and Community Services in 2017, following recommendations from the Royal Commission into Family Violence (2016) (The Royal Commission) .

The Royal Commission recognised elder abuse as a form of family violence, and noted that older people who experience abuse are largely invisible to the family violence service system, and do not have their abuse recognised or addressed within the broader aged and health sectors. Consequently elder abuse is under reported, largely unrecognised and not adequately responded to within all sectors.

The IMoC aims to address the under recognition and response of elder abuse in the aged and community sector and is currently funded until August 2023 across 5 regions within Victoria. Within each IMoC there are 4 components of elder abuse prevention and response including:

1. Elder abuse informed financial counselling & therapeutic counselling/ family mediation
2. Workforce elder abuse training (building capacity and awareness of best practice: recognition, response and referral; DFFH approved)
3. Elder Abuse Prevention Network (undertaking local community & service provider engagement to raise awareness around ageism & elder abuse).
4. Elder Abuse Liaison Officer (EALO)

The EALO provides secondary consultation (advice) and support to local service providers who suspect, witness or receive a disclosure of Elder Abuse. The EALO role is delivered in both regional and metropolitan settings across the 5 healthcare sites of Latrobe Community Health (regional), Melbourne Health, Monash Health, Peninsula Health, and Western Health.

Each trial site has adapted the IMoC project, & legislative changes that govern clinical practice related to family violence somewhat differently, dependent on the organisation and service setting. Several EALO's are authorised within their healthcare network to assess and respond to information sharing requests on behalf of their healthcare network (Information Sharing Entities ISE's). Our collective view is that this enhances the quality of the secondary consultations provided, as they are able to share information about the victim/ survivor and/ or the person using violence in a timely manner. Whilst at other sites, either the EALO is not authorised to share information (nominated ISE) within the organisation, or the EALO site is not attached to a service regarded as an ISE. This impacts their ability to make informed recommendations that seek to enhance risk assessment and safety planning.

Reflections:
This submission to the 'Review of family violence information sharing and risk management' is the collective feedback from IMoC EALO's. In this, we endeavour to raise concerns specific to the needs of people in later life who are impacted by family violence/ Elder Abuse.

The recent National Elder Abuse Prevalence Study (Australian Institute of Family Studies, 2021) identified that the overall elder abuse prevalence in Australia is 14.8%, and that 6 out of 10 victims of elder abuse DO NOT seek help or advice.

In this context, information sharing for the purposes of assessment and risk management for older people has been of significant benefit for older victim survivors, who have engaged services that are

part of the MARAM framework and in turn, the capacity to keep the 'behaviours of concern' (abuse) in view. The information sharing scheme has:

- enabled access to information for service providers to better respond to and manage the risk to an older person (victim/ survivor)
- improved the safety of older people experiencing elder abuse, by accessing information about the 'person using violence' (perpetrator) including existing services and location
- in some instances, this has provided the first opportunity for identification and naming of elder abuse for a victim survivor, enabling them to access specialist assistance to support their needs
- facilitated comprehensive risk assessments and safety planning for this unique cohort
- improved the capacity of the service system to collaborate to keep the perpetrator of abuse in view

Case example:

- The EALO provided secondary consultation to The Orange Door about an older woman who had been 'physically assaulted' by her adult son. The woman had accepted assistance for security measures at her home, but declined any further support. The EALO was able to share information about the location of the son/ respondent (currently in ED) resulting in his discharge to police custody.

Information sharing limitations in the community aged care sector (primarily 'MyAgedCare')

Services to support older people are funded from a variety of sources across federal, state and local government jurisdictions. As information sharing legislation is specific to Victoria, this impacts the capacity of some service providers to adequately assess risk and safety planning, and has highlighted the challenges and gaps within the system that adversely impact older people experiencing family violence. Even those services with clear information sharing capacity within the MARAM framework may have different levels of responsibilities to comparable organisations, impacting consistency of response. Service response is more complicated outside of MARAM, with staff relying on their own organisational policy and procedures that may not be best practice.

The core aged care services which older people access, including the Commonwealth Home Support Program, Home Care Packages, Regional & Aged Care Assessment Services, and the National Disability Insurance Scheme, are not information sharing entities (ISE's). This can contribute to confusion within organisations that are within scope of FVISS, such as a Health network about what can be shared between which programs, creating further complexity that may adversely impact the assessment of risk and safety of older people.

For example, Victorian Health Services are ISEs, but the Aged Care Assessment Services (ACAS) that they auspice are federally funded and are therefore not considered to be an ISE, and so not party to information sharing. This can create barriers to accessing relevant information about both victim/ survivor and perpetrator, and may unintentionally expose older victims to higher risk of harm. Additionally, interfaces between services seeking to assist victims of elder abuse who are participants in the National Disability Insurance Scheme (NDIS), can be hampered by difficulties associated with sharing and seeking information from the NDIS and their providers. For example, consider a caregiver/spouse of a participant who doesn't have decision-making capacity, whereby an NDIS service provider reports neglect to Victoria Police, which ultimately results in the caregiver excluding the service provider from the home. The GP believed there was no concern, although had not visited the home. The difficulties at service interface between NDIA, NDIS service providers, and ISE's such as

community health care services who are seeking to manage risk during a 'protection phase' remains problematic and confusing in practice, particularly when a timely response is required.

Risk Identification for older people

There is a lack of understanding within all sectors about elder abuse, ageing and how intersectionality can present differently for people later in their lives. Consequently identification of risk factors can be easily minimised, dismissed as 'ageing' and further increase the risk of harm for the older person. If a service does not identify that an older person is at risk of harm (due to lack of clarity/ understanding of thresholds of risk for older people), then they may not share information about a perpetrator or identify the seriousness of the risk to the older person. This can result in an older person not having access to services and supports that they require.

Consistency of sharing Information across networks

There has been instances of confusion about the sharing of third party information for risk assessment and management. For example, where a referral is being made from a Family violence service to a specialist elder abuse service or health service to support the victim survivor, the L17 (police report) is not always included as it is deemed by the Family Violence service to be third party information, and they are not able to send it on. This information can be very useful in relation to risk management and access to the victim survivor. It would be helpful to have clarity/ consistency regarding this issue.

Specialist family violence advisors have been funded across different sectors and organisations with expertise in mental health, AOD and in our case older people. Some positions are embedded in the same organisations and work closely together whilst others are quite separate. It is not only the legislation that is impacting the effectiveness of the FVISS, but the structures, policies & positions within the system and individual organisations.

<u>Recommendations:</u>

- **Exploration of, and subsequent inclusion of, risk factors that are unique to older people** e.g. the risk of matricide and patricide from adult children with mental health concerns, coercive control manifesting as social isolation, older men as victim survivors who have different access to family violence resources when compared to women, dementia/ cognitive decline in both victims & perpetrators & the common myths that continue to guide practice in response to elder abuse, which leaves many care recipients and caregivers at unknown or under assessed risk of serious harm.
- The **unique characteristics of older people from diverse backgrounds** are included in future information sharing scheme guides (i.e. specific training and information on disability – including cognitive decline & dementia, LGBTIQ+, First Nations and migrant & refugee populations in their later lives). For example, an older gay man's experience of & needs related to family violence identification and response, will be very different than a younger gay man's. Consequently, exploration of advancing age as a co-intersectional factor, and generational differences is essential when providing guidance related to intersectionality and family violence.
- **General Practitioners: as crucial health partners in older people's support network**, further education, engagement and resourcing, to enhance GP's collaboration and responsibility to respond in a best practice manner to their older patients who are impacted by family violence.
- **Clarity for services regarding the sharing of third party information for risk assessment and management**.
- **Advocacy with all Federal funded aged, disability and carer programs** delivering services to older Victorians to be incorporated into the MARAM framework

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- Consideration of the interface of different information sharing roles, their respective 'locations' and opportunities to streamline or suggest best practice approaches, specific to the needs of older people. For example, AOD services in various regions sit outside the local health service (ISE) framework, & concerns have emerged around Specialist Family Violence Advisers, primarily using a gendered lens to inform their application of risk assessment & information sharing opportunities with other services. This results in under recognition of risk and under response to elder abuse situations. Commonly this presents as a male AOD client excluded from his usual residence with his intimate partner due to violence. The AOD client typically returns to the home of their aging parent, and commonly transfers 'behaviours of concern' to the older person, who may be unfairly cast as somebody 'enabling' substance misuse by AOD service providers. In this instance it is not only the legislation that may impact the effectiveness of the FVISS, but also the concurrent service structures, policies & positions within the system and organisations.

Moving forward, we believe there is a strong case to further define the threshold of risk that results in information sharing to establish risk. As at present, age related myths and chiefly gendered concerns typically guide practice. Professionals utilising information sharing need to better understand advancing age, dementia and disability in order to use the information sharing framework as it was intended. Erroneous beliefs about aging, and excusing or minimising behaviours of concern when dementia is a factor are widespread, resulting in under recognition of risk and under response to elder abuse. Consequently, further research & attention to the unique needs of older people is required to ensure the needs of older people are met within the current framework, alongside the needs of younger people experiencing intimate partner violence.