Seniors Rights Victoria

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

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Contents

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.

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[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 depression[10] 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.

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[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."

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[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 [redacted] 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 follows[19]:

	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.

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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.*

COTA
For older Australians

COTA VICTORIA WORKING PAPER NO. 1

SOCIAL ISOLATION: Its impact on the mental health and wellbeing of older Victorians

Anne Pate
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COTA
For older Australians

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COTA VICTORIA WORKING PAPER NO. 1

COTA Victoria is the primary organisation representing the interests of older Victorians. Our vision is to see a just, equitable, inclusive and humane society in which older people live well, with dignity and purpose. From its inception in 1951 as the Old People's Welfare Council of Victoria, COTA has sought to ensure older people are able to optimise their opportunities for health, security and participation as valued members of their community.

This series of working papers is designed to bring the policy focus of COTA Vic's work to as wide an audience as possible and to promote discussion among older people, policy makers, academics and those interested in the wellbeing of older people on issues of importance.

The working papers are formulated by Policy Council with the following criteria in mind: to share knowledge and increase understanding of the issues being debated by Policy Council; to encourage broader engagement in COTA Vic's policy development processes from preliminary thinking to setting policy directions; and to present this work in a form that is scholarly, well written and which has a clear sense of purpose.

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Sally Stabback
Sue Healy
Terry Seedsman

CONTENTS

FOREWORD

COTA Victoria began this work with the question: do current Government policies create greater risks of social isolation and mental health issues for older people?

For more than sixty years COTA Victoria has developed programs and advocated for policies to prevent and address social isolation among older people. As the primary organisation representing the interests of older Victorians, we are acutely aware of the importance of social connections for wellbeing in later life. Older people tell us they value, and want to maintain, their participation in family, community and social spheres. Research confirms that being socially isolated can negatively affect mental as well as physical health. In particular, chronic loneliness can adversely affect mental wellbeing.

This Working Paper summarises COTA's understanding of how being socially isolated can affect mental health. It identifies implications for policy and practice in relation to older people. The discussion is particularly timely in a policy context which may, inadvertently, increase the risk of social isolation for some older people.

Maintaining opportunities for social participation should be a key factor for policy development affecting older people. The experience of social isolation requires a multi-faceted, holistic policy response. A broad societal response would aim to prevent social isolation among older people through the development of age-friendly communities which enable them to participate fully. COTA Victoria looks forward to continuing to work with older people themselves as well as with government, business and civil society to realise this vision, in particular through the implementation of COTA Age Friendly Victoria.

We hope this paper will stimulate debate and that together we can all work to build an age-friendly community where older people are able to participate fully and to maintain valued social relationships.

Sue Hendy

CEO

1. SETTING THE SCENE

1.1 COTA's interest in social isolation and mental health among older people

For more than sixty years, COTA Victoria has worked to protect and uphold the human rights of all older people, especially those who are disadvantaged and are socially excluded across a range of dimensions.

As the primary organisation representing the interests of older Victorians, we are acutely aware of the importance of social connections for wellbeing in later life. Older people tell us that they value and want to maintain their participation in family, community and social spheres.

COTA Victoria has addressed this by developing programs and advocating for policies to prevent and address social isolation among older people. For example, in partnership with the Municipal Association of Victoria (MAV), COTA Victoria supported the development of positive ageing strategies in local government areas between 2005 and 2009. Many strategies and projects focused on expanding opportunities for community connections with the aim of reducing social isolation. Today, COTA Age Friendly Victoria is partnering with older people to develop age friendly communities where older people live safely, enjoy good health and stay involved. As part of the World Health Organisation's Global Age Friendly Cities and Communities initiative, COTA Victoria takes a health promotion approach to support the mental health of older people. We view mental health as the embodiment of social, emotional and spiritual wellbeing.

With this history of investment in strategies and interventions to promote older people's social participation and health, we initiated this Working Paper to enhance our understanding of how older people's experience of social isolation affects their mental health. Crucially, we wished to explore whether current government policies, both at Federal and State level, create greater risk of social isolation and mental health issues for older people. We believe that the connection between social isolation and mental health needs to be considered much more fully in policy development than has been the case.

COTA Victoria's concern about social isolation among older people is shared by COTA Australia and the other state and territory COTA organisations. For example:

- *COTA Australia* is a member of the national Benetas taskforce focusing on strategies to address social isolation. The state and territory COTA organisations are providing evidence for the taskforce on effective strategies and programs.
- *COTA NSW* conducts regular surveys of older people. These have highlighted the importance of transport for the ability to maintain social connections. Other consultations have revealed increasing levels of isolation amongst older people living in public housing. Consultations in regional and rural areas have found that older men moving from farms into regional towns are also at risk of depression and isolation.
- *COTA Queensland* is involved in research being conducted by Adelaide University into the effectiveness of interventions to reduce social isolation. 900 older Australians will be surveyed over three years, and focus groups will be held with policy makers and service providers. The research will consider the evidence that the most effective programs have an educational component, are targeted at specific groups, and involve people from the same neighbourhood. It will also examine the impacts of gender, location, housing options, age, the presence of a disability, and socio-economic status on what programs work best.
- *COTA Tasmania* is developing initiatives which will support older Tasmanians who are socially isolated or are at risk of social isolation.[1]
- *COTA WA* commissioned Murdoch University in 2009 to develop a scoping paper on social isolation, in order to inform the development of policy responses. The report recommended focusing on policies which support positive relationships and ensure adequate transport.

COTA Victoria recognises that older people are a highly diverse group. Such diversity is expressed through variables around age and disability as well as:

- Older people from culturally and linguistically diverse communities, including communities which have recently arrived in Australia, have specific needs and experiences.
- Older Australians from Aboriginal and Torres Strait Islander backgrounds are likely to experience multiple disadvantages as a result of lifelong discrimination.
- Gender and sexual orientation are powerful factors in shaping experience.
- Location is another important variable. Older people living in rural, regional and urban areas have quite different experiences.
- Socioeconomic factors have a profound impact on the resources and capabilities which people accumulate, influencing their experiences of later life.

The terms 'older people' and 'later life' are used in this paper with this diversity in mind.

1.2 The policy context

Changes in how ageing is conceptualised and framed in policy give grounds for hope that social isolation and its relationship with mental health will become more visible and influential in the policy agenda. At a broad scale, the World Health Organisation defines 'active ageing' as the 'process of optimising opportunities for health, participation and security in order to enhance quality of life for people as they age'.[2] Participation should be a focus of policy effort within jurisdictions.

This strengths-based approach to ageing represents a shift from a medical model of ageing, which largely viewed older people in terms of dependency and care, to a rights-based approach founded on optimising the possibilities of later life. Although much remains to be done to realise a rights-based approach in policy and programs affecting older people, this discourse is beginning to reshape older people's expectations and to influence policy in Australia.[3]

For example, the report of the *Victorian Parliamentary Inquiry into Opportunities for Participation of Victorian Seniors* released in 2012 makes explicit reference to the World Health Organisation's call for a new paradigm which views older people as active participants and contributors in an age integrated society.[4] The report makes a series of recommendations to enable older people's social, economic and community participation. [5]

Social isolation is also increasingly recognised as a key dimension of older people's experience of social exclusion.[6] The policy focus on social inclusion has been influential in recent years in the UK and in Australia, and situates the issues of isolation and loneliness in a broader context. This provides a framework for guiding social interventions which recognises the connections between isolation and the experience of exclusion across multiple domains.[7]

This exploration of the links between social isolation and mental health is particularly timely in a policy context which may increase the risk of social isolation for some groups of older people. For example, policy reform to support older people to live at home for as long as possible may have unintended consequences, leading to higher levels of social isolation and associated mental health issues. The risks contained within specific current policies are discussed in Section 4 on *Implications for Policy and Programs*.

1.3 Overview of this paper

This Working Paper summarises key concepts and research, highlighting areas for consideration in policies and programs affecting older people. The paper describes:

- What is known about social isolation, and estimates of its prevalence among older Victorians.
- Risk factors and pathways into social isolation in later life.
- The relationships between social isolation and mental health.
- Evidence on effective strategies and interventions to address social isolation.
- Impacts of current policies and programs on older people living in Victoria who are at risk of or experiencing social isolation and mental health issues.

Although the link between social isolation and mental health can work in both directions, this paper focuses primarily on how social isolation can be detrimental for mental health.

2. SOCIAL ISOLATION

2.1 What is social isolation?

The latest Census figures show that more than one in three women and one in five men over the age of 65 in Australia live alone. People often think that living alone means to be alone and / or to experience loneliness.[8] However, living alone appears to be a very limited predictor of risk of social isolation. For example, a large longitudinal study of women aged 60-72 in the U.S. found that although living independently did predict greater risk of needing to move into residential care it was not related to social isolation.[9] Living alone is not in itself a target for social intervention or change.

Social isolation is sometimes confused with loneliness. Yet spending a great deal of time alone can be a matter of personal choice, one that for some people does not give rise to feelings of loneliness.

When social isolation and loneliness began to be investigated in the 1970s, the concepts of social isolation, loneliness, living alone, being alone and solitude were often used interchangeably.[10] There has been some effort of late in the literature to differentiate between these related but distinct concepts.[11]

Careful definition of these concepts is particularly important for this discussion because it is the subjective, felt experience of loneliness and the perception of a lack of social support which appear to impact most strongly on mental wellbeing.

To better understand the concept of social isolation, this section looks at different ways of defining social isolation, firstly in terms of the extent of social networks, and secondly in terms of the subjective experience of loneliness.

Social isolation and social networks

Social isolation can be defined as the absence of relationships with family or friends on an individual level, and with society on a broader level.[12] Objective measures of social isolation consider the extent, range and depth of a person's social networks.

A 'social network' is the structure of linkages or relationships among a particular group of people. These social networks can influence individual behaviour and attitudes. The relationships and flow of resources within networks shape members' access to opportunities as well as providing constraints on their behaviours.[13]

An important resource provided by social relationships and networks is social support, including ongoing support and support in a crisis. The concept of 'perceived levels of social support' refers to the extent to which people feel they are able to rely on their social network for support in a range of ways and situations. Surveys such as the ABS General Social Survey collect data on people's perception of the social support available to them through their relationships with others.

Effective social networks are flexible, creating opportunities for give and take between members.[14] Five types of networks have been distinguished:[15]

- locally integrated support networks - large groupings including relationships with family, neighbours and friends;
- wider community-focussed networks - primarily friendship-centred;
- local family dependent support networks;
- local self-contained support networks - small and mostly neighbourhood-based;
- private restricted networks - characterised by an absence of local family and only minimal ties with neighbours.

Older people whose networks are self-contained or private restricted may be at higher risk of social isolation.

Social isolation and loneliness

In everyday usage, people tend to describe social isolation in terms of loneliness. Research commissioned by COTA WA found that most defined social isolation as the subjective, highly individual experience of feeling lonely, making a distinction between alone-ness and loneliness.[16]

The interaction between social isolation and loneliness is complex, however. One person with few social connections may not feel lonely, while another with a larger number of social relationships may feel lonely.[17]

So what is loneliness? Loneliness is 'the subjective, unwelcome feeling of lack or loss of companionship'.[18] The experience of loneliness involves an individual's perception and interpretation of their social relationships, and their sense of a discrepancy between what they have and what they desire. This individual, subjective experience varies in intensity and duration.

Some definitions distinguish between loneliness due to 'social isolation' and loneliness due to 'emotional isolation'.[19] Here, loneliness due to social isolation concerns a person's lack of social integration in social networks, while loneliness due to emotional isolation refers to the absence of a reliable attachment figure such as a partner. A leading researcher in this area has observed that the impact of loneliness depends not on the quantity of social interactions but the extent to which these satisfy a person's subjective need for social connection.[20]

Given the subjective nature of loneliness it is not surprising that feelings of loneliness may be related to social and cultural expectations. A European survey found that older Greeks reported the highest levels of loneliness despite the fact that they had high levels of daily contact with family and friends, and only a small minority lived alone.[21] This further underscores the need

to distinguish between objective measures of social isolation and the subjective experience of loneliness.

Whether the subjective experience of loneliness has its origins in lack of integration in social networks or lack of a close relationship, it has harmful effects on health.[22] Furthermore, loneliness which is persistent or chronic is of far greater concern than transient feelings of loneliness.[23] Chronic loneliness can create a persistent, self-reinforcing loop of negative thoughts, sensations and behaviours. It is persistent loneliness rather than situational or passing loneliness which impacts on mental wellbeing. The detrimental effects of loneliness on mental wellbeing are explored in *Section 3*.

From the perspective of public policy or intervention, older people who are isolated and lonely, or lonely while not isolated, are subjects for concern.[24] Before moving into the discussion of current policy settings in *Section 4*, however, it is important to consider how many older people are socially isolated in Victoria; who is at risk of social isolation; and the pathways into and out of social isolation in later life. This helps to deepen our understanding of the experience of social isolation and to suggest the nature, scope and focus of interventions which may prevent and address it.

2.2 How many older people are socially isolated in Victoria?

There is a lack of data on the extent of social isolation, in part because the stigma associated with admitting loneliness makes it more difficult to measure.[25]

Research studies of social isolation

In a comprehensive literature review prepared for the Queensland Government, only one Australia-wide study of loneliness was identified, and it focused on young adults.[26] A further study, in Queensland, found that 35.7% of respondents reported being lonely, however it provided no breakdown by age.[27]

A small number of Australian studies have focused on older people. A survey of 353 people over 65 living in Perth found that 7% reported severe loneliness, with higher levels of loneliness reported by single participants, those who lived alone, and those with poor self-reported health.[28] A national study of veterans, most of whom were over 70, found that 10% were socially isolated, and another 12% were at risk of social isolation.[29]

In the UK, a longitudinal study of 999 people over the age of 65 found that 9% of older people reported severe loneliness, 30% reported that they were sometimes lonely, and 61% reported that they were never lonely.[30] These prevalence rates were similar when participants were followed up eight years after the first survey.

This result is consistent with the findings of studies of social isolation amongst older people which have been conducted in the UK over the past 60 years, which have consistently shown that 7-8% of older people are socially isolated at any given time.[31] There is no evidence that the prevalence of social isolation among older people has increased over the past 60 years.

In Victoria, a report prepared for the Myer Foundation contains projected prevalence rates for social isolation amongst older people in the state, taking into account population projections and based on the assumption that 7-8% of older people are socially isolated. If these assumptions are correct, in 2010 54,000 older people living in Victoria were socially isolated, and this figure will rise to 74,860 in 2020, 95,590 in 2030, and 115,460 in 2040.[32]

In other words, the number of socially isolated older people in Victoria is predicted to double within the next few decades. However, these projections do not consider the possible impacts of demographic changes within the population of older people. For example, an increasing proportion of older people in Victoria will be from culturally and linguistically diverse (CALD) backgrounds. Their experience of social isolation often differs from that of other population groups, and may require different policy responses. Furthermore, as the proportion of older people from a CALD background increases, the rate of social isolation may also increase beyond these projections.

Population survey data

The ABS *General Social Survey* is a sample survey of people over the age of 18 living in private dwellings conducted every four years. It excludes people living in residential care. The survey gathers data about participation in informal social activities (by type of activity) in the past three months, and in a social or support group in the twelve months prior to interview. These items are indicators of social isolation.

In the 2010 *General Social Survey,* the proportion of respondents who had actively participated in a social or support group in the previous twelve months declined with age. While the rate of participation in social groups was between 60% and 65% for all age groups up to and including 65-74 years, this declined to 56% for those aged 75-84 and 47% of those aged 85 years and over.[33]

Respondents are also asked whether they have had contact in the previous week with family and friends living outside the household (subdivided into any form of contact and face-to-face contact).[34] In the 2010 General Social Survey, 79% of people aged 18 years and over reported having weekly face-to-face contact with family and friends with whom they did not live, and there was little difference between age groups on this measure. People under 35 or over 85 years of age were more likely than other age groups to have daily face-to-face contact with family and friends with whom they did not live.

In 2010, overall levels of social attachment, as measured by weekly contact (in all its forms) with family and friends, or the ability to ask for small favours such as collecting mail, or the ability to ask for support in a crisis, were similar to the levels reported in 2002 and 2006. Of all people over the age of 18 years, 94% reported that in a time of crisis they could get support from outside their household.[35] This proportion declined slightly but not significantly with age. Household income was a more significant factor than age, with nearly all people in the highest income quintile (97%) having someone to turn

to, compared with 89% of those in the lowest income quintile.

However, the 2010 *General Social Survey* found that the proportion of people who had three or more friends living outside their household in whom they could confide decreased significantly with age. The proportion of people with three or more family members living outside their household in whom they could confide did not vary particularly with age.[36]

The ABS *National Survey of Mental Health and Wellbeing* sample survey of people aged 16-85 years includes items on contact with family and friends and whether the respondent has family they can rely on or confide in about a serious problem. The 2007 Survey showed that 90% of people with a mental illness had contact with friends at least once a month, compared to 95% of people without a mental illness.[37] This Survey also showed that people with a mental illness were less likely to have family they could rely on and confide in about a serious problem (85%) than people without a mental illness (92%).

A higher proportion of older people than younger people live alone: in Victoria 27% of people over 65 were living alone at the 2011 Census, compared to 9% of people aged 15-64.[38] These percentages are consistent with patterns across Australia. The peak age for living alone in Australia was 55-59 years in 2006, but this is projected to increase to 80-84 years in 2031.[39]

Living alone is a gendered experience, with older women being more likely than older men to live alone. Of women aged over 65 in Victoria, 35% lived alone at the 2011 Census, compared to 18% of men aged over 65. As discussed in the next section, older men appear to be more at risk of social isolation than older women, which confirms the weakness of using 'living alone' as an indicator for social isolation. As noted earlier, living alone is a very limited predictor of social isolation.[40]

2.3 Who is at risk of social isolation?

The risk of experiencing social isolation is determined by individual, social, community, and environmental factors which operate across all age groups.

Older people are often assumed to be more at risk of social isolation than people in other age groups. The common stereotype of old age assumes that older people are the loneliest age group, and that loneliness is an inevitable part of old age. In fact, research indicates that the levels of loneliness of people over the age of 65 years are comparable with those of young adults, while people in mid-life are less at risk of loneliness than younger or older people.[41]

Social isolation is not an inevitable feature of later life. However, the risk of social isolation can be increased by common experiences of later life such as becoming physically frail or the deaths of family and members of one's community network. Rather than treating older people as a homogenous group, we need to look at different population groups within the broad category older people.

Specific groups at greater risk of social isolation include the oldest old, older men, some people from a culturally and linguistically diverse background, LGBTI older people, carers, older people who are socially excluded, older people living in rural areas, and people in residential care:

Age Social isolation and loneliness are not uniformly distributed through the older population. The increase in loneliness is highest among people in the oldest age cohorts, who are more likely to become socially constrained due to caring for a spouse, mobility restrictions or living with dementia.[42]

Gender Research indicates that women tend to have more developed social networks than men. Therefore older men may be at higher risk of social isolation. One UK study found that older men had fewer friends, were more socially isolated, felt lonelier, and were less likely to have confidantes than older women.[43] An Australian study also found that older men were at greater risk of social isolation, reinforcing the findings of a community-based study that older women had significantly more contact with friends and extended family than older men.[44]

An analysis of data from the *General Social Survey* 2006 and *Australian Time Use Survey* 2006 explored the frequency and duration of social contact with people outside their household of retired and non-retired men and women in Australia.[45] The study found that for frequency of social contact, gender was a more important factor than retirement, with men having less frequent social contact and a greater risk of social isolation than women, whether or not they were retired.

As well, the interaction between being male and retired had a greater impact on time spent in contact with family or friends outside the household than did either variable separately. Paradoxically, retired men had less social time than non-retired men, whereas retired women had more social time than non-retired women. The report

concluded that 'substantive issues exist concerning social isolation and exclusion among older, non-working, retired men'.[46]

Ethnicity Almost a third of Victorians aged over 65 years are from a culturally and linguistically diverse (CALD) background. Some older people from culturally and linguistically diverse backgrounds may be at increased risk of social isolation due to the limitations of poor English and low knowledge of or ability to access services.

Studies indicate that older migrants who have lived most of their lives in Australia have different needs from people who have migrated in later life to join their adult children. This second group may face quite significant adjustment problems.[47] For people who have entered Australia as refugees, the effects of trauma can further magnify these difficulties.

Sexuality The National LGBTI Health Alliance points out that same-sex attraction, gender dysphoria and intersex conditions may make people more vulnerable to negative experiences and discrimination, which can result in conflicted familial and other social relationships and diminished emotional and practical support.[48] There is great diversity within this group, with generational differences between older people who grew up in a context of severe societal stigma and those who have lived openly about their sexual or gender identity. Further research is needed into the social, support and care networks of older LGBTI people.[49]

The impact of caring responsibilities Carers are at greater risk of social isolation and loneliness, since social networks often shrink as a result of caring for a partner or parent.[50] After the death of their spouse or parent, older carers may also experience loss of role, and further isolation as formal services are withdrawn.

Social exclusion Social exclusion involves restricted access to opportunities and resources to participate economically and socially. Older people who are socially excluded across a range of dimensions are at greater risk of loneliness.[51] A 2008 Age Concern report observed that the risk of being severely socially excluded increases with age, with people aged over 80 more than twice as likely to be severely excluded as those who are ten years younger.[52] In a later report, Age Concern identified factors associated with severe risk of experiencing social exclusion, including being in poor health, living in rented accommodation, being a member of a minority ethnic community, having low occupational status, and never having been married.[53]

Living in a rural area While there is a lack of research into social isolation among older people living in rural and remote settings, living in a rural or remote area can mean having reduced access to services, being geographically isolated and losing connections with family.[54] More research is needed to explore what this means for older people's levels of connection and risk of social isolation.

Living in residential care Social isolation among older people living in residential settings has been relatively under-researched, according to a recent journal article.[55] Although the evidence is limited, these authors suggest that it is reasonable to assume that poor health and / or diminished cognitive capacity limit the extent to which older people in residential care can interact with others, both within the facility and with their existing family and friends.

The authors note that some research has indicated that reliance on staff for help with personal care is associated with lower levels of 'social loneliness', but they comment that this depends on the nature and quality of resident-staff interactions. For example, an Australian study has found that staff-resident interactions were predominantly task-oriented.[56]

2.4 Pathways into and out of social isolation in later life

In recent years several large-scale longitudinal studies on social isolation in later life have been published.[57] Victor and Bowling's study in the UK found that while overall prevalence of loneliness was similar when participants were followed up eight years after the first survey, there was significant movement into and out of loneliness.[58] 60% of participants had a stable loneliness rating at follow up, while 25% demonstrated decreased loneliness, and 15% demonstrated increased loneliness.

Findings such as these shed light on the patterns and stability of social isolation over extensive periods. Among the specific findings of these studies are:

- Older people may become more isolated and lonelier over time.
- The social network composition of older people is often unstable as people enter and leave the network over time, which can contribute to social isolation. The way the network is organised, and the expectations attached to the relationships, is deeply embedded in the given cultural environment.[59]

Longitudinal research has begun to identify distinct pathways into and out of social isolation in later life. Social isolation can be a continuation of previous experience; a new experience triggered by a key life event or transition in later life; or it can decrease in later life. The factors which enable some older people to adapt well to life changes or transitions, thus protecting them from becoming socially isolated, need to be researched further.

Isolation as a continuation of previous experience

People who are socially isolated in mid-life may face further isolation as they grow older.

According to one study, those who experience lifelong isolation tend to be men, with an alcohol problem, and who describe themselves as loners with marginal lifestyles.[60]

Isolation as a new experience triggered by a key life event or transition in later life

Transition points into isolation include retirement, loss of a driver's licence, death of a partner or relationship breakdown, relocating to a new community, and sudden disability.[61]

Decreasing loneliness

Victor and Bowling's finding that some older people 'recover' from loneliness suggests the need for further research into the factors which enable such recovery.[62] Their research found that improvements in physical health and improved social relationships were linked to reduced levels of loneliness. They concluded that strategies to combat loneliness should not be confined to social interventions such as befriending schemes, but should also encompass treatment of chronic and long-term health conditions. The complex inter-relationships between health and social isolation are explored in the next section.

The previous chapter described the related but distinct concepts relevant to this discussion. 'Social isolation' can be defined in terms of the extent, range and depth of social networks, including the extent to which people feel able to rely on their social network for support, and the felt experience of loneliness. Social isolation is not an inevitable feature of later life. However, some experiences of later life can increase risk, and specific groups within the older population may be at greater risk of social isolation. Longitudinal research has begun to identify distinct pathways into and out of social isolation in later life.

Numerous studies have demonstrated a relationship between social isolation and physical health. For example, a meta-analytic review of 148 studies looked at the influence of social relationships on mortality and a 50% increased likelihood of survival for people who had stronger social relationships compared with those who had weaker relationships. [63]

Indeed, the influence of social relationships on the risk of death was found to be comparable with well-established risk factors such as smoking and alcohol consumption, and to exceed the influence of risk factors such as physical inactivity and obesity. Being socially isolated is harmful for physical health regardless of whether or not it prompts feelings of loneliness or a perceived lack of social support.

3. THE RELATIONSHIPS BETWEEN SOCIAL ISOLATION & MENTAL HEALTH

3.1 Mental health in later life

Mental health has been described as the embodiment of social, emotional and spiritual wellbeing.[64] COTA accepts this description, and further understands that mental health occurs on a continuum from mental wellbeing through to mental distress. People who have a diagnosed or undiagnosed mental illness, like those who do not, may sit at various points on this continuum at any given time. For everyone, regardless of whether or not they have a diagnosis of mental illness, mental health is an essential aspect of life.

While some older people develop a mental illness as they age, others grow older with a continuing experience of a mental illness which developed earlier in their lives. Very often mental health issues have not been identified and treated at earlier stages of life, with serious impacts on older people's health and quality of life. The emergence of mental health issues as people age has only recently begun to be acknowledged.

Mental illnesses include depression, anxiety, psychosis and bipolar disorders. Mental distress or illness is not a normal part of ageing, or indeed of any stage in life.65 However, older adults may be more vulnerable to depression and anxiety if they experience chronic health conditions, loss of status and respect following retirement, lower income, negative community attitudes, loss of spouse, and loss of social networks due to decreased mobility, change in residence and/or death.

The prevalence of mental distress in older people

A recent survey of Australians aged 50-89 years by the National Seniors Productive Ageing Centre found that the self-reported mental health of people aged 60 years and over was better than the mental health of people aged 50-59 years. For example, people in their fifties were more likely to have felt depressed or anxious in the past four weeks than people in the older age groups, and less likely to have felt calm and peaceful or happy.[66]

In general, there is an absence of data on mental health issues among older people, in part due to under-diagnosis and under-reporting of mental illness by health professionals. In addition, mental health surveys and research often exclude people over the age of 65 years.

Cultural background can influence a person's perception of health, their response to it, and their approach to accessing services, and one result of this is that older people from ethnic communities may be particularly under-represented in statistics. The Ethnic Communities Council of Victoria (ECCV) has found that the experience of migration, along with language and culture, are significant influences on people's perceptions of mental health and on their engagement with mental health services.[67]

For these reasons, the figures provided below probably under-estimate the prevalence of mental distress among older people:

- Anxiety disorders are the most common mental illnesses at any age, and women have a higher rate of diagnosed anxiety disorders. Anxiety is less common amongst women aged 65-85 (6.5%) than in women aged 16-54 years (21%).[68]
- Depression is estimated to affect 10-15% of older people living in the community, and up to 50% of older people living in residential care.[69] The extent to which depression is a cause or a consequence of admission to residential care needs further investigation.
- The prevalence of psychotic symptoms in older people without dementia is reported to range between 5.5% and 14.1%. Depression, alcohol and drug addiction, and delirium can all cause psychotic symptoms.[70]
- Although bipolar disorder is more common in younger people than in older adults, it has been reported that up to 10% of older people in residential care settings or hospitals have bipolar disorder.[71]
- 25% of people over the age of 85 have dementia. Dementia is the single greatest cause of disability in Australians over the age of 65.[72] People with dementia, which has a range of causes including Alzheimer's disease and vascular pathology, experience a progressive loss of memory, intellect, rationality, social skills and physical functioning. On average symptoms of dementia are noticed by families three years before a firm diagnosis is made.[73] Recent research in the UK and Denmark provide the strongest evidence yet that rates of dementia are beginning to decline as the population grows healthier and better educated.[74]

Older people with multiple physical co-morbidities have been found to be at higher risk of depression and anxiety than other older people, suggesting that physical and mental health are often interconnected.[75] The same literature review found that other groups of older people at higher risk of depression and anxiety are older people living in residential care or in hospital, older people with dementia, carers, women, Indigenous people and older people from CALD backgrounds. This is a similar list to that of groups which are at higher risk of experiencing social isolation.

Older people have a much higher risk of suicide than the general population. In Australia a higher proportion of men over 85 commit suicide than in any other age group.[76] Moreover, of those who attempt suicide, older people are most likely to complete the attempt, with older men three to four times more likely to commit suicide than older women.

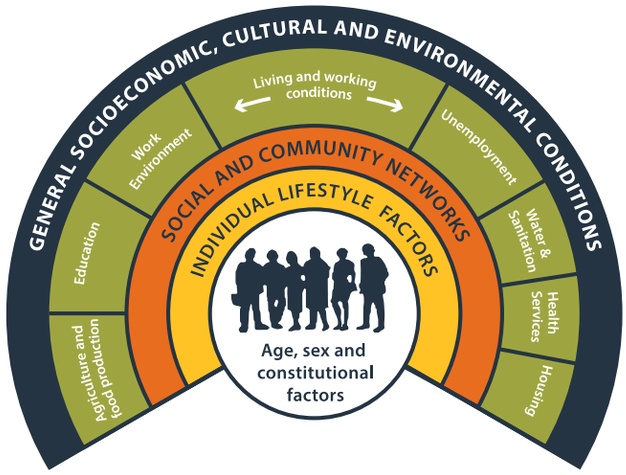
3.2 Factors which influence mental health

Crucially for this discussion, mental health is determined not just by individual characteristics and lifestyle factors but also by the characteristics of social and community networks, and general socio-economic, cultural and environmental conditions.

The diagram below illustrates some of the determinants of health which occur at each of these levels.[77] Social and community networks influence mental as well as physical health, and individuals' social ties are embedded within broader social structures.

The Main Determinants of Health

COTA Victoria takes a health promotion approach to mental health. Such an approach seeks to address the broad social influences on mental health and wellbeing as well as local community level impacts and individual behavioural factors.



3.3 How social isolation affects mental health

The report by National Seniors Australia discussed earlier concluded that the subjective wellbeing of older Australians 'depends not so much on their health as on a range of contextual and social factors – among which social engagement plays an important role'.[78]

Precisely how social isolation affects mental health is an emerging field of study. The nature of the relationship between social isolation and mental health is contested, particularly since 'social isolation', as we have seen, is a complex concept which can be measured both objectively and subjectively. The question is whether low levels of social contact have an impact on mental health, as is the case for physical health, or whether other aspects of 'social isolation' are the critical factors for mental health.

A recent study explored the extent to which social disconnectedness or isolation (e.g. small social network, infrequent participation in social activities) and perceived isolation (e.g. loneliness, perceived lack of social support) have distinct associations with physical and mental health among older adults.[79] The researchers examined the results of a large nationally representative survey of older adults in the United States, and interviewed 3000 older people. They found that lack of social relationships is associated with worse physical health, whether or not loneliness is experienced. However, they concluded that the link between social isolation and mental health may be mediated by whether the person feels subjectively lonely and has a perceived lack of social support. Older adults who felt the most isolated reported 65% more depressive symptoms than those who felt less isolated, regardless of their actual levels of connectedness.

Lower levels of contact with social networks and loneliness have also been found to be associated with an increased risk of cognitive decline and dementia, while frequent emotional support and social activity appear to reduce the risk of cognitive decline.[80] Another study found that older adults who have poor social support reported the highest level of depressive symptoms, while seniors embedded in diverse social networks are less likely to report depression.[81]

Some studies have tried to disentangle the variables of social support and loneliness. Research which explored the links between loneliness, health and depression among 217 older men found that loneliness may influence the experience of depression.[82] This research found that social support variables were unrelated to depression.

The subjective experience of loneliness can affect mental health in a number of ways. Loneliness can lead to feelings of anger, sadness, depression, worthlessness, resentment, emptiness, vulnerability and pessimism.[83] Loneliness can also alter behaviour, increasing risky habits such as drug-taking, with consequences for both physical and mental health.[84] Loneliness is also a known risk factor for suicide.

As discussed previously, it is vital to distinguish between transient feelings of loneliness and chronic loneliness … 'loneliness becomes an issue of serious concern only when it settles in long enough to create a persistent, self-reinforcing loop of negative thoughts, sensations and behaviours'.[85] Once loneliness has become chronic, it can be difficult to break the cycle because people can become stuck in a loop of negative behaviour which pushes others away.

The effect of chronic loneliness is vividly evoked in the following statement included in the UK report, 'The Lonely Society'

> *'To some extent, all conversations with other people are mental health interventions. … People who are completely isolated can risk losing their minds because they have no one to help them get a perspective. … There is an interesting interplay between loneliness and serious psychiatric conditions, such as paranoia, anxiety and depression'.*[86]

The relationship between social connectedness and mental health works in both directions. People who are experiencing mental distress are at greater risk of experiencing social isolation since they may be unable to participate fully in the community because of the difficulties they face in everyday functioning.[87] Dementia has been linked specifically with a decreasing number of social engagements in later life.[88]

What protects against social isolation and mental distress

More research is needed into how older adults adapt to changes in their social relationships, since adaptation may protect against loneliness. This adaptation can take subtle forms, even for people who appear objectively isolated. For example, in an exploratory study of nineteen older people who live alone with cognitive impairment or early stage dementia, Duane et al found that for some, loneliness was 'warded off through their social world of memory'.[89] One participant spoke about the consoling memories sparked by looking at photos of her life displayed on her wall, while others spoke of conversations or retaining a sense of ongoing connection with their husband who had died.

The link between social isolation and dementia has been recognised in Victoria's *Dementia Framework*, which outlines strategies to promote positive ageing and social connectedness to prevent or reduce dementia risk and at the early stages of dementia.[90]

Overall, researchers agree that strong social networks and participation are beneficial for mental health.[91] However, some research suggests that the protective effects of strong social networks and participation may not be uniform across all groups in society.[92] The nature of the network determines whether it supports or is detrimental to mental health. Some women, for example, may be providing significant support to others in the context of strong social networks which are harmful to their mental wellbeing due to the 'role strain' they experience.

3.4 Summary

In this paper, we have set out our understanding, based on our experience and the literature, of the meaning of social isolation and of mental health, and the relationship between them.

Mental health is understood as the embodiment of social, emotional and spiritual wellbeing. People who have a diagnosed or undiagnosed mental illness, like those who do not, may sit at various points on the continuum from mental wellbeing through to mental distress at any given time. For everyone, regardless of whether or not they have a diagnosed mental illness, mental health is an essential aspect of life. Mental health is influenced by age, sex and hereditary factors, and individual lifestyle factors. Significantly, social and community networks and general socio-economic, cultural and environmental conditions also impact on mental health.

Social isolation is a risk factor for mental illness including dementia, depression and anxiety. Precisely how social isolation affects mental wellbeing is an emerging field of study, although early indications suggest that persistent loneliness may lead to changes in self-perception and behaviour, creating a self-reinforcing negative loop. Perceived lack of social support is another factor which appears to impact on mental health.

These experiences link social isolation to mental health and wellbeing. Research is needed on which of these variables is the critical factor for depression and other mental health conditions. However, it seems clear that an individual's perception that they lack companionship or social support is more important for their mental health and wellbeing than their actual level of social connection, objectively measured.

This relationship between social isolation and mental health operates differently to that between social isolation and physical health. In the latter, lack of social relationships is harmful, whether or not this gives rise to feelings of loneliness and a perceived lack of social support.

The next section considers effective interventions to prevent or address social isolation, and explores whether current policy settings create greater risk of social isolation and mental health issues for older people.

4. IMPLICATIONS FOR POLICY & PROGRAMS

4.1 COTA Victoria's role

COTA Victoria seeks to support older people's participation in social, economic, cultural, spiritual and civic affairs so they remain socially connected and are able to realise their human rights. Older people who are connected to their local community are likely to have a better quality of life, stronger sense of self-control, and be more satisfied with their life.[93]

COTA Victoria takes a health promotion approach to mental health, through the development of age-friendly communities where older people have opportunities for participation and connectedness. This is consistent with the recommendations of a recent Australian study into understandings of loneliness, and how support and service providers should assist older people managing loneliness.[94] The authors argued that 'if older people felt more valued and connected to the community then loneliness would be less of an issue'.[95] They recommended that ideas around social inclusion and age friendly communities should be expanded to reflect a broad approach to well-being and participation in the community.

COTA Age Friendly Victoria will involve older people in twenty local government areas across the state, working in partnership with academia, government, business and civil society to develop communities where they can live safely, enjoy good health and stay involved. This initiative will ensure that older people themselves shape, implement and evaluate an action plan in their community to bring about sustainable change.

The notion of age-friendly communities should encompass a broad approach to wellbeing and participation in the community.[96] Participation involves meaningful participation in work, family and community life and opportunities for lifelong learning.[97]

4.2 What is being done to address social isolation?

Social isolation is a growing area of policy concern and program intervention. Programs directly addressing social isolation may be delivered at the individual, community or societal level, as the following examples indicate.

Working at a societal level, the *Campaign to End Loneliness* coalition of organisations and individuals in the UK drives research, policy, campaigning and innovation to combat loneliness and inspire individuals to keep connected in older age.[98] The campaign specifically targets organisations with responsibility for health and wellbeing to ensure that addressing loneliness is incorporated into strategic planning.

Facilitating supportive relationships through 'post-bureaucratic' services built around the user is seen by some as the key to tackling social ills. For example, Charles Leadbetter from the UK social enterprise group Participle argues that 'we should reimagine public services as feeding the relationships that sustain us in everyday life'.[99]

Also in the UK, the action research program *Neighbourhood Approaches to Loneliness* run by the Joseph Rowntree Foundation supports older people to develop community activities to reduce social isolation.[100] Action research is being used to build the evidence base on how neighbourhoods as a whole can support people who live with loneliness.

Research suggests that the neighbourhood is a key source of security, identity and support networks for older people, whose daily activities are often concentrated in a few fixed locations.[101] Consequently, the local environment, whether in an urban or rural area, is a significant determinant of older people's ability to maintain and develop social connections.

Policy measures and programs to enhance the quality of neighbourhood environments may therefore help to reduce social isolation.

A recent study of the associations between neighbourhood characteristics and ageing well found that negative perceptions of the physical environment may be a barrier to good general (physical) health.[102] The study also found that perceptions of neighbourhood cohesion (measured through four items including feeling that people in the area are trustworthy, and feeling a sense of belongingness in the area) were a significant predictor of total social network size, and interacted with retirement status and time in residence to predict loneliness.[103] Neighbourhood support appears to provide an important element of broader social support resources, which assist older adults to cope with troubles and stressors.[104]

While noting that the causal direction of relationships between neighbourhood quality and wellbeing outcomes requires further investigation, the authors concluded that enhancing the quality of neighbourhood environments may contribute in a positive way to broader strategies assisting older Australians to age well in place.[105]

4.3 What do we know about what works?

Assessing the evidence on 'what works' is complex due to the difficulty of comparing different types of intervention, and the relatively small number of validated studies. A review of randomized controlled studies of group peer support, one-to-one support, and service provision interventions, found that the most effective interventions to address and prevent social isolation were group interventions with a focused educational component, and interventions which targeted specific population groups.[106] Other features of effective interventions were that they enabled participant input, and were developed within an existing service or embedded within existing neighbourhoods or communities.

However, this review found that ineffective interventions involved indirect contact between the participant and others, and one-to-one interventions conducted in people's own homes. This is a particularly interesting finding given the frequent use of befriending schemes to address social isolation. Evidence on the effectiveness of such schemes is equivocal.

The evaluation of the Queensland *Cross-Government Project to Reduce Social Isolation of Older People* indicated that community development approaches are effective in reducing social isolation in later life.[107] Best practice guidelines developed as an outcome of the project identify the importance of targeting interventions soon after a critical event or life transition.[108]

In a literature review conducted by the National Ageing Research Institute (NARI) and COTA Victoria for the Victorian Department of Health, the evidence on effective programs to support older people's participation in all aspects of community life was assessed.[109] A number of key strategies for successful participation programs for older adults were identified, including:

- Using multi-faceted approaches or integrated strategies to enhance the health and wellbeing of older people across healthy ageing domains within one program (for example, nutrition, physical activity, emotional wellbeing and social connection)
- Using mixed approaches to reducing social isolation (for example, direct service delivery and developing and consolidating support networks for older adults at risk of social isolation)
- Using collaborative partnership approaches
- Involving older adults in planning, implementing and evaluating programs
- Using volunteers to run the programs
- Having an evidence-base to the development of the program that aims to address the known protective and risk factors
- Using approaches, methods and models that address local needs and fit with existing resources
- Utilising a life course approach.

These strategies highlight the multiple drivers for and program solutions to reduce social isolation. For example, the connection between physical health, mental health and social isolation suggests that 'social isolation interventions' should address physical health.[110] The treatment of chronic and long-term health conditions can be an important element in combating loneliness.

This discussion of effective strategies suggests that social isolation requires a multi-faceted policy response, with policy settings across a range of domains evaluated through this lens. The following section provides an indicative overview of the current policy environment affecting older Victorians.

4.4 A scan of the current policy environment

The policy domains of mental health, housing and transport are considered here along with health and aged care support. These are selected because they were identified at the roundtable on social isolation held by Benetas and the Victorian Department of Health in November 2011 as being of critical importance for addressing social isolation.[111] COTA Victoria's own consultations and experience with older people confirms the significance of these domains.

Federal Government Policy

Mental health

The Australian mental health system is overwhelmingly skewed towards providing acute and continuing psychiatric care to people aged between 12 and 64.[112] Older people are much less likely than people in other age groups to be referred to mental health specialists, leaving older people with mental health issues inadequately supported.[113] Moreover, despite these indications that older Australians are not receiving sufficient mental health support, people over the age of 65 are also largely invisible within mental health policy reforms.

The National Mental Health Plan and the five year National Mental Health reform initiatives which were announced in the 2011-12 Commonwealth Budget are focused particularly on young people.[114] This reform package included investment in provision for children, who are another important 'under-serviced' group in the population, while older people are not mentioned. Older people and workers from local and state government and aged care organisations who attended the Benetas roundtable agreed that 'the third age is missing from our current national focus on mental health'.[115]

The absence of older people from the national reform agenda is likely to limit the achievement of some objectives. For example, the Australian Government continues to prioritise suicide prevention through the National Suicide Prevention Program and the National Suicide Prevention Strategy.[116] Social isolation is a modifiable factor in relation to suicide, and it is also possible to increase protective factors which reduce the

likelihood of suicidal behaviour, for example by improving self-esteem.[117] Given the high risk of suicide among older people, particularly socially and geographically isolated older men, it is of great concern that this group in the population is not sufficiently considered in mental health policy reform, and continues to have lower rates of access than people in other age groups to early intervention and mental health support services.

The role of general practitioners is of particular importance in this context. Research has suggested that older people prefer to visit a general practitioner rather than a mental health professional.[118] General practitioners have an important role in identifying older people's mental health needs and referring them to appropriate sources of support.[119] However, lack of training in, and understanding of, older people's mental health needs may result in under-diagnosis and under-referral.

Aged care

The *Living Longer Living Better* package of reforms announced by the Federal Government in April 2012 provided $3.7 billion over ten years to build an aged care system that will meet the needs of older people, and be financially sustainable into the future.[120] The proposed reforms enact some of the recommendations of the Productivity Commission Inquiry report *Caring for Older People* released in 2011.

One of the key recommendations made was to increase support to enable older people who need care support to live in their own homes for as long as possible. *Living Longer. Living Better* aims to achieve this by introducing two new levels of care packages, and increasing the proportion of community care packages to residential care places, while also directing additional funds to both community and residential care. Residential care is expected to be increasingly focused on people who are nearing the end of life.

These reforms reflect the strongly stated preference of older people to the Inquiry to receive care at home rather than in residential settings, an aspiration which COTA endorses. There is a risk, however, that some older people may become more isolated and less well supported, unless community services are resourced to meet the needs of our ageing population. The ideal of supporting older people to live at home 'for as long as possible' is often framed in terms of meeting people's needs for physical care. A fuller understanding would recognize that older people want to continue to participate in social and community life, and that social connections are important for wellbeing. Community care support needs to be designed and resourced to reflect this understanding.

Evidence from countries which have already reoriented service provision towards community care unfortunately gives weight to concerns regarding the possible negative impacts of well-intentioned policy reform. A recent UK study suggests that cuts to community care and health services have led to more social isolation amongst older people, resulting in increased levels of depression and physical health issues.[121]

This qualitative research involving 165 older people found that they viewed social interaction as one of the most important factors for well-being and quality of life, but that they were feeling more isolated as service cuts had a real impact. The research also found that the level of support available to older people to enable them to continue living in their own home was not sufficient.

These findings reinforce the importance of ensuring that the move towards supporting people to live at home 'for as long as possible' is backed up by properly funded and resourced community services of all kinds. It is also clear that aged care services are only one element of what is needed to ensure that older people are able to maintain and develop social connections, as the discussion below on housing and transport policy indicates.

From 1st August 2013, all new Home Care Packages will be delivered on a Consumer Directed Care basis, with all packages transferring to this model in 2015. The Commonwealth Government's Living Longer. Living Better website states that Consumer Directed Care will enable consumers and their carers to have greater control over their own lives by allowing them to make choices about the types of care and services they access and the delivery of those services.

Self-directed approaches can in fact involve a spectrum of options including self-directed planning, self-directed funding, and self-directed support, all of which are now influencing the delivery of support to people with a disability, both within the Victorian disability service system and in the rollout of DisabilityCare. The introduction of Consumer Directed Care is to be welcomed if it results in real choice and control for older people receiving community care, and enables them to maintain their social connections. This approach will need to be properly resourced if this is to happen.

The Coalition Government elected in November 2013 has expressed its commitment to the aged care reform package *Living Longer. Living Better*.

Victorian Government Policy

Mental health

COTA Victoria advocates for a stronger focus by the Victorian Government on mental health prevention and early intervention for older people.[122] The State Government should:

- develop targeted mental health promotion, prevention and early intervention initiatives for older people;
- ensure there is a greater focus on programs, services and facilities appropriate for older people within and alongside mainstream mental health service settings;
- address barriers obstructing access to aged care, community support, and supported accommodation for older people with mental health issues and illnesses;
- improve care options specific to mental health within mainstream services such as aged care and supported accommodation; and
- support research for effective prevention and early intervention strategies for older people.

While it retains responsibility for Home and Community Care (HACC) services, the State Government should ensure they are resourced and supported to identify people at risk of depression and other mental health issues.

Aged care

The *Active Service Model* (ASM) is already reshaping Home and Community Care (HACC) services in Victoria. As a literature review conducted for the Victorian Department of Human Services points out, the emphasis on wellness and independence in a holistic sense should result in increased support for social participation.[123] The learning and cultural change brought about through the implementation of this approach needs to be retained when responsibility for HACC is transferred to the Commonwealth in 2015.

Housing

Affordable, appropriate housing is critical for people of all ages. Housing has been described as a 'neglected social justice issue' on the ageing policy agenda.[124] There is a growing awareness that some groups of older people are particularly vulnerable to housing insecurity and consequently to frequent moves and loss of social networks.

Older people on low incomes who are in the private rental market have been identified as a high risk group. According to the Housing for the Aged Action Group (HAAG), there is considerable evidence that the private rental market is becoming unsuitable as a form of housing tenure for older people, particularly those on low incomes.[125] It is too expensive, offers limited security of tenure, and does not have to meet minimum housing standards. It can also be very difficult for older people to gain permission from landlords to modify these dwellings to maintain their independence as they age.

These factors create a situation of housing insecurity for many low-income older people in private rental accommodation, and can lead to people having to re-locate from their communities, with consequent disruption to their social networks.[126] These risks for people in private rental accommodation are of particular concern since the proportion of older people who rent is expected to increase in coming decades, as home ownership becomes increasingly unaffordable for many people.

Current housing policy settings create risks of social isolation and mental health issues for some older people. It is important that social housing continues to provide housing security for low-income people who are unable to access other forms of housing.

Transport

The role of transport in enabling people to remain socially connected is well-evidenced.[127] Transport was one of the most frequently raised issues in COTA Victoria's state wide consultations with older people on aged care reform during 2011 and 2012, and was seen by participants as fundamental to maintaining their social connections.[128] The range of activities which the ability to get around facilitates is indicated by this comment made in earlier research by COTA Victoria … 'having my scooter is more than transport and mobility, it's about my independence so I can catch up with friends and family as well as present issues to my local councillors'.

As people grow older, their reliance on public transport often increases as driving or affording a private car becomes more difficult.[129] However, public transport, especially in rural communities, is either non-existent or too infrequent, taxis are unaffordable for many older people, and volunteer driver services provide inadequate coverage. Policy directions in Victoria continue to prioritise private over public transport, to the detriment of many in the community but with particular impacts on older people who no longer drive.

Research conducted by Victoria Walks with support from COTA Victoria and funding from VicHealth, found that walking is an important activity for older people, especially as they are less likely than other age groups to drive a car or take part in vigorous forms of physical activity.[130] The survey of 1128 older people found that they value walking for a range of reasons including improved health, wellbeing, independence, personal mobility and social connectedness. However, the walkability of the environment is a more important determinant of walking than functional limitations, and the report recommended that the Victorian Government develops a cross-sectoral walking strategy to increase walking.

Inquiry into Opportunities for Participation of Victorian Seniors

COTA Victoria welcomed the *Parliamentary Inquiry into Opportunities for Participation of Older Victorians*, which reported in 2012. The Inquiry report contained a series of recommendations to enable older people's social, economic and community participation, central to which was a ten year strategic action plan for an ageing Victoria, along with the appointment of a Commissioner for Older People.

COTA Victoria looks forward to working closely with the Commissioner for Senior Victorians and the Ministerial Advisory Committee (MAC) to improve the lives of older Victorians. To be successful, both the Commissioner and the MAC will need to be resourced adequately to further the recommendations of the *Inquiry* and ensure better outcomes for older Victorians.

This discussion has identified some gaps and missed opportunities in current policy affecting older people. Of particular concern is the invisibility of older people in national mental health reforms.

5. CONCLUSIONS

This paper has summarised the relationship between social isolation and mental health, identifying the particular role of chronic loneliness and perceived lack of social support in adversely affecting mental wellbeing. The risks faced by particular groups within the population of 'older people' have been indicated.

The review of policy and programs suggests the need for a broad societal response which would aim to prevent social isolation among older people through the development of age-friendly communities which enable them to participate fully. COTA Victoria looks forward to continuing to work with older people themselves as well as with government, business and civil society to realise this vision.

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