Midterm evaluation of Eastern Community Legal Centre's ROSE and ELSA service trials

Midterm Report

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Executive Summary

This report presents the findings from the midterm evaluation of Eastern Community Legal Centre's (ECLC) delivery of the National Elder Abuse Service Trials conducted by RMIT University's Social and Global Studies Centre (SGSC) in partnership with the National Ageing Research Institute (NARI). ECLC's delivery of the National Elder Abuse Service Trials constitutes two service trials: Engaging and Living Safely and Autonomously (ELSA), a health justice partnership with Eastern Health, and Rights of Seniors in the East (ROSE), a Specialist Elder Abuse Unit in partnership with Oonah Belonging Place (formerly Healesville Indigenous Community Services Association).

The overarching aim of this evaluation is to detail the extent to which ROSE and ELSA are providing effective, efficient, sustainable services. The evaluation is in three parts; a baseline survey, a midterm review and a final evaluation. This report presents the findings from the midterm review.

This evaluation employed a mixed-methods approach, combining qualitative thematic analysis of primary and secondary data with descriptive statistical data to address the evaluation questions. The evaluation drew on all available data, including ECLC documentation and quantitative data. The evaluation team conducted interviews and small focus groups with professional stakeholders, including ECLC staff, and with people who had used ROSE and ELSA.

Preliminary findings

The findings from the midterm evaluation indicate that both the ROSE and ELSA service trials have been implemented successfully, are generally reaching the desired cohort and are successful at achieving what outcomes are possible in the complex context of elder abuse. Victoria's COVID-19 restrictions during 2020 and 2021 have made service provision more challenging for ROSE and ELSA and their respective partner organisations. The restrictions limited ELSA's co-location at Eastern Health, a core element of the program design, and for the ROSE program limited partnership development with Oonah Belonging Place.

Additional challenges include the hesitancy of older people to use the options available to address abuse. This was due to a complex suite of factors, primarily relating to a desire to maintain relationships with their children who perpetrated the abuse, concerns regarding repercussions, concerns for the welfare of the abuser, and a lack of availability of alternative options such as mediation.

Despite these barriers the integrated practice model appears to be effective and efficient, with clients overwhelmingly reporting their needs had been met even if the abuse was not entirely resolved. Clients consistently reported improvements in empowerment, choice and control in making their own decisions. This finding is consistent across all available data.

The model used by both services appears to be appropriate. The integrated practice approach combines secondary consultation and community education to link the broader service system together. The evaluation also identified some areas, such as systemic advocacy, to be considered for further development.

Acknowledgments

This evaluation was conducted on Aboriginal lands, including the land of the Boon Wurrung and Woi Wurrung (Wurundjeri) peoples of the Kulin Nation. This land was never ceded. The Social and Global Studies Centre at RMIT University acknowledges the Australian Aboriginal and Torres Strait Islander peoples of the nations of Australia, the custodians of this land. We pay our respects to ancestors and Elders, past and present. We are committed to honouring Australian Aboriginal and Torres Strait Islander peoples' unique cultural and spiritual relationships with the land, waters and seas and their rich contribution to society.

The evaluation team would like to thank all participants who gave considered feedback, particularly those who used the services and shared their experiences with the evaluation team.

Abbreviations and Terms

CALD	Culturally and linguistically diverse
CE	Community Education
CLE	Community Legal Education
COVID-19	Coronavirus disease
CSQ	Caregiving Scenario Questionnaire
ECLC	Eastern Community Legal Centre
ELSA	Engaging and Living Safely and Autonomously
LGBTIQ+	Lesbian, Gay, Bisexual, Transgender/Gender Diverse, Intersex and Queer
NARI	National Ageing Research Institute
RMIT	Royal Melbourne Institute of Technology University
ROSE	Rights of Seniors in the East
SCORE	Standard Client/Community Outcomes Reporting
SGSC	Social and Global Studies Centre
VCAT	Victorian Civil and Administrative Tribunal

1 Introduction

This report presents the findings from the midterm evaluation of Eastern Community Legal Centre's (ECLC) delivery of the National Elder Abuse Service Trials conducted by RMIT University's Social and Global Studies Centre (SGSC) in partnership with the National Ageing Research Institute (NARI). ECLC's delivery of the National Elder Abuse Service Trials constitutes two service trials: Engaging and Living Safely and Autonomously (ELSA), a Health Justice Partnership with Eastern Health, and Rights of Seniors in the East (ROSE), a Specialist Elder Abuse Unit in partnership with Oonah Belonging Place (formerly Healesville Indigenous Community Services Association).

The evaluation is in three parts; a baseline survey, a midterm review and a final evaluation. This report presents the findings from the midterm review.

In this report, the evaluation team have used terminology consistent with contemporary family violence practice rather than legal terminology (i.e. client/victim/survivor and perpetrator/abuser, rather than complainant and accused/defendant).

1.1 Background

1.1.1 Elder abuse in Australia

The World Health Organization defines elder abuse as '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.'[1] The definition includes financial, physical, emotional or psychological abuse, sexual abuse and neglect, and can occur in a range of contexts within a range of relationships where trust is expected. Elder abuse is a serious issue that has significant consequences for the health and well-being of older people and has been gaining more attention internationally and locally in Australia. Given that it intersects with diverse and often siloed legal, social, and primary, tertiary and public health contexts, there have been increasing efforts to better understand its nature so as to guide future policy and practice directions.[2]

Recent endeavours to increase understanding reveal a complex issue that requires a multidimensional approach to address. It is often under-recognised by older people, their families, and the professionals they encounter. In addition, these endeavours highlight that this is an issue that is under-reported, under-documented and challenging to research.[3] In recognition of this emerging and growing problem, the *National Plan to respond to the Abuse of Older Australians 2019- 2023* has recommended a series of priorities, which include building a better understanding of elder abuse across Australia to target and streamline responses, increase community awareness to create an impetus for change, strengthen service responses, help older people plan for the future, and strengthen safeguards for older people. Implementation of the national plan remains a work in progress, with the

[1] World Health Organisation, 'Elder Abuse' <https://www.who.int/news-room/fact-sheets/detail/elder-abuse>.

[2] John Chesterman, '"The Abuse of Older Australians (Elder Abuse)": Reform Activity and Imperatives' (2020) 73(3) *Australian Social Work* 381 ('"The Abuse of Older Australians (Elder Abuse)"').

[3] Briony Dow et al., 'Elder Abuse in Australia' in Mala Kapur Shankardass (ed), *International Handbook of Elder Abuse and Mistreatment* (Springer, 2020) 559 <https://doi.org/10.1007/978-981-13-8610-7_30>.

results of the first population-based prevalence study imminent and evaluations of innovative service models underway.[4]

1.1.2 Existing elder abuse services

In 2019, the Commonwealth government completed a comprehensive stocktake of elder abuse services across the country. The report, titled '*Everybody's business: stocktake of elder abuse awareness, prevention and response activities in Australia, March 2019',* outlines a series of services available for older people across Australia's states and territories.[5] These include confidential helplines, which offer information, advice and referrals. A statewide Victorian example is Seniors Rights Victoria, which also provides community education. Other services include partnership or collaborative models that provide social work, legal and financial advice, and services that offer mediation between family members who were victims/survivors and perpetrators.

Many of these service types rely on individuals to identify they are experiencing abuse and initiate contact with a helpline or an advice service independently. In light of this and of the fact that many older people may not recognise they are experiencing abuse or feel comfortable seeking advice, there is growing interest in implementing sustainable partnership models. These models could provide alternative pathways to identify abuse and to work with an older person to link them with appropriate services. Examples of such models include health justice partnerships. Recent studies indicate that services of this type have been well received by staff and service users in Victoria[6] and Queensland[7] and have been considered to show great promise for both clients and service capability across the country.[8]

1.1.3 Eastern Community Legal Centre

ECLC is a community legal centre that provides services in Melbourne's east, in the local government areas of Boroondara, Knox, Manningham, Maroondah, Whitehorse and Yarra Ranges. ECLC offers a range of legal services, community legal education, law reform and policy work. ECLC has an established commitment to integrated practice and the provision of multidisciplinary services, including in the areas of family violence, mental health, homelessness and drug and alcohol related services. In 2021 ECLC published *Better Practice Principles*,[9] detailing the centre's approach to integrated practice.

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[4] Council of Attorneys-General, *National Plan to Respond to the Abuse of Older Australians (Elder Abuse) 2019-2023* (Attorney-General's Dept.], c[2019, 2019) <https://www.ag.gov.au/RightsAndProtections/protecting-the-rights-of-older-australians/Pages/default.aspx>.

[5] Commonwealth of Australia, *Everybody's Business: Stocktake of Elder Abuse Awareness, Prevention and Response Activities in Australia* (Australian Government Attorney-General's Department, March 2019) 121.

[6] Virginia J Lewis et al., 'Addressing Elder Abuse through Integrating Law into Health: What Do Allied Health Professionals at a Community Health Service in Melbourne, Australia, Think?' (2020) 39(2) *Australasian Journal on Ageing* e220 ('Addressing Elder Abuse through Integrating Law into Health').

[7] Monica Taylor, 'Access to Justice: Prevention Is Better than Cure: Health Justice Partnerships in Queensland' [2020] *The Proctor*.

[8] Suzie Forell and Marie Nagy, *Health Justice Partnership as a Response to Domestic and Family Violence: Health Justice Insights* (Health Justice Australia, 2021).

[9] Eastern Community Legal Centre, *Integrated Practice - Better Practice Principles* (Eastern Community Legal Centre, 2021).

1.2 Establishment of ROSE and ELSA

The National Elder Abuse Service Trials are funded by the Commonwealth Attorney-General's Department as part of the Council of Attorneys-General's (2019) *National Plan to Respond to the Abuse of Older Australians (Elder Abuse) 2019–2023*. In the 2018-19 Federal Budget, the Commonwealth Government announced the *More Choices for a Longer Life – Protecting Older Australians* package. This included the *Elder Abuse Service Trials* program, which funded elder abuse service trials across Australia using three distinct models:

- Specialist elder abuse units staffed by lawyers and social workers
- Health justice partnerships
- Case management and mediation services

ECLC was subsequently funded to provide a specialist elder abuse unit (Rights of Seniors in the East, or ROSE) and a health justice partnership (Engaging and Living Safely and Autonomously, or ELSA). Both service trials provide direct support to people aged 65 years and over, or Aboriginal and Torres Strait Islander people aged 50 years and over, secondary consultations and community education.

Both service trials aim to be accessible for the following groups:

- older people from CALD backgrounds
- older Aboriginal and Torres Strait Islander people
- older people experiencing cognitive decline
- older people experiencing social isolation
- older people with disabilities
- older people experiencing or at risk of homelessness
- older LGBTIQ+ people

ROSE

ROSE (Rights of Seniors in the East) is a partnership with Oonah Belonging Place. ROSE uses an integrated model to provide legal, financial counselling and social work advice, information, and case management support to older people with increased vulnerability, experiencing or at risk of elder abuse.

ROSE employs an elder abuse advocate and a community lawyer, with the ELSA financial counsellor providing financial counselling as necessary. ROSE accepts referrals from any person or organisation in the catchment area.

ELSA

ELSA (Engaging and Living Safely and Autonomously) is a health justice partnership between ECLC and Eastern Health. ELSA employs a community lawyer and a financial counsellor and works only with patients of Eastern Health to provide legal, financial counselling, information and legal case management support to older people with increased vulnerability, experiencing or at risk of elder abuse. ELSA employs a Partnership Coordinator, who is a social worker seconded from Eastern Health. The Partnership Coordinator provides secondary consultations, education, information, advice and referrals, but does not provide case management. Initially, ELSA did not include an advocate, as it was anticipated that Eastern Health social workers could fulfil this role in the health justice partnership, but in October 2021 Eastern Health seconded an Elder Abuse advocate to ELSA.

A Managing Lawyer (Elder Abuse) provides program, stakeholder and staff management and leadership across both programs. An Intake and Administration Officer supports both service trials, providing information and advice while facilitating access to the service trials.

1.3 Baseline survey

In March 2020, the evaluation team launched a survey for Eastern Health staff to capture a baseline level of awareness, knowledge, and understanding of elder abuse by clinical staff providing care. The survey employed the Caregiving Scenario Questionnaire (CSQ).[10]

The CSQ presents participants with a scenario and requires participants to identify various statements as "elder abuse", "not elder abuse", and "potentially elder abuse". These statements are pre-identified as fitting into one of these categories. It is possible to assess their understanding of elder abuse by comparing their response to the survey with the pre-identified correct responses. The CSQ is a recognised tool for assessing perceptions of elder abuse, particularly with health professionals, and has been deployed overseas and in Australia.[11]

The survey was distributed to all medical, nursing and allied health staff who work in specialist older person's health services at three Eastern Health sites:

- Peter James Centre (380 staff)
- Geriatric Evaluation Medicine, Box Hill (approx. 60 staff)
- Wantirna aged care, palliative care and ambulatory community rehabilitation services (220 staff)

Unfortunately, the survey initially launched in March 2020 as Eastern Health responded to the first COVID-19 restrictions in Melbourne, and only two responses were received. The survey was relaunched in December 2020, with an additional 44 responses received, for a total of 46.

The survey data showed that 73% of respondents could consistently correctly identify elder abuse. However, the small sample means these data should be treated with caution. Analysis of the data showed counterintuitive results, with staff who had completed training in elder abuse run by ECLC (n=14, 70%) scoring lower than those who had not (n=32, 74%). This is at odds with data collected at the training sessions (see 3.6.6 below) and is likely due to low survey response numbers.

The evaluation team will liaise with ECLC to determine future options for collecting survey data.

1.4 Literature review and legislative analysis

The evaluation team conducted a literature review and a legislative analysis that has informed the evaluation. Peer-reviewed papers and government reports were sourced, and a narrative literature review approach and a doctrinal legal analysis were undertaken. Although the results of Australia's first population-wide prevalence study are not yet available, a growing body of evidence reveals a complex picture that requires a multidimensional approach to understand and mitigate in the first instance. One of the key findings from this review is that the current policy, service and legal frameworks vary significantly across the country. Each

[10] Amber Selwood, Claudia Cooper and Gill Livingston, 'What Is Elder Abuse—Who Decides?' (2007) 22(10) *International Journal of Geriatric Psychiatry* 1009.

[11] See e.g. Ioana Caciula et al., 'Recognition of Elder Abuse by Home Care Workers and Older People in Romania' (2010) 22(3) *International Psychogeriatrics* 403; Susi Pelotti et al., 'Recognition of Elder Abuse by Italian Nurses and Nursing Students: Evaluation by the Caregiving Scenario Questionnaire' (2013) 25(6) *Aging Clinical and Experimental Research* 685 ('Recognition of Elder Abuse by Italian Nurses and Nursing Students'); Briony Dow et al., 'Health Professionals' and Students' Perceptions of Elder Abuse' (2013) 32(1) *Australasian Journal on Ageing* 48.

Australian state and territory has different policy and practice frameworks. The legislative context spans state and federal laws, none of which have been designed to respond specifically to this issue.

At the moment the mechanisms for identifying and responding to elder abuse are not straightforward. While there is some evidence supporting the use of protocols,[12] there are no validated elder abuse screening tools that Australian health professionals can use in their daily practice, nor is the need for such tools widely accepted by health[13] or legal professionals.[14] Furthermore, while the WHO definition is widely cited and accepted, it is also heavily contested for multiple reasons. Among other things it is felt that it does not specify whether abuse can be unintentional; it does not provide guidance to measure abuse; it does not detail a continuum of severity; it does not define a relationship of trust; nor does it state what would be considered a successful outcome of an intervention.[15]

Australian evidence generated to date is in its infancy.[16] Most data have been developed through research partnerships with elder abuse, health care and legal services. Studies reveal that perpetrators are often adult children of the older person. The nature of this relationship can play a significant role in whether an older person identifies their experience as abuse and whether they wish to seek help.[17] Family dynamics are also noted, with most victims/survivors older women, and most perpetrators their adult sons in their 40s and 50s. However, the gender mix is less marked than in intimate partner violence statistics. Co-habitation was noted as a key risk factor. Any attempts to understand elder abuse must also consider the overarching context in which it is occurring and this includes how it intersects with ageism, gender and caregiving norms, as well as contemporary issues of increasing job insecurity, housing affordability, and challenges with accessing mental health, gambling, and alcohol and other drug services.[18]

The review could find no primary evidence to understand the experience from the perpetrator's perspective. Data is also scarce regarding people who identify as Aboriginal and or Torres Strait Islander, people from culturally and linguistically diverse communities, those who identify as LGBTIQ+, and those who reside in residential care settings.

A complete literature review and legislative analysis will be published separately.

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[12] Barbara Blundell, Amy Warren and Emily Moir, 'Elder Abuse Protocols: Identifying Key Features and Establishing Evidence for Their Use and Effectiveness' (2020) 32(2) *Journal of Elder Abuse & Neglect* 134 ('Elder Abuse Protocols').

[13] Bianca Brijnath et al., '"Build Rapport, Otherwise No Screening Tools in the World Are Going to Help": Frontline Service Providers' Views on Current Screening Tools for Elder Abuse' (2020) 60(3) *The Gerontologist* 472 ('Build Rapport, Otherwise No Screening Tools in the World Are Going to Help').

[14] Nola M Ries, 'Elder Abuse and Lawyers' Ethical Responsibilities: Incorporating Screening into Practice' (2018) 21(1) *Legal Ethics* 23 ('Elder Abuse and Lawyers' Ethical Responsibilities').

[15] Barbara Blundell and Mike Clare, 'Designing Australian Responses to Elder Abuse: Issues and Challenges' in Mala Kapur Shankardass (ed), *International Handbook of Elder Abuse and Mistreatment* (Springer, 2020) 539 <https://doi.org/10.1007/978-981-13-8610-7_29> ('Designing Australian Responses to Elder Abuse').

[16] Ibid.

[17] Bianca Brijnath et al., 'A 7-Year Trend Analysis of the Types, Characteristics, Risk Factors, and Outcomes of Elder Abuse in Community Settings' (2021) 33(4) *Journal of Elder Abuse & Neglect* 270; Briony Dow et al., 'Barriers to Disclosing Elder Abuse and Taking Action in Australia' [2019] *Journal of Family Violence* <https://doi.org/10.1007/s10896-019-00084-w>.

[18] Briony Dow and Bianca Brijnath, *Elder Abuse: Context, Concepts and Challenges* (No 14, Australian Institute of Health and Welfare, 2019) 17.

2 Evaluation methodology

This evaluation employed a mixed-methods approach, combining qualitative thematic analysis of primary and secondary data with descriptive statistical data to address the evaluation questions.

2.1 Aims and scope

The overarching aim of this evaluation is to detail the extent to which ROSE and ELSA are providing effective, efficient, sustainable services. Efficacy, efficiency and sustainability are understood by the evaluation team as interlinked and interdependent, with service quality being achieved by balancing these factors.

2.2 Key evaluation questions

The key evaluation questions have been adapted from the *Preparation for the evaluation of the Elder Abuse Service Trials* prepared by Inside Policy for the Commonwealth Attorney-General's Department. These questions address three key areas; process, outcome and economic.

Process

1. How are the service trials implemented?
    a. How are the health justice partnerships implemented?
    b. How are the specialist elder abuse units implemented?
    c. What were key features of the partnership and how did these contribute to client outcomes?
    d. How effective is the integrated, multi-disciplinary service delivery?
2. To what extent are the service trials reaching the desired cohort?
3. What are the barriers or challenges to implementing the service trials?
4. How are barriers to implementing the service trials being addressed?
5. What are the features of the service trials that are of most benefit to primary clients?

Outcome

6. To what extent have the service trials outcomes been achieved?
    a. Older people feel supported and services meet their needs
    b. Older people receive justice and legal restitution
    c. Older people are satisfied their issues have been resolved appropriately
    d. Older people respect and trust services
7. To what extent did each service trial type achieve its immediate and intermediate outcomes?
8. How well did each service trial type meet the needs of older people at risk of experiencing elder abuse? Including:
    a. older people from CALD backgrounds
    b. older Aboriginal and Torres Strait Islander people
    c. older people experiencing cognitive decline
    d. older people experiencing social isolation
    e. older people with disabilities
    f. older people experiencing or at risk of homelessness
    g. older LGBTIQ+ people
9. What (if any) were unintended outcomes resulting from the service trials?
10. What were the lessons learnt?

Economic

11. To what extent did the service trials provide value for money?
12. Are the service trials the best use of resources?

These questions informed the interview schedule so that, where relevant, all stakeholders were consulted on each question (see Appendix 3.) In addition to the above questions, the evaluation focuses on the experiences of the people who have used or are eligible for ROSE and ELSA and has assessed the success of the services in response to their experience.

2.3 Data collection

The evaluation drew on all available data, including ECLC documentation and quantitative data, and conducted interviews and small focus groups with professional stakeholders, including ECLC staff, and with people who had used ROSE and ELSA.

2.3.1 Review of ECLC documentation

The evaluation team reviewed a range of establishing and implementation documentation including policies, protocols and procedures, the Attorney-General Department's program logic, data collection tools and accompanying documentation, promotional materials, referral guidelines and relevant reports. Case studies, developed for the Attorney-General Department's reporting requirements, had already been reviewed.

2.3.2 Interviews with people who have used ELSA and ROSE

ELSA referred eight clients for interview, four of whom were able to be interviewed, and ROSE referred three clients, two of whom were able to be interviewed. Two men and four women participated. As noted at 2.5 these numbers are below the original recruitment target, and this will be addressed in the final stage of the evaluation.

2.3.3 Professional stakeholder interviews and focus groups

In total, 28 professional stakeholders participated in interviews or focus groups; 10 ECLC staff, including ROSE and ELSA staff, 5 ROSE external stakeholders and 13 ELSA external stakeholders. ROSE external stakeholders included key stakeholders from a diverse range of community organisations while all ELSA external stakeholders were Eastern Health social workers. This is significantly above the target for recruitment for this group, which was initially 6 ECLC staff and 8-10 external stakeholders across both stages of the evaluation.

2.3.4 Quantitative data

Quantitative data were collected by ROSE and ELSA staff, primarily based on the Data Exchange Framework (DeX). ROSE and ELSA staff also used the Standard Client/Community Outcomes Reporting (SCORE) to document improvement in client circumstances, client goals and client satisfaction. In addition, ROSE and ELSA conduct client exit surveys and community education session surveys from which quantitative data has been drawn.

2.4 Data analysis

The interviews and focus groups were audio-recorded, professionally transcribed and loaded into NVivo qualitative analysis software. All qualitative data were double coded, using well-rehearsed conventions of

thematic analysis,[19] and, where possible, by one evaluator who had facilitated the interview or focus group and one evaluator who had not. Qualitative data were analysed explicitly against the key evaluation questions (see 2.2) and implicitly for emergent themes not related to the key evaluation questions. This resulted in two coding frameworks; one corresponding to the evaluation questions and one adduced from the data. Quantitative data were processed in Microsoft Excel and Microsoft Power BI.

The evaluators then synthesised the thematic coding, correlated with the findings from the quantitative analysis, which was reviewed by the evaluation team for discussion and refinement. Emergent themes and recommendations were developed, tested, and refined. This thematic analysis forms the basis for the structure of the findings of this report.

2.5 Limitations

The evaluation to date has been limited by several factors, primarily Victorian Government COVID-19 restrictions, the small number of ROSE and ELSA clients available to participate, professional stakeholders' length of engagement with clients and familiarity with outcomes, aspects of the recruitment process, and an inability to recruit a lived experience researcher.

The Victorian Government COVID-19 restrictions contributed to low response rates in the baseline survey and to the need to conduct all interviews and focus groups online. The original evaluation plan also included a co-location component, with an evaluator based on site at ECLC during the data collection period. This was not possible due to COVID-19 restrictions but will be undertaken in the final evaluation stage if restrictions permit.

In addition, as discussed below, Victorian Government COVID-19 restrictions over 2020 and 2021 have made service provision more challenging for ROSE and ELSA and their respective partners. The restrictions limited ELSA's co-location at Eastern Health, a core element of the program design, and for the ROSE program limited partnership development with Oonah Belonging Place (discussed at 3.7.2 below). The original evaluation plan sought to interview 20 people who had used ROSE or ELSA across both the midterm review and the final evaluation. As noted at 2.3.2 above, this was not possible due to the large proportion of clients experiencing cognitive decline and/or memory issues and the low proportion of clients who consented to be contacted. Ultimately, only six clients were interviewed at this stage of the evaluation, meaning data from this group must be interpreted with caution. The evaluation team hope to reach the target of 20 for the final evaluation and, for the analysis for this report, have triangulated the robust quantitative data and qualitative professional stakeholder data with what limited client data is available.

The evaluation team were able to recruit above the target number of professional stakeholders, but while nearly all of these stakeholders referred to and received referrals from ROSE or ELSA they did not continue to work with the clients over long periods of time. This meant that they were not well positioned to provide feedback on longer term outcomes for clients. As seen at 3.5, the quantitative outcomes data are largely able to fill this gap.

A minor limitation is that while Eastern Health social workers were recruited directly by the research team ROSE stakeholders and all clients were referred by ECLC. Although this was unavoidable, such processes may allow for some bias in the recruitment process.

[19] Virginia Braun et al., 'Thematic Analysis' in Pranee Liamputtong (ed), *Handbook of Research Methods in Health Social Sciences* (Springer Singapore, 2019) 843 <http://link.springer.com/10.1007/978-981-10-5251-4_103>.

The original evaluation plan sought to recruit a lived experience researcher to the evaluation team. Despite consultations with relevant advocacy and support organisations, this was not possible. Unlike in other sectors, such as intimate partner violence or mental health, there is no established lived experience workforce in the elder abuse sector. However the evaluation team will again attempt to recruit to this role prior to the final evaluation.

2.6 Ethics and governance

This evaluation is approved by the RMIT Human Research Ethics Committee (#HREC22857). Ethics approval for the baseline survey was provided by the Eastern Health Human Research Ethics Committee (#LR20/017)

Quotes from participants have been edited for readability and to safeguard anonymity. Participant identification numbers are not sequential. Where participants are identified it is with their explicit consent.

3 Preliminary findings

The findings from the midterm evaluation indicate that both ROSE and ELSA have been implemented successfully, are generally reaching the desired cohort and are successful at achieving what outcomes are possible in the complex context of elder abuse. COVID-19 restrictions have restricted implementation, with ROSE unable to fully realise the partnership with Oonah Belonging Place and ELSA often unable to co-locate with Eastern Health.

Additional challenges include the reluctance of older people to use available options to address abuse. This was due to a complex set of factors primarily relating to a desire to maintain relationships with their children who perpetrated the abuse, concerns regarding repercussions, concerns for the welfare of the child, and a lack of availability of alternative options such as mediation services where confronting conversations could be facilitated in a safe place. Despite these challenges, the integrated practice model appears to be effective and efficient, with clients overwhelmingly reporting their needs had been met even if the abuse was not entirely resolved. Clients consistently reported improvements in empowerment, choice and control in making their own decisions. This finding is consistent across all available data.

The model used by both services appears to be appropriate. The integrated practice approach combines with secondary consultation and community education to link the service system together. The evaluation also identified some areas, such as systemic advocacy, to be considered for further development (see details below). Preliminary recommendations are summarised in section 4.

The findings have been structured thematically, based on the emergent themes arising from the data analysis. Client and stakeholder perspectives are presented together as there were no significant differences of perspective.

3.1 Practice context

ROSE and ELSA operate within a broader practice context that informs their service delivery. The dominant factor influencing the practice context during the service trials has been the Victorian Government COVID-19 restrictions.

During the service trial period, Melbourne experienced nearly nine months of lockdown due to COVID-19 restrictions, becoming the most locked-down city in the world. This had a profound impact across all service systems. Service delivery to older people became particularly difficult, with many older people less comfortable using videoconferencing and e-health technology, and susceptible to isolation.[20] Overseas studies show that elder abuse increased significantly during lockdowns,[21] while one local qualitative study provided insight into the intersection of ageism and the pandemic, exploring how older people perceived the disaster in Victoria.[22] Courts

[20] Alyssa Elman et al., 'Effects of the COVID-19 Outbreak on Elder Mistreatment and Response in New York City: Initial Lessons' (2020) 39(7) *Journal of Applied Gerontology* 690 ('Effects of the COVID-19 Outbreak on Elder Mistreatment and Response in New York City').

[21] E-Shien Chang and Becca R Levy, 'High Prevalence of Elder Abuse During the COVID-19 Pandemic: Risk and Resilience Factors' (2021) 29(11) *The American journal of geriatric psychiatry* 1152 ('High Prevalence of Elder Abuse During the COVID-19 Pandemic').

[22] D Parkinson, K O'Halloran and J Dinning, *The Impact of COVID-19 Pandemic Response on Older People* (Respect Victoria, 2021); K O'Halloran and B Brijnath, *Literature Review of The Impact of COVID-19 Pandemic Response on Older People* (Respect Victoria, 2020).

and tribunals, particularly the Victorian Civil and Administrative Tribunal which is responsible for guardianship and administration cases, experienced a backlog of cases. For ELSA, the health justice partnership could no longer be co-located. All services responded differently, with solutions such as providing teleconferencing technology for hospital inpatients, and both ROSE and ELSA providing online community education. Despite these initiatives, it must be assumed that many people who might otherwise have been supported by ROSE or ELSA were not referred or were not able to access the services.

There are many other influences on the practice context, including system reform and increased awareness of family violence following the Victorian Royal Commission into Family Violence and the lack of prevalence data for elder abuse. Within ECLC, staff turnover has influenced service delivery. Each of these factors are addressed below where relevant.

3.2 Client experiences of abuse

This section outlines the experiences of elder abuse identified by clients and documented by professional stakeholders. Broadly, these data reflect existing literature on elder abuse,[23] indicating that ROSE and ELSA are working with a generally representative client population. For both ROSE and ELSA, the most common presentation was an older person whose child was inflicting psychological, emotional and financial abuse but who was hesitant to take decisive legal action because they valued their relationship with their child.

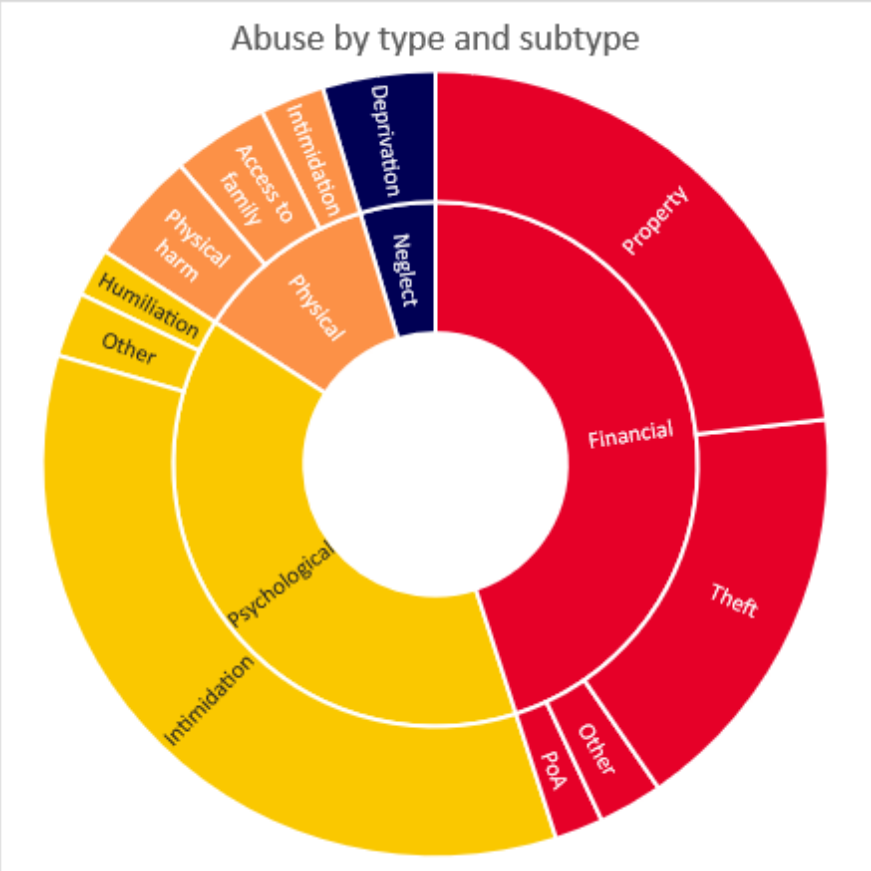

Figure 1 - Abuse by type and subtype

As shown in Figure 1, the types of abuse experienced by ROSE and ELSA clients were primarily financial and psychological abuse, with a minority of clients experiencing physical abuse and/or neglect. No significant differences between ROSE and ELSA were identified. This is consistent with available data. Financial abuse was commonly for amounts less than $10,000, although four clients reported losing more than $500,000. Three quarters of clients had lost some money or assets.

[23] Melanie Joosten et al., *Seven Years of Elder Abuse Data in Victoria (2012–2019)* (National Ageing Research Institute in partnership with Seniors Rights Victoria, 2020)

One external stakeholder noted visa-related abuse, where the older person was threatened with deportation by their adult child. No instances of sexual abuse were recorded. The distinction between different 'categories' was often not clear in practice, with experiences of multiple types of abuse also common.

Often clients would be referred for one issue and receive support for another:

> *This client was happy to accept a referral to talk to someone about the physical violence, but it was when we started asking further questions that we realised there were more important things to her that she wanted to focus on. (ECLC Staff 2)*

Financial abuse reported included refusal to repay money, mismanagement of funds, or adult children refusing to pay board or household bills when still living at home. Psychological and emotional abuse were in the form of verbal threats, intimidation, and control. Rose Client 3 experienced financial and psychological abuse and was locked in his house by his son:

> *He changed the locks of the house, he didn't give me a key. I couldn't get out, I couldn't get into the garage, he changed the remote control to the garage. (Rose Client 3)*

ELSA Client 2 experienced mainly verbal abuse and intimidation:

> *I frustrate him – I mean, I frustrate him – I ask him a question, he yells at me sort of thing.*
> *…*
> *he used to flicker the lighter in front of my face, right, and I was scared stiff, and sort of threatened me, but wouldn't go to the extent of hurting me.*
> *(ELSA Client 2)*

ROSE clients were less likely (17%) than ELSA clients (39%) to be receiving some kind of support for their issue before coming to ECLC.

3.3 Perpetrators of abuse – characteristics and drivers

The data collected by ELSA and ROSE on perpetrators of elder abuse are consistent with other available data. Figure 2 shows both ROSE and ELSA clients experience abuse primarily from adult children, followed by adult family members and only a proportionately small number of non-family members. All clients who participated in the evaluation identified their children as the perpetrator of abuse, although not with that explicit description. Some participants also identified other perpetrators such as neighbours or former partners.

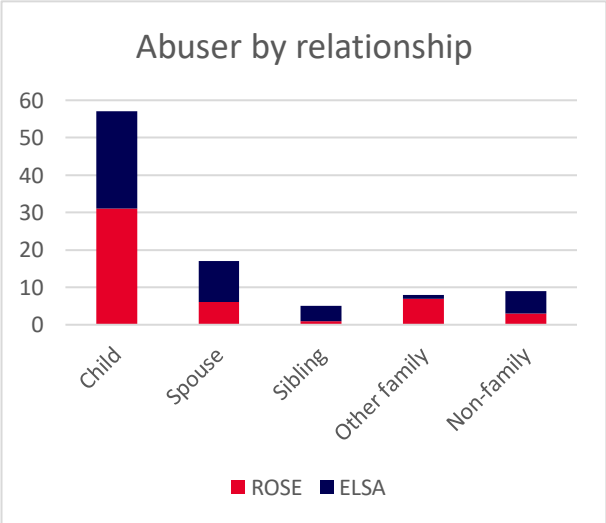

Figure 2 - Abuser by relationship

The data consistently indicate complexity in the lives of abusers, with many recorded as living with disability, adversity, drug and alcohol use, unemployment, homelessness or other complicating factors. A related factor was the prevalence of children with complex needs living in their parents' home due to lack of other housing options or needing parental care. This was not always the case, but clients who participated in the evaluation

tended to associate their children's perpetration of abuse as being related to this complexity, rather than inherent to their personality. ELSA Client 6's experience was characteristic of this dynamic:

> *I have a son who has epilepsy and schizophrenia as well, and I was just worried – he was on drugs for a number of years… I was really worried about my son being evicted from where he's renting because he gets evicted from everywhere he lives. ... He's going to be homeless if he gets evicted and I didn't want that pressure of him being forced to come here. (ELSA Client 6)*

The available data are not consistent on this issue. All interviewed clients identified complexity of needs as a key factor in the abuse, whereas case studies and quantitative data were less consistent. ROSE and ELSA currently collect data on details of perpetrator, perpetrator's disability, other attributes and relationship dynamics but it is not clear how these issues relate to the perpetration of abuse in each case or if they are background factors which are not related to the abuse. ECLC should refine quantitative data collection for issues leading to abuse, including individual and structural factors (Recommendation 7).

Sometimes, elder abuse occurred in the context of intergenerational family violence, with victims/survivors of intimate partner violence from partners then experiencing elder abuse from their own children. ELSA Client 4 described this dynamic:

> *They think my ex-husband's fantastic. Gosh, what he did to me, you know. … He used to belt the living daylights out of [son]. I thought, you've got a short memory. (ELSA Client 4)*

For many people, the abuse was not distinctly elder abuse, but patterns of abusive family violence that had played out over decades and only become elder abuse when the victim/survivor became older. It appears that the majority of instances of elder abuse experienced by ROSE and ELSA clients will not be addressed without also addressing the underlying issues for the perpetrators. ROSE Client 1 felt an obligation to allow her daughter to move in with her, even though she did not want her to:

> *My immediate reaction was, "No, I don't want her here." But she's our daughter. She would have been a bag lady; she had no job, no money. (ROSE Client 1)*

Despite this, ROSE Client 1 was committed to her relationship with her daughter:

> *Sometimes we get on really well, she can be quite good company, but that's rare. (ROSE Client 1)*

Clients interviewed consistently expressed a desire to maintain relationships with children who were perpetrating abuse. Only 24% of ELSA clients indicated they did not want an ongoing relationship with the perpetrator.[24] This desire, sometimes expressed as a sense of obligation to their abuser, was a major factor contributing to clients' hesitancy to take action to address the abuse. This was described by multiple stakeholders, including ROSE Stakeholder 3, who was a regular referrer to ROSE:

> *Well, we're more working with people right before they've ever sought help. So we're trying to soften that process for them and help them understand the different options. But mostly people are really reticent to go a legal pathway. First, they want to know how they might be able to resolve it in other ways. (ROSE Stakeholder 3)*

This was also clearly understood by ECLC staff:

[24] ROSE does not collect this data, but should begin to do so (Recommendation 6)

> *People experiencing elder abuse… they're quite heavily reliant on the people that are the perpetrators. … they've got to consider as well about how that's going to impact their lives if they take full blown legal action against them. It complicates it a bit. (ECLC Staff 2)*

It also appears that ROSE and ELSA are operating to address these underlying issues, where possible. As ROSE Client 3 told the evaluation team:

> *ROSE wanted someone to come and assess his mental status. He said "I don't want". So then my lawyer said, "You have done everything that you can, but if he doesn't want then that's it". (ROSE Client 3)*

ECLC's role is to identify the socio-economic and cultural drivers of elder abuse to empower victims/survivors and influence change in the social conditions that can drive perpetration of elder abuse. ECLC should engage in systemic advocacy which contributes to the development of strategic interventions that address these conditions and advocate for interventions that address the specific needs of perpetrators. Failures in social and health systems which impact perpetrators increase the risks to older people. Systemic and targeted interventions which address the phenomenon of elder abuse and its key drivers can help prevent locating the problem of elder abuse with the victim/survivor and instead target the structural conditions and individual factors leading to abuse (Recommendation 18).

3.4 Client demographics and equity of access

Overall, ROSE and ELSA appear to be accessible to potential clients from diverse backgrounds and with diverse experiences. Examples provided included ELSA working with Eastern Health social workers to take videoconferencing equipment into hospital beds to allow for legal consultations, provision of easy read and video materials, and generally it being very easy to refer into both programs:

> *There's someone usually very available on the phone as soon as you call, or calling back within a very short period of time from my experience. Which isn't the same for other advocacy organisations that require an email or contact us form or something on their website. (ROSE Stakeholder 2)*

In the context of elder abuse, where there are so many potential barriers to a person seeking help, this is particularly important. For the general population, the evaluation team identified no major accessibility issues. As discussed above, at 1.2, ELSA and ROSE both aim to be accessible to, and meet the needs of, particular groups of people, specifically:

- older people from CALD backgrounds
- older Aboriginal and Torres Strait Islander people
- older people experiencing cognitive decline
- older people experiencing social isolation
- older people with disabilities
- older people experiencing or at risk of homelessness
- older LGBTIQ+ people

For nearly all measures, ROSE and ELSA clients are more diverse than the population of over 65's for the catchment area, although for some groups the numbers are very small. This is reflected in the qualitative data, with all stakeholders agreeing that the service trials are generally accessible and meet the needs of these particular groups, but highlighting occasional areas for improvement. ECLC should explore opportunities to promote equity of access for these communities through proactive measures which address barriers for different groups (Recommendation 3) and should consider setting defined targets for each group to enable evaluation of access equity (Recommendation 4).

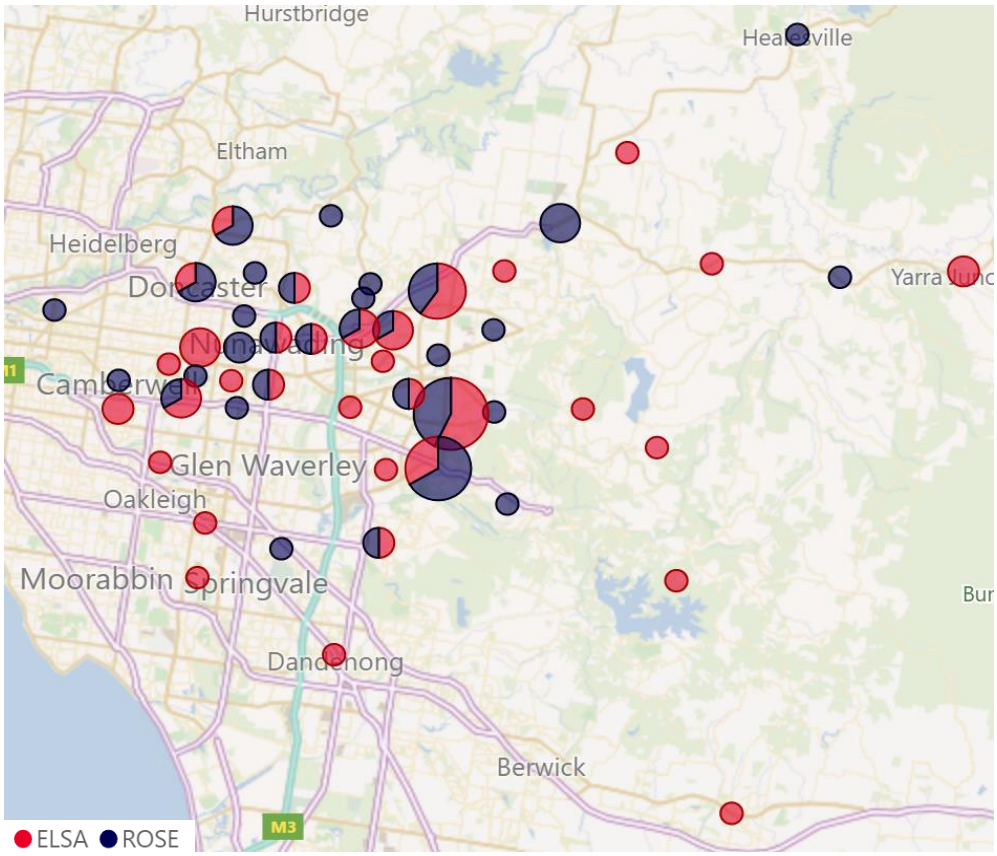

Figure 4 - Clients by location

Location and socioeconomic status

Figure 4 shows ROSE and ELSA clients by home location, indicating equity of access across the catchment broadly consistent with population with some tendency towards lower socioeconomic areas.

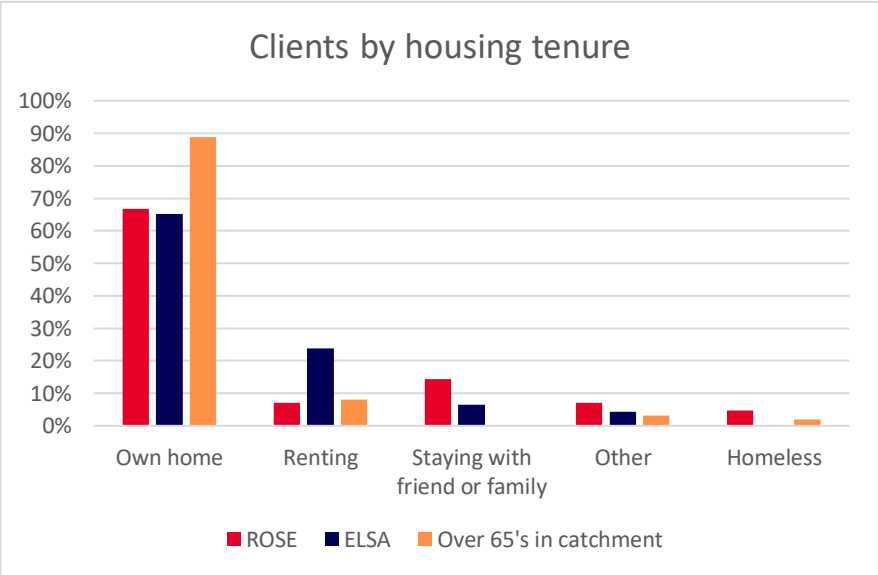

Figure 3 - Clients by housing tenure

Figure 4, showing clients by housing tenure, also indicates that both service trials are tending towards less socioeconomically advantaged older people, working with proportionately more renters and ROSE working with proportionately more people experiencing homelessness. Despite people experiencing, or at risk of experiencing, homelessness being a target population for both service trials, no ELSA clients were recorded as homeless.

One ROSE stakeholder indicated that if a client was homeless or at risk of homelessness they would refer first to a homelessness service rather than to ROSE. This suggests ROSE should work with homelessness services in the

area to increase awareness of the service. ECLC should also work with Eastern Health and other stakeholders to promote equity of access for this group (Recommendation 3.3).

Age

Figure 5 shows that ROSE and ELSA are being accessed by clients with a diverse range of ages. The eligibility criteria allow some flexibility with regards to age, with Aboriginal and Torres Strait Islanders aged 50 and over eligible for the program. In some cases, the eligibility criteria may be waived to promote access for other groups, such as people with early cognitive decline.

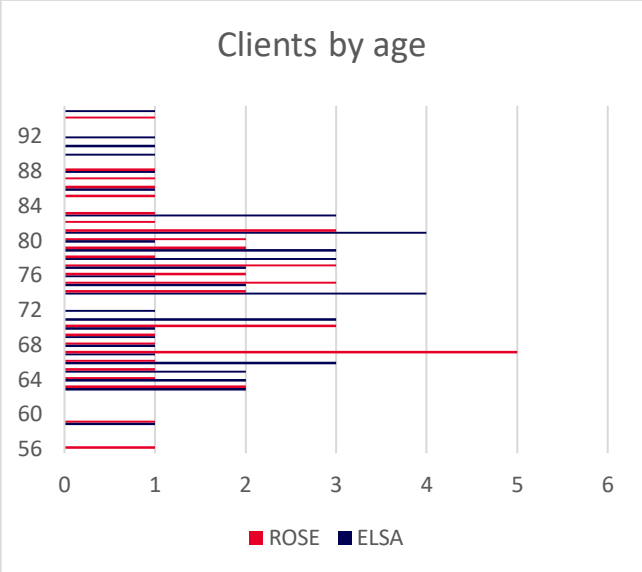

Figure 5 - Clients by age

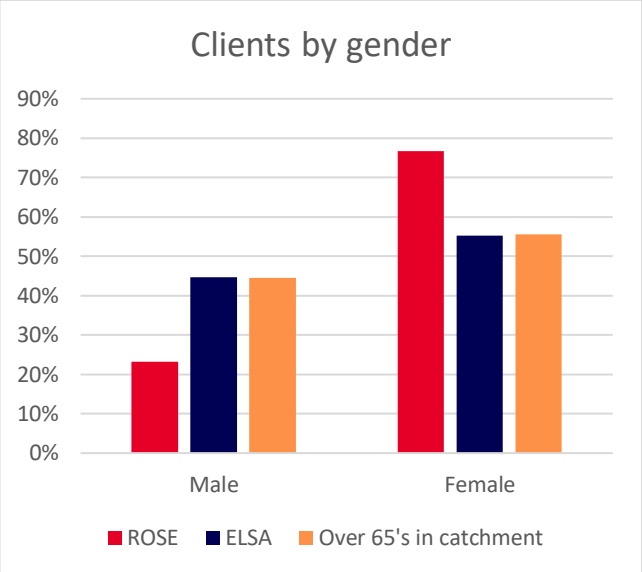

Figure 6 - Clients by gender

Figure 6 shows that while ELSA clients reflect the gender demographics of the catchment for over 65's, ROSE has worked primarily with women. This disparity is consistent with other elder abuse services,[25] but without solid prevalence data it is not possible to determine if either ELSA or ROSE are proportionately accessible for people experiencing elder abuse. Based on other data is seems likely that women are more likely to experience elder abuse but that men are less likely to report, so actual prevalence is not possible to determine. In the absence of prevalence data ECLC should ensure that it is accessible as possible to people of all genders (Recommendation 3.1).

Older LGBTIQ+ people

No other genders were recorded in either ELSA or ROSE data, but as reliable gender diversity data is not available for comparison, this may reflect the demographics of eligible potential clients.[26] No LGBTIQ+ clients were recorded as using either program. This is potentially a reflection of the demographics of eligible clients, with fewer than 2% of couples aged 65 and over being same-sex couples,[27] or it may reflect a reluctance of clients to disclose. However, as the Royal Commission into Aged Care Quality and Safety found that LGBTIQ+ people were at increased risk of abuse in institutional settings,[28] the same may apply in the community. Older LGBTIQ+ people

[25] Melanie Joosten et al. (n 23).

[26] As the 2021 census data will be released in June 2022 this question will be revisited in the final evaluation.

[27] ABS, *2016 Census - Counting Persons, Place of Usual Residence* (Australian Bureau of Statistics, 2016).

[28] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect* (2021) ('*Final Report*').

may not disclose their sexual orientation, relationship status, gender history or other experience based on past experiences of discrimination,[29] and LGBTIQ+ people of all ages are more likely to experience family violence.[30] ECLC should ensure that ROSE and ELSA are accessible as possible for LGBTIQ+ older people (Recommendation 3.2).

Older people from CALD backgrounds

Figure 7, comparing the main language spoken at home for ROSE and ELSA clients with 2016 census data, shows that both service trials are working with linguistically diverse communities at roughly population levels. ROSE, in particular, appears to have strong links to the Chinese community, which is confirmed by the qualitative external stakeholder data. Many stakeholders indicated the complexities of working with elder abuse with cultural and linguistically diverse communities, with barriers including communication, cultural values and community connections.

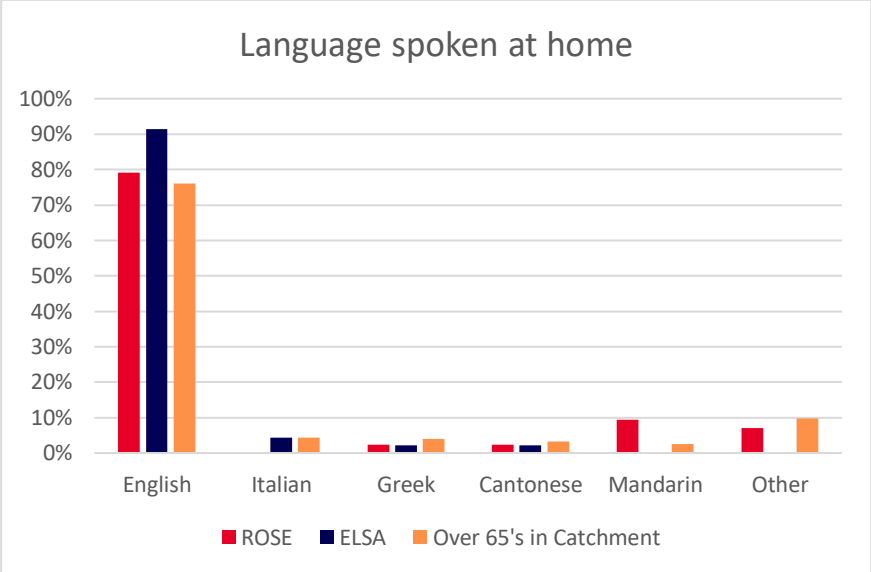

Figure 7 - Language spoken at home

There may be some opportunities to increase equity of access, as 31% of over 65's in the catchment area have an English proficiency of 'not well' or 'not at all', and ROSE and ELSE only used interpreters with 21% and 9% of clients respectively. ELSA in particular does appear to be working with proportionately fewer linguistically diverse communities and should consider strategies for ensuring equity of access in partnership with Eastern Health (Recommendation 3.4).[31] This was recognised by ECLC staff:

> *There's a lot of shame around, well, as there is in most, all communities really, there's varying degrees of shame about admitting to elder abuse. Yes, we need to promote the fact that we can provide assistance in those circumstances. (ECLC Staff 3)*

Older Aboriginal and Torres Strait Islander people

Only one person who self-identified as Aboriginal was recorded as using ROSE, and none were recorded using ELSA, although qualitative data indicates that at least two Aboriginal people used ROSE or ELSA but did not consent to have their data included in the reporting database. As the proportion of Aboriginal and Torres Strait

[29] Rebecca Reynolds, Samantha Edmonds and Y Gavriel Ansara, 'Silver Rainbows: Advances in Australian Ageing and Aged Care' (2015) 34(S2) *Australasian Journal on Ageing* 5 ('Silver Rainbows').

[30] Kate O'Halloran, 'Family Violence in an LGBTIQ Context' (2016) Spring/summer *DVRCV Advocate* 4.

[31] For ELSA, this is possibly an 'upstream' referral issue, as roughly 6% of Eastern Health patients of all ages used an interpreter in 2019-20 and approximately 9% spoke a primary language that was not English, while 2016 census data indicates 17% of people in the catchment area have an English proficiency of 'not well' or 'not at all'. Interpreter data for Eastern Health patients over 65 is not publicly available but will be sought for the final evaluation.

Islander people aged over 50[32] in the catchment is only 0.24%, this is not disproportionate.[33] However, as ROSE was initially conceived as a partnership with Oonah Belonging Place, this requires ongoing attention. The partnership with Oonah Belonging Place is discussed at 3.7.2.

Older people with disabilities

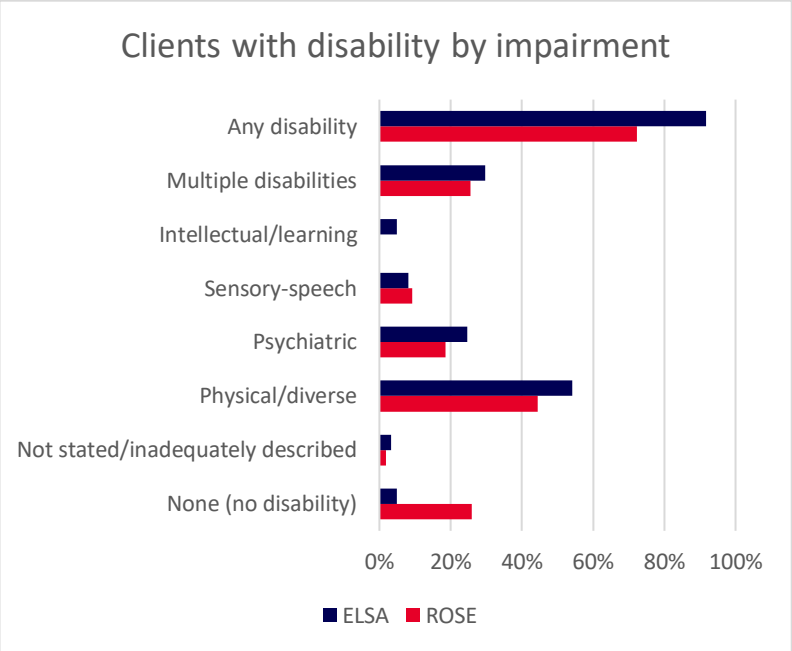

Figure 8 – Clients with disability by impairment

Both service trials appear to be generally accessible for people with disabilities, with 72% of ROSE clients and 92% of ELSA clients identifying as having at least one experience of disability as compared with 18% of over 65's in the catchment. ELSA's higher proportion is likely explained by the referral pathway through the health system. Figure 8 shows that physical disabilities were most common, with multiple clients having multiple disabilities.

One area of concern, particularly during COVID-19 restrictions, was accessibility for people with hearing impairments who did not use videoconferencing or email. ECLC should continue to encourage access strategies for these people through the National Relay Service, teletypewriter or other facility (Recommendation 3.6). As discussed below at 3.8.1, there are also opportunities to promote equity of access by implementing supported decision-making measures.

Older people experiencing cognitive decline

ROSE and ELSA do not collect data on cognitive decline as distinct from other impairments. However many stakeholders noted the interactions between the substituted decision-making regimes of powers of attorney, guardianship and administration, and elder abuse. In general, stakeholders indicated that people experiencing cognitive decline and elder abuse would be referred to the Victorian Civil and Administrative Tribunal (VCAT) or the Office of the Public Advocate rather than to ROSE or ELSA. In many cases this may be appropriate, but in some cases may result in reduced access to justice for people who could be supported to exercise capacity to give instructions through supported decision-making measures (see 3.8.1).

Older people experiencing social isolation

Social isolation is defined by the Australian Institute of Health and Welfare as 'the state of having minimal contact with others'.[34] Stakeholders repeatedly identified the challenges in supporting people experiencing elder abuse in

[32] Aboriginal and Torres Strait Islander people over 50 are eligible for ELSA and ROSE.

[33] No data is available to indicate the prevalence of elder abuse in Aboriginal communities.

[34] Australian Institute of Health and Welfare, *Australia's Welfare 2021* (Australian Institute of Health and Welfare, 2021).

a context of social isolation to access support, particularly where the person is not connected to the community and experiencing coercive control:

> *You actually have the person here and the person controlling or abusing them is not watching them. Whereas I think when they're at home, there's a lot of control and they're monitored, whereas here, that person does not – they're not here. We can actually openly have conversations. (Eastern Health Social Worker 14)*

The hospital was seen as an ideal space to engage with people who were socially isolated, either by circumstance or by coercive control:

> *Just giving them that space, expert knowledge, and advice as if it's for the first time in perhaps many years or many months. So, it's about creating that safe arena for them to open up. (Eastern Health Social Worker 12)*

For ELSA, the health justice partnership is clearly providing increased access to justice for people who are otherwise isolated from support services. However, a person should not have to be admitted to hospital in order to be provided with assistance for elder abuse. Although there is no immediately obvious solution to address this, ECLC should continue to develop and promote alternative ways to increase accessibility for socially isolated ROSE clients (Recommendation 3.5).

ROSE and ELSA should identify if clients are experiencing social isolation and record this in the database. (Recommendation 5)

3.5 Client outcomes and experiences

The data indicates a high level of client satisfaction with both ROSE and ELSA. All but one of the clients who were interviewed spoke very positively about their experience:

> *It's been wonderful. Yes, (ECLC Lawyer) was just so good and the whole process. Yes, it was really good. (ELSA Client 4)*

And:

> *I've got not a complaint in the world. It was absolutely brilliant what they did. They were nice, they were kind, and they went out of their way to help you. You can't ask for anyone better than that. (ELSA Client 1)*

Client interview feedback was overwhelmingly positive. The quantitative data help add detail to this. The Standard Client/Community Outcomes Reporting (SCORE) data presented in Figure 9 and Figure 10 show improvements across all domains. On average, the pre-post SCORE reflects a 36% improvement for all clients for both service trials.

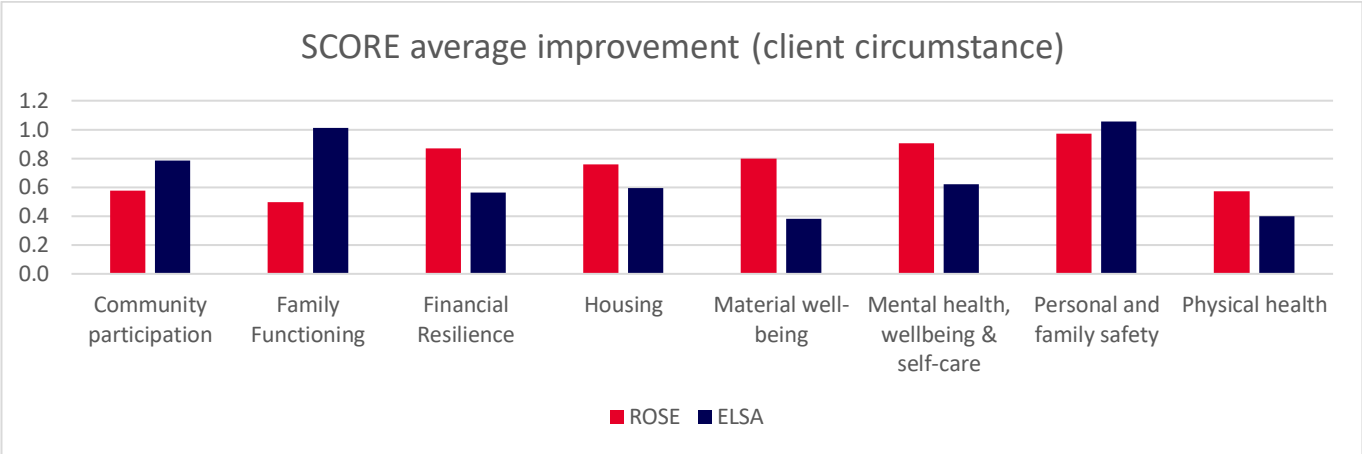

Figure 9 - Standard Client/Community Outcomes Reporting improvement (client circumstance)

These are also reflected in the qualitative data, with clients reporting an improvement in their circumstances as a result of working with ROSE or ELSA:

Interviewer:	*So in relation to your son, he got the letter and then what happened?*
ELSA Client 1:	*He just started just becoming normal – piped down – I wasn't mucking around anymore.*
	…
Interviewer:	*And so has his behaviour changed towards you?*
ELSA Client 1:	*Yes.*
Interviewer:	*So is he more respectful now?*
ELSA Client 1:	*Yes. Now he can come in the house and we can talk now instead of just grumping all the time with me and being the way how he was. Because when I'd come home, thought I was coming home to nothing.*
Interviewer:	*Yes. That's hard.*
ELSA Client 1:	*It's your son, he lives in the house, he doesn't pay the rent, he doesn't pay nothing, and I just asked – all I wanted was respect out of him, that's all I wanted.*
Interviewer:	*Yes. So you don't care that he doesn't pay rent?*
ELSA Client 1:	*No.*

This perspective from ELSA Client 1 was characteristic of the client feedback, inasmuch as there were no major or complex legal interventions, but information and advice paired with a legal letter that empowered the client to establish his rights within the family. For ELSA Client 1 resolving the abuse was not about regaining lost rent money but about regaining a relationship with his son.

ELSA Client 2 was similarly supported with a legal letter, and similarly satisfied with the results:

Interviewer:	*OK. Well, that's good to know. So it was mainly the letter?*
ELSA Client 2:	*Yeah, it was the letters. One to my daughter and one to my son, and they did receive them, and they read them, and my son moved out. My daughter, we came to an agreement that she'd pay for cleaning products and things like that and help me in the house a bit.*

ROSE Client 1, conversely, had a legal letter written to her adult daughter and was not pleased with the results:

> *It was about seven weeks later that this email came and it was, what I thought was very wishy-washy and just repeated what I'd said… the letter was useless. So I asked them to revise it to make it a bit more sort of forceful. (ROSE Client 1)*

ROSE Client 1 was dissatisfied with the lack of outcome, but also unwilling to take further action in relation to her daughter:

> *We started paying for her phone bill when she was with us last time. ... So, we have been paying her bill for months. … Now I could cut that off. I desperately would love to say, "I'm stopping your bill." But she's testing my limits with that. … all I want is family peace and harmony. (ROSE Client 1)*

Underlying this desire for 'peace and harmony' and hesitancy to challenge the abusive behaviour was a real fear of physical violence:

> *Now, look, (Adult Child) did attack me years ago… physically bashed me. I haven't told anybody at all. And I didn't want that to happen to me now that I'm older, and I just didn't want that to happen again. … in the back of my mind is, "If I do cut off her bill, what will she do to me?" (ROSE Client 1)*

For people in this situation, ROSE was limited in the options it could provide, other than referral to other services. This is something that ROSE Client 1 recognised:

> *I don't know what other suggestions they could have, apart from appealing to her better nature. She does have a better nature. (ROSE Client 1)*

The impossibility of this situation reinforces the need to locate the solution where the problem actually is - not with the client, but with the perpetrator - and target services toward the perpetrator to address the underlying factors contributing to the abuse. This is not something that ROSE or ELSA are designed to do, but ECLC should contribute to advocacy for the implementation of such services (Recommendation 18). It is also possible, although not certain, that other options, such as mediation, may have been more useful for ROSE Client 1 (see 3.8.2).

Participants reiterated that more substantial legal avenues, such as family violence intervention orders or extended and complex litigation were unlikely to result in improved outcomes:

> *And you look at them, and some of them are pretty blunt instruments. And do you want to get into mentioning the order that says he can't come near you when you're still living in the same house? You know, is that going to make it better? (ECLC Staff 10)*

Instead, both ROSE and ELSA attempted to resolve issues without resorting to litigation or court orders wherever possible. This appears to be fairly effective, based on the improvement shown in Figure 10, which shows improvement in client goals.

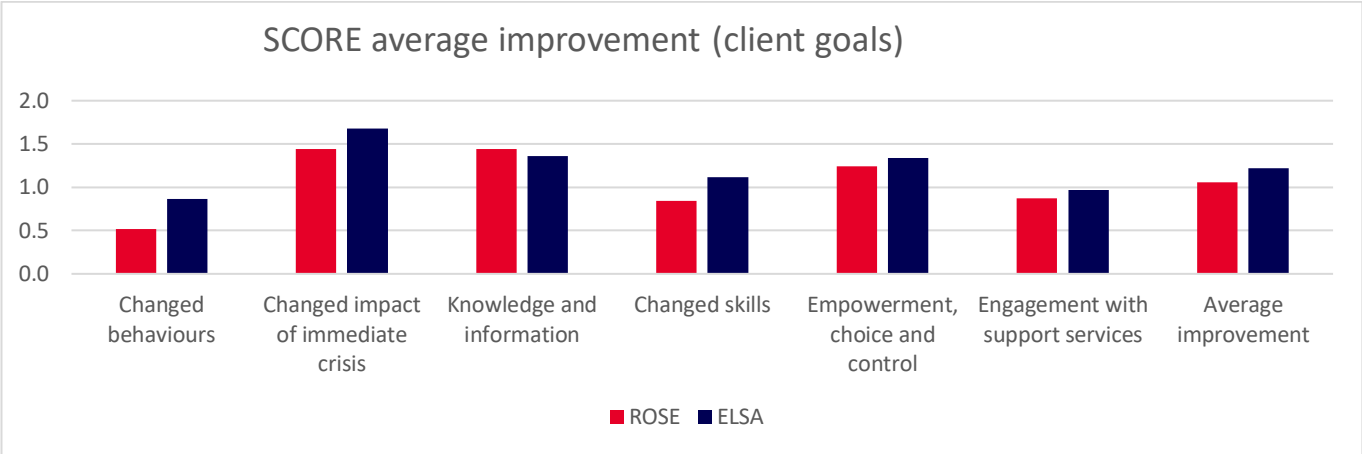

Figure 10 - Standard Client/Community Outcomes Reporting improvement (client goals)

The qualitative data also support improvements in knowledge and information, and empowerment, choice and control. Every single client in both service trials who completed the SCORE recorded an improvement in empowerment, choice and control to make their own decisions.

ELSA Client 6 noted this:

> *They've left my options open. I've got phone numbers and things. I've got that in my file. … [It was] was comfortable and reassuring for me to know that they're there. (ELSA Client 6)*

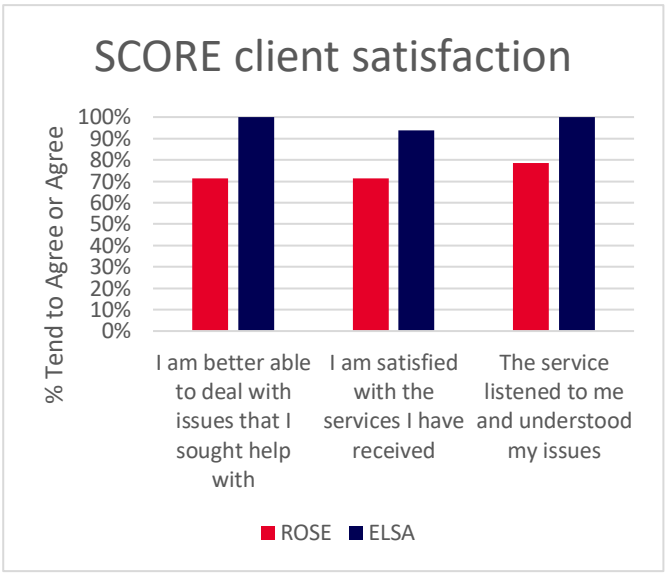

Figure 11 - Standard Client/Community Outcomes Reporting client satisfaction

The client satisfaction data from SCORE show very high levels of client satisfaction for ELSA, and high levels for ROSE.[35] This is consistent with the qualitative data, which showed very high levels of client satisfaction directly from clients and in the second-hand reports from professional stakeholders, and with the ECLC exit survey data.

The ECLC exit survey data also reflect high, but lower, levels of satisfaction for ROSE clients. While all surveyed ELSA clients identified they got the help they wanted from ELSA, 29% of ROSE clients surveyed did not. Similarly, all ELSA clients indicated they were satisfied with the options provided, while 33% of ROSE clients were not. This pattern is repeated across all domains, including satisfaction with referrals, resolving issues and overall impact. This does not indicate that ROSE is necessarily performing at a lower level than ELSA; as noted at 3.2 and 3.4, ROSE clients are much more diverse and much less likely to be receiving other forms of support than ELSA clients. It seems likely that ROSE's success at targeting clients with higher levels of need has contributed to more difficulties in achieving outcomes and subsequently client satisfaction. The only tangible and resolvable issue identified as contributing to lower satisfaction was delay in contacting or follow up for two ROSE clients, although there is no evidence that this issue is widespread. ECLC should consider developing or applying a metric to record

[35] These data should be used with caution as only 17 responses were recorded for ELSA and 11 for ROSE.

response times to enable the evaluation of delays in contacting or following up clients (Recommendation 9). In the difficult and complex area of elder abuse, the fact that 78% of ROSE clients felt supported or very well supported by the service indicates a high level of success, albeit not quite as high as ELSA's 100% satisfaction rate on the exit survey data.

These high levels of client satisfaction are promising, but the recorded client outcomes are less conclusive. This may be explained by the complexity of elder abuse and questions about what constitutes success in these cases, and how the impact and effectiveness of similar services should be measured to reflect what is realistic and possible. As indicated in Figure 12, 26% of ROSE clients and 36% of ELSA clients had their elder abuse issue resolved with 21% and 10% respectively having their matter resolved with ROSE or ELSA assistance. A further 15% of ROSE clients and 12% of ELSA clients did not have their issues resolved but were referred elsewhere.

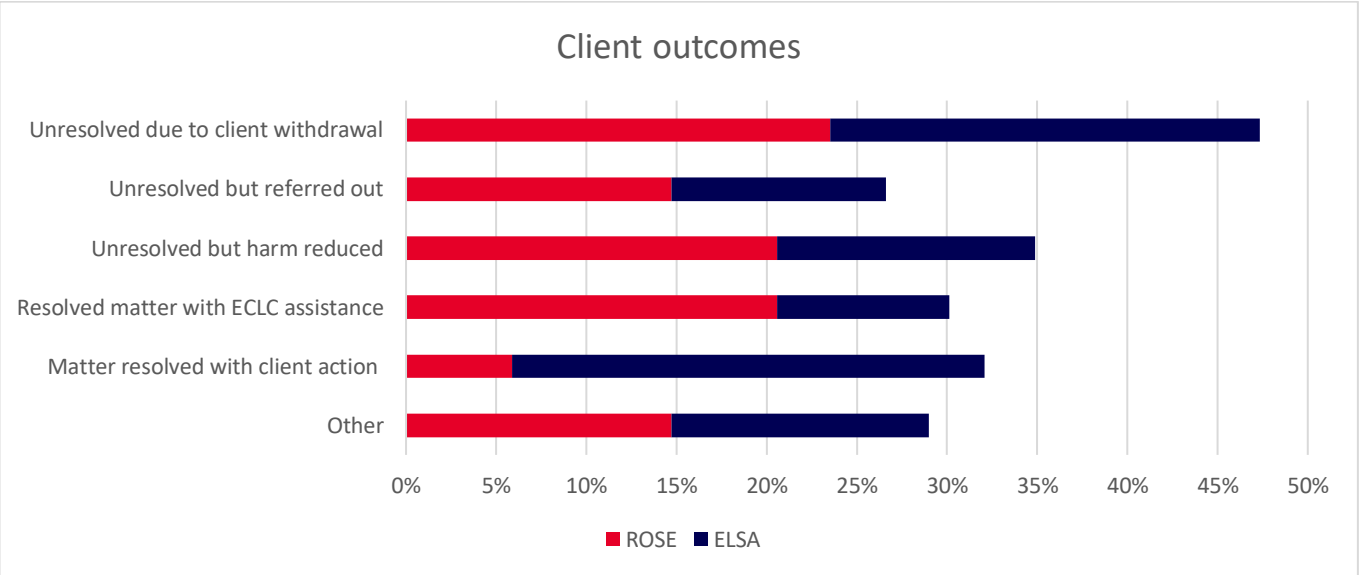

Figure 12 - Client outcomes

In the context of elder abuse, a 'successful outcome' and understanding what constitutes effectiveness and how it should be measured may not always be about resolving the identified elder abuse. A senior ECLC staff member provided this insight to explain why outcomes data does not match the data showing improvement in empowerment, choice and control to make own decisions:

> *People always say that older people don't want to take action. They don't want to take action against their kids. But we think it's really important that they actually understand that what they are experiencing often is elder abuse, and actually have that explained to them and there are options they can choose to take. And if they choose not to take action because they want to maintain the relationship or they don't want to take action, that is their choice not to pursue action. (ECLC Staff 10)*

This is consistent with other studies on elder abuse, and reflective of the broader cycle of family violence, where a victim/survivor might or might not take action over a long period. Compounding this is the lack of genuine options, with legal resolution requiring evidence and, in some cases, financial resources. This sometimes meant that some outcomes could be achieved but others could not. ROSE Stakeholder 3 described a case that was still before the courts but stalled for lack of evidence relating to an asset dispute:

> *It has achieved some immediate outcomes, having her bank account back in control or slowly gathering some information, getting some control back of her life, … She was able to see her own doctor rather than a doctor that the adult children arranged for. Yeah, there were some outcomes achieved, but the ultimate asset dispute or reconciliation still hasn't [occurred] (ROSE Stakeholder 3)*

Another challenge related to lack of evidence and potentially unrealistic expectations on the part of some clients, particularly in cases involving financial abuse, and lack of documentation evidencing financial transactions such as loans made resolution difficult. ECLC also recognised that there are limits to what the service trials can achieve in terms of tangible outcomes, particularly when clients were not ready to take action. This was explained as being part of a rights-based approach:

> *It's just at the end of the day, so if it is a rights-based approach model, and we are a legal centre, so if we can't, if the client is not shifting, and we get to a point where there's nothing we can do legally, we're not going to hang on for months and months with a client, hoping that they're going to change through the work that the advocate is doing, or the financial counsellor is doing, or the social worker at Eastern Health is doing. (ECLC Staff 8)*

These barriers to successful legal resolution, combined with the complexities of elder abuse, may explain the discrepancy between the recorded outcomes and high client satisfaction. For service trials such as ROSE and ELSA, it may be that success should not be evaluated in terms of straightforward legal resolution, but instead should use a variety of methods to understand effectiveness and impact, including client satisfaction, access to justice, increased knowledge and confidence, and client empowerment.

The interview and SCORE data indicating consistent improvement across these domains suggest the ROSE and ELSA service trials are being successfully implemented. However, it is important to note that a more thorough evaluation of the programs' impact and effectiveness will not be possible until access to the other national service trial data is available. This will provide further insight into the complexity of outcomes definition and measurement and what can be realistically expected of elder abuse services in the context of the existing broader service and policy framework.

The following section examines the practice models in detail to determine which factors have contributed to the service trials' success.

3.6 Practice model

ROSE and ELSA share a similar practice model, with each operating in a partnership, with Oonah Belonging Place and Eastern Health respectively. The key difference is that ROSE has a community lawyer and an elder abuse advocate while the ELSA team consists of a community lawyer and a financial counsellor. ROSE initially also employed a financial counsellor, although this staff member left and now the ELSA financial counsellor currently provides financial counselling to ROSE clients as required. ELSA did not initially have an advocate, as Eastern Health social workers were expected to fulfil this function as part of the health justice partnership, but in late 2021 Eastern Health seconded an Elder Abuse advocate to ELSA.

This section considers the role of integrated practice before examining each of the key elements of the service trials; legal information, advice and casework, financial counselling, advocacy, secondary consultation and community education.

3.6.1 Integrated Practice

The model of integrated practice used by ROSE and ELSA has informed ECLC's *Better Practice Principles*.[36] This approach was highly valued by both clients and professional stakeholders, who described a service that was not only more effective due to integration, but also more efficient. Clients initially meet with both the community lawyer and financial counsellor (ELSA) or advocate (ROSE) to reduce duplication and to establish common goals. The community lawyer and financial counsellor or advocate then coordinate ongoing work with the client. Where financial abuse or issues are identified, the ELSA financial counsellor will work with the ROSE community lawyer and advocate.

This approach was very highly valued by stakeholders, given the complexity of issues clients were experiencing (see 3.2). Stakeholders found an integrated response addressed issues that sole practitioners working separately would not have been able to resolve. Stakeholders also commented on the way in which the model removed the need for older people to co-ordinate multiple appointments with different services and navigate complex service systems:

> *I think that is a really huge factor. It just means that people aren't making multiple appointments and multiple things that can kind of be handled all at once and all the parts to that, because it's often quite a complex issue. It's not usually just as straightforward as one thing. (ROSE Stakeholder 6)*

This holistic approach was highly valued by non-specialist organisations who regularly referred to the service trials:

> *We love ROSE because of the case management that they can offer. And just their holistic approach where you can refer someone there and they would be assessed in terms of the legal support that they can be offered. Their rights, as well as the psychosocial elements that are going to be needed to be supported and financial counselling as well. So, I think it's really amazing. So that's why we hope – we love it, if people can be supported with ROSE. (ROSE Stakeholder 5)*

Beyond the efficiency of providing an integrated service, staff described how the combined approach was more persuasive in providing people with the impetus they required to take action for themselves:

> *If a lawyer, if the lawyer and financial counsellor meet with them then and actually acknowledge everything that you've said and validate further, sometimes we know – for people who're experiencing family violence or elder abuse – it can take ten 20 times for them to actually feel actually, yes, what's occurring for me is not OK and for them to actually come to the realisation that they might want a difference. (ECLC Staff 4)*

Another identified benefit was the way in which the professionals supported each other. ROSE Stakeholder 3 described a situation where the advocate worked with the client to develop a safety plan that was coordinated with legal proceedings, ensuring safe access to the lawyer:

> *I really appreciated the way that they kept the situation under control in terms of the risk for a client. Helping that client to have an excuse ready to leave the house in order to go and have appointments with them and providing that transport, and just kept her safe, right until the point where they were*

[36] Eastern Community Legal Centre (n 9).

ready to initiate the contact around legal proceedings with the family. They really controlled that very well and just managed that risk. (ROSE Stakeholder 3)

This was seen as a stepped process, where the ROSE advocate would support the person to the point where they could take action:

There is that work that does need to be done with people to get them to the point to take action, which is why an advocate like a non-legal advocate is really important in this space. (ROSE Stakeholder 1)

The financial counsellor also worked in a comparable way, enabling access to justice through integrated practice:

[A client] was going to the Supreme Court, but we had court ordered mediation beforehand. The other side wouldn't agree to use anyone pro bono as the mediator. So, [the client] had to fork out $1,500 for our share of the mediation fees. … And so, the financial counsellor was able to access a grant to pay for that. (ECLC Staff 8)

For ELSA, the integration extended to include Eastern Health social workers, who, despite the lack of co-location due to COVID-19 restrictions, reported very high levels of integration:

I've had I felt very supported. They've felt kind of part of the team when it's come to decision making, very engaged, their follow up has been very prompt, very timely. They're certainly have been able to offer a great level of support to our patients. (Eastern Health Social Worker 3)

One aspect that could be improved in the relationship between ELSA and Eastern Health is feeding back outcomes to the initial referrer where appropriate. This is discussed below at 3.7.1.

This integration extended to the professional skills of the workers involved, who all reported improving their ability to address elder abuse using approaches from other disciplines. Lawyers reported an increased understanding of the social context of elder abuse and social workers noted an increased understanding of the legal options.

Overall, however, it appears the integrated practice model is both well suited to this context and well implemented by ECLC in both ELSA and ROSE.

3.6.2 Legal information, advice and casework

The community lawyers in both service trials provide legal information, advice and casework, although court work was rare:

It's mostly advice and casework. Rarely [court work] Or we do find, for example, we will file or lodge an application which we get, and a matter will be resolved prior to a hearing. (ECLC Staff 5)

This approach is an intentional feature:

Of course, my emphasis when I talk to clients is to resolve these matters out of court because of their age and the trauma associated with litigation. I'm more mediation-and-out-of-courts focus but as long as I get a best result, a best outcome for the client. (ECLC Staff 5)

This approach helps contextualise some of the client outcomes data discussed at 3.5

3.6.3 Financial counselling

Financial counselling services provided included assistance in managing debts, accessing benefits or applying for grants or waivers. This service was particularly useful in assisting to manage the relationships with children who perpetrated elder abuse, such as when infringements incurred by children in the client's name could be waived under family violence provisions without alerting the perpetrator. In another case, the client was able to avoid taking legal action against his daughter by simply asking the bank to refund the money:

> *I had a client who the daughter had spent about over five-thousand dollars out of an EFTPOS card and I asked the [bank] to repay that. I said, "I know you don't have to do. I know the client gave – who's got limited mobility – he gave his card to his daughter. He's breached the terms and conditions. I get that. But in this case it's elder abuse. ... It would be great for compassionate reasons." A very non-lawyer letter. We ask for compassion but point out other things subtly to them. Yes, he got that money refunded. (ECLC Staff 1)*

The role of the financial counsellor and their 'special relationship' with banks and financial institutions was recognised and valued by other stakeholders:

> *As a social worker, I sometimes feel it's a little bit magical what they're able to do in terms of the financial counselling side of it. … they're able to achieve things that I wouldn't have thought could be achieved in that context. (Eastern Health Social Worker 11)*

As noted above at 3.6, the demand for financial counselling for ROSE was lower than anticipated, yet financial counselling is a component of the integrated practice model that is highly valued by stakeholders and clients.

3.6.4 Advocacy

The advocacy provided by the ROSE advocate was also highly valued by clients and stakeholders, although less clearly defined than the roles of their legal and financial counselling colleagues. The advocate, who is a social worker, provided a diverse range of supports, characteristic of social work practice. The evaluation team identified safety planning, goal planning, assisting with communication, system navigation, individual rights education, coaching, housing supports and service linkages, but these are only indicative of the variety of work involved. Stakeholders noted a flexible, client driven, solutions-focused, problem-solving approach that is difficult to clearly articulate but highly valued:

> *They can also help clients with other issues because they have an advocate and they have a social worker. So it's taken more holistically, rather than just take ages. … a lot of times there are all different things involved which also need a social worker. (ROSE Stakeholder 2)*

Much of this work is focused on supporting and enabling the client to engage with the lawyer and/or financial counsellor, as noted at 3.6.1. This was particularly important in the context of how long some clients would take to reach a point where they were able to take more decisive action:

> *It's also interesting to see how long it takes. Assuming that we're talking about the majority of the cases, which is adult son, daughter, sometimes grandchildren against the older person, there is that reluctance to act at that level until things escalate. … There is that work that does need to be done with people to get them to the point to take action, which is why an advocate like a non-legal advocate is really important in this space. (ROSE Stakeholder 1)*

The advocate also provided a different set of solutions, assisting clients to achieve non-legal outcomes:

> *The advocate from ROSE program gave the couple some ideas of what their obligations and rights are so they know how to talk to their adult children without intimidating them. (ROSE Stakeholder 2)*

One stakeholder, who had worked with both ROSE and ELSA, identified that the absence of an advocate for ELSA was sometimes an issue, where a client was still working with the ELSA lawyer, but Eastern Health were no longer providing direct or intensive social work support. Since Eastern Health seconded a social worker as an advocate to ELSA in October 2021, this should now be resolved.

3.6.5 Secondary consultation

In addition to direct work with clients, both ROSE and ELSA provided secondary consultation to a wide range of stakeholders. ROSE secondary consultation also provides a space for family members and friends of the older person to learn how to best support and encourage them to use the service or other options. Figure 13 shows that between 31/10/2019 and 7/10/2021, ELSA provided 144 secondary consults, mainly within Eastern Health, primarily to Eastern Health social workers but also to other allied health and medical, and occasionally to friends and family. During the same period, ROSE provided 218 secondary consults to 50 different organisations, including internally to other ECLC staff.

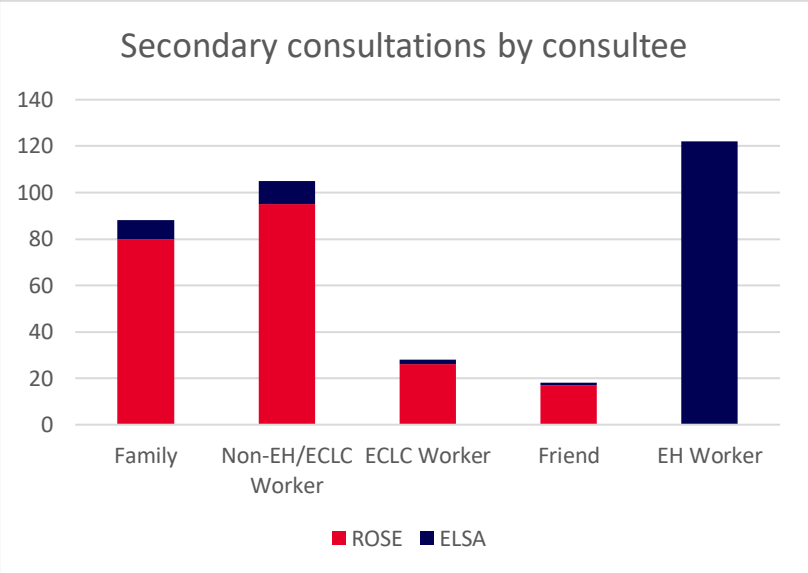

Figure 13 - Secondary consultations by consultee

The main function of these secondary consultations, as identified by external stakeholders, was to fill gaps in the worker's knowledge, both of elder abuse and the potential options for resolving issues.

Eastern Health Social Worker 11 gave a concrete example of where contacting ROSE for a secondary consult resulted in an immediate improvement in the service they could provide:

> *I haven't done an intervention order for quite a long time, so I spoke with ELSA just to kind of refresh myself a little bit more, and make sure that I was going to be giving the patient the correct information so that they could make an informed decision. (Eastern Health Social Worker 11)*

This was also a kind of quality assurance mechanism, where stakeholders would seek assurance that what they had done was the correct thing to do in the circumstance. As noted above at 3.2, many people experiencing elder abuse are not ready or unwilling to take action to address it, and the secondary consultation would allow stakeholders to confirm they had done everything they could do:

> *I found it very easy to consult with the ELSA team and with the clinicians, and just to run it past them, get some advice, asking for their opinion if the referral is appropriate and really getting a*

little bit of guidance. So, for me as clinician I found it very helpful to have the ELSA team. (Eastern Health Social Worker 5)

The secondary consultation process also allowed clients without capacity to give instructions to receive some level of support via the consultee. This issue of diminished capacity to give instructions is discussed in more detail at 3.8.1.

These secondary consultations have become an integral part of the elder abuse service response in Melbourne's East, as illustrated in the referral map in Appendix 1.

3.6.6 Community education and community legal education

ROSE and ELSA both provide community education and community legal education, which includes resources such as the *Planning for your Future* brochure. In the period 14/08/2019 to 5/08/2021 ROSE conducted 31 education sessions with 20 different organisations while ELSA conducted 57 with Eastern Health. During COVID-19 restrictions these sessions took place online, using various media including webinars, videos and podcasts.

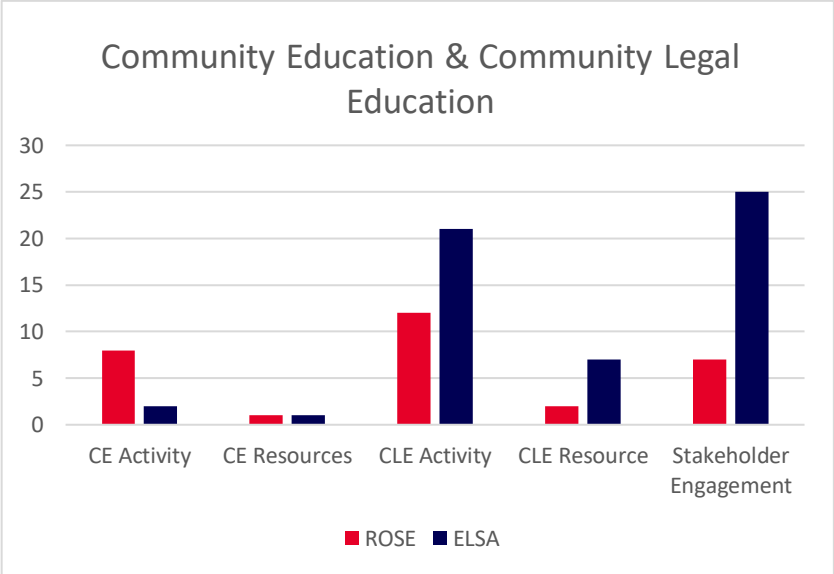

Figure 14 - Community Education & Community Legal Education

Eastern Health social workers identified an improved understanding of elder abuse issues following secondary consultation with ELSA staff as well as via education sessions and working with clients together:

> *Yes, so it's great that it's gone right across the network. Yes, no it's just been really helpful. And even around their education sessions, that's been good. They did a case study a while ago, that we did an education session. So, yes, I think it's just – yes, as we said, because it's not our bread and butter, it's just helpful to have ongoing education support from their service. (Eastern Health Social Worker 9)*

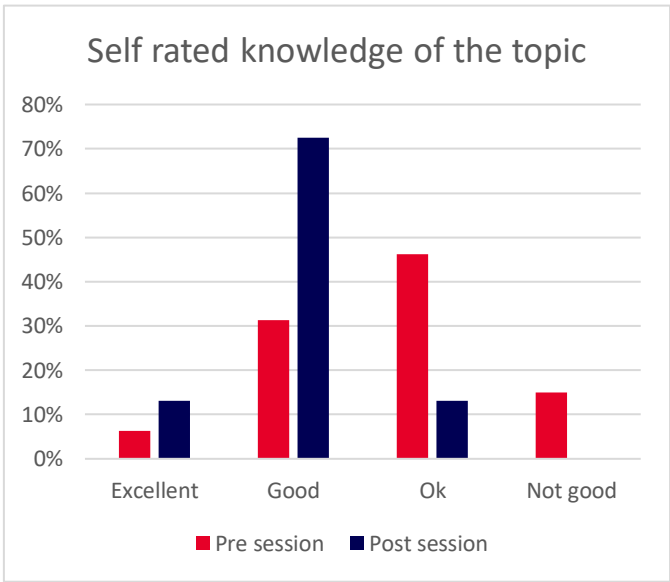

Figure 15 - Self rated knowledge of topic

ECLC collects survey data from community education and community legal education sessions, including online sessions. These data are overwhelmingly positive and are consistent with the qualitative data. Of the 68 responses included in the analysis, 67 felt they would be better able to inform their clients about the topic area, and 66 felt their understanding had increased as a result of the education session. Figure 15 shows post-session self-rated knowledge of the topic

increased dramatically overall compared to the pre-session self-rated knowledge. All available data indicate community education and community legal education are successful and integral aspects of ROSE and ELSA. However, this data should be treated with care as completion rates are consistently below 50% and likely reflect the experience of people who completed the whole session until the end. Overall, the ROSE and ELSA practice models appear well suited to the program aims, and, with some minor adjustments, should continue to be delivered without significant changes (Recommendation 1).

3.7 Referrals and partnerships

Both service trials are premised on effective partnerships; ROSE with Oonah Belonging Place, and ELSA with Eastern Health. In general, ELSA's partnership with Eastern Health is extremely successful, while ROSE's partnership with Oonah Belonging Place has not yet been fully established. This section situates both service trials in the broader context then examines each of these partnerships in detail.

As noted at 3.2, the evaluation team identified many barriers to referral arising from the context of elder abuse, including hesitancy to take action on the part of the older person, issues with capacity to give instructions, stigma, fear of retribution from the perpetrator, cultural attitudes, communication issues and a lack of awareness of elder abuse in the community. Consistently stakeholders reinforced the importance of building trust as the basis for a referral:

> *A patient might only be on our ward for two or three days, if they don't have a very good rapport with us, they're not going to disclose the problem in the first place. (Eastern Health Social Worker 2)*

Both qualitative and quantitative data reflect referrals into and out of both ROSE and ELSA to and from a range of external organisations. All feedback from professional stakeholders was positive:

> *I don't know of a service more responsive really, that's my perspective. (ROSE Stakeholder 5)*

The referral map in Appendix 1 shows the key role ELSA and ROSE play in linking people to appropriate services. It is not possible to determine how many people might now have received appropriate referrals if not for ROSE and ELSA, but 81% of ROSE clients and 100% of ELSA clients reported in exit surveys that they were now more aware of additional services and supports available.

Referrals out are to a diverse range of organisations, most often to private lawyers or other community legal centres, or to various helplines or community services. These data also reflect that where a person is not eligible for ELSA because they are no longer a patient of Eastern Health, they may be referred to ROSE. Detailed incoming referral data are not collected (Recommendation 8).

Figure 16 shows that ELSA is mainly referring out at the end of a service period, while ROSE is referring elsewhere when potential clients do not meet the program eligibility criteria. This is likely a result of the high level of program comprehension of Eastern Health social workers who are referring to ELSA and the effectiveness of the secondary consultation process which screens many inappropriate referrals before they are made.

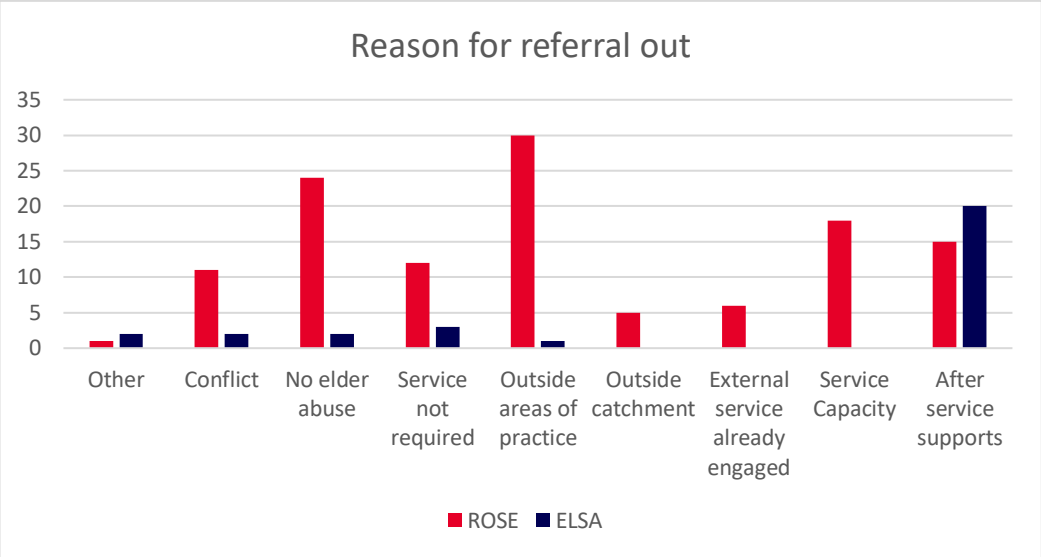

Figure 16 - Reason for referral out

As noted in Figure 16, a number of ROSE clients were referred elsewhere due to a conflict of interest, which will usually occur when the perpetrator of the violence has previously been a client of ECLC. A legal service is not allowed to act for both parties in a legal dispute. In this case, a client would usually be referred to another Community Legal Centre. This would often be Seniors Rights Victoria, a statewide organisation which is very unlikely to have acted for adult children or other perpetrators under 65. Referrals are mostly 'cold' in nature (information and resource issuing). Of the total 126 ROSE incoming referrals where a person was recorded as not eligible, 11 of these were due to a conflict of interest. Of these 11 only 5 received a warm referral to another service, and only 2 were referred to Seniors Rights Victoria. This is likely an under-representation, as the qualitative data indicates this occurs much more frequently. Both ELSA and ROSE should ensure that warm referral data are collected consistently and accurately (Recommendation 11).

Conflicts of interest are unavoidable and beyond ECLC's control. However, as it was consistently raised as a referral barrier by stakeholders, ECLC should consider ways to mitigate negative impacts arising from this (Recommendation 10). This may include more warm referrals, following up contacts to maintain engagement, or providing ongoing secondary consults to other professionals, where appropriate.

Another issue identified in the referral mapping process is that referrers often had no understanding of the outcome for the client. For some, this was not a concern, and they trusted the service to provide appropriate support. For others, there appears to be a missed opportunity to provide feedback, with the client's explicit consent, about the general action taken by ELSA or ROSE to support the client. This was noted as having the potential to be particularly useful for ELSA, where a person might return to Eastern Health multiple times, but their file would only reflect an initial referral. This would also assist with building understanding of the possible outcomes available, while raising awareness of successful outcomes would promote the service and deepen the partnership (Recommendation 14).

3.7.1 Eastern Health

The partnership with Eastern Health appears very robust. All 13 Eastern Health social workers valued ELSA highly, noting the effort ELSA staff had put into the relationship:

> *I think they have worked so hard. They have just been so willing to be out there, to talk to anyone, to educate anyone around what they do, and to be, they've reached out, they've made contact, they*

haven't just waited for us, they've constantly – they'll check in, they've put on sessions. (Eastern Health Social Worker 13)

For most, the relationship was a genuine partnership, despite the barriers erected by COVID-19 restrictions:

I think it's relatively integrated. I feel as though there is a sense of relative urgency when referrals come in through the hospital setting, that is acted on in a pretty timely way, and that the communication channels between whoever the various professionals in ELSA that you're dealing with, that always seems to go smoothly. I think COVID has potentially had an impact in so far as being able to come into the hospital has been problematic for families as well as professionals. (Eastern Health Social Worker 6)

Others did not feel the relationship was 'internal', but this did not mean the service was not valued, despite the lack of co-location:

I've never thought of it as an internal relationship we have with them. But I mean they're always, whenever I've had to call them, they're always there and available. So, I don't think it's really impacted, that they're not sitting in the room or anything. (Eastern Health Social Worker 2)

Consistently, and without prompting, both Eastern Health social workers and ECLC staff noted that one key element to the success of this partnership was that the ELSA Partnership Coordinator was an Eastern Health social worker seconded to ECLC:

I have worked with [ELSA Partnership Coordinator] before so that probably makes it for me much, much easier. I've worked with her together on wards, I know her for many, many years so it makes me very comfortable really knowing someone I can contact and knowing that she has a really good clinical knowledge. And so I felt really comfortable contacting her. And I was quite happy that she was in this position. So for me it was much easier knowing someone there. (Eastern Health Social Worker 5)

This secondment allowed the partnership to navigate the complexities of health and legal systems with much more ease than would otherwise have been the case, and this is a key learning from this service trial which should be repeated in other health justice or community partnerships (Recommendation 17).

One potential area of concern is that the relationship with Eastern Health appears to be entirely with social workers and not with any other professionals. Whilst it seems appropriate that social workers would be the main point of contact, lack of broader engagement with relevant Eastern Health staff may limit opportunities to refer:

I think no. I think they know a little bit about it, but no they would have no idea really. It's being mainly promoted to social workers… if you were in an emergency department or where there wasn't a social worker, perhaps. So, at the moment I think it's just risk assessments by the social worker who are then referring. (Eastern Health Social Worker 14)

This is not a major cause for concern but should be explored with Eastern Health to confirm people experiencing elder abuse but not seen by a social worker are not being missed (Recommendation 15). If, as suggested above at 3.7, ELSA provided a closing letter back to the original referrer, which then became part of the client's file, the understanding of ELSA by other Eastern Health professionals may increase.

Another area for consideration is that, as discussed at 3.4, ELSA clients are much less culturally diverse than ROSE clients, although not less diverse than the over 65's in the catchment area. ECLC and Eastern Health should

consider further strategies for expanding equity of access, such as liaising with Eastern Health's Aboriginal Cultural Advisor, Aboriginal Health Team or Eastern Health Language Services Department, as appropriate.

Overall, it is clear that the health justice partnership with Eastern Health is successful, with some areas to consider refining.

3.7.2 Oonah Belonging Place

The partnership between ROSE and Oonah Belonging Place has not yet reached a point that it can be adequately evaluated, although the early data suggest potential for a positive and multi-layered working relationship. Only one person who identified as Aboriginal is recorded as using ROSE, and this person was not referred by Oonah Belonging Place.[37]

A number of factors were identified as contributing to this, but primarily ECLC staff indicated that COVID-19 restrictions had meant that the kind of activities which promote effective partnerships and build trust with Aboriginal Controlled Community Organisations became much more difficult:

> *In the lockdown phase that's unfortunately stopped. So, we were having regular contact. They would host a lunch every couple of months really for the service providers to meet. There were only a few members of the community there, but it was a good time to kind of network and link in with other services. But what was happening is we had a roster where we would go to Oonah and assist them to run the foodbank, Tucker Bag, it was called. And I loved doing that, yes, that was really good, but then they had to stop. (ECLC Staff 3)*

Another factor is the lack of momentum, as a lack of referrals means no subsequent word-of-mouth referrals:

> *I think it's going to take having a couple of referrals and that being fed back to the community as being positive to get a foot in. (ECLC Staff 4)*

A senior ECLC staff member suggested that referrals from Oonah Belonging Place was a poor metric for the success of the partnership:

> *It's never always been so much about how many clients can we get through Oonah, because I think they have got people who've got elder abuse challenges. But it's not like their patients who just refer on the same kind of way; it's a totally different way of working. And we've had a fair bit of engagement, so we've had, like when we have our strategic advisory group meetings, which is part of that overall governance structure, we've probably had somebody from Oonah there probably at least half the meetings, so they've been a bit engaged at that kind of level. And we've been talking to the management about some of those things more broadly. (ECLC Staff 10)*

This speaks to the amount of time required to develop trusting relationships with Aboriginal Controlled Community Organisations. Other factors are also impacting the relationship, with staff turnover at both Oonah Belonging Place and ECLC at key points in the relationship likely contributing. Further engagement with Oonah Belonging Place is required to better understand the needs of the community it serves and how the relationship with ROSE might be developed. Cultural factors such as, for example, language and terminology need to be better understood. One stakeholder indicated that simply using the word 'elder' in 'elder abuse' when discussing the

[37] Qualitative data indicate other Aboriginal people may have used the service and did not consent to have their data recorded.

phenomenon was inappropriate, suggesting conceptual and practical limitations to the model. It may be that other models, such as embedding staff within Aboriginal Controlled Community Organisations or Aboriginal legal services, are more effective in this cultural context, but without extant research it is not yet possible to determine what might be the most effective and culturally relevant approach.

Given the above, it is too early to assess the quality of the partnership between ROSE and Oonah Belonging Place. ROSE only conducted one recorded stakeholder engagement session at Oonah Belonging Place and three community education sessions at Mullum Mullum Indigenous Gathering Place. With COVID-19 restrictions easing, a main focus for ROSE in the next period will be working with Oonah Belonging Place and other partners to continue building a strong and resilient referral relationship and pathways (Recommendation 16).

The evaluation team will revisit this question in detail for the final evaluation.

3.8 Specific considerations

This section identifies other specific considerations which emerged from the evaluation process and data. These are support for decision-making, ensuring access for diverse groups, mediation, housing options and the economic impact of the service trials.

3.8.1 Support for decision making

Many stakeholders identified that a person's capacity to consent was a specific challenge to providing services, with 11 stakeholders raising the issue 35 different times. This was often viewed as something that a person did or did not have, rather than a dynamic and decision-based assessment:

> *If they don't have the capacity to give us legal instructions there's not a huge amount we can do to help further. (ECLC Staff 2)*

This approach to decision-making capacity is widespread in practice and within what is required by law for legal practitioners,[38] but does not reflect developments in understanding the link between legal and decision-making capacity since the introduction of the *Convention on Rights of Persons with Disabilities*.[39] Contemporary best practice requires that people are supported to exercise capacity wherever possible, and that capacity is decision and time specific.[40]

Stakeholders also reflected this way of understanding decision-making capacity, with Eastern Health social workers indicating that if capacity was not able to be established they would proceed to VCAT rather than refer to ELSA, although one social worker indicated they would consider both options. In cases where there was already a guardian or administrator appointed, referrers indicated they would refer to the Office of the Public Advocate, rather than to ELSA or ROSE.

There appears to be a missed opportunity to work to support a person to maintain and exercise decision-making capacity, rather than simply assessing them as lacking decision-making capacity and in doing so denying them

[38] Law Institute of Victoria, *LIV Capacity Guidelines and Toolkit* (Law Institute of Victoria, 2018).

[39] Committee on the Rights of Persons with Disabilities, 'General Comment No. 1, Article 12: Equal Recognition before the Law, UN Doc. CRPD/C/GC/1 (2014)'.

[40] Although it should be noted that the premise of capacity assessments is viewed as inconsistent with the CRPD by some scholars. See e.g.: Eilionóir Flynn, 'The Rejection of Capacity Assessments in Favor of Respect for Will and Preferences: The Radical Promise of the UN Convention on the Rights of Persons with Disabilities' (2019) 18(1) *World Psychiatry* 50.

legal capacity. In addition, amongst stakeholders, decision-making capacity to give instructions and to receive legal advice was conflated with capacity to make lifestyle, financial, legal or health decisions.

One example that highlights the importance of this is documented in an ELSA case study, where ELSA identified that the Office of the Public Advocate guardian was not following the National Guardianship Standards. Through ELSA's advocacy, the client was able to achieve housing and other outcomes which had initially been denied by the guardian. Had the initial referrer assumed that because the client was subject to a Guardianship Order they lacked capacity to give instructions, this client would not have received this support from ELSA.

The evaluation team did identify various ways in which decision-making support was already being provided, such as bringing in a support person, or taking instructions from another person who was appointed by a court or tribunal to assist the client. One example given was working with the client on matters they could exercise decision-making capacity on:

> *We can see if there're some things that they will have the capacity to understand and work with them on those things. I think that they're going to get a better service from us than they would from other services. (ECLC Staff 2)*

The integrated practice model, discussed at 3.6.1, was also used to support decision-making, with the social worker (either ROSE advocate or Eastern Health social worker) working with the lawyer to provide supports:

> *It would come back to my knowledge of the lawyer making that assessment. They would know the situation, hopefully, in the background for that person, they'd make their assessment based on; does this person understand? Sometimes the social worker will say, "There's fluctuating capacity and so if you call in the morning that's going to be much better." (ECLC Staff 6)*

These examples of providing support for decision-making are promising but not widespread and not indicative of a clear and consistent model to guide all staff. ECLC should develop an approach to embed the examples of best practice to ensure all possible decision-making supports are provided (Recommendation 12), and to promote understanding amongst stakeholders that capacity is decision specific and that people who need support to make decisions are entitled to the same access to services as anyone else (Recommendation 13).

Even if a person cannot be supported to exercise their legal capacity to give instructions, there may be ways to provide them with information they can use, for example by providing secondary consultations to other professionals, as noted at 3.6.5.

3.8.2 Mediation

Participants consistently communicated that recourse to serious legal processes, including intervention orders and litigation, was often counterproductive, or not palatable or available to the client. Clients consistently identified wanting a continued relationship with their perpetrator. This is also reflected in the large number of referrals out from both service trials to mediation services. Mediation and other alternative dispute resolution options may be a useful addition to the integrated practice model, with the similar benefits associated with a holistic service approach as already identified in the integration of legal support, financial counselling and non-legal advocacy. ECLC should consider including mediation in any expansion of the service trials or in any future service development (Recommendation 20).

3.8.3 Housing options

Participants identified a key limitation for non-legal options for ROSE and ELSA clients is housing availability other than aged care. In some cases, clients were able to access emergency housing, but this was not always the case, putting them at risk of further abuse.

> *Some kind of housing solution for people who don't need to go into aged care. This is especially I think for ROSE. They are generally healthier and if they don't need to move out and they're not eligible for aged care because of their age or the visa status or whatever that there is some kind of housing funds, resources for them. (ECLC Staff 5)*

Housing issues were also identified as direct barriers to accessing justice, given the limitations of legal recourse such as intervention orders:

> *In a situation where someone's living in a granny flat at the back of their children's house, you can understand why taking an intervention order against them might not be practical. (ECLC Staff 2)*

This meant that older people were at increased risk of abuse:

> *I kept him in the house under the roof, but he wasn't allowed to swear or touch me, or anything like that. (ELSA Client 2)*

Even when the perpetrator was not living with them, precarious housing for her son meant ELSA Client 6 was anxious that he would attempt to return home:

> *He's been evicted from home as well, I've kicked him out. It's just too much having him in the house, you know? But like I said, he is off the drugs now and has been for a number of years, but he's still not an ideal tenant to rate, so I know he's going to be homeless at some point in the future. (ELSA Client 6)*

A distinct, but related issue, is the provision of support for victims/survivors. Support is limited and can contribute to the potential for abuse if not adequately provided. ELSA Client 2 was somewhat protected from abuse, as well as loneliness, because her daughter lived with her, but would have been very isolated without this support:

> *I'm glad she's there because I think I would have taken my life by now if she wasn't there – I really do, if it was just me. (ELSA Client 2)*

ELSA Client 4 was hesitant to show vulnerability because she was concerned about the potential to be moved to aged care if she couldn't maintain her housing:

> *I've got to look as if I can manage or else they'll put me in a home, won't they? (ELSA Client 4)*

The issue of housing affordability is well documented as a barrier in family violence more broadly, but there appear to be few options for older people and even less support available for perpetrators whose risk of perpetrating abuse increases due to their own housing precarity. ECLC should consider systemic advocacy on this issue (Recommendation 19).

3.8.4 Economic impact

Using the key evaluation questions adapted from the *Preparation for the evaluation of the Elder Abuse Service Trials* prepared by Inside Policy for the Commonwealth Attorney-General's Department, the evaluation team

investigated ROSE and ELSA's economic impact. Stakeholders consistently identified that these questions were not possible to answer in the context in which ROSE and ELSA operate. Many did identify potential savings, such as reductions in hospital visits or other welfare service use, but it is not possible to determine these savings with any accuracy. In many cases, it would be expected that by ensuring older people get access to services they are entitled to ROSE and ELSA would in fact increase overall expenditure. In consultation with ECLC, the evaluation team have not attempted to precisely evaluate the economic impact of ROSE or ELSA.

3.8.5 Recruitment, training and supervision

The integrated practice model is working well, as discussed at 3.6.1, but it has taken some time to achieve this. This process reveals important lessons for future programs, as well as for ongoing recruitment, professional development, and supervision. The developmental nature of the service trials offers significant opportunity for learning which means that it also requires time and investment to develop workforce capability in the integrated practice model.

The evaluation findings reinforce the importance of recruiting professionals who are inclined towards and capable of implementing professional practice, and the need for ongoing reflexive practice to deepen and broaden integrated practice and partnership approaches. The evaluation team heard from multiple ECLC staff that arriving at this point had taken some time and effort, with significant learning about disciplinary differences as the trials have progressed. A senior ECLC staff member explained:

> *This is not standard lawyering. And some people have been taught very differently around this. So, actually getting people to think and operate in a different way is not easy for some people. And you can't find them off the shelf. … How do you recruit for a role like that where actually there aren't a lot of people out there who know what it means to lead a multidisciplinary legal team with social workers and others in a collaborative way, particularly with elder abuse expertise? (ECLC Staff 10)*

ECLC should use the experience of the integrated practice model gained through the service trials to inform ECLC's *Better Practice Principles* and continue development of resources to inform integrated practice in the sector (Recommendation 2).

4 Interim recommendations

These interim recommendations have been developed by the evaluation team based on the analysis of the data from the midterm evaluation.

Continue program development

1. Continue to develop and deliver the ROSE and ELSA service trials
2. Continue to inform ECLC's *Better Practice Principles* and develop resources to inform integrated practice in the sector

Equity of access

3. Document existing strategies and develop strategies to further promote equity of access, including for:
   - 3.1. People of all genders
   - 3.2. People of diverse sexual orientation or relationship status
   - 3.3. Older people at risk of or experiencing homelessness
   - 3.4. Older people from CALD backgrounds
   - 3.5. Older people experiencing social isolation
   - 3.6. Older people with disabilities
   - 3.7. People with hearing impairments who do not use videoconferencing or email
4. Set targets for priority groups to enable evaluation of access equity

Data collection

5. Capture client social isolation data
6. ROSE should record client's desire to continue their relationship with the perpetrator and reasons for this
7. Capture data on issues for perpetrators which contributed to abuse
8. Record incoming external referrals by service type
9. Consider the appropriateness of a metric to enable the evaluation of response and follow up times
10. Consider strategies to mitigate adverse consequences in cases where there is a conflict of interest preventing service provision

Develop and deepen partnerships

11. Ensure that warm referral data are collected consistently and accurately
12. Develop a consistent approach to support decision-making capacity in line with contemporary best practices
13. Provide community education to stakeholders on contemporary best practices in supporting decision-making capacity
14. Where appropriate and with explicit consent, provide a closure letter to the initial referring organisation
15. In conjunction with Eastern Health explore if additional referral pathways to ELSA from other professional groups within Eastern Health should be established
16. Co-develop a comprehensive plan to further develop the partnership with ROSE and Oonah Belonging Place
17. Continue to maintain and embed partnerships through secondment and co-location

Systemic advocacy

18. ECLC to contribute to broader advocacy and systemic reforms designed to address drivers of elder abuse
19. Consider advocacy on housing options for older people experiencing abuse

Miscellaneous

20. Consider including mediation or other alternative dispute resolution services in any expansion or future service development

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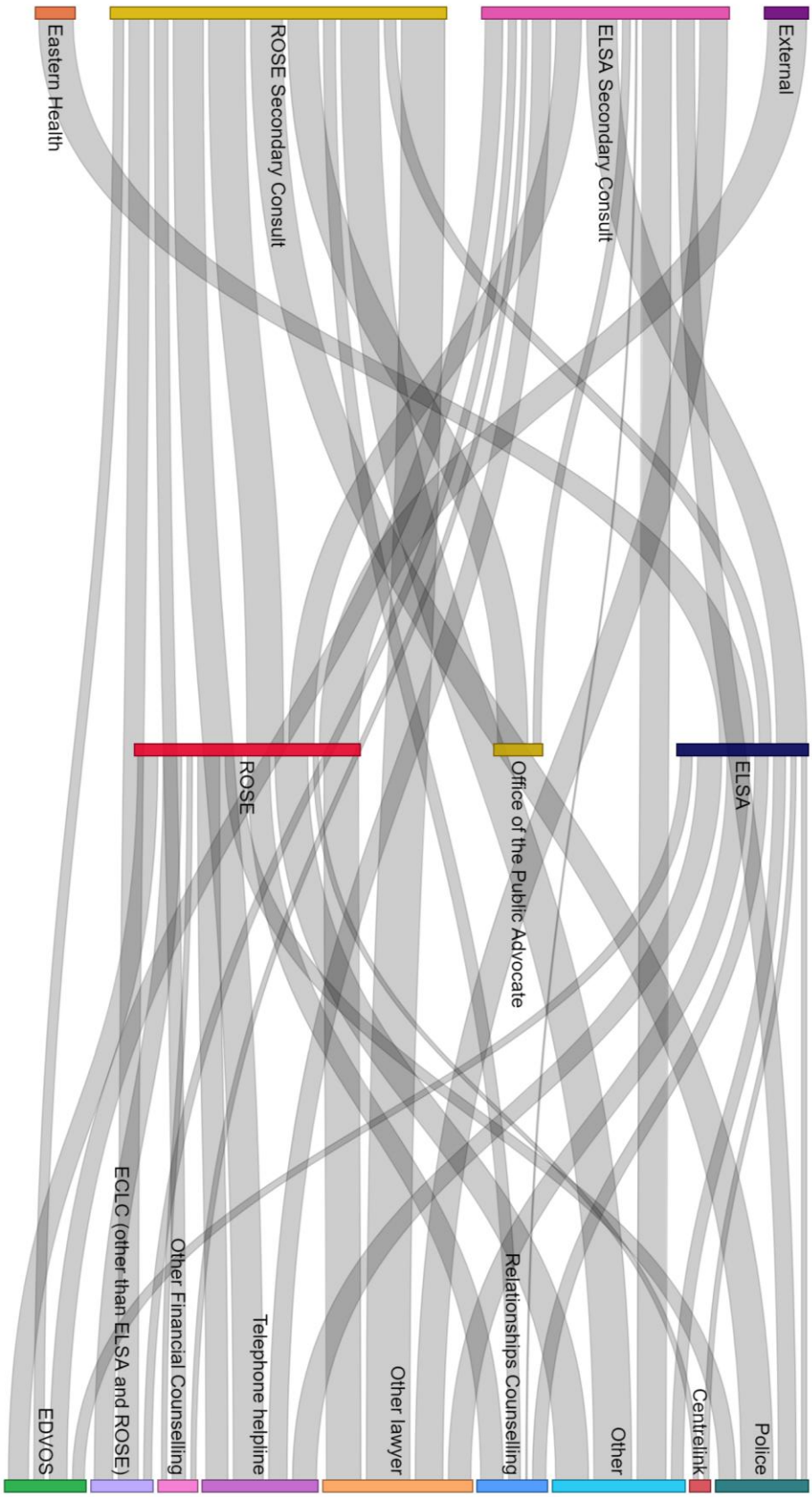
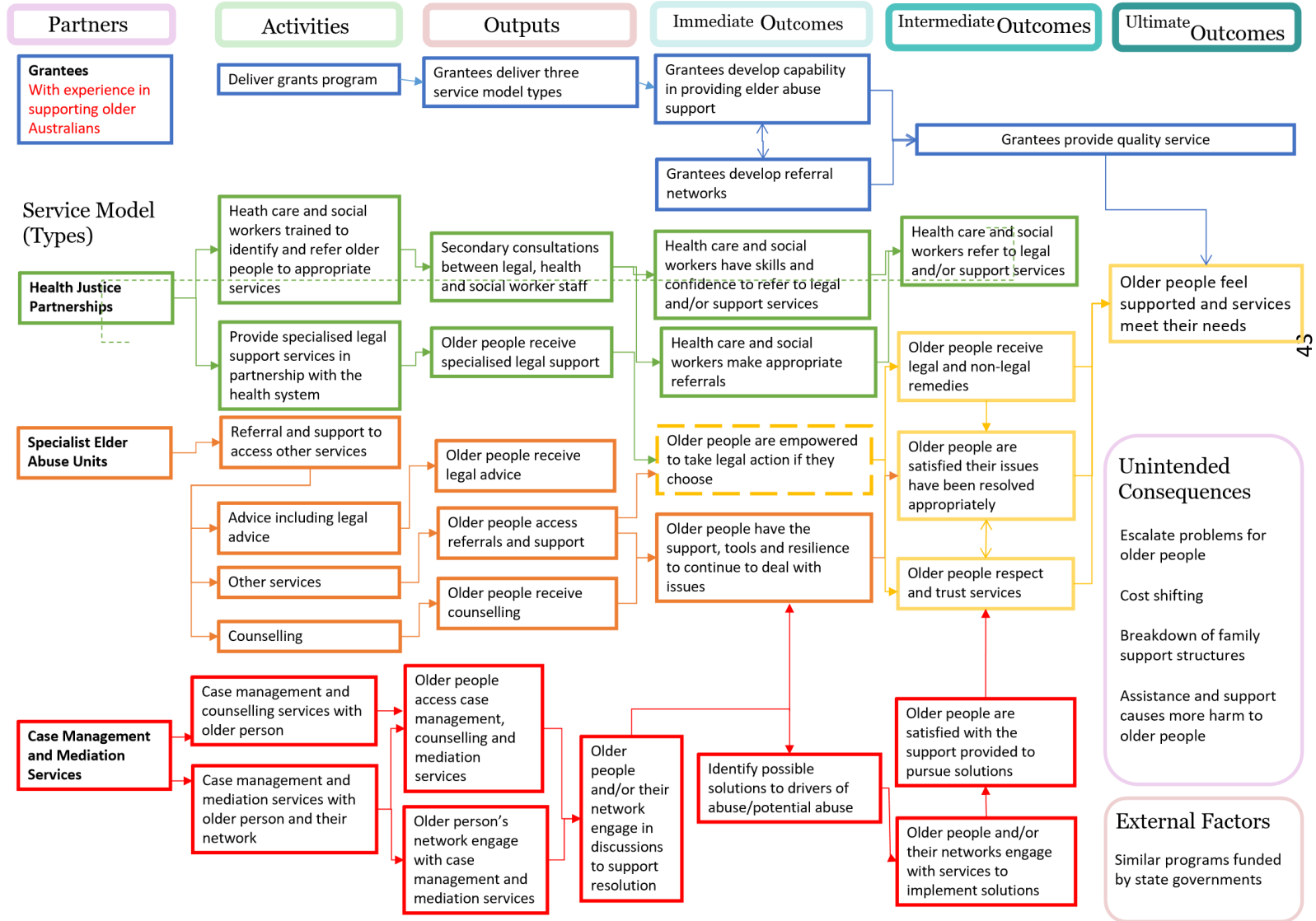
Appendix 1. Referral mapping



Expand and Evaluate Elder Abuse Service Trials Program Logic

Program need	Older people experiencing or at risk of elder abuse lack support from high-quality services
Overarching program objectives	To trial, develop and promote a 'service system' to address elder abuse
Grant objective	To trial three service models to understand strengths of each model and the conditions in which they are successful



Appendix 3. Question matrix

	Evaluation question	ELSA and ROSE Staff	Professional Stakeholders	ELSA and ROSE Users
Process	How are the service trials being implemented?	Can you describe how ELSA and/or ROSE are being implemented?	Can you describe how ELSA/ROSE is being implemented?	Can you tell us about your experience of using ELSA/ROSE?
	What were key features of the partnerships? How did these features contribute to client outcomes?	What were key features of these partnerships? How did these features contribute to client outcomes? Prompt: what makes you think this?	What have been the key features in the partnerships? How did these features contribute to client outcomes?	X
	How effective is the integrated, multi-disciplinary service delivery?	How effective is the integrated, multi-disciplinary service delivery?	How effective is the integrated, multi-disciplinary service delivery?	What supports did you use through ELSA/ROSE? Did they work well together?
	To what extent are the service trials reaching the desired cohort?	To what extent are the service trials reaching the desired cohort?	To what extent are the service trials reaching the desired cohort?	X
	What are the barriers or challenges to implementing service trials?	Have you experienced any barriers or challenges in implementing ELSA/ROSE?	Have you noted any barriers or challenges in working with ELSA/ROSE?	Were there any barriers or challenges in engaging with the ELSA/ROSE?
	How are these barriers being addressed?	How are these barriers being addressed?	How are these barriers being addressed?	What would have made it easier to engage?
	What are the features of the service trials that are of most benefit to primary clients?	What features of the services trials have been most beneficial to your clients?	What features of the services trials have been most beneficial to your clients?	What aspects of the service have supported you most?

	Evaluation question	ELSA and ROSE Staff	Professional Stakeholders	ELSA and ROSE Users
	To what extent have the service trials outcomes been achieved?	To what extent have client outcomes been achieved?	To what extent have client outcomes been achieved?	What were you able to achieve through support from ELSA/ROSE?
	Do older people feel supported and services meet their needs?	Did your clients feel supported? Did the ELSA/ROSE service meet their needs?	*(If not answered above)* Did your clients feel supported? Did ELSA/ROSE meet their needs?	*(If not answered above)* Did you feel supported by ELSA/ROSE? Did ELSA/ROSE meet all your needs? Were there any needs they did not meet? What were they?
	Do older people receive justice and legal restitution?	Did your clients receive justice and legal restitution? Why or why not?	Did your clients receive justice and legal restitution? Why or why not?	Did ELSA/ROSE result in legal outcomes? Did you feel that you got justice?
Outcome	Are older people satisfied their issues have been resolved appropriately?	*(If not answered above)* Were your clients satisfied that their issues had been appropriately resolved?	*(If not answered above)* Were your clients satisfied that their issues had been appropriately resolved?	*(If not answered above)* How satisfied were you with the resolution of the issues you faced?
	Do older people respect and trust the services?	Did your clients respect and trust the services?	Did your clients respect and trust the services?	Did you feel respected by ELSA/ROSE? Did you have trust in ELSA/ROSE?
	To what extent did each service trial type achieve its immediate and intermediate outcomes?	*(If not answered above)* To what extent did ELSA/ROSE achieve its **immediate** outcomes? To what extent did ELSA/ROSA achieve its **intermediate** outcomes?	*(If not answered above)* To what extent did ELSA/ROSE achieve its **immediate** outcomes? To what extent did ELSA/ROSA achieve its	X

	Evaluation question	ELSA and ROSE Staff	Professional Stakeholders	ELSA and ROSE Users
			intermediate outcomes?	
	How well did each service trial type meet the needs of older people at risk of experiencing elder abuse? • Older people from CALD backgrounds, • Older Aboriginal and Torres Strait Islander people, • Older people experiencing cognitive decline, • Older people with disabilities, • Older people experiencing or at risk of homelessness, • Older LGBTIQ+ people.	How well did each ELSA/ROSE meet the needs of older people at risk of experiencing elder abuse? • Older people from CALD backgrounds, • Older Aboriginal and Torres Strait Islander people, • Older people experiencing cognitive decline, • Older people with disabilities, • Older people experiencing or at risk of homelessness, • Older LGBTIQ+ people.	How well did ELSA/ROSE meet the needs of older people at risk of experiencing elder abuse? • Older people from CALD backgrounds, • Older Aboriginal and Torres Strait Islander people, • Older people experiencing cognitive decline, • Older people with disabilities, • Older people experiencing or at risk of homelessness, • Older LGBTIQ+ people.	You mentioned earlier that you identified as [XXX category]. Did you have any specific needs, and were they met?
	What, if any, were unintended outcomes resulting from the service trials?	Were there any unintended outcomes resulting from the service trials? What were they?	Were there any unintended outcomes resulting from the service trials? What were they?	Did you experience any surprise or unexpected outcomes during or after your engagement with ELSA/ROSE?

	Evaluation question	ELSA and ROSE Staff	Professional Stakeholders	ELSA and ROSE Users
	What were the lessons learnt?	What did you (or your organisation) learn from the service trials?	*(if appropriate)* What did you (or your organisation) learn from the service trials?	X
	To what extent did the service trials provide value for money?	To what extent did the service trials provide value for money?	Do you think ELSA/ROSE provide value for money?	X
	Are the service trials the best use of resources?	Are the service trials the best use of resources?	Are the ELSA/ROSE services the best use of resources?	X
	What improvements could be made to the services trials?	What improvements could be made to the services trials?	What improvements could be made to ELSA/ROSE ?	What improvements could be made to the service you received?
Economic	Are there any other target groups who could be supported by these services?	Are there any other target groups who could be supported by these services?	Are there any other target groups who could be supported by these services?	X