Preventing Elder Abuse

A LITERATURE REVIEW FOR THE SMPCP ELDER ABUSE PREVENTION NETWORK

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Southern Melbourne
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Acknowledgements

We acknowledge the Traditional Owners of country throughout Australia and recognise their continuing connection to land, waters and culture. We pay our respects to their Elders past, present and emerging.

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Foreword

I commend the steering committee of the Southern Melbourne Primary Care Partnership (SMPCP) Elder Abuse Prevention Network (EAPN), whose members are industry practitioners, for undertaking a rapid literature review on primary prevention of elder abuse.

Elder abuse is a complex problem. We are at the early stages of working in prevention of elder abuse and understanding its underlying causes. Elder abuse can result from a range of drivers, including ageism, gender inequality, power imbalances and family dynamics. Difficult family relationships are often present, where perpetrators of abuse could be adult children who are themselves dealing with their own issues.

As Ambassador for Elder Abuse Prevention, during my travels across the state talking to senior Victorians, prevention of elder abuse consistently arises as an issue of critical importance. It is not easy for older people and their families or carers to talk about abuse. Reluctance to reveal abuse is an inhibitor to taking action. In light of this, primary prevention of abuse is imperative.

Currently, in Victoria, there are ten elder abuse prevention networks, five of which are associated with the trial sites of the Integrated Model of Care responding to suspected elder abuse. This Integrated Model is inclusive of primary, secondary and tertiary interventions. I look forward to all the initiatives that will be developed and implemented by the newly formed networks.

This publication encourages us to build upon best practice primary prevention health interventions in Victoria and strengthen nuanced strategies to address elder abuse. It provides a valuable overview of the findings of the literature to date and outlines a focus for future work.

I sincerely thank the authors for this welcome addition to the knowledge base of primary prevention of elder abuse.

Gerard Mansour
Commissioner for Senior Victorians and Ambassador for Elder Abuse Prevention

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Family Violence definition

This document uses the definition of family violence as noted in the Victorian Royal Commission into Family Violence. In addition to this, the authors acknowledge that in enacting the 2008 Family Violence Protection Act, the Government recognised features of family violence which are:

(a) *that while anyone can be a victim or perpetrator of family violence, family violence is predominantly committed by men against women, children and other vulnerable persons;*

(b) *that children who are exposed to the effects of family violence are particularly vulnerable and exposure to family violence may have a serious impact on children's current and future physical, psychological and emotional wellbeing;*

(c) *that family violence —*

(i) *affects the entire community; and*

(ii) *occurs in all areas of society, regardless of location, socioeconomic and health status, age, culture, gender, sexual identity, ability, ethnicity or religion;*

(d) *that family violence extends beyond physical and sexual violence and may involve emotional or psychological abuse and economic abuse;*

(e) *that family violence may involve overt or subtle exploitation of power imbalances and may consist of isolated incidents or patterns of abuse over a period of time.*

While this review notes the range of definitions of Elder Abuse currently in use, the authors also acknowledge the definition as used by the State Government of Victoria which is adopted from the Australian Network for the Prevention of Elder Abuse (ANPEA). This definition holds which that Elder Abuse is:

> *Any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. Abuse may be physical, sexual, financial, psychological, social and/or neglect.*

Preface and Executive Summary

This review of literature has been developed to support the work of the Southern Melbourne Primary Care Partnership (SMPCP) Elder Abuse Prevention Network (EAPN) Steering Committee. Specifically it has been developed to support the work that is underway in preventing elder abuse and seeks to examine four key questions:

1. What does the current literature tell us that is relevant to primary prevention in the context of elder abuse?
2. What is the intention of prevention in managing elder abuse?
3. Do the current strategies that are used to prevent violence against women and their children (as a part of the broader work in family violence) apply easily to preventing elder abuse?
4. What should be included in a primary prevention framework for elder abuse specifically?

A rapid review

This report takes the form of a rapid review rather than a systemic review of the available literature on primary prevention of elder abuse.

In asking the questions put forward above, it seeks answers from the perspective of a practitioner in primary prevention.

Using the PICOT[1] criteria, the authors, on behalf of the EAPN:

1. Seek to understand what population groups current elder abuse primary prevention work addresses?
2. What interventions are used for the cohort?

At this stage, the review does not:

- Evaluate or compare interventions used
- Define timelines for the utilisation of evaluation and comparisons.

What becomes apparent in this rapid review, is that there are a great range of definitions of elder abuse but more from a response perspective rather than from the perspective of primary prevention.

[1]*The PICOT is a helpful approach to summarise the value of possible research questions as part of evaluation of the collective impact intervention Guyatt G, Drummond R, Meade M, Cook D. The Evidence Based-Medicine Working Group Users' Guides to the Medical Literature. 2nd edition. McGraw Hill; Chicago: 2008.*

Our emerging conclusions

The range of experience and capacity held by EAPN Steering Committee resulted in the agreed view that these two questions should be widely discussed and debated within the sector. To develop this review of literature, the authors have drawn from both national and international research on the matter of primary prevention of elder abuse. The authors conclude that even though there is wide ranging and consistent agreement that elder abuse is a prevalent issue in our community that needs to be addressed:

- There is a paucity of evidence about the role of primary prevention specifically to address abuse of older members of our community
- Of the interventions described, the EAPN Steering Committee would hold they do not fall within the remit of primary prevention – rather they are secondary and tertiary response strategies
- There are mixed views as to whether elder abuse is best understood as a form of family violence, or as a unique issue in its own right. However, we support the view of the Victorian Royal Commission into Family Violence that it must be considered as family violence.

Taking preventative action to stop the abuse of older people in our community must be about addressing the attitudes that enable, minimise or condone elder abuse in our community.

There are many lessons to be learnt from the innovative and pioneering work undertaken by the prevention leads in family abuse – the EAPN draw inspiration from how this work seeks to create structural change by addressing the drivers of abuse in the family particularly against women and their children.

The authors and the EAPN contend that:

- The approach undertaken by leadership in the violence against women and children sector aims to change discourse, create structural change and address the drivers of gendered violence. It would be useful to consider this model in the development of our framework for the prevention of elder abuse
- That the issue of elder abuse has connections to family violence as it includes intimate partner violence but is also distinct and unique.
- We need to move away from the medical model of addressing elder abuse to change the attitudes and behaviours that perpetuate the abuse of older people
- A framework for creating structural change and addressing the drivers of elder abuse needs to be created to enable real primary prevention of elder abuse in our community

Introduction and Goal

Acting on a request from the Steering Committee of the SMPCP EAPN, this literature review seeks to outline the current thinking and practice on the primary prevention of elder abuse.

Consultation with the committee has identified that there is value in undertaking a literature review which identifies the research and activity to date on primary prevention of elder abuse as there are concerns that activity currently targeting the primary prevention of elder abuse may not build on legacy of past best practice in the health sector.

This literature review will attempt to:

1. Outline the problem
2. Define the scope of the review and process used, including what the review will not seek to do
3. Define elder abuse and seek to define the links of elder abuse to family violence
4. Define primary prevention
5. Seek to outline current policies - domestic and international – on elder abuse, primary prevention and links to the family violence agenda
6. Provide an overview of the current major models of primary prevention
7. Come to a conclusion on possible gaps in current activity, research and policy that the EAPN may consider and make recommendations for areas of future focus.

Outline of the problem

The challenge confronting this paper is the shortage of evidence specifically addressing primary prevention of elder abuse.

A scoping study undertaken by the National Ageing Research Institute (NARI) in 2017 states in their review of literature that there is a "...paucity of evidence regarding the effectiveness of elder abuse prevention and intervention measures" (Joosten, et al., 2017) mainly due to the lack of quality evaluation. A significant literature review quoted by the NARI scoping study adds to this. It finds that, of the 14 prevention studies that were reviewed to measure and evaluate the effects of existing interventions on the prevention of elder abuse three solutions were typically used: "education of caregivers, adult protective service workers, and health care personnel; support group meetings; and a daily money management program."

Another systemic review of elder abuse research (which included a review of some 16 databases for research reports on abuse of people age 55 years and over) found that:

"Prevention of elder abuse will require a comprehensive approach involving a multifaceted intervention including multiple sectors of society. Other appropriate and potential interventions for preventing elder abuse that haven't been tested in a rigorous trial include legislation, respite programs, social support, batterer interventions such as, anger management, cognitive therapy, and couples therapy." (Daly & Merchant, 2011)

NARI are of the view that "research and evaluation is needed to understand whether public education and awareness-raising aimed at older people is an effective intervention or prevention measure for elder abuse." (Joosten, et al., 2017)

Defining Elder Abuse and its relationship to Family Violence

Victorian definitions of family violence were outlined on page four of this document. In exploring definitions at an international level, we turn to the 2002 report by the World Health Organization (WHO) which dedicated a whole chapter to Abuse of the elderly.The World Report on Violence and Health notes that "it is generally agreed that abuse of older people is either an act of commission or omission (in which case it is usually described as 'neglect" and that it may be either intentional or unintentional" (Dahlberg, et al., 2002). Further, the WHO report recognises the same multifaceted nature of elder abuse and, the cultural context of its definition. The WHO definition states that:

> *Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person (aged 60 years and older). It includes physical, sexual, psychological/emotional abuse; financial and material abuse; abandonment; neglect; and serious loss of dignity and respect. (World Health Organisation, 2018)*

The National Research Council of the National Academies provides a regularly cited definition in the report from the ***Panel to Review Risk and Prevalence of Elder Abuse and Neglect:***

> *"elder mistreatment" refers to (a) intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm. The term "mistreatment" is meant to exclude cases of so-called self-neglect—failure of an older person to satisfy his or her own basic needs and to protect himself or herself from harm—and also cases involving victimization of elders by strangers. (Bonnie & Wallace, 2003)*

Another definition of Elder Abuse informed from a legal perspective is:

> *Any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. Abuse may be physical, sexual, financial, psychological, social and/or neglect. (Ellison & Schetzer, 2004)*

Locally, Seniors Rights Victoria (SRV) defines elder abuse as:

> *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.*
>
> *(Seniors Rights Victoria, 2018)*

Some research studies and literature reviews have highlighted definitions of elder abuse are inconsistent (Pillemer, et al., 2016). Across these four definitions we can identify commonalities including a breach of trust, the range of forms that abuse takes and that it is distinct from self-neglect (that is not self-imposed by the older person but an act willful or unintentional that is done to them). However, a notable difference between definitions is the extent to which intimate partner violence is in scope.

Prevalence of elder abuse

There is consensus that elder abuse in Victoria is an issue and is prevalent. Victoria's Royal Commission into Family Violence recognised the issue and its prevalence in its final report concluding that family violence "encompasses other forms of violence such as elder abuse and violence against parents and siblings" (Neave, et al., 2016). The Australian Institute of Family Studies (AIFS) has found evidence "suggests that prevalence varies across abuse types, with psychological and financial abuse being the most common types of abuse reported, although one study suggests that neglect could be as high as 20% among women in the older age group" (Kaspiew, et al., 2016). The Victorian Royal Commission into Family Violence also recognised the intersectional issues affecting older women experiencing abuse.

While there are few comprehensive Australian data sources that indicate the prevalence of economic abuse of older people there is some evidence that identifies the gendered nature of the issue. In 2010, Monash University analysed public advocate, helpline and public trustee data, and found that women are more likely to experience financial elder abuse than men. It also found that the primary perpetrators were sons, followed by daughters. The finding that women are more likely to experience financial elder abuse than men is consistent with Seniors Rights Victoria helpline data where women make up approximately 72 percent of calls (Neave AO, Faulkner AO, & Nicholson, March 2016).

The AIFS provides a helpful review of evidence on prevalence citing a range of studies internationally and locally. The AIFS review cites two studies specifically about the extent of abuse of older women in Australia. Australia's National Research Organisation for Women's Safety (ANROWS) performed an analysis of the ABS 2012 Personal Safety Survey to assess violence against women (sexual assault by any perpetrator and partner violence - physical threat, sexual assault and sexual threat). The ANROWS analysis found that for cohabiting partner violence " 0.4% of women aged 55 and older reported this experience in the preceding 12 months (c. 12,800 women), compared with 3% of 25-34 year old women, the age group where this form of violence is most common" and for sexual assault "0.2% of the sample aged 55 plus (c. 7,000 women) reported experiencing sexual assault in the preceding twelve months, against a national average rate across all age groups of 1%" (Kaspiew, et al., 2016). The Longitudinal Study of Women's Health (2014) is the other significant study quoted by AIFS in their review which measures "vulnerability, coercion, dependence and dejection" from a random sample via sampling frame from Medicare where the older cohort was born in 1921-1926.

"When this cohort was surveyed in 2011 (at age 85-90), the findings suggested that 8% had experienced vulnerability to abuse, with name calling and put-downs being the most common forms. A similar level of prevalence was evident for this cohort in a preceding wave, conducted in 2008 (age 82-87), and slightly lower prevalence levels were found at younger ages (70-81 years). Measures the researchers used to assess neglect indicate a relatively stable prevalence rate of about 20% across waves, from ages 70-75 and 85-90 years." (Kaspiew, et al., 2016)."

From a Victorian perspective, the prevalence of Elder Abuse can be informed by a 2015 study by the National Ageing Research Institute (NARI) on the "Profile of elder abuse in Victoria". Commissioned by SRV, it reports on prevalence based upon matters being reported to the SRV helpline. [2]The study looked at the prevalence of elder abuse across different groups and found:

"financial abuse and psychological/emotional abuse were the most common matters reported, and that two-thirds of abuse is perpetrated by a son or daughter of the older person. In fact, over 90 per cent of alleged perpetrators of elder abuse are related to the older person, or in a de facto relationship."

Focusing on intersectionality the NARI study does draw out impact of diversity on the issue[3].

"The total number of older women reporting abuse was approximately 2.5 times that of older men."

"Over half (62 per cent) of older people who reported an abuse matter had some kind of disability, the majority (45 per cent) being physical" (Joosten, et al., 2015).

However, as SRV's 2014 report on elder abuse stated that the terms of the study were limited.

"the lack of more specific questions to probe CALD specific issues or family dynamics prior to the abuse; and the lack of diversity in the CALD participants. For example there were no participants from newly arrived or collectivist cultures" (Vrantsidis, Dow, Joosten, Walmsley, & Blakey, 2014).

As with elder abuse in general, insight into elder abuse in particular contexts is limited, including among Aboriginal communities, culturally and linguistically diverse (CALD) communities, rural communities, and gay, lesbian, bisexual, transsexual, intersex and queer (GLBTIQ) communities (Higgins, 2004). As the dynamics of elder abuse are context dependent, there remains much to be understood about the extent to which the dynamics of elder abuse are different or similar in varying contexts, and the extent to which different responses may be required (Kaspiew, et al., 2016).

Having said this, noting that family violence encompasses elder abuse, the Victorian Royal Commission report into Family Violence (Victoria 2015) makes it very clear that culturally and linguistically diverse people face higher prevalence rates and increased risk of violence. Consequently tailored strategies will be required to ensure that elder abuse prevention strategies reaches all groups.

It is worth highlighting the work of the Ethnic Communities Council of Victoria (ECCV) whose project Elder Abuse prevention in ethnic communities[4] seeks to address and prevent elder abuse within the context of cultural behaviours, values and expectations. The project has worked with 12 communities from 2012 to 2018 to increase awareness of elder abuse in targeted communities, increase protection, and raise understanding of culturally appropriate community education strategies (amongst others). The model and resources that are being developed demonstrate the value of a tailored, targeted and collaborative impact approach to change and prevention of elder abuse.

[2]*It is worth noting that SRV acknowledges that while the report gives an indication of elder abuse in the community the report is only based on those incidents reported through the help line and therefore "it is expected that many incidents of elder abuse go unreported and the number of unreported incidences may differ between the various types of abuse" (Joosten, Dow, & Blakey, June 2015)*

[3] *The reports of elder abuse via the SRV Helpline were self-reported from victims of abuse.*

[4]*http://eccv.org.au/projects/elder-abuse-prevention-in-ethnic-communities*

Risk factors

The AIFS study informs us that there is a lack of systemic local evidence on risk factors to older Australians experiencing abuse. Perhaps more importantly for this paper AIFS tells us there is limited evidence on "the factors that may protect (older Australians) against risk" (Kaspiew, et al., 2016).

The 2015 NARI/SRV Report identified from its research into trends through the advice call line identified significant risk factors included (Joosten, et al., 2015):

- Family conflict
- Older person has a lack of information about their rights
- Older person is in poor physical health

Internationally, evidence tells us that cognitive impairment and social isolation of the older person increases vulnerability while depression and misuse of alcohol and drugs by perpetrators may also increase risk (Kaspiew, et al., 2016).

From a primary prevention perspective there is some literature that seeks to understand the underpinning drivers of elder abuse. Again the AIFS report identifies that international research relates to the role of attitudes and values "but has not necessarily been directly measured in research" (Kaspiew, et al., 2016).

New Zealand research (2009) commissioned by the Families Commission took a social policy perspective on safety of older people identifying that strong underlying perceptions of the value of older people, combined with persistent images of older people's poor health and mental incompetence reinforce negative social attitudes to ageing (Peri, et al., 2009). This is compounded by other intersectional attitudes to gender and culturally and linguistically diverse groups.

"Women in the 'old' age cohort, meaning those over the age of 75 years, and women from some ethnic communities were considered to be at higher risk of this type of abuse." (Auckland service provider focus group)

Quote from interviews in (Peri, et al., 2009)

The social research also observed prevalence increased with economic and family changes (e.g. increase in time pressure), and financial pressures (Peri, et al., 2009).

Relationship with Family Violence

The Victorian Royal Commission into Family Violence expressed the prevailing view that elder abuse is a form of family violence. That is to say, it is a subset of family violence. Research commissioned by SRV and NARI has also clearly placed elder abuse within the broader family violence area (Joosten, et al., 2015). However there is currently no agreed definition of elder abuse specifically as a form of family violence. This is in part due to the nuances of elder abuse which includes its relationship to intimate partner violence, gender based violence, and intergenerational violence.

The fact that elder abuse can occur outside of the family context and can be perpetrated by friends and non-family members adds further layers of complexity (Seniors Rights Victoria, 2018). The Family Violence Protection Act Victoria (2008) includes a broad definition of family, including “any other person whom the relevant person regards or regarded as being like a family member if it is or was reasonable to regard the other person as being like a family member having regard to the circumstances of the relationship” (AustLII, 2010).

The authors of this review (as health and wellbeing practitioners) acknowledge that this complexity has previously impacted on scholars’, governments’, service providers’ and community members’ ability to view and address elder abuse as a form of family violence.

In some cases the presence of intimate partner violence is considered a driver to elder abuse highlighting the way that “elder abuse” is a distinct subset of family violence. Although scholars and practitioners who address elder abuse or domestic violence recognise intimate partner violence occurs in later life, there is no cohesive and easily identified body of literature examining this issue. This is, in part, because older women often are invisible in scholarly investigations of domestic violence, and intimate partner violence in later life is regularly overlooked in elder abuse. Domestic violence research and intervention is typically “grounded in a gendered perspective but does not account for age”, whereas the elder abuse literature is often “grounded in an aging perspective but does not account for gender” (Roberto, et al., 2014).

Until recently, the family violence sector has tended to focus on younger women and their dependent children and has not paid much attention to older women experiencing ongoing domestic violence. In addition, the dominant definition of 'elder abuse' in the ageing sector does not draw from feminist explanations of family violence and does not address issues of gender, power and control (Bagshaw, et al., 2009).

Although there is a gendered aspect of elder abuse (as shown through the data) the abuse of older women in the literature it has not been included in violence against women policy and practice, but again something with unique nuanced characteristics. As practitioners, we acknowledge that there is a strong gendered influence and this needs to be considered as part of gender abuse work. We also acknowledge that elder abuse is both intergenerational and intimate. This may be a new area for practice and prevention.

This positioning can be illustrated in Figure 1 below.

Figure 1. Intersection of family violence and elder abuse (Senior Rights Victoria and Justice Connect, 2016)

SRV and Justice Connect have also illustrated the overlap between family violence, financial abuse and elder abuse - Figure 2.

Figure.2. Overlap between family violence, financial abuse and elder abuse.

In developing primary prevention strategies to address elder abuse, this paper contends that there are a number of drawbacks in an approach that only considers elder abuse as a subset or part thereof, of family violence. By viewing elder abuse as a subset of family violence alone and not grasping the nuanced aspects of such abuse we will fail to consider a multipronged approach and risk missing opportunities to prevent the abuse before it begins.

It is worth noting that "whilst prevention activities have occurred in other Australian states and territories, only Victoria has thus far implemented such 'concentrated government policy and leadership' for the prevention of violence against women" (Walden & Wall, 2014). Primary prevention efforts take a long time to achieve measurable change. At best we can point to current best practices and positive impacts in programs for young people (Ministry of Women's Affairs, 2013).

In considering the nuances of elder abuse, we must consider that for some, elder abuse overlaps with intimate partner violence in that it is a continuation of long standing intimate partner violence. For others the abuse is perpetrated by friends or family and starts when the intimate partner dies or abuse may take place in institutional settings. While there is evidence to suggest elder abuse occurs between intimate partners there are many other distinct features to consider. These include capacity, dignity of risk, ambivalence[5], neglect, dementia, and inheritance impatience. The occurrence of elder abuse both within families (intergenerational and cross-generational) and outside family relationships (neighbours, friends, carers) further complicates both definitions and prevention approaches.

Another complicating factor is the definition of 'old'. Older can be defined in the literature from 50 – 65 years with some literature also identifying an 'old old' age cohort as being 75- 80 years plus (Crichton, et al., 1999). This variance makes it difficult to determine where family violence ends and elder abuse begins. Finally it is the unique issue of ageism to the elder abuse context that further differentiates elder abuse from other forms of family violence.

Elder abuse literature stems largely from research by medical professionals who have only begun researching the area since the 1980's. While there is some literature on the causes most of the

[5]*Ambivalence here refers to intergenerational ambivalence and is defined as mixed or contradictory feelings toward a family member in another generation*

literature has focused on definitions, prevalence and interventions. The emphasis has often been on individual risk factors and has not considered the social and political context. There has been very little research on the primary prevention of elder abuse.

This is in striking contrast to family violence where, after 50-60 years of research and women's action, the drivers of family violence and intimate partner violence are now well established. Gender inequality has been identified as the key driver of violence against women (by such peak research organisations as ANROWS and Our Watch) bringing an intersection of issues particularly to older women. Addressing gender inequality and ageing not only helps women, but also men who are impacted by constraining traditional role models of masculinity which may prevent them from coming forward with concerns. Gender inequality, and ageing also impacts those older Australians who may not identify as non-binary. We would further note that a broader range of relationships of perpetrators (e.g. sons, daughters, sisters, brothers, neighbours etc.), the larger number of male victims and the impact of ageism as a driver can lead to the conclusion that utilising the current family violence models as a basis for addressing elder abuse may be inappropriate.

One of the necessary prerequisites for a prevention program is to establish what the causes of elder abuse are. As mentioned, much research to date has attempted to establish risk factors associated with the victim of elder abuse. Such risk factors include experiencing cognitive impairment, age, gender and the presence of a disability.

Elder abuse literature has included little recognition of the gendered nature of victims and the sexism inherent in ageism. The intersectionality of sexism and ageism as a social construct involved in elder abuse is yet to be explored in elder abuse literature.

Furthermore, our current understanding of family violence has its origins in the women's movement. The focus has been on younger women and the area as a whole has been blind to the vast number of older women past their childbearing age experiencing abuse.

One of the strengths of the women's movement is that women can identify with other women and that all women can be potential victims of family violence. This may not be the case with older people. Research into the conceptualisation of elder abuse by older people has investigated individual and societal issues but there has been little exploration of sexual and emotional abuse (Killick, et al., 2015).

Furthermore, research shows that over time perpetrators of intimate partner abuse reduce physical violence and instead increase the control of their partners through economic abuse, coercion and verbal threats (Crockett, et al., 2015).

Given the lack of a conclusive evidence base, the authors of this review note that elder abuse in its own right has not yet attained a unique identity working of its own practices, preventative measures, research base and health promotion strategies.

A note on Primary Prevention[6,7]

Throughout the world there has been extensive primary prevention work over a number of years to address family violence. These include mass media campaigns, influencing government policy, fostering coalitions, mobilising community, education and social marketing, empowering women socially and economically and changing individual knowledge of family violence. Many countries have national action plans to address family violence.

Primary prevention strategies are universal strategies aimed at transforming the norms, practices and structures that enable violence. One characteristic of primary prevention strategies is that they are aimed not at the target for change (older people in the case of elder abuse), but at the community around them. When we think about primary prevention, we can start with the definition of health promotion as per the Ottawa Charter which characterises health promotion as "a positive concept…[and] goes beyond healthy life-styles to well-being" (World Health Organisation, 1986). Furthermore we note the evolution of the Charter at the 6th Global Conference on Health Promotion in Bangkok (2005) which recognises the increasing global changes and trends that are affecting health and wellbeing and, because of this the evolution of health promotion strategies to address increasing inequalities and complexities in our community (World Health Organisation, 2005).

The practice of health promotion and primary prevention are evolving. Furthermore, we acknowledge the risks inherent in health promotion which over the years have been mitigated through reflective practice and continuous improvement. Ensuring that health promotion practitioners do not ignore the realities of community and individual context, individual's need for agency in their own lives, and being vigilant to the causes of health and social problems (Keleher, et al., 2007) from which risk behaviors arise is vital if primary prevention and health promotion work is going to continue to be relevant. Past criticism of primary prevention through health promotion has accused the area of practice of being "narrowly cast", "culturally inept" and "lacking in capacity to enhance people's agency" (Keleher, et al., 2007).

A recent paper from the Australian Health Promotion Association (APHA) and the Public Health Association Australia (PHAA) to support a joint policy statement on health promotion and illness prevention (Australian Health Promotion Association and Public Health Association of Australia, April 2018), identifies some of the barriers to effective sustained health promotion and illness prevention.

The background paper concludes that other risks to successful health promotion and primary prevention include siloed approaches from policy makers and policy structures, moving emphasis to short-term planning (additional challenge when outcomes of primary prevention work are often over the long-term), a lack of coherence in approaches (sustained and multifaceted), sporadic national leadership on illness prevention and health promotion, and ongoing habit to focus on "health problems" rather than "health promotion" (Australian Health Promotion Association and Public Health Association of Australia, April 2018) and ubiquitous view of the overriding agency of individuals at the expense of appreciating the social determinants of health.

The strong emphasis on individual responsibility …makes it difficult to gain support from decision makers for health promotion and illness prevention activities that reshape environments in which people

[6]*Sections of this part of the paper are drawn from soon to be published 2018-19 State of Women's Health in the South East: An annual environmental scan from Women's Health in the South East 2018*

[7]*This section has been informed by the soon to be published Women's Health in the South East, Environmental Scan State of Women in the South East of Melbourne 2018-2019*

live. (Australian Health Promotion Association and Public Health Association of Australia, April 2018)

It is acknowledged evidence obtained through research that improvements in health have "been achieved largely as a result of economic environmental and legislative factors…[aka] structural variables" (Jancey, Barnett, Smith, Binns, & Howat, 2016). Dominated by the "social determinants of health" (SDH) the blueprint for health promotion workers developed 10 years ago, aimed to improve daily living conditions, tackle inequitable distribution of power, money and resources and measure/understand the problem and assess the impact of action (Commission on Social Determinants of Health, 2008).

In terms of health promotion and primary prevention, current research and thinking are moving to a form of practice that recognises the increasing levels of complexity in health inequality and, that the once simple pathways and equivalence where health equalled economic inequality need to now consider culture, psychosocial processes and the socio-political environment (Eckersley, 2015). Moving from biomedical approaches to health promotion that often involves "traditional health education activity" is being discussed (Whitehead, 2003). So-called "upstream" movements of socio-ecological change that seek to respond more to complexity and dynamic levels of social determinants. These require integrated strategic plans of action (Keleher, et al., 2007). With more health issues in our community stemming from chronic global burdens of disease (non-communicable diseases or NCDs) in addition to the dynamic social determinants, health promotion workers will need to create integrated strategies that actually tackle "wicked problems" of which health inequity is one. These wicked problems often defy logic and are characterised by "having innumerable causes, [are] tough to describe, and [don't] have a right answer" (Camillus, 2008). In 1973 the notion of wicked social problems was introduced by Horst W.J. Rittel and Melvin M. Webber in their article "Dilemmas in a General Theory of Planning," Rittel and Webber state that:

1. There is no definitive formulation of a wicked problem. It's not possible to write a well-defined statement of the problem, as can be done with an ordinary problem.

2. Wicked problems have no stopping rule. You can tell when you've reached a solution with an ordinary problem. With a wicked problem, the search for solutions never stops.

3. Solutions to wicked problems are not true or false, but good or bad. Ordinary problems have solutions that can be objectively evaluated as right or wrong. Choosing a solution to a wicked problem is largely a matter of judgment.

4. There is no immediate and no ultimate test of a solution to a wicked problem. It's possible to determine right away if a solution to an ordinary problem is working. But solutions to wicked problems generate unexpected consequences over time, making it difficult to measure their effectiveness.

5. Every solution to a wicked problem is a "one-shot" operation; because there is no opportunity to learn by trial and error, every attempt counts significantly. Solutions to ordinary problems can be easily tried and abandoned. With wicked problems, every implemented solution has consequences that cannot be undone.

6. Wicked problems do not have an exhaustively describable set of potential solutions, nor is there a well-described set of permissible operations that may be incorporated into the plan. Ordinary problems come with a limited set of potential solutions, by contrast.

7. Every wicked problem is essentially unique. An ordinary problem belongs to a class of similar problems that are all solved in the same way. A wicked problem is substantially without precedent; experience does not help you address it.

8. Every wicked problem can be considered to be a symptom of another problem. While an ordinary problem is self-contained, a wicked problem is entwined with other problems. However, those problems don't have one root cause.

9. The existence of a discrepancy representing a wicked problem can be explained in numerous ways. A wicked problem involves many stakeholders, who all will have different ideas about what the problem really is and what its causes are.

10. The planner has no right to be wrong. Problem solvers dealing with a wicked issue are held liable for the consequences of any actions they take, because those actions will have such a large impact and are hard to justify.

Many of the risks identified to better health outcomes 10 years ago are still present. Since 2008 the World Health Organisation has advised that “poverty and disadvantage harm health” (Eckersley, 2015) – and indeed there is evidence to suggest that inequality is growing both economically (Organization for Economic Cooperation and Development, 2017) and socially[8]. However, what is also clear from the complexity of data provided in this scan from our region is that the dynamics of social and economic change will mean that more and more of our work will be confronted with wicked problems from which overlaps and connections between policy, research and practice will generate better ways of building knowledge and skills for practice, response and policy (Liamputtong, 2016).

Utilising approaches to health promotion across the streams of action from access to health services, through to targeted programs to address personal development of individuals and systemic change through community and capacity development, policy advocacy, change management and programs that address the determinants of health will be required across all areas of work.

[8]Economically the Australian Council for Social Services tells us that “in terms of average income somebody in the highest 20%has around five times as much income as somebody in the lowest 20% income group.” For average wealth the difference is around seven times. (Saunders, Wong, & Bradbury, 2015)

Primary prevention and family violence - Victoria takes a social and ecological model

Current global research into violence against women has established there are a number of factors that contribute to the perpetration of family violence. These include the unequal distribution of power and resources between men and women and an adherence to rigidly defined gender roles.

There is a consensus that communities and government can prevent violence even before it has occurred by focusing on its causes by addressing the key determinants (Victorian Health Promotion Foundation, 2017).

Prevention in family violence has primarily followed the public health approach which concentrates on the entire population through education, and prevention of disease and injury. In addition, there have been significant legal interventions in the area of family violence with changes to court and policing procedures. Deterrence can be considered another form of prevention and this is the policy supported by the courts and the police. Within the public health model, prevention is spread across a continuum with three main areas of focus. Tertiary prevention targets people who have already experienced the issue by providing support and services. Secondary prevention aims to reduce the progression of the issue and primary prevention focuses on addressing the determinants or causes of the issue. As a discipline, the public health approach seeks to address social, political and economic determinants of health (Dyson, 2014).

The public health model has been adopted by the family violence sector and VicHealth has lead the way in piloting prevention programs across Victoria. A key strategy of VicHealth has been use of the social/ ecological model for informing the understanding of family violence and prevention. The model is based on the concept that family violence is a complex interplay of various factors (Dyson, 2014).

The social model encompasses changing culture norms, values and beliefs. It comprises four elements the first of which is the individual whose experiences and personality shape their response to stressors. The second element is the relationship of the individual with others while the third element incorporates the community and organisations. The final element considers the social aspects which involve changing social behaviour and norms.

The discourse around family violence has changed significantly over the last 50 years. It was in the 1960's and 70's when feminist rallies were taking place that the issue of family violence was first raised as a public policy issue. At this time the broader community viewed family violence as as a private matter and not of concern for public discourse. Family violence was seen as a domestic matter to be managed within the partner relationship. As we head towards 2020, it is now regarded as a societal problem to be addressed at all levels of community, health services, police and government. Primary prevention has potential to be part of the solution in addressing the issue but this must be supported by both secondary and tertiary prevention to ensure older people are safe. In essence, the discourse around elder abuse must evolve as it has around intimate partner violence. This can be achieved through the reinforcement of laws, education of the judiciary, the United Nations conventions, media, many projects and conferences, research, the Victorian Royal Commission into Family Violence and public advocates such as Rose Batty.

Prevention of elder abuse

The online portal ***Violence Info*** (an information system that collates published scientific information on the main type of interpersonal violence) contains a review of worldwide studies to prevent violence by the World Health Organisation (WHO). The review identifies only six studies submitted by all WHO regions that meet the quality requirements of WHO.

These six identified studies all focus on care giver support programs with varying sample sizes[9]. For the authors this is further evidence of the gap in knowledge in prevention of elder abuse – a challenge exacerbated by the fact that it would appear "the most pressing need in the field of elder abuse...[is] for interventions that have the potential to prevent mistreatment" (Pillemer, et al., 2016).

There is a great gap in the knowledge of primary prevention programs in the area of elder abuse. The WHO (2014) Global Status Report on Violence Prevention reports that only 23% of countries reported funding public information campaigns on elder abuse. The most common large scale prevention activities to address elder abuse are professional awareness campaigns, public information campaigns, caregiver support programs and residential care policies.

There is general agreement in the literature that there are few high quality evaluations of elder abuse prevention initiatives. There are mixed findings on the effectiveness of professional education, to reduce elder abuse as evaluations have been of low methodological quality reliable data does not exist (Sethi, et al., 2011), (Pillemer, et al., 2016).

[9]The lack of formal study of non-carer family members or others in a position of trust suggests an assumption that only carers are perpetrators while Victorian statistics indicate that this is far from the case.

Thus “Little can be concluded about which interventions may be most effective in reducing or preventing elder abuse” (Pillemer, et al., 2016). The most promising activities have been money management programs, helplines, refugees (underutilised by older women) and multidisciplinary teams specifically for financial abuse (Pillemer, et al., 2016).

In the last decade in Australia there have been short lived programs on money management, professional education, community awareness and programs to support carers. A large scale approach has been lacking in all states and federally. Furthermore, effective programs require a coordinated response. In Australia the Federal government is currently working on a national elder abuse plan which may lead to an effective coordinated response to elder abuse prevention.

Although there has been little in the way of coordinated approaches, we would like to acknowledge the work of Our Watch in developing and delivering initiatives such as the framework ‘Change the story’, Strengthening Hospital Responses to Family Violence, Respectful Relationships education and ‘Counting on change: A guide to prevention monitoring’ (Our Watch, 2018). Furthermore, the commissioned work of Think Impact in undertaking research to improve the understanding of the primary prevention of elder abuse and how EAPNs can most effectively operate in a primary prevention role will provide some evidence useful in the development of a coordinated approach. The similar focus, work and goals of these organisations will facilitate greater collective impact.

Examples of interventions to prevent Elder Abuse

Caregiver interventions were among the first models used to prevent elder abuse. These interventions provide services to relieve the burden of caregiving, such as housekeeping and meal preparation, respite care, education, support groups, and day care and are promoted as abuse-prevention strategies. There is suggestive evidence that these interventions, when directed specifically to abusive caregivers, may help prevent revictimisation (Reis & Nahmiash, 1998) (Reay & Browne, 2001). Further, there is some indication that the potential for the onset of abuse may be reduced by caregiver support interventions (Livingston , et al., 2013), (Sethi, et al., 2011). Caregiver interventions therefore are a promising approach to prevention.

Extensive case study reports suggest that individuals vulnerable to financial exploitation can be helped through money management programs (Nerenberg, 2003). Such programs feature daily money management assistance, including help with paying bills, making bank deposits, negotiating with creditors, and paying home care personnel. These programs are targeted to groups at high risk for financial exploitation and in particular individuals with some degree of cognitive impairment and who are socially isolated. This intervention is also promising, as the preventive potential is high and with well-trained and accredited money managers, the risks of adverse outcomes are low.

Drivers

Drawing upon existing methods of understanding prevention, there is some evidence from social policy on understanding the drivers of elder abuse.

The New Zealand Families Commission report (2009) states that from its research "Societal influences that increase the risk of abuse were seen as being embedded in what is commonly termed ageism… [and] that age prejudice is still considered socially acceptable" (Peri, et al., 2009). Further, like violence against women, elder abuse is based upon social constructions of ageing.

The social construction of "old age" is strongly determined by the way older people are portrayed, with negative depictions often instilled by a process of socialisation through language, religion, literature, the media and the practices of medical institutions and social services. Currently, common societal portrayals of older adults are that they are "lesser beings", asexual, intellectually inflexible and at the same time forgetful and unproductive (Peri, et al., 2009)

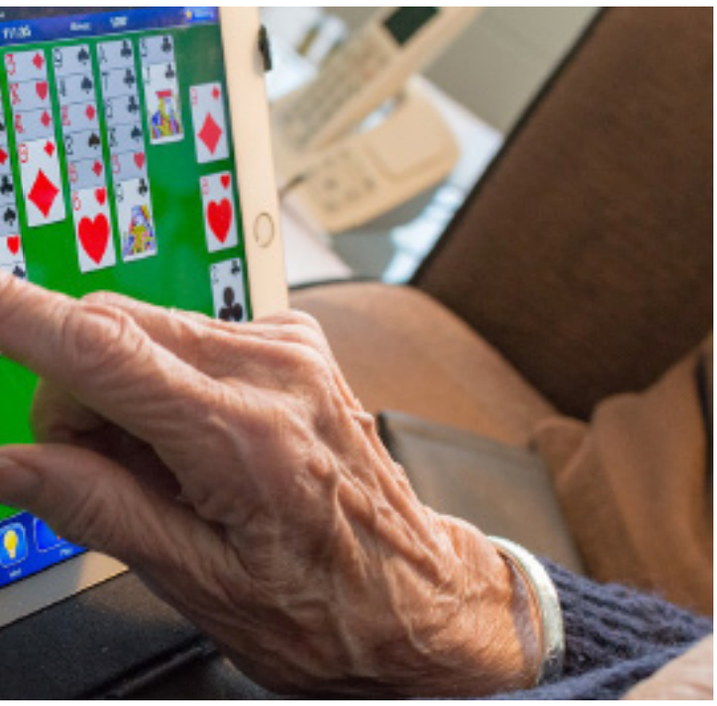
Reinforcing this, New Zealand research and reviews as part of the nation's positive ageing policy also found that attitudes and perceptions of older people have a significant impact on quality of life.

"…in a range of surveys, older people have identified common factors that determine quality of life. Adequate income, good health and social contacts, were determinants of each individual's quality of life…sense of security self-management, and having a respected place in the community…are closely related with self-esteem, a healthy mental state, and the ability to maintain a positive outlook (Dwyer, et al., 2000)."

Recent research, reviews and recommendations in Australia have also considered ageism as a significant factor in elder abuse risk. Recommendations for the development of a National Plan from the 5th National Elder Abuse Conference include addressing ageism and awareness campaigns to change attitudes, inform Australians of their rights and promote understanding (Seniors Rights Service, 2018).

There appears to be no systemic evaluation of prevention strategies for elder abuse (Ploeg, et al., 2009). However, there is some empirical evidence about what are called "protective factors" or "factors that may protect individuals from elder abuse or promote resilience after mistreatment" (Pillemer et al., 2016). Literature reviews of this evidence identify these factors as falling into two key areas:

- Social embeddedness and social support where it appears that higher levels of social support and connection mitigate risks for elder abuse
- Shared living arrangements appear to be a significant risk factor for physical and financial elder abuse (Pillemer et al., 2016).



Ageism

Much research has been led by gerontologists and those working with the aged cohort, but there has been limited research on the influence of ageism as a driver of elder abuse (Nelson, 2002). Ageism is gendered in that there are different stereotypes, practices and structures affecting older men and older women. This is important to our understanding of elder abuse as a gendered issue and the potential of improved gender equality to reduce or prevent elder abuse.

Yon et al (2010) found that ageist attitudes amongst university students correlated with elder abuse and that negative attitudes increased the likelihood of psychological abuse. Additionally, they found those who experienced close, high quality contact between generations were less likely to possess negative attitudes.

Ageism can occur on both the individual and societal level with both having the potential to contribute to elder abuse. It is thought that a lack of respect for elders contributes to both the occurrence of abuse and low rates of identification and response (Walsh, et al., 2007).

There are many complex factors that can contribute to the prevalence of ageism. On an individual level, internalised negative attitudes in older people can result in a 'self-fulfilling prophecy' while at a societal and political level, negative language and policy discourse tend to frame ageing as a burden, economic cost to society and a problem to be managed. There is a distinct lack of perception as to the positive aspects of older people's lives which leads to an overestimation of the negative aspects (Nelson, 2002), (The Benevolent Society, 2017).

Given this evidence and, in the absence of an existing model to address elder abuse, it would seem appropriate to develop a framework which includes an advocacy campaign. Such a campaign should aim to empower individuals and organisations to challenge ageist stereotypes and facilitate meaningful intergenerational contact and interactions (The Benevolent Society, 2017).

Our major concern lies in the fact that there is no in-depth literature from a policy, research or practice perspective on the link between ageism and elder abuse as highlighted by Nelson (2017) "In light of the magnitude of (the problem of elder abuse), it is somewhat extraordinary that there has been little research – if almost none – on the relationship between ageism and elder mistreatment…Whether ageism actually causes or contributes to the cause of elder mistreatment or could be an outcome of ageism is unknown."

Sexism

While gender inequality, power and control are embedded in the issue of family violence, it is not straightforward to transfer this concept into the elder abuse space. There has been a lack of concentration in research on the relationship between elder abuse and sexism. Those who have written about elder abuse within the medical model have avoided this connection and older women are invisible in the family violence sector. More work needs to be done to understand how gender is a major driver of elder abuse and the link to other key drivers such as ageism. The usefulness of the feminist model of understanding family violence needs to be broadened to include the complexity of elder abuse. Certainly the issue of power and control is salient (Crichton, et al., 1999). Furthermore there are different types of abuse which often have their own context. In elder abuse the victim is not always a female as in intimate partner violence and the perpetrator is not always a male.

A note on Victorian Government – Broad Strategies

The AIFS reports a range of legal instruments and policies at State and Federal level whose role is to respond to criminal acts of abuse as well as practice guidelines and frameworks that outline various forms of abuse and response. Some of these guidelines do contain aspects related to prevention. For instance, Victoria's Elder Abuse Prevention and Response Guidelines for Action (2012-2014) do seek to 'encourage sector collaboration and coordination' (Kaspiew, et al., 2016).

More recently, the Victorian Government has funded a number of initiatives towards the prevention of elder abuse to build further evidence to inform future approaches in the prevention of family violence.

- Establishment of ten elder abuse prevention networks across Victoria and funded to June 2020
- A behaviour change and public awareness raising campaign
- Strategy targeting carers (Carers Victoria)[10]
- Broadening the role of Commissioner for Senior Victorians to include Ambassador for Elder Abuse Prevention
- A sector capacity building project in primary prevention of elder abuse in a family violence context
- Research to be undertaken by Our Watch on the primary prevention of intimate partner violence against older women
- Development of the publication, Your Voice – Trust your choice, and an associated training program.

The State Government has also implemented an integrated model of care – however this approach is more focused on responding to suspected elder abuse[11]- one part of the integrated model is the establishment of local prevention networks in each catchment area.

One of the recommendations of the Victorian Royal Commission into Family Violence was to establish a new agency to focus on family violence prevention. Respect Victoria aims to ensure systemic family violence prevention efforts are accelerated and embedded across the Victorian Government and community. The primary roles of the agency are to provide prevention design, implementation and monitoring advice, guide investment, policy development and best practice knowledge. Furthermore, the agency will have responsibility for generating and sharing knowledge to support best practice and address cultural and structural drivers of family violence.

[10] *https://www2.health.vic.gov.au/ageing-and-aged-care/wellbeing-and-participation/preventing-elder-abuse/funded-projects-to-prevent-elder-abuse*

[11] *https://www2.health.vic.gov.au/ageing-and-aged-care/wellbeing-and-participation/preventing-elder-abuse/integrated-model-of-care-for-responding-to-suspected-elder-abuse*

Changing Broad Community Values and Attitudes

It is worth noting that there is a great body of knowledge on primary prevention of violence addressing the drivers of violence coming out of groups such as ANROWS and Our Watch. The frameworks that they use to change the drivers of violence against women, fundamentally connect with changing attitudes to gender and acceptance in the community of gender inequality.

In response to the WHO's World Report on Violence and Health's chapter on "Abuse of the Elderly" (previously quoted) observes that "If we follow the key recommendations of the WHO report, then it is the interventions... aimed at prevention that are the most crucial in preventing abuse" (McCallum & Parsons, 2002). Specifically the review notes "informal and formal social support services" and goes on to conclude that in the future, "primary prevention in a 'public health' approach" will be required (e.g. community forums, information resources, media campaigns to educate the wider community, perpetrator programs and training programs for health and community workers) (McCallum & Parsons, 2002).

An evaluation of treatment and prevention of elder abuse and prevention in Israel (2014) unpacks a range of prevention frameworks many of which are outlined in this review including, therapeutic, legal and other 'prevention' strategies that would be characterised by the authors of this paper as secondary and tertiary response interventions e.g. Referring cases for further treatment, criminal sanctions and other 'interventions' (Alon & Berg-Warman, 2014). Interestingly the review of models which was undertaken to establish a strategy on elder abuse for Israel identified work that evaluated the effectiveness of education about family violence on elder abuse and found that "home visits (from police and domestic violence workers) plus public education yielded more frequent calls to police than (only home visits from police and domestic violence workers)" (Alon & Berg-Warman, 2014). However, noting the challenges in making generalisations from findings, the evaluation did show that:

No differences were found between intervention groups and control groups regarding knowledge of elder abuse and awareness of services, self-esteem, and psychological well-being (Alon & Berg-Warman, 2014)

Mitigating Drivers

In terms of preventing drivers of elder abuse, there appear to be specific strategies tailored to either predictors of elder abuse or, types of elder abuse. The majority of strategies at the moment appear to be targeted at financial abuse and mitigating this by increasing financial independence and potential victims appreciation of their financial rights. Examples of specific strategies to address drivers include:

- Increasing financial literacy of older women – e.g. ASIC's MoneySmart[12] Program offers free tools and impartial information on financial advice on areas such as retirement savings, budgeting and financial planning. Some national peaks and corporates have their own information (e.g. Australian Banking Association Financial Abuse Prevention[13]).
- Information and advocacy services to educate older members of the community on their rights – a clear example of this in Victoria is SRV. Other national peak organisations such as COTA and National Seniors Australia undertake advocacy around social inclusion issues which seek to address some of the drivers of ageism in the community and indeed, implicit bias in policy.
- Programs designed to support and teach coping mechanisms to carers who are supporting older people with dementia have "moderate quality evidence" of success (Baker, et al., 2017).

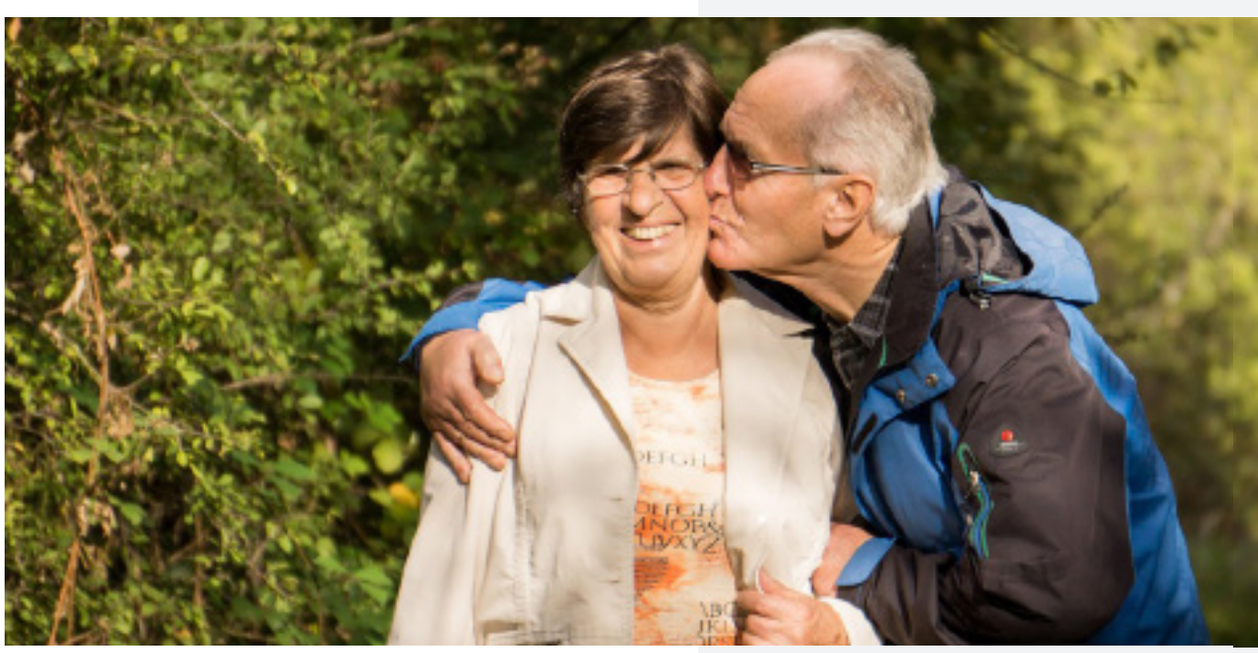
[12] *https://www.moneysmart.gov.au/ and https://www.moneysmart.gov.au/superannuation-and-retirement*

[13] *https://www.ausbanking.org.au/customers/financial-abuse-prevention/*

Evaluation of prevention strategies

One question that we seek to understand in writing this paper is 'what strategies are successful in prevention of family violence and can they be adapted in the area of elder abuse prevention?' It must be noted that prevention is not an exact science and it is very difficult to evaluate the effectiveness of prevention programs. Measuring changes in social attitudes are difficult to link to a particular program (Dyson, 2014).

Programs to change cultural and social attitudes are the most noticeable strategies used for prevention (such as media advertisements). The WHO survey reports that more than 40% of countries surveyed in all regions used social and cultural change strategies.



The WHO report states that these programs are the least evaluated and need to be rigorously evaluated to assess their impact (World Health Organization, 2014). Even where evaluation has taken place, the evaluation has focused on change in attitudes and does not demonstrate how improved knowledge or changed attitudes prevented violence. The evidence base for the effectiveness of prevention programs is currently very much incomplete (World Health Organization/ London School of Hygiene and Tropical Medicine, 2010). Some experts are proposing that youth education and school based programs are the most promising area of social change. This has been demonstrated to be effective in school based programs for adolescents' in preventing intimate partner violence (World Health Organization, 2010).

There have been investigations on interventions to prevent or stop elder abuse with regard to the role of carers. Some conclude that it is unclear whether improved knowledge actually leads to an improvement in skills or behaviour of health professionals and carers. Although educational interventions seem to provoke an increase in the reporting of elder abuse it is unclear whether this was due to an increase in willingness to report abuse or whether it reflected an actual increase in the incidence of abuse (Huyck, et al., 2006).

Strategies that seem "promising"

In spite of the lack of evaluation and evidence on the success of prevention strategies on elder abuse, review of literature has revealed approaches that are attracting attention (Kaspiew et al, 2016), (The Benevolent Society, 2017). These include:

a) Changing broad community values and attitudes

b) Mitigating risk factors

c) Increased positive intergenerational interactions

Conclusions

Prevention aims to reduce the underlying causes of problems and promote factors that contribute to safety and wellbeing. In elder abuse more quality research is required to establish the drivers. This work is imperative for future prevention programs.

Whilst this is a brief and initial review of literature on prevention strategies, it shows clearly the prevailing view that:

a) Elder abuse is complex with multiple drivers including ageism, gender and power imbalance

b) The prevailing view is that whilst elder abuse can be a form of of family violence, it is still a distinct area to address independently

c) Prevention strategies need to utilise a rich range of factors (multifactorial) that is in keeping with the complexity of the issue

d) There is insufficient evidence of effective elder abuse prevention strategies

e) Prevention strategies utilised appear to be at secondary and tertiary levels rather than systemic primary prevention to change attitudes and behaviours towards the elderly.

In addition to primary prevention strategies, Seniors Rights Victoria argues for the importance that “legal and advocacy services have in addressing elder abuse” (Vrantsidis, et al., 2014).

Regardless of the drivers, in order to be successful, primary prevention programs will need to change the discourse surrounding elder abuse. The development of a framework for understanding drivers of elder abuse would greatly facilitate progress in changing this discourse. Only long-term evaluation will be able to demonstrate the success or otherwise of such strategies.

Recommendations

The authors propose that the paper conclude with a set of recommendations to practically ground the review, and articulate clearly what action needs to happen as a result of the work.

The authors put forward that the recommendations could comprise:

1. That an agreed framework for primary prevention of elder abuse in our community needs to be developed
2. The framework can then inform the broader activity and work to reduce family violence in our community
3. As distinct from early intervention and response, specific investment and focus on primary prevention activities and health promotion of elder abuse needs to occur. As with intimate partner violence and gender based violence, it will be work in primary prevention of elder abuse that will change the discourse and behaviours that lead to the abuse of older Australians in our community
4. A specific policy area on primary prevention of elder abuse needs to have long term commitment to programs and rigorous evaluation so that the practice and policy can evolve.

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