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FINAL REPORT
FEBRUARY 2023

Final evaluation of Eastern Community Legal Centre's Elder Abuse Response Programs - ROSE and ELSA service trials

ROSE Rights of Seniors in the East | ELSA Engaging & Living Safely & Autonomously

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Suggested citation: Maylea, Chris; Christina David, Paulene Mackell, Helen Borland, Penny Cearns, Esther Le Couteur, Anastasia Kanjere and Briony Dow (2023) *Final evaluation of ECLC's ROSE and ELSA service trials,* Melbourne: La Trobe University. DOI:10.26181/21753659

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ACKNOWLEDGEMENT

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 La Trobe University, RMIT University and the National Ageing Research Institute acknowledge 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.

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.

We also acknowledge the assistance of the data custodians at the Australian Institute of Family Studies and the Victorian Crime Statistics Agency.

ABBREVIATIONS AND TERMS

ABI	Acquired brain injury
CALD	Culturally and linguistically diverse
COVID-19	Coronavirus disease
EEAN	Eastern Elder Abuse Network
ECLC	Eastern Community Legal Centre
ELSA	Engaging and Living Safely and Autonomously
FCLC	Federation of Community Legal Centres
LGA	Local government area
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

EXECUTIVE SUMMARY

This report presents the findings of the evaluation of the first three years of Eastern Community Legal Centre (ECLC)'s elder abuse service trials – a specialist elder abuse unit, Rights of Seniors in the East (ROSE), and a health justice partnership, Engaging and Living Safely and Autonomously (ELSA). ELSA and ROSE were funded by the Commonwealth Attorney-General's Department as part of the National Elder Abuse Service Trials, and have both since converted to ongoing programs. ELSA and ROSE provide an elder abuse response service in Melbourne's East, using an integrated practice model of legal advice and casework, financial counselling and advocacy. ELSA and ROSE also provide secondary consultations and advice to health and welfare professionals and community education. ROSE operates in partnership with Oonah Belonging Place and ELSA is a health-justice partnership with Eastern Health.

The evaluation conducted interviews and focus groups with 19 people who had used ELSA or ROSE, 18 ECLC staff, and 25 external stakeholders from services who had engaged with the service trials. The evaluation also drew on internal ELSA and ROSE service data and data from a range of external sources, including recently available data on the prevalence of elder abuse.

Overall, nearly all clients valued the services they received highly, even in situations where the abuse was ongoing or issues unresolved. ELSA and ROSE have been shown to be very effective at addressing and responding to elder abuse in roughly half of cases. Where they were not able to resolve the abuse or other issues, this was due to system gaps, failures in the broader health and welfare systems, and/or clients not being able to take up advice due to the complexity of their experience.

The key elements underpinning the success of ELSA and ROSE are the integrated interdisciplinary practice model, which provides a wide range of support options, and the partnerships with health and welfare services. The secondary consultation and community education elements of ELSA and ROSE were highly valued by external professional stakeholders. Despite the challenges posed by COVID-19 restrictions, both programs have achieved their goals to the highest level possible in the circumstances.

The program-level recommendations below largely relate to building on the success of the program or fine-tuning accessibility and service delivery. Where substantial program-level issues, such as inconsistent referrals, were identified, they were outside of the control of ECLC and resolution relies on working with partners who are also responding to COVID-19 restrictions and other challenges. The most substantial recommendations relate to systemic barriers, particularly failures in other health and welfare systems.

The evaluation findings clearly support the adaptation of the ELSA and ROSE models to other geographical locations and their continuation and expansion within the eastern Melbourne region. Other specialist elder abuse services, including prevention, early intervention, mediation and family therapy, are also needed, but ELSA and ROSE provide an excellent model for future service expansion.

RECOMMENDATIONS

Recommendations for ELSA, ROSE and ECLC

1. Continue to provide ELSA and ROSE services
2. Develop further guidelines to assist in role clarity for the advocate role
3. Continue to ensure accessibility and cultural safety for older people
   - **3.1** Experiencing neglect
   - **3.2** Experiencing sexual abuse
   - **3.3** Who identify as Aboriginal and Torres Strait Islander
   - **3.4** With sight and hearing impairments
   - **3.5** With learning and intellectual disabilities and Vacquired brain injury
   - **3.6** Who require support exercising capacity
   - **3.7** Of all genders
   - **3.8** Of diverse sexual orientations or relationship status
   - **3.9** Of diverse cultural and linguistic backgrounds
4. Continue to promote the programs in the community through diverse and accessible formats, including to older people and with elder abuse awareness training for front-line staff in relevant public and community services
5. ELSA to continue co-location with Eastern Health
6. Continue to develop links with professionals (e.g. health and allied health) other than social workers at Eastern Health
7. Revisit the partnership with ROSE and Oonah Belonging Place and other Aboriginal community-controlled organisations with a view to co-designing the provision of the most culturally appropriate model
8. Promote the services in under-represented geographic locations
9. ELSA and ROSE to continue to support the primary prevention and early intervention work of ECLC
10. Develop a process to ensure that warm referrals and their outcomes are appropriately documented
11. Seek consent from clients to follow up where abuse is still present, or issues remain unresolved
12. Develop and document a consistent approach to support decision-making capacity
13. Revise the program logic and future evaluation tools to reflect the practice context and scope
14. Design, develop and implement a co-design and community-led development strategy for service review and development

Recommendations for government regarding services

15. Provide specialist legal elder abuse services to all older people who have experienced elder abuse
16. Provide future legal services based on the ELSA and ROSE model of integrated practice, including:
    - **16.1** Service networks based on the EEAN model
    - **16.2** Secondary consultations
    - **16.3** Community education
    - **16.4** Links to pro bono partnerships
    - **16.5** Advocacy
    - **16.6** Financial counselling
17. Co-design future services and expansion of existing services with people who have experienced elder abuse
18. Provide other elder abuse services, including mediation and family therapy, for people who do not need or want legal resolution, and trauma counselling for survivors of elder abuse
19. Fill gaps in service delivery to perpetrators to prevent drivers and events that precipitate elder abuse
20. Implement primary prevention and early intervention services to prevent older people from experiencing abuse
21. Promote services to broader community links, including faith and cultural leaders, and other contact points (e.g. hairdressers) for people not engaging with health and community services
22. Continue community-level education, advertising and promotion campaigns to improve community understanding of elder abuse and access to support services.

Recommendations for government regarding policy and legislative changes

23. Provide clarity on legal professional privilege for integrated practice settings (Victorian State Government)
24. Consider conflict of interest policy settings (Victorian State Government/Legal Services Board and Commissioner)
25. Consider a legislated regime for safeguarding adults (Victorian State Government)
26. Collect SCORE outcome and circumstances data with clients, not unilaterally recorded by staff (Commonwealth Attorney-General)

INTRODUCTION

This report presents the findings from the evaluation of Eastern Community Legal Centre's (ECLC) elder abuse service trials, Engaging and Living Safely and Autonomously (ELSA) and Rights of Seniors in the East (ROSE). The service trials are funded by the Commonwealth Attorney-General's Department. ROSE operates in partnership with Oonah Belonging Place and ELSA is a health-justice partnership with Eastern Health. The evaluation was conducted in partnership between La Trobe University, RMIT University and the National Ageing Research Institute. The evaluation draws on data from the establishment of ELSA and ROSE in October 2019 to October 2022, and was conducted in two stages, a midterm review published in November 2021,[1] and a final stage review conducted from July to December 2022.

The evaluation has been conducted by a team of evaluators with backgrounds in law, social work, ageing and elder abuse, and included for the final stage two evaluators with lived experience of elder abuse.

1.1 Context

1.1.1 Elder abuse in Australia

Elder abuse is defined as 'a single or repeated act or failure to act, including threats, that results in harm or distress to an older person. This occurs where there is an expectation of trust and/or a power imbalance between the party responsible and the older person.' An older person[2] is generally defined as a person aged over 65, although Aboriginal or Torres Strait Islander people are eligible to receive some older person specific services from the age of 50.

According to the recent National Elder Abuse Prevalence Study, it is estimated that 14.8% of older Australians experience elder abuse.[3] Most older people who experience elder abuse experience psychological abuse (11.7%), followed by neglect (2.9%), financial abuse (2.1%), physical abuse (1.8%) and sexual abuse (1%). Most elder abuse is perpetrated by adult sons and daughters (18%), followed by intimate partners (10%), partners of adult children (7%) and grandchildren (4%). Elder abuse is also perpetrated by friends (12%), neighbours (7%) and acquaintances (9%). Men are more likely to commit elder abuse than women (55% to 45%), and perpetrators are often experiencing their own mental health (32%) and financial problems (21%), and physical health issues (20%). Studies in the United States suggest that rates of elder abuse have further increased during the COVID-19 pandemic.[4]

Elder abuse has received increasing attention internationally and in Australia over the last decade, with a range of inquiries across Australian jurisdictions. The National Plan to Respond to the Abuse of Older Australians (Elder Abuse) 2019-2023, agreed to by the Council of Attorneys-General, sets out a cross-jurisdictional response to the issue.[5] In response to this plan, the Commonwealth Attorney-General's Department funded the Elder Abuse Service Trials, including specialist elder abuse units, health-justice partnerships and case management and mediation services, run by 12 different organisations across Australia. ELSA is one of these health-justice partnerships, and ROSE is one of these specialist elder abuse units. A national evaluation of all of these service trials was conducted by Inside Policy on behalf of the Commonwealth Attorney-General's Department.[6]

[1] Chris Maylea et al, Midterm Evaluation of Eastern Community Legal Centre's ROSE and ELSA Service Trials (Report, RMIT University, 14 February 2022) <https://rmit.figshare.com/articles/report/Midterm_evaluation_of_Eastern_Community_Legal_Centre_s_ROSE_and_ELSA_service_trials/16890580/1>.

[2] World Health Organization, The Toronto Declaration on the Global Prevention of Elder Abuse (2002).

[3] Lixia Qu et al, National Elder Abuse Prevalence Study: Final Report (Report, Australian Institute of Family Studies, 2021) 338.

[4] 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.

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

[6] Inside Policy, Final Evaluation of the Elder Abuse Service Trials - Final Report (Report, Inside Policy, 6 August 2021).

1.1.2 Elder abuse services in Victoria

ELSA and ROSE are the only federally funded Elder Abuse Service Trials in Victoria. However, there are a few other specialist elder abuse services, such as Seniors Rights Victoria, a primarily Victorian government-funded state-wide specialist community legal service that specifically targets elder abuse. Like ELSA and ROSE, Seniors Rights Victoria provides legal advice, casework and advocacy. The Justice Connect Seniors Law team provides legal assistance to older people in Melbourne through health justice partnerships and is also predominantly funded by the Victorian State Government. 1800 ELDERHelp is a national contact line that redirects callers seeking information and advice on elder abuse to the phone service in their state or territory.

In addition to these specialist elder abuse services, many family violence services also support older people experiencing elder abuse. These include FVREE (formerly EDVOS), 1800RESPECT and Safe Steps. Other key stakeholders in the elder abuse prevention and response sector are Victoria Police, the Office of the Public Advocate, community organisations and health services.

The Victorian Government is trialling an integrated model of care to respond to elder abuse in selected healthcare services, which includes workforce training, elder abuse liaison officers, counselling and prevention services. Also in Victoria, the Office of the Public Advocate has recommended that the Victorian government legislate a new specialist function for safeguarding adults with powers to receive, assess and investigate reports of abuse, neglect and exploitation of at-risk adults, including older adults. [7] Although primarily focused on adults with disabilities, this function would also substantially increase the ability of the state to respond to elder abuse.

1.1.3 Elder abuse programs and interdisciplinary practice at ECLC

ECLC's commitment to tackling elder abuse predates the introduction of ELSA and ROSE, having helped establish and worked closely with Seniors Rights Victoria since its inception. It has engaged in policy, advocacy, and community education on elder abuse for many years. More recently, ECLC has provided support and advice to develop the Victorian Government's elder abuse primary prevention framework and elder abuse toolkit, again highlighting the leading role ECLC occupies in the elder abuse prevention and response sector. In 2023, ECLC will develop a resource to support medical treatment decision-making and advance care planning in collaboration with the Commissioner for Senior Victorians.

ECLC coordinates the Eastern Elder Abuse Network (EEAN), established in 2010, which has a dual prevention and response focus. ECLC employs an Elder Abuse Prevention Lead who facilitates partnerships through the Eastern Elder Abuse Network and the Elder Abuse Primary Prevention Community of Practice. Key outcomes of this role have included development of a regional Primary Prevention Framework to Prevent Elder Abuse, the Older People, Equity, Respect and Ageing (OPERA) project, which is a partnership between ECLC and Swinburne to explore older people's experience of ageing and age discrimination in Melbourne's East, and the Matter of Trust Workshops with culturally and linguistically diverse (CALD) communities.

ECLC also has a well-developed approach to integrated interdisciplinary practice, as documented in *ECLC's Better Practice Principles*.[8] This approach informs the team composition of ELSA and ROSE, and the nature of the partnerships with other organisations, as discussed below.

[7] Office of the Public Advocate, Line of Sight: Refocussing Victoria's Adult Safeguarding Laws and Practices - Office of the Public Advocate (Report, Office of the Public Advocate, 2022) <https://www.publicadvocate.vic.gov.au/opa-s-work/research/503-line-of-sight-refocussing-victoria-s-adult-safeguarding-laws-and-practices>.

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

1.1.4 ELSA and ROSE

In 2019, the National Plan to Respond to the Abuse of Older Australians (Elder Abuse) 2019–2023 was released by the Council of Attorneys-General.[9] In the 2018-19 Federal Budget, the Commonwealth Government announced the More Choices for a Longer Life – Protecting Older Australians package. This included the National 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), but not case management or mediation.

Both ELSA and ROSE provide direct support and referrals to people aged 65 years and over or Aboriginal and Torres Strait Islander people aged 50 years and over, secondary consultations to other health and welfare professionals, and education to community members and health and welfare professionals (referred to as 'community education', for convenience.) 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.

1.1.4.1 ROSE

ROSE (Rights of Seniors in the East) uses an integrated model to provide legal, financial counselling and advocacy, information, and case management support to older people with increased vulnerability, experiencing or at risk of elder abuse. ROSE accepts referrals from any person or organisation in the catchment area. ROSE partners with Oonah Health & Community Services Aboriginal Corporation, also known as Oonah Belonging Place.

1.1.4.2 ELSA

ELSA (Engaging and Living Safely and Autonomously) is a health justice partnership between ECLC and Eastern Health. ELSA works only with current or recent patients of Eastern Health to provide legal and financial counselling and advocacy to older people with increased vulnerability, experiencing or at risk of elder abuse. ELSA employs a Partnership Co-ordinator, who is a social worker seconded from/within Eastern Health. The Partnership Co-ordinator co-ordinates the ELSA team and provides secondary consultations and education to Eastern Health staff.

1.1.4.3 Staffing

A Managing Lawyer (Elder Abuse) (1 FTE) provides program, stakeholder and staff management and leadership across both programs and oversees other elder abuse response programs and initiatives at ECLC. A financial counsellor (0.5 FTE) works across both programs, and an Intake and Administration Officer (1 FTE) also supports both programs, providing information and advice and facilitating access to the service trials. ELSA and ROSE both employ an advocate (1 FTE) and a community lawyer (1 FTE), respectively, although ELSA staff have also provided services to ROSE clients when service capacity permits. Both advocates and the Partnerships Co-ordinator are social workers, although this is not a formal requirement for the role. A volunteer also works a few hours per week, and external pro bono lawyers accept referrals from both ROSE and ELSA.

1.1.4.4 Evolution of the programs

As service trials, both ELSA and ROSE have evolved since inception. Both programs had to shift online during COVID-19 lockdowns, preventing co-location with Eastern Health and Oonah Belonging Place, although face-to-face client appointments were still offered where necessary. These adaptations are detailed in the midterm review. In 2022 both programs returned to face-to-face service provision where appropriate. ELSA resumed co-location with Eastern Health in late 2022.

The staffing profile has also shifted to meet demand, with the financial counsellor role now shared across both programs. ELSA did not initially include an advocate role, as it was thought that Eastern Health social workers would provide all necessary social work support. However, as noted in the midterm review and discussed below in 2.1.2.2, the advocate role differs from a hospital social worker role. In October 2021, an advocate joined the ELSA team on secondment from Eastern Health, providing advocacy for clients. This was possible through additional funding from AGD to the Service Trials.

In 2023, ECLC will recruit an additional financial counsellor and a strategic advocacy and policy role. This strategic advocacy policy role will work to improve understanding of elder abuse, develop and implement a strategic advocacy plan, and develop strategic networks for policy advocacy.

1.1.5 Midterm review

This evaluation was undertaken in two phases, a midterm and a final stage review. The midterm review was published in November 2021 and covered ELSA and ROSE service delivery for the first two years.[10] At the midterm stage, 4 ELSA clients, 2 ROSE clients, 10 ECLC staff and 18 external stakeholders participated in interviews. ELSA and ROSE service and reporting data were also analysed.

The midterm review identified that ELSA and ROSE had been implemented successfully, despite the challenges posed by Victoria's COVID-19 restrictions, which were the longest and most enduring in the country. Clients identified that their needs had been met even if the abuse had not been resolved, and professional stakeholders valued the integrated services provided by ELSA and ROSE. The ELSA partnership with Eastern Health was well developed, although the ROSE partnership with Oonah Belonging Place required ongoing development. It appeared the partnership with Oonah Belonging Place was more significantly impacted by the pandemic restrictions and their impact for First Nations communities.

The majority of the findings from the midterm review are confirmed and elaborated in the final stage of the evaluation, as reported below, with no significant dissonance between the two. The key differences relate to a relaxing of COVID-19 restrictions, the maturation of the ELSA and ROSE models, and the increased availability of both internal and external data, particularly elder abuse prevalence data, as discussed in the methodology section at 3.3.3.

This evaluation was undertaken in two phases, a midterm and a final stage review. The midterm review was published in November 2021 and covered ELSA and ROSE service delivery for the first two years

[9] Council of Attorneys-General (n 5).

[10] Maylea et al (n 1).

FINDINGS

This section presents the findings from the evaluation in four parts. First, the ELSA and ROSE programs are described and evaluated, considering their deliverables and the operation of the elements of the service model. The model is shown to be working effectively and as intended. Then, the accessibility of the programs is evaluated, with barriers to access identified and discussed. Following this, the client experience of ELSA and ROSE and client outcomes are discussed. This shows that the client experience is overwhelmingly positive and that approximately half of the clients had their abuse or other issue resolved to their satisfaction. Where clients remain unsafe or have issues unresolved, this is the result of service and support gaps that are beyond the control of ECLC. Finally, the importance of building on the successful service trials by implementing co-design and community-led development is highlighted. Discussion of the methodology used follows this findings section.

2.1. ELSA and ROSE in practice

2.1.1 Summary of deliverables

2.1.1.1 Number of clients

Over the initial three-year period, ELSA worked with 65 clients, with 4 clients receiving multiple periods of service, and ROSE worked with 91 clients, with 4 clients receiving multiple periods of service. The average age of clients for both programs is 75, ranging from 59 to 95 for ELSA and 52 to 94 for ROSE. ELSA saw 23 men and 42 women; ROSE saw 27 men and 64 women. Neither service saw clients who identified to the service as trans or gender diverse.

2.1.1.2 Time spent with clients

ELSA spent 233 hours of service with clients, for an average of 3 hours spent with each client, while ROSE provided 633 hours of service with clients, for an average of 6.4 hours spent with each client. This only includes time spent directly with clients and does not include time spent on work done without the client present (for example, all preparatory or follow up work done by professionals outside of client appointments).

ELSA cases were open an average of 83 days, and ROSE cases an average of 75 days. On average, ELSA clients proceeded from referral to intake within 2 business days, 3.5 days for ROSE.

Figure 1 – Total case load

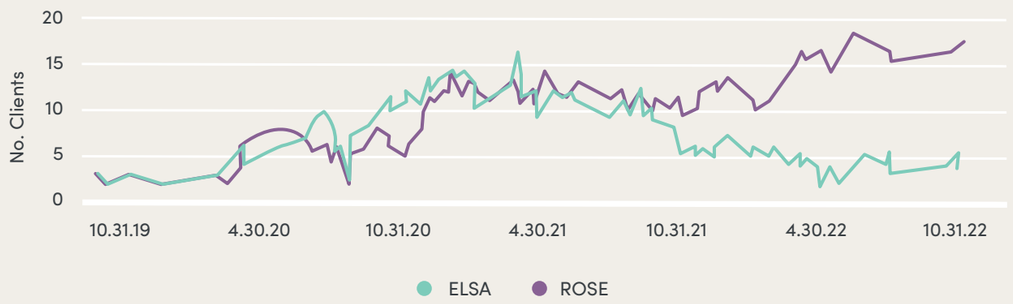
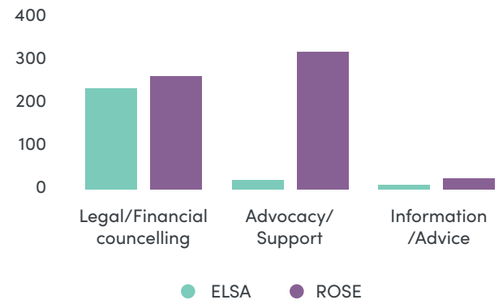


Figure 2 - Sessions provided



ELSA provided a total of 270 service sessions, mostly specialist legal or financial counselling, as ELSA had no designated advocate until October 2021. ROSE provided 609 service sessions.

A session comprises a time spent by a ROSE or ELSA professional directly with a client which is 15 minutes or more. It does not include time spent on client work without the client present, such as time spent writing letters or communicating with other stakeholders on behalf of a client.

The difference in service provision data between ELSA and ROSE, shown in Figure 2, is due to two factors. The first is that ELSA initially planned to utilise Eastern Health social work staff to perform advocacy functions and did not have a dedicated advocate until October 2021. ELSA provided only slightly fewer legal or financial counselling sessions (238) than ROSE (258). The second, discussed below at 2.1.6, is that Eastern Health, like all Victorian health services, faced a range of stressors during 2020-2022 that impeded referrals. When the ELSA caseload was low, ELSA staff assisted with ROSE cases, further increasing the discrepancy in the service data. ELSA has conducted many more community education and service promotion activities, and the qualitative data from Eastern Health staff indicate ELSA is highly valued, so it seems likely that as the stressors lift on the health service system, referrals will increase. Co-location with Eastern Health, which was able to resume in October 2022, will also assist with this (Recommendation 5).

On census night in 2021, there were 162,791 people aged 65 and over living in the ELSA and ROSE catchment area. Extrapolating from the prevalence data, approximately 24,000 will have experienced some form of elder abuse. Combined, over three years, ELSA and ROSE have provided a service to approximately half of a per cent of that number. Not all older people who have experienced abuse will want or need the kind of support that ELSA and ROSE offer. There is, however, a vast unmet need for more elder abuse services, both within and beyond the ELSA and ROSE catchment (Recommendations 1 & 15). Future legal elder abuse services should build on the effective and successful model developed by ELSA and ROSE (Recommendation 16), with other approaches providing advocacy for people who do not want or need legal services (Recommendation 18).

2.1.1.3 Key performance indicators & program logic

As ELSA and ROSE are service trials, there are no formal key performance indicators in the funding agreements with the Attorney-General's Department. There is a program logic (see Appendix 2) that details the expected outputs and outcomes, but no measurable targets for indicators against those outputs or outcomes. It appears from the qualitative and quantitative data that ELSA and ROSE's maximum case load, of approximately 15 clients per service, represents a rough cap beyond which service quality is likely to deteriorate. As detailed below, the effectiveness of the service relies on the responsiveness of the service delivery and the amount of time that staff can spend with clients to develop the trusting relationships required to consider available options and the specific consequences of taking action in elder abuse contexts, as considered further at 2.3.3.1.

The deliverables and other data able to be collected do not correlate well with the program logic developed by the Commonwealth Attorney General's Department (Appendix 2), which includes outcomes such as 'Older people are empowered to take legal action if they choose', 'Older people are satisfied their issues have been resolved appropriately' and 'Older people receive legal and non-legal remedies'. As noted below, at 2.3, the abuse and other related issues are routinely not resolved, but not because older people 'choose' to continue to be abused. Vignette 5 best illustrates this, as it shows the limited options that are available to older people experiencing abuse, options that often

[11] Inside Policy (n 6).

do not address the impossible predicament associated with addressing abuse, particularly when perpetrated by a family member. Older people are rarely 'satisfied' when they have had to take legal action against their own children. Similarly, the evaluation questions, developed by the Commonwealth Attorney General's Department, 'To what extent did the service trials provide value for money?' and 'Are the service trials the best use of resources?' are not able to be assessed using the methodology developed by the Commonwealth Attorney General's Department, as they require a cost-benefit analysis reliant on variables that are not available, such as the costs of elder abuse to the community and to health and welfare services. The program logic and future evaluation tools should be revised to reflect the complex nature of the context in which the services are operating and to assess service performance based on providing access to options and building capacity to make informed decisions (Recommendation 13). This was also a recommendation from the evaluation of all the Attorney-General's Department funded elder abuse service trials.[11]

2.1.2 Integrated practice

The integrated practice approach used by both ELSA and ROSE brings together free legal advice and casework, advocacy and financial counselling, supported by and integrated with management, intake and partnership development staff. Critical success factors included the service's responsiveness, timeliness, and the wrap-around nature of the model. Appropriate caseloads meant the service could take the time to build trust, and thus provide a trauma-informed service that could support informed decision-making. This model is distinct from most legal, advocacy and financial counselling services provided by individual practitioners or as distinct programs and services, each with its own eligibility criteria, waitlists, fees, location and approaches.

It is clear, both at the organisational and practice levels, that the integrated practice model has matured into a very effective approach that underpins the success of the programs and leads to the outcomes identified below. A key element of this maturity is identifying the right staff. Professionals that worked well in this model needed to be able to work with other disciplines and be flexible enough to work in an integrated interdisciplinary practice approach. This was clearly expressed by ECLC management:

> *We're still figuring it out and I don't think you really know what something is, a type of practice is capable of, until it's matured. Unless it's been tested in different ways. Until you're working with different clients, different practitioners. It has evolved over the years at ECLC. I can tell you which practitioners really didn't do well in integrated practice. And I can tell you those where that type of practice suits them.* (ECLC Staff 7)

This development of the approach over time was also reflected by staff, who identified having learned and grown as professionals as a result of the integrated practice model:

> *When I first came in, I wanted this really black and white understanding of what does an advocate do? What are the rules? Where does the boundary begin and end? How does it work? Where are the ethical obligations for advocates or social workers in the same black and white way as they exist for lawyers? I quickly learned that there are no such rules in the same black and white way as what I'm used to as a lawyer.* (ECLC Staff 6)

Clients consistently appreciated the integrated practice model. Primarily, the model meant that appropriate tailored, responsive, and free support could be provided immediately, rather than waiting for another referral and the burden of navigating different service systems whilst also experiencing abuse. In ROSE Client 6's case, the lawyer could be brought in immediately:

> *I got an appointment, a phone appointment, with the social worker. And then she followed up and said, "Well, I would like you to talk to the lawyer about estate planning." Pretty much straight away, within a week, or something like that – or, she may have brought him into the conversation... at the end of the same meeting, something like that, or invited him to sit in or something. So, I don't think I followed his advice exactly, but it was still another perspective. So, they were very responsive, I should say that.* (ROSE Client 6)

The value of the integrated service approach is demonstrated in the following quote by a client who describes the advocate helping with crisis planning and practical support, including housing, while the lawyer organised the intervention order:

> *[The advocate] helped me in finding places to go and things like that, and [the lawyer] helped me with the legal issues. For instance, he helped me put a intervention order against my wife, my previous wife, because now we're separated. Yeah. He was there all the time. I mean, he guided me through the whole thing because I didn't know about these things.* (ELSA Client 3)

Similarly, ROSE Client 1 appreciated the different approaches the different professionals brought:

> *The lawyer was more hard on the problem. The advocate was very gentle on it, so we had both sides of the story and that was good. But it really basically still comes back to us, and that's where the issue is at the moment.* (ROSE Client 1)

Only ROSE Client 9 had a negative experience with the integrated model, reporting that speaking with multiple professionals on the same day added to the stress they were experiencing:

> *It would have been better if the social worker contacted me separately, because I spoke to them both on the same day and one transferred me over to the other and it was a bit much for me. But that's just me, it could be me and the stress I was under at the time.* (ROSE Client 9)

This feedback speaks to the need to be highly attuned to the sensitivities and preferences of each older person in light of the complexity in extremely stressful situations, which may require negotiating the speed of the response. Despite this one piece of constructive feedback, the integrated practice model was highly successful in expanding the clients' knowledge of supports and options available, with many indicating they were aware they could return to the service at a time in the future if they required. Each element of the model – legal advice and casework, advocacy and financial counselling – is discussed in the following sections.

2.1.2.1 Legal advice & legal casework

The legal advice and legal casework provided by ELSA and ROSE were generally consistent with community lawyering, focusing on providing options and guidance in navigating legal systems to resolve issues informally, although some cases required resorting to litigation. This is a highly specialised skillset requiring substantial versatility, flexibility and a broad knowledge base:

> *The ELSA and ROSE lawyers can bring that unique community lawyering skill set. So you have your specialist private firms doing that really detailed areas of law kind of conversation that's not our – but it means that they can focus and be valued for those lawyering skills, the community lawyering skills that they bring to this. Which is a unique skillset.* (ECLC Staff 10)

ROSE Client 6 noted the variety of areas for which the ROSE lawyer could provide legal advice or referrals:

> *Give someone a community treatment order, that's a legal issue, I guess. Mental health tribunal is a legal issue. Compulsory treatment's a legal issue. Having police and ambulance is legal. Intervention order is a legal issue. So, it does all sort of connect, I guess. And planning your will is definitely a legal issue, I guess. So, they were very good.* (ROSE Client 6)

Some areas of law, most relevantly wills and estates, are generally not covered by community lawyers and were sometimes referred to private lawyers. In some cases, ELSA and ROSE were able to obtain pro bono legal services, as discussed below at 2.1.3.2.

2.1.2.2 Advocacy

The clients and stakeholders highly valued the advocacy provided. Both advocates are social workers, not lawyers, and their advocacy is informed by their social work training, although the role was not advertised as restricted to social workers. Of the three elements of the integrated practice model, that of advocate has the least definition, as advocacy is practiced very differently in different contexts. More so than the lawyers and financial counsellors, the advocates have had to define their role as the trials progressed. This has allowed the advocates to respond to the needs of the person as individuals, rather than subscribing to a pre-defined model. In some cases, the role of the advocate was to support the legal process:

> *The role of the advocate isn't just to provide a family violence service. ... They're supporting legal advice. They're making legal options more accessible. ... For a woman to be able to disclose sexual assault, or to be able to disclose where she's at in her decision making of separating from a violent partner, there needs to be a level of trust, and there needs to be a level of response. And legal options need to be provided in a way for them to be accessible.* (ECLC Staff 12)

In other situations, the role of the advocate was much more generalist:

> *They came into it and they started asking me, "did I have support? did I have help? did I have whatever?" Which I didn't have any of, really, and then they put all this in place, all the help and putting me in contact with My Aged Care and I actually have a little guy here cleaning my gutters for me and shower rails have been put in or are going to be put in... all the services that I had no idea about.* (ROSE Client 4)

ROSE Client 4's experience of being linked to other services is reflected in Vignette 1 – Andrea. Other examples given included assisting clients in accessing housing, applying for funding, and navigating Centrelink. Examples of support outside the advocate's role include mediation, working with perpetrators in any way, and social work style case management. ELSA and ROSE are currently developing guidelines for the advocacy role to assist with role clarity. These will be scenario-based guidelines, rather than a list of rules, that will reflect the fluid and responsive nature of the role. (Recommendation 2).

2.1.2.3 Financial counselling

The financial counselling role, now shared across ELSA and ROSE, was also highly valued and was often directly linked to tangible financial outcomes. Many evaluation participants – ECLC staff, external stakeholders and clients – noted the way that the financial counsellor could achieve outcomes that were unexpected:

> ***Magical. I've had some of them achieve getting banks – like big banks to write off, or yes, moratoriums, but then take $100,000 – $200,000 off mortgages because of issues of family violence.*** **(External Stakeholder 5)**

In some cases, clients had been laden with debts for years, which the financial counsellor was able to have waived:

> ***It was about $40,000. Plus, he had a credit card of a few thousand dollars. … And he had been paying this debt for 20 years, for no benefit. … It was a bit of toing froing with that, but I got that waived.*** **(ECLC Financial Counsellor)**

These outcomes were particular to the financial counsellor role and not achievable by other professionals, highlighting again the impact of the integrated practice model. ECLC Staff 2 explained how banks reacted defensively when approached by lawyers but supportively when approached by the financial counsellor:

> ***In my experience, when lawyers have gone through that, they've been, 'Oh, we had to refer this through the legal team, send us something in writing, send us the ID.' … Instead, [I] called the financial counsellor and mentioned this had happened, and she was able to, through her connections, organise a meeting, and we were on the phone with the bank an hour or something later, with a manager there, and got all the accounts closed up so that the daughter couldn't access them.*** **(ECLC Staff 2)**

This process is shown in Vignette 2 – John. The financial counsellor also appreciated the support available from the lawyer and the advocate:

> ***If I'd had some of the clients that we've had, and I was in a generalist financial counselling service in the community, I wouldn't have been able to – the client outcomes wouldn't have been the same. I would have had to refer – I might have been able to handle the debts. But we've had to refer them on to another service.*** **(ECLC Financial Counsellor)**

The financial counselling aspect of the integrated practice appears to be implemented successfully. No changes are recommended for this role, other than to increase the capacity of the financial counsellor to meet demand (Recommendation 16.6).

2.1.2.4 Legal professional privilege

One issue that remains unresolved for the integrated practice model is legal professional privilege. Victorian law is unclear as to the extent to which information provided to the advocates and the financial counsellor is protected from subpoena in the way legal files are, although the Federation of Community Legal Centres (FCLC) has produced a guide to navigate this issue.[12] It appears the risk is lower in elder abuse related litigation than in other integrated practice settings. However, the practice model would benefit from legal clarity so ELSA and ROSE staff can provide clear guidance to clients. This is an issue for many integrated practice approaches, so ECLC should work with FCLC and others such as the Victorian Legal Services Board and Commissioner to seek clarity through a legal ruling or legislative amendment (Recommendation 23).

2.1.3 Partnerships

The success of ELSA and ROSE is based on the partnerships with community and health sectors that refer to the programs and provide avenues and options for clients. Overall, the partnerships have sustained this success whilst acknowledging the substantial challenges posed by the COVID-19 pandemic and other factors. This experience was replicated nationally, as shown in the evaluation of all the Attorney-General's Department funded elder abuse service trials.[13] Whilst some of these challenges continue to impact the programs, and some remain unresolved, the feedback from external stakeholders was universally positive and highlighted the importance of collaboration and partnership in addressing complex social issues such as elder abuse:

We have got the same attitude on helping people and we connect together. They have been very informative and very helpful, even with secondary consultations they sometimes provide more information than I need. I also find that helpful. Sometimes they will also come to me for other assistance as well and we'll also provide as much as we can. I guess the relationships we've built on co-working the case together and we are also learning together, sharing information, sharing resources. I guess that's how community organisations build collaboration with other community organisations. (External Stakeholder 2)

2.1.3.1 Eastern Health

As a health-justice partnership, ELSA's key partner is Eastern Health. The partnership is very solid, with Eastern Health social workers indicating that they understood ELSA's role and valued it as a referral option. When it was possible, ELSA staff were co-located at Eastern Health sites, allowing older people to receive legal advice and other support from their hospital bed:

They came into the ward to see me with a nice young man and a lady – I've forgotten their names now – they came in and spoke to me probably for about half an hour. I'm assuming the hospital might have notified the ELSA people to come in. I just don't know how they came in or why they came in but they did come in and spoke to me in my bed. …. ELSA, they were very good. The nice people I saw, they advised me on what my rights were and what I could do and what I couldn't do. … advising me about, just about where I stood and what sort of rights financially and all that sort of thing, which was a great help. … The little talks I had with them I thought were very good. (ELSA Client 1)

During COVID-19 restrictions, this was much more difficult with staff having to communicate via phone or Zoom:

> ***The client's in hospital and we're not allowed to go. [They are] 95, speak Italian, want their niece there and the interpreter. And there's a lawyer and the financial counsellor on the phone. There's a lot of people on the phone. … they didn't want to use Zoom, so it's a phone call. And I had trouble deciding who was talking and who's not talking. And they're 95 and it's difficult.*** **(ECLC Staff 1)**

Both referrals and secondary consultations from Eastern Health have been very strong at times, as discussed below, but COVID-19 restrictions and staffing pressures into 2022 have caused variability in referrals. ELSA has a partnership co-ordinator who is seconded by Eastern Health and promotes referrals through community education and secondary consultations:

> ***It would be great to continue to grow the partnership. I think COVID has thrown a lot of challenges into a partnership model with a public health service at this time. But it seems like there's a little bit more momentum happening at the moment in terms of people wanting education sessions and seeming like they have a little bit more capacity to engage, which has been good. So I think just continuing to grow that partnership and hopefully increase the referral base.*** **(ECLC Staff 8)**

There appears to be little that ELSA can do beyond what they are already doing to promote referrals. Co-location has recently resumed and should assist with this (Recommendation 5).

For many ELSA clients, it is difficult to see how else they might have received support to address their abuse if not through contact with Eastern Health and then referred to ELSA. This is shown in Vignette 1 – Andrea and Vignette 3 – Juanita, where hospital visits for unrelated issues identified the abuse and resulted in a referral. But for these visits, the abuse would have continued. This emphasises the worth of the health-justice partnership.

As a health-justice partnership, ELSA's key partner is Eastern Health. The partnership is very solid, with Eastern Health social workers indicating that they understood ELSA's role and valued it as a referral option.

[12] Federation of Community Legal Centres, *Integrated Practice Toolkit - Privilege and Mandatory Reporting* (Report, Federation of Community Legal Centres, 2018) <https://www.fclc.org.au/integrated_practice_toolkit>.

[13] Inside Policy (n 6).

2.1.3.2 Oonah Belonging Place

As with ELSA and Eastern Health, broader contextual issues regarding Covid-19 have hampered the development of the partnership between Oonah Belonging Place. ECLC have worked with Oonah Belonging Place, offering wills and powers of attorney information sessions and a wills clinic in partnership with a private legal firm. However, as noted above, no Aboriginal or Torres Strait Islander people consented to have their data recorded, and no referrals from Oonah Belonging Place were recorded in the quantitative data provided. The qualitative data indicate one referral from Oonah Belonging Place in 2022. The evaluation team explored the potential reasons for this during interviews with Aboriginal community stakeholders, who noted that the lack of referrals was not a reflection on the way the local Aboriginal community views ECLC. The stakeholders emphasised the trust and respect ECLC has developed in its work with the community:

> *Eastern Legal have got a good reputation here in the east, with Aboriginal – with Mullum and certainly with Oonah and other communities out here because of the people from Eastern Legal, as I say, they're genuine. Genuine people are compassionate. So we had a thing a fortnight ago, a fundraiser thing for the Aboriginal community and so forth, and there were several people there from Eastern Legal there on the night. They're very supportive. They're well received. … Aboriginal organisations, for various reasons and things to do with treatment in the past and so forth, it's very hard to earn their trust, but once you have it, I mean, you're in. And Eastern Legal have got a – like I say, a well-earned reputation as being people that they can count on. They're not there just to tick the boxes and count Aboriginal people just again put down purely as statistics. They care. And so they've – and they've reached out to the Aboriginal community here in the east with the ECLC and the ROSE programs. And I know there are – I know there are some community members that are clients of them.* (External Stakeholder 6)

And:

> *I just know that a lot of the programs and things that we've done with ECLC have always been extremely productive and very good for our community. I think it's a service that is really – it's wonderful for us, really. … the fact that they have an office here in town is even better, and they've always been extremely open and hospitable to any suggestions and ideas and very, very respectful, really, in working with our community, which is wonderful.* (External Stakeholder 1)

There is also no lack of understanding of the ROSE program or its availability at Oonah Belonging Place:

> *We're all very aware of the program and that we can refer people into ECLC and work with them for any clients that need assistance.* (External Stakeholder 1)

COVID-19 was likely a key contributor to the lack of actual referrals, but this is just one of many potential factors. Issues such as attending to Sorry Business are a significant priority for the community. In addition, Victoria is currently undergoing a treaty process and a Yoorrook Justice Commission, a formal truth-telling process into injustices experienced by First Peoples in Victoria, which also requires time and energy from the community members and of Oonah Belonging Place. ECLC Staff 10 noted that amongst the array of issues facing First Nations communities, the relationship with ECLC is not the top priority:

> *There is so much Sorry Business going on. It's just this is just not the top of the radar for our First Nations communities and I don't think it's for want of relationship building and I don't think it's for want of not trying and on both parties. I just think it's where this potentially sits in the order of priorities for community. … We just need to live and walk alongside our First Nations communities and deeply respect what's happening for them at the moment.* (ECLC Staff 10)

Cultural norms may also be limiting Aboriginal and Torres Strait Islander older people from coming forward. Impact on the broader community and family relationships with perpetrators is a factor for many older people, as discussed below at 2.3.3, but may be particularly true where the older person does not trust the legal systems to treat their perpetrators fairly:

> *The victim… he or she is even more reluctant to own up to it, to admit to it, to put a finger and to name names because of the family – how the family is structured. … It's just this reluctance too – probably more than non-Aboriginal communities, "to put family members in" and admit that there's a breakdown because the community – the family unit is just so strong. … And that's why it's an even bigger shame when I see and hear some of the things that I see with – and particularly a lot of the younger ones that are coming along, they seem to be the ones that are perpetrating some of this abuse.* (External Stakeholder 6)

> In Aboriginal and Torres Strait Islander communities, the term 'Elder' is used to describe a person with community-endorsed cultural authority who may or may not be an older person.

Terminology may also be an issue. In Aboriginal and Torres Strait Islander communities, the term 'Elder' is used to describe a person with community-endorsed cultural authority who may or may not be an older person. This means the terminology of 'elder abuse' may or may not be appropriate in these settings[14] something recognised by ECLC:

> *I know that this is a very problematic term generally, but particularly for a First Nations community because of the different connotations. … we didn't think it was a great term at all, but we have to use it because of the recognised language within the areas that we work, and we're funded from AGD as an elder abuse response program.* (ECLC Staff 7)

The lack of referrals may also be due to the availability of Aboriginal specialist legal services, such as Djirra. External Stakeholder 1 suggested that Djirra would be more used to working with Aboriginal cultural sensitivities:

> *Djirra is an Aboriginal legal firm, and I think for her that's probably her first choice would be to go there rather than ECLC, and primarily I think that it's because it is an Aboriginal-controlled organisation and it has a lot of Aboriginal people working within that organisation and who have an understanding of the sensitivities around the cultural aspects of working with Aboriginal people and what their needs are.* (External Stakeholder 1)

There is no single factor that has led to the lack of referrals but a range of intersecting potential issues. External Stakeholder 6 noted that in the future, the community needed to be more involved in co-designing the service:

> *If the program were to be kept on, if you like, expanded in any way or whatever, I think that what I'd like to see, and the community would like to see, is to have some sort of a input into it and the way that we do that is – what has happened in the past is, there'll be various community events and Eastern Legal in this case, someone would come along and speak to the issue and so forth, and do – ask – and get input from the community. Now, obviously not every idea that people come up with can be put into place, but it's a – that would be a good thing, I think, to happen. … That would make it more effective if it's – well, we can come up with all of these great programs and, of course, if it doesn't fit the end user or the user, well, what's the point?* (External Stakeholder 6)

External Stakeholder 1 suggested an Aboriginal lawyer would be a useful addition:

> *Ideally it would be great to actually have an Aboriginal lawyer potentially or someone who was understanding of cultural needs. Not to say that ECLC aren't sensitive in that respect, but yeah, that would be an ideal. That's blue sky dreaming is to have an Aboriginal person who sits in or represents or works with our community, especially with our elders.* (External Stakeholder 1)

[14] 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>.

Research on preventing and responding to elder abuse in Aboriginal and Torres Strait Islander communities is scarce, with only two studies published to date. However, the South Australian Health and Medical Research Institute What keeps you safe: approaches to promote the safety of older Aboriginal people report outlines fundamental principles and values and a three-step process for underpinning community co-design that would be a valuable resource for working with Oonah Belonging Place and other Aboriginal community-controlled organisations into the future.[15]

> ***As the ROSE model is very effective in working with many non-Aboriginal and Torres Strait Islander groups, the evaluation team does not recommend fundamentally changing how ROSE works. This means a co-design process may need to consider a distinct program or approach that can be genuinely co-designed with the local Aboriginal community and Aboriginal community-controlled organisations*** **(Recommendation 7).**

2.1.3.3 Eastern Elder Abuse Network (EEAN)

As noted above, ECLC runs the Eastern Elder Abuse Network (EEAN), established in 2010, which predates ELSA and ROSE. The network consists of 150 individual members and has representation from 50 organisations, including local government, community health, legal services, police, aged care, hospital, women's health, primary care partnerships, state government departments, family violence, finance, ethno-specific and multicultural agencies, and other specialist services and organisations. The EEAN has two working groups, one focused on response and the other on primary prevention.

The EEAN is a manifestation of the way in which ELSA and ROSE are integrated into the broader health and community services networks. Nearly all referrals come from EEAN members, and there is an established feedback loop where the EEAN hear about ELSA and ROSE outcomes, further deepening understanding of the services and service model. Any service expansion outside of the Eastern Melbourne region should attempt to replicate this successful model (Recommendation 16.1).

2.1.3.4 Pro bono lawyers

ELSA and ROSE have developed strong relationships with private legal firms, including Norton Rose Fulbright, MinterEllison, Maddocks, Lander & Rogers, Hall & Wilcox and others. These partnerships have resulted in clear outcomes for ELSA and ROSE clients, particularly in cases involving property where the older person would be ineligible for support from other means-tested avenues. The support offered was often very substantial, with one example being $50,000 in legal fees, all funded pro bono. These partnerships are still being developed, with six clients accepted for pro bono matters, in addition to other pro bono support offered by the pro bono partners including training for ECLC staff, secondary consultations and other legal advice.

External Stakeholder 5, a lawyer who had provided pro bono services to an ELSA client, noted that the ongoing support from ELSA was crucial to the success of the legal case:

> ***They were quite involved, which I thought was really positive for the client, because she had so many different avenues of support, depending on what issue it was.*** **(External Stakeholder 5)**

The same lawyer noted that without ELSA's support, the client would likely have left the abusive partner and missed out on more than half a million dollars:

> ***What would have likely happened if she hadn't been referred to ECLC is she probably would have just left, and never know what her entitlements were, that she was even entitled to a property settlement.*** **(External Stakeholder 5)**

The partnerships with pro bono lawyers, while only recently developed, have already shown the potential to add a significant amount of value to ELSA and ROSE. Vignette 3 – Juanita highlights the value of these partnerships, as ELSA continues to support Juanita while she receives representation from the pro bono lawyer (Recommendation 16.4).

2.1.4 Secondary consultations

ELSA and ROSE provide secondary consultations, where they will provide information, advice and guidance to other professionals working with people who are experiencing or at risk of elder abuse. These are mostly telephone or online consultations. These interactions with other professionals also increase their knowledge and understanding of elder abuse and provide a screening process to ensure that referrals made to ELSA and ROSE are appropriate and that the service has the capacity to take on the client. External Stakeholder 2 noted this dynamic:

> ***I'll have clients and I'll actually talk to the advocate, doing a secondary consultation. If there are any more capacity for the ROSE team to take it up then I'll assist the client to make appointments.*** **(External Stakeholder 2)**

External Stakeholder 1 shared how much they valued the service as a whole, and particularly the secondary consultation function:

> ***I know that I can talk to anybody and tell them about – if I hear of anything from the client, or whatever, or if they tell you different stories, I can basically say, "Look, there's these programs for you." But even for me personally, I just think it's a fantastic service, absolutely fantastic service, and I'm really happy that we're affiliated so closely with an organisation that offers these sorts of programs, and I know that any time I've got an issue or if I hear of something or I have concerns or if I have questions, I can just get on the phone and I can talk to one of the girls down there and they'll help me.*** **(External Stakeholder 1)**

For ELSA, secondary consultations are provided to Eastern Health staff, mostly social workers, as shown in Figure 3. Most referrals for ELSA also come from social workers, given the central role they play in referring patients out of hospital, but there may be opportunities to work more closely with other Eastern Health professionals (Recommendation 6). ELSA has provided training on elder abuse to Eastern Health geriatricians and is working to develop broader links with Eastern Health. The value of secondary consultations is highlighted in the quote below:

> ***The secondary consult role with the hospital based service … I think that makes sense, it's really critical to have that expertise available on-site with the hospital staff; to try and pick up those matters where there's that window of opportunity while someone is actually away from home and in hospital, to disclose and to support staff to whom those disclosures are made.*** **(External Stakeholder 7)**

Figure 3 - ELSA secondary consultations

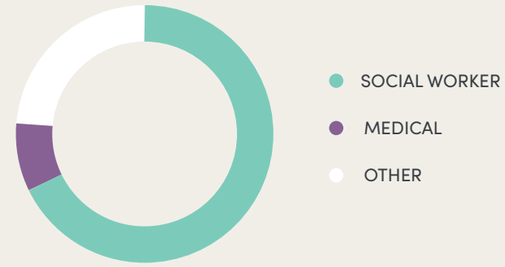


Figure 4 - ROSE secondary consultations

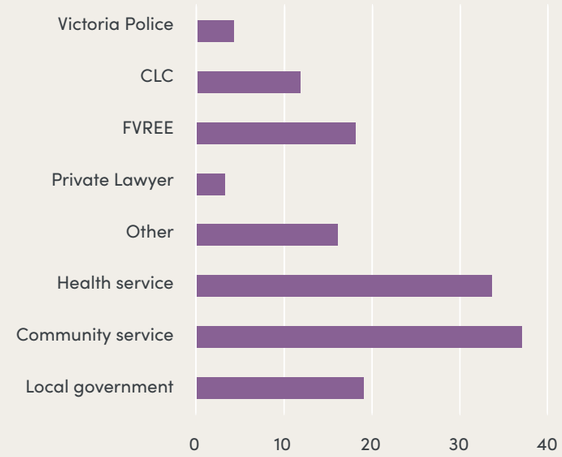


Figure 4 shows that ROSE is providing secondary consultations to a range of community organisations and other partners, roughly similar to the incoming referral profile.[16] The secondary consultation element of ELSA and ROSE is a key contributor to driving referrals and promoting understanding of elder abuse amongst the most relevant professionals and should be incorporated into any future expansion (Recommendation 16.2).

[15] Annette Braunack-Mayer et al, *What Keeps You Safe: Approaches to Promote the Safety of Older Aboriginal People* (Report, South Australian Health and Medical Research Institute) <https://create.sahmri.org/wp-content/uploads/2019/12/What-Keeps-You-Safe-Report_FINAL.pdf>.

[16] Note FVREE was formerly Eastern Domestic Violence Service (EDVOS).

2.1.5 Community education

ELSA conducted 74 education sessions, with 835 attendees recorded, largely Eastern Health social workers, with some medical, nursing or other allied health professionals or external community members. ROSE conducted 58 sessions with 1,392 attendees recorded from a wide range of organisations, including community services, councils, Aboriginal community-controlled organisations, and the general community. Topics included information about ELSA and ROSE, generalist awareness raising, information and education on elder abuse, specialist legal information on wills, powers of attorney, decision-making capacity, and financial counselling. Community education also drives increased referrals, improves the relevance of referrals, and should be continued in diverse and accessible formats, including for front-line staff in relevant public and community services (Recommendation 4).

ELSA and ROSE collected pre/post surveys at some community education sessions, whose results are shown in Figure 5, Figure 6 and Figure 7. These results are overwhelmingly positive, showing significant self-assessed changes in practice, knowledge and relevance, and pre/post improvements in understanding elder abuse. These results should be interpreted with caution due to the data collection methods used and the high risk of sampling bias. Despite this, they do indicate a very positive response from attendees.

Figure 5 - Community education survey responses

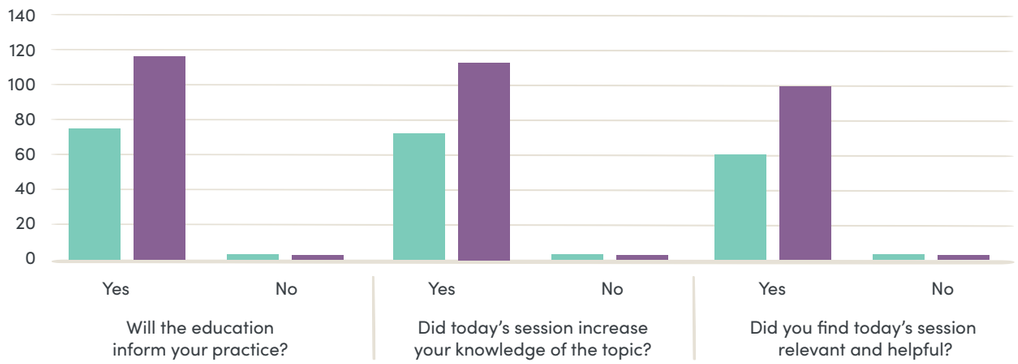


Figure 6 - ELSA community education

Figure 7 - ROSE community education

The community education roles of ELSA and ROSE are working effectively and are supporting the direct service provision and should be included in any future service expansion (Recommendation 16.3).

2.1.6 Prevention and early intervention

The evaluation team were asked to determine what impact ELSA and ROSE had on the prevention and early intervention of elder abuse, using the framework in ECLC's Elder Abuse Toolkit.[17] Both ELSA and ROSE are preventing elder abuse at the tertiary level in preventing abuse from re-occurring, as highlighted below at 2.3.2. There is also clear evidence that ELSA and ROSE support broader ECLC work on prevention and early intervention, mitigating risk factors and promoting positive attitudes, mainly by grounding that work in practice and the experience of older people. Community education work is also likely contributing to a growing awareness of elder abuse in the broader community, particularly among health and welfare professionals. Beyond this, no evidence was available that could be used to measure prevention and early intervention. By the time clients were referred to ELSA and ROSE, they were well past the primary prevention and early intervention stage. ELSA and ROSE should continue to support the primary prevention and early intervention work of ECLC (Recommendation 9) but should not be expected to do more than this. The work undertaken by other ECLC programs is clearly valuable, but a much broader, whole-of-society level approach is required to improve general community understanding of elder abuse and access to services, in the way that family violence campaigns have done in recent years (Recommendations 20 & 22).

2.1.7 Referrals

ELSA and ROSE play an essential part in generating pathways through the service systems that people require to address elder abuse. Referrals in and out have been significantly impacted by COVID-19 restrictions, and referrals from Eastern Health continue to be disrupted due to ongoing health service stressors.

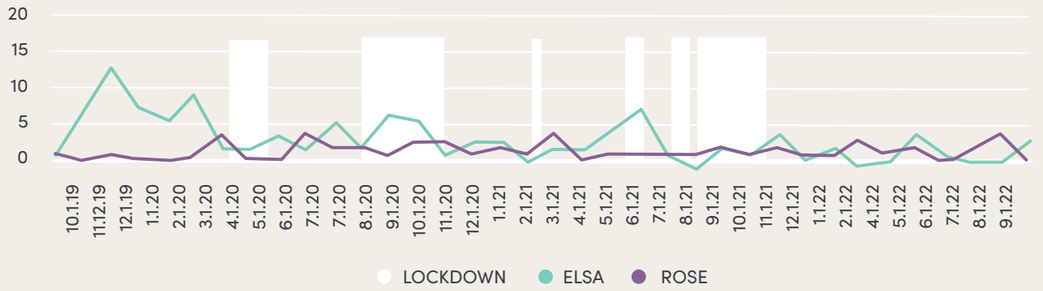
2.1.7.1 Referrals in

Figure 8 shows that the early growth in referrals achieved by ROSE was difficult to maintain after COVID-19 lockdowns began in 2020, but that otherwise referrals in have been fairly consistent over time. ELSA referrals have been lower overall for the reasons discussed at 2.1.3.1. ECLC Staff 5 suggested a direct link between lockdowns and referrals:

> We certainly found during lockdowns our referrals reduced but post lockdown they increased. Every service found that. But there were changes in lockdown and it was family members returning home because they'd lost their jobs, or family breakdown and these were the kind of factors that lay behind many elder abuse cases. So, we found an increase and I'm sure it's the same across family violence services as well. There was a rise in the number of cases. (ECLC Staff 5)

However, the quantitative data in Figure 8 show a more complex picture, with ELSA incoming referrals decreasing during and after lockdowns but also staying low through 2022 as Eastern Health continued to face staffing and other stressors. Note Figure 8 includes referrals that were not accepted and were referred to another appropriate service.

Figure 8 – Referrals in, per month



Despite this complexity, Figure 9 and Figure 10 show that ROSE is accessible by both service providers and self-referring older people and that ELSA is receiving appropriate referrals from a range of Eastern Health sites. The varied ways older people come to ELSA and ROSE are illustrated in the vignettes, with Andrea and Juanita referred by Eastern Health, John seeing a local newspaper advertisement, Kyaw referred by her council, and Linda referred by a friend at her church.

[17] Eastern Community Legal Centre, *Elder Abuse Toolkit - For Local Governments Working with Older People* (Report, Eastern Community Legal Centre, 2013) <https://eclc.org.au/wp-content/uploads/Elder-Abuse-Toolkit1.pdf>.

Figure 9 - Accepted referrals in by referrer

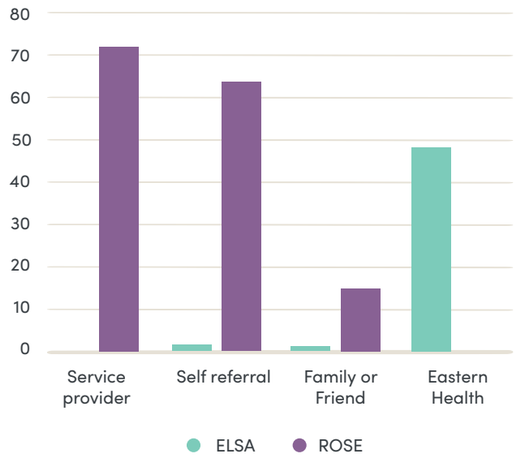
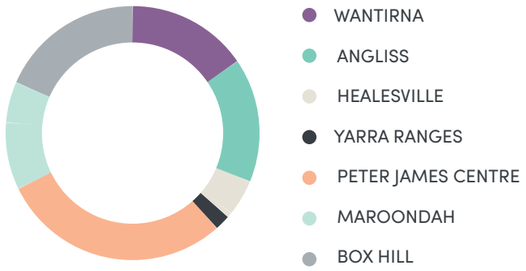


Figure 10 - Accepted ELSA referrals by Eastern Health site

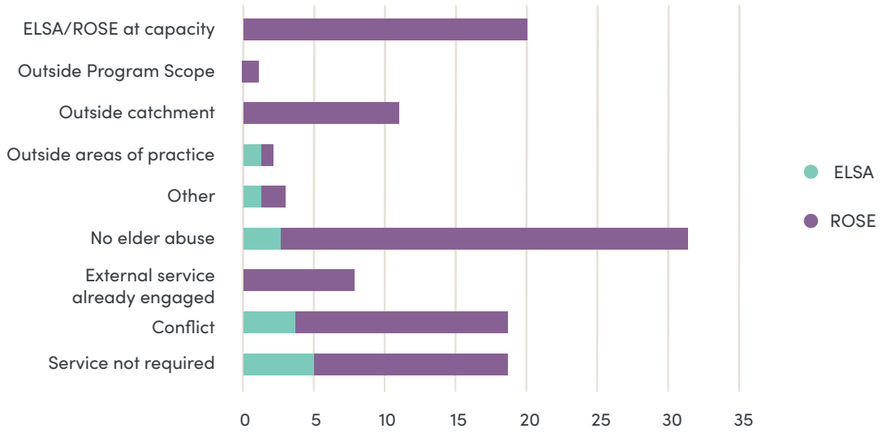


The qualitative data reflect this accessibility, with clients reporting referrals via the local council, police, family members and other community services such as EDVOS (now FVREE). Others indicated they had seen advertising on television (likely for 1800-ELDERHELP, which may have then linked the person to ROSE) or in the local newspaper. Others, such as ELSA Client 2, did not have to reach out for help but were approached by ELSA or ROSE through effective and integrated referral networks:

I didn't go – what amazes me is I didn't go looking, it came to me. So, I say, "I must've earnt this because it came to me. All this help came to me. It found me." That tells me I must deserve the help. (ELSA Client 2)

Given the association between elder abuse and social isolation, elder abuse services cannot rely on older people coming to them but must also seek to find older people who are disconnected and directly offer them support (Recommendation 22).

Figure 11 - Reason for referral not being accepted



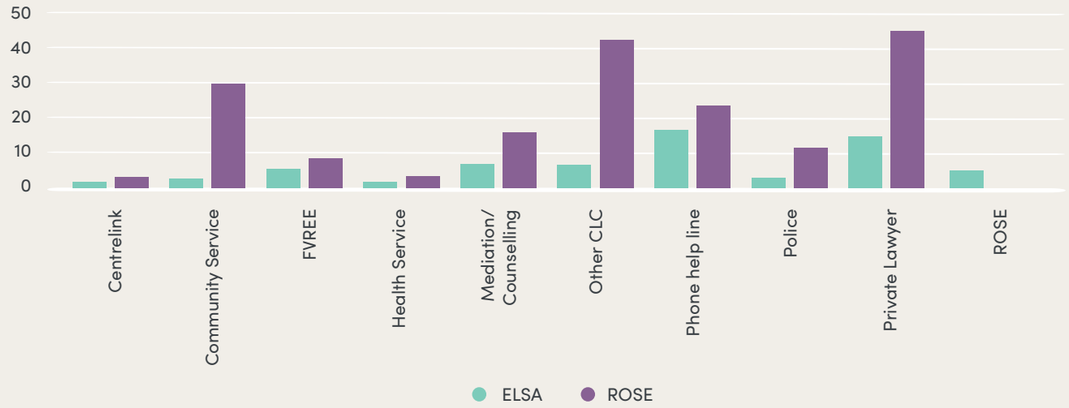
Referrals are generally appropriate, as shown in Figure 11, with some out of geographic area or out-of-legal-practice area issues referred to Seniors Rights Victoria or elsewhere as appropriate. Clear communication of eligibility criteria with Eastern Health has resulted in more appropriate referrals for ELSA. A substantial number (n=19) of referrals were unable to access the service due to legal conflict of interest, discussed below at 2.2.6.

There are many opportunities for further service promotion, but these activities have a resource cost, and for ROSE, which is generally operating at capacity, would only generate referrals that would not be able to receive service. For ELSA, the current approach of working with Eastern Health is appropriate. For future service expansion, participants raised a range of possible targets, including primary healthcare and mental health crisis services. There may also be value in promotion in other areas, such as hairdressers and faith leaders, who could play a role in identifying and linking people with services (Recommendation 21). The accessibility data, discussed at 2.2, also indicate some gaps in the incoming referrals.

2.1.7.2 Referrals out

Figure 12 shows that both ELSA and ROSE are making referrals to a wide range of relevant services. The discrepancies in referrals out in some areas are likely accounted for by the health-justice partnership. It is expected that ELSA clients would require fewer referrals to community services and other supports as they have already likely received social work support from Eastern Health.

Figure 12 - Referrals out



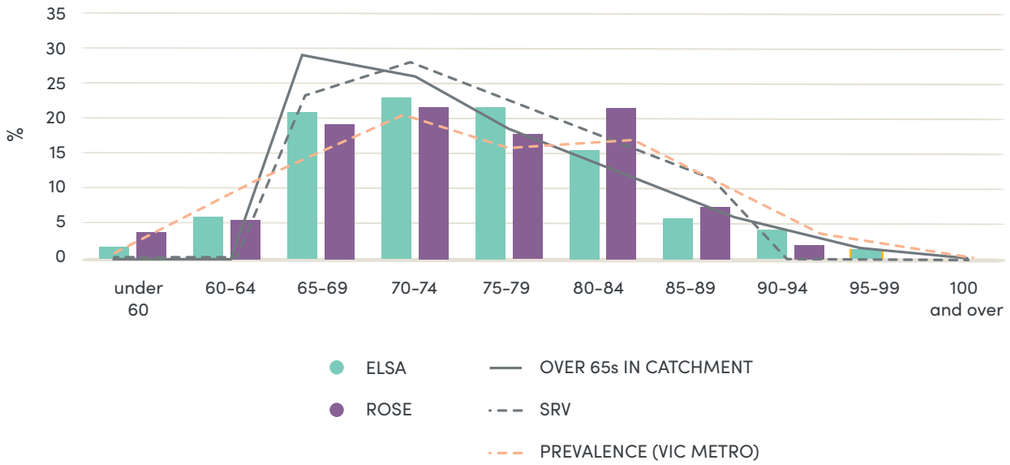
ELSA recorded 8 and ROSE recorded 41 warm referrals, i.e. referrals where the referrer contacts the other service with the person, ensuring the referral is received and acted on, rather than just providing contact details. Given the large number of referrals staff reported making, these numbers are likely due to data collection issues. ELSA and ROSE should ensure that warm referrals are made when appropriate and are correctly recorded (Recommendation 10).

2.2 Accessibility

In general, both ELSA and ROSE appear to be highly accessible to people seeking support for elder abuse. A small number of gaps were identified, primarily relating to people experiencing neglect or sexual abuse, people with sensory disabilities, and people who were not allowed access to the service because of a legal conflict of interest. These issues are explored in this section.

2.2.1 Demographic accessibility

Figure 13 - Client age



As shown in Figure 13, ELSA and ROSE are working with older people in age ranges consistent with both the population level demographic and the population profile of people experiencing elder abuse in Victoria's metro region. This profile is also consistent with Seniors Rights Victoria data, thus indicating good accessibility for all age ranges. Gender data are also consistent with the prevalence data for Victoria's major cities, as shown in Figure 14.

Figure 15 shows clients in comparison to Victoria police data on family violence responses involving older people aged 65 and over and the relative percentage of older people in the population. Police and population data correlated within a few percentage points, again a useful comparison with the service data. ROSE appears to be relatively less accessible to residents of Boroondara while ELSA is relatively less accessible to residents of Manningham.[18] The clients for other LGAs appear roughly consistent with the police and population data. ELSA should promote the service with Eastern Health programs servicing Manningham, and ROSE should engage with Boroondara council and local community services (Recommendation 8).

Figure 14 - Clients by gender

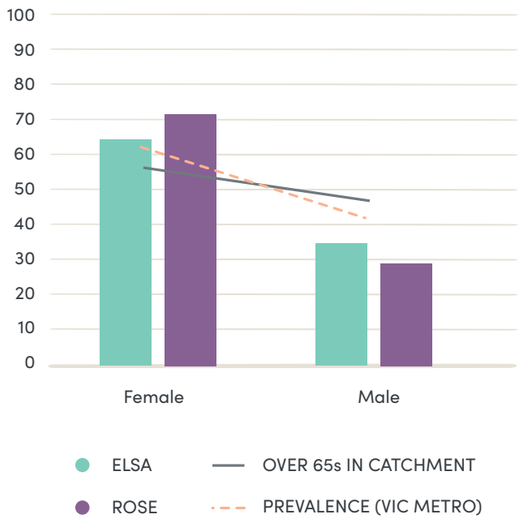


Figure 15 - Clients by location in comparison with police and population data

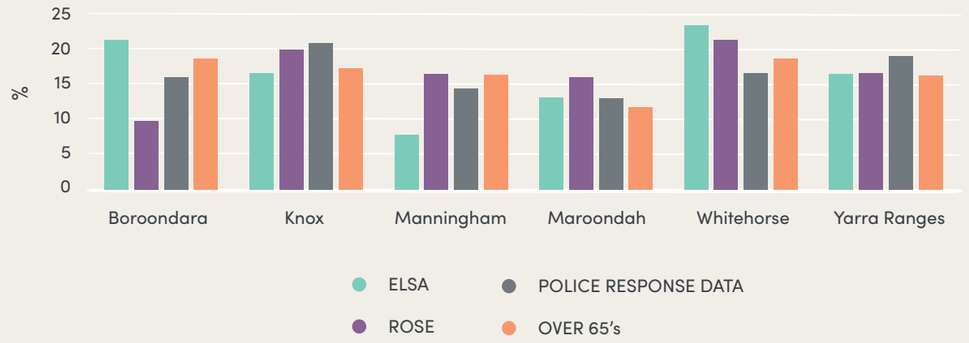


Figure 16 shows that ROSE is accessible to people who speak languages other than English at home at rates reflecting the Victorian major cities prevalence data, if not the population level data. Given the consistent underrepresentation of culturally and linguistically diverse communities in mainstream health and welfare services, this is an impressive achievement. Most common other languages spoken are Cantonese, Greek, Mandarin, Italian and Russian. No data is yet available to indicate if elder abuse is more or less prevalent in different cultural or linguistic groups.

Figure 16 - Language spoken at home

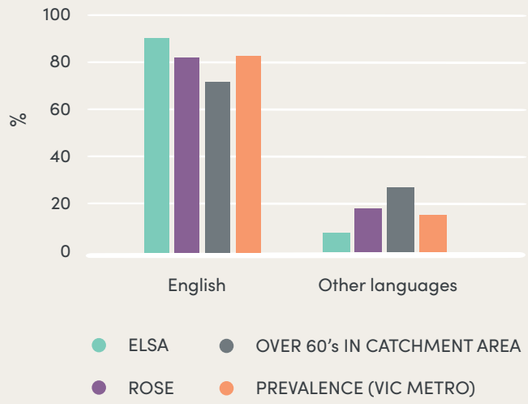


Figure 16 also shows that ELSA is not providing services to a representationally diverse client group. As ELSA relies on referrals from Eastern Health, ELSA should work with Eastern Health to increase accessibility for people who speak languages other than English.

There are two groups that are not represented in the data, Aboriginal and Torres Strait Islander older people and LGBTIQ+ older people. The qualitative data indicate that there are some Aboriginal and Torres Strait Islander clients who used the service but did not consent for their data to be included in the evaluation. As Aboriginal and/or Torres Strait Islander people over 65 make up only 0.2% of the population of over 65 in the catchment area, they are not technically underrepresented. Since Aboriginal and Torres Strait Islander people are a target group for the programs, as discussed above at 2.1.3.2, this requires more engagement with Aboriginal community-controlled organisations to explore future opportunities (Recommendations 3.3 & 7).

The best available estimates indicate that 3% of Australians aged over 65 are LGBTIQ+,[19] so the absence of LGBTIQ+ older people in the data does not necessarily indicate underrepresentation or service inaccessibility. However, ELSA and ROSE should continue to work to ensure equity of access for LGBTIQ+ people (Recommendations 3.7 & 3.8).

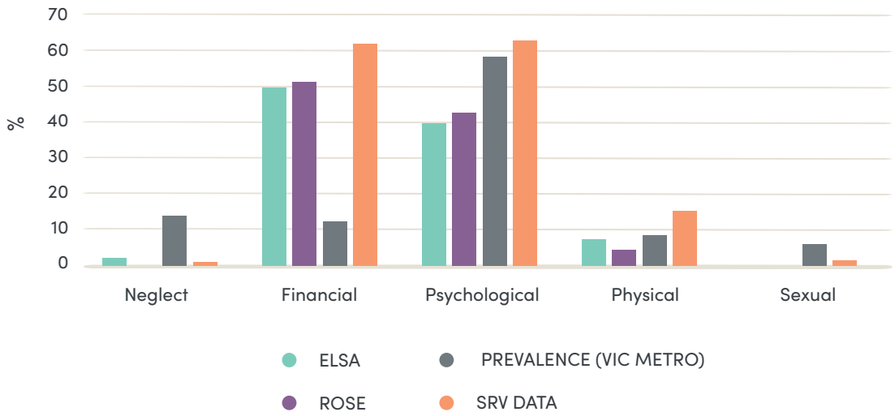
[18] This may be due to the Austin Health catchment, which overlaps with Eastern Health in Manningham and Boroondara.

[19] Australian Institute of Health and Welfare, *Older Australians, Older Australians Who Identify as Lesbian, Gay, Bisexual, Transgender or Intersex* (Report, Australian Institute of Health and Welfare, 2021) <https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/diversity/identfy-as-lgbti>.

2.2.2 Neglect and sexual abuse

Figure 17 shows that ELSA and ROSE are working with older people experiencing a range of abuse types broadly consistent with the prevalence data, Seniors Rights Victoria (SRV) data and the findings of the evaluation of all the Attorney-General's Department funded elder abuse service trials. There is some inconsistency between the ELSA, ROSE and SRV data and the Victorian metro prevalence data for neglect and sexual abuse.

Figure 17 - Abuse types experienced



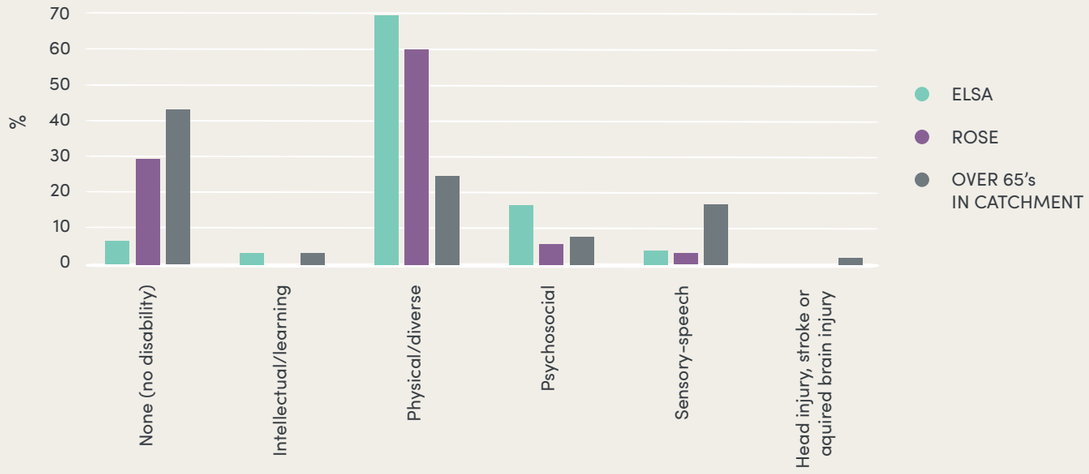
For neglect, this discrepancy is likely due to the prevalence study not relying on people to contact services themselves but reaching out directly via telephone to people in their homes. This may also be because the other types of abuse have more readily available legal solutions. An external referrer, having identified a neglect issue, may seek to provide aged care or other support for the older person rather than seek legal assistance to address the issue of neglect. This is particularly likely to be the case for ELSA, where Eastern Health social workers may support applications for aged care support.

For sexual abuse, it is likely that there is a combination of factors leading to ELSA, ROSE and SRV all seeing low or no referrals. These include stigma, low likelihood of convictions and other well-documented factors that lead to low levels of reporting for sexual assault for people of all ages. Older people are most likely to experience sexual abuse from friends (42.6%), acquaintances (13.7%) and neighbours (9.5%), with current partners at 9.2%, so it may be that this form of abuse is falling in the gap between the family violence and institutional abuse response systems. ELSA and ROSE should work with the EEAN to develop strategies, including education, to support accessibility for older people experiencing neglect and sexual assault where appropriate (Recommendations 3.1 & 3.2).

2.2.3 Health and disability barriers

The national prevalence data do not specify disability types but do show that older people self-identifying as having poor health and/or a disability are twice as likely to experience abuse. Using population data, Figure 18 shows that ELSA and ROSE are working with people with physical and psychosocial disabilities at or above population level rates. People with sensory and/or speech disabilities, including hearing and sight impairment, are significantly underrepresented for both services. People with intellectual and learning disabilities are not being seen at all by ROSE which is of concern given its community focus. The data also shows that neither service has been accessed by someone with an acquired brain injury (ABI). ELSA and ROSE should develop and implement an accessibility plan to ensure equity of access for people with communication impairments, learning and intellectual disabilities, and ABI (Recommendations 3.4 & 3.5).

Figure 18 - Clients by disability



2.2.4 Social isolation

The national prevalence data show that people living with a partner were less likely to experience elder abuse and that people with less frequent contact with family members and friends and a lower sense of social support were more likely to experience abuse.[21] Socially isolated older people are also more likely to experience neglect than other types of abuse. In nearly all cases, people who accessed ELSA and ROSE did so with the support of another non-abusive family member or through a health or welfare service. For those who do not have such supports or networks, ELSA and ROSE are not easily accessible.

It will always be more challenging to provide equity of access for socially isolated people. When the services are operating at capacity, such as ROSE often is, increasing referrals through intensive outreach, whilst important, can create workflow and response challenges. For future service expansion, the services should be resourced to be able to respond to all immediate need (Recommendation 15) and be promoted to broader community links, such as faith and cultural leaders, hairdressers, senior citizens clubs, libraries and other points of contact (Recommendation 21). Future initiatives for the safeguarding of adults should specifically consider social isolation as a barrier to access (Recommendation 25).

2.2.5 Capacity and supported decision-making

Many people who might benefit from ELSA or ROSE are also in the age group in which dementia and other cognitive issues may influence decision-making. Lawyers and legal services cannot work with people unless they can take instructions, and people can only give instructions about issues they have capacity to make decisions about. Although there are no quantitative data available to show prevalence, the qualitative data indicate that there are barriers to demand or access for people who have been assessed as not having decision-making capacity:

> ***Another barrier, I think is people with cognitive impairment. So, people who don't have capacity, but are experiencing elder abuse. Again, that's not a barrier to – I'm mean, we're restricted in our services to what we can do in that situation, because of the legal framework that we operate in.*** (ECLC Staff 6)

The qualitative data indicate some concern that potential referrers may not understand that capacity is decision-specific or that it can often be exercised with support and so assume that a person who has a guardian, administrator or power of attorney cannot give instructions:

[20] Inside Policy (n 6).

[21] Qu et al (n 3).

There's not enough intellectual discourse around capacity. We always – whenever we talk about capacity, people just refer to the person with dementia or whatever. But there are shades of grey in terms of capacity. So capacity where the person of course may not be able to make informed decisions on making financial investments or buying a property, but the person does have capacity in managing their household budget, their expenses, and things like that. So I think that's where in terms of – when we talk about capacity, sometimes we forget that people do have the right to make choices about the quality of their life and how they want to live their life, irrespective of the – irrespective of the cognitive decline they have, they are still able to make choices. (External Stakeholder 3)

An ECLC staff member who previously worked at a referring agency identified that they had previously not understood the complexities of exercising capacity:

I wasn't that informed about cognitive decline and legal capacity before I came here. I just thought you had or you didn't have – and I really liked the way that the lawyers and advocates and now myself, work with them. And that it's not black and white. It's you might be able to do this and you might struggle with that. So, work within that. (ECLC Staff 1)

Both ELSA and ROSE should continue to work to promote a more complete understanding of supporting capacity and legal capacity assessments in potential referrers (Recommendation 3.6).

The evaluation also identified a range of ways in which ELSA and ROSE work to support decision-making with their clients, for example, by bringing in other supports:

A lot of those cases, majority of them, there will be a supportive person, son, daughter, mostly daughter, supporting that person. … And we make sure that when we organise an appointment for clients that we also involve the support person. … We'll involve other organisations, support organisations to assist the client. They might be better equipped, trained counsellors or social workers, in an area where we'll also be assisting the client. And then we'll be working together as to how to assist that client. (ECLC Staff 3)

Or by using specific communication approaches to suit the person:

There's certainly consistent approaches that we use in terms of supported decision-making, like meeting with people certain times of the day, calling them, meeting them in person, seeing if they want a support person present – all those types of things and, yeah, so we do it all the time, but I think there's still opportunity for us to, like, have more consistent terminology across the team for sure. (ECLC Staff 6)

But there is no consistent or documented approach to supporting decision-making:

We're still using all of those tactics all the time in the way that we work, but I still don't see that there's consistent terminology that we're using in the team. (ECLC Staff 6)

For example, ROSE Client 4 needed assistance recording tasks, contacts and appointments:

I'm not a very organised person, paperwork wise and they'll give me a name and a phone number, … I would really love a list of who these people are – and I know it's up to me, but I'm just – I write something down and it'll be on the back of an envelope or something like that, and because I get this all the time, and I mightn't be quite where I need to be. (ROSE Client 4)

ELSA and ROSE should develop a comprehensive, consistent, and evidence-based approach to supporting decision-making to promote the ability of clients to make their own decisions wherever possible (Recommendation 12).

2.2.6 Conflict of interest

As noted above at 2.1.7.1, 4 ELSA and 15 ROSE clients could not access the service because of a potential conflict of interest. This occurs when ECLC has previously provided legal advice or representation to the perpetrator. In these cases, clients are referred to other services, including Seniors Rights Victoria. However, this represents an equity issue when ELSA and ROSE provide such a bespoke, targeted and high-quality service. ECLC does have a process for waiving conflict of interest considerations in some cases:

Let's say the person came more than seven years ago. They came for a night [service appointment with a volunteer lawyer], so just one-off and they've never come back again, and the issue is not – and it was not an elder abuse issue, and their other party at that time was not our person that we want to make a client. There's a process and it has to be documented and everything, but [ECLC Staff member] can then waive that conflict. That doesn't waive all conflicts of course that come through. There's still loads of conflicts. (ECLC Staff 7)

ECLC are doing everything they can internally to address this issue. However, there appears to be an option to reconsider the underlying policy, as Victoria Legal Aid has recently done with the support of the Victorian Legal Services Board and Commissioner. ECLC is aware of this, and the evaluation team recommend that ECLC work with the Victorian Legal Services Board and Commissioner, the Federation of Community Legal Centres and others to consider more equitable policy settings (Recommendation 24). Ultimately, the issue will only be solved when there are multiple, accessible, specialist elder abuse services resourced to meet the need in the community (Recommendations 18 & 21).

2.3 Client experiences & outcomes

The client experience was overwhelmingly positive, with 92% of clients who completed the internal survey agreeing that they felt supported by ELSA or ROSE. The client outcome data are more mixed, with the abuse and related issues addressed in approximately half of cases. The following three sections explore this dynamic, showing that the complexity of elder abuse, particularly where perpetrators are adult children, means that older people are often left with an apparently irresolvable and impossible predicament. The data clearly show that ELSA and ROSE are helping older people through this impossible predicament by increasing the options that are available to them, building their confidence and capacity to make informed decisions, and doing so in a way that is highly valued by their clients. However due to broader service gaps, system failures and structural challenges many older people remain unsafe and continue to live in circumstances where they remain vulnerable to abuse.

2.3.1 Client experience

Client participants in this evaluation shared stories of pain, shame and heartache that led them to use ELSA or ROSE. In many cases, the harm from the abuse was compounded by the abuser being someone they loved and trusted. Clients identified that the support they received from ELSA and ROSE was what they needed to support them through this distress:

And oh my God, I can only use one word. It's fantastic. They were absolutely – my heart can cry for it, but I won't cry now because I learnt not to cry when it's – you know, happy emotions. But God, it's like – I call them all my angels. And I think if it wasn't for them, I don't even think I'd be here. I'd be maybe in a mental hospital, maybe committed suicide, maybe overdose myself. Maybe just ran away and just left everything, (ROSE Client 10)

This feedback was consistent across both ELSA and ROSE:

They were marvellous. They were really, really, so good. (ROSE Client 4)

I just think it's invaluable. … I just can't speak highly enough of it to be honest. I really can't. (ELSA Client 2)

The positive experience is also consistent across all demographic groups, including commonly discriminated against groups such as people who speak languages other than English at home. Part of the explanation for the positive assessment is the time taken with each client, which allowed for trust-building, trauma-informed practice:

Coming in to meet someone who's been through a trauma... they were very, what I call very tactful. They were very aware and very concerning about how they spoke and how they mentioned things, and how they could help me with a nice tactful way, I think. An understanding way is probably the best answer. An understanding way, how they approached me and how they spoke to me and that sort of thing. (ELSA Client 1)

ROSE Client 2 also reflected this:

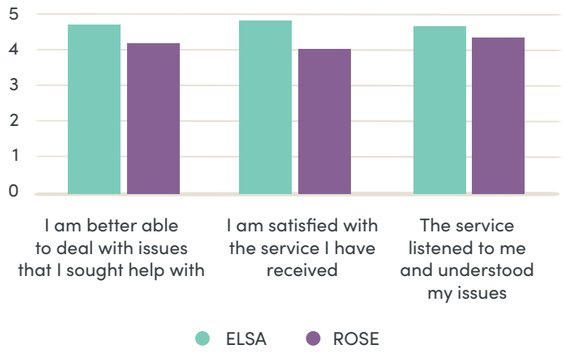
It was really just to make me feel that there's someone there that's in my corner, there's someone there that understands what I'm going through. ... although you had never met, they were there to say, "Look, we are here. We understand. We understand what has happened. And we will do whatever is we can." So that was really moral support via phone. And I really appreciate that, yes. (ROSE Client 2)

This sense of trust was essential in building relationships that could lead to positive outcomes. Older people experiencing abuse will not work with services they do not trust.

The high satisfaction levels are also reflected in the qualitative data, with SCORE data shown in Figure 19. Clients are asked to rate their answer depending on how much they agree with each statement. This is consistent with the internal survey data.

Only one evaluation participant, ROSE Client 9, had negative feedback about an aspect of the service. The client had expected a lawyer to contact her to follow up, but an advocate had contacted her instead. This may reflect a breakdown in communication or perhaps the client's misunderstanding of what would happen following contact with the service.

Figure 19 - SCORE client satisfaction



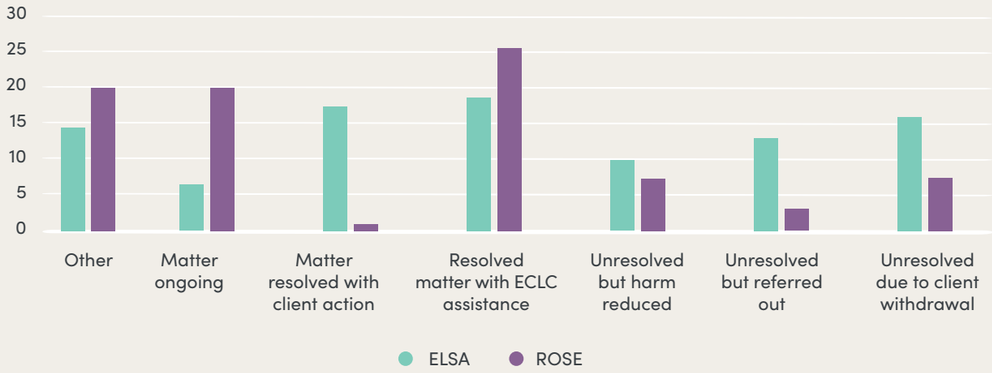
2.3.2 Client outcomes

Despite the high levels of satisfaction evident across all data sources, client outcome data are much more mixed. Internal survey data show that while only 8% of clients did not feel supported by ELSA or ROSE, 23% were no safer than they were before using the services, and 21% were negative or ambivalent that their abuse had been addressed. This is also present in the qualitative data, where only half of the clients interviewed identified that their abuse was resolved. The outcome of being satisfied with the service despite the abuse they were experiencing being unresolved is reflected in the following comment:

We don't expect any agency to be able to solve a lot of people's problems. It's not really the way it works, is it? But I think they're – they seemed very understanding and sympathetic towards the complexity of this kind of thing. (ROSE Client 6)

The following data illustrates the spectrum of outcomes experienced by ROSE and ELSA clients. This data, collected by ELSA and ROSE staff, shown in Figure 20, shows 18-25% of client outcomes were resolved with ECLC assistance. Excluding situations where matters were ongoing or 'other', 48% of ELSA and 59% of ROSE cases were resolved.

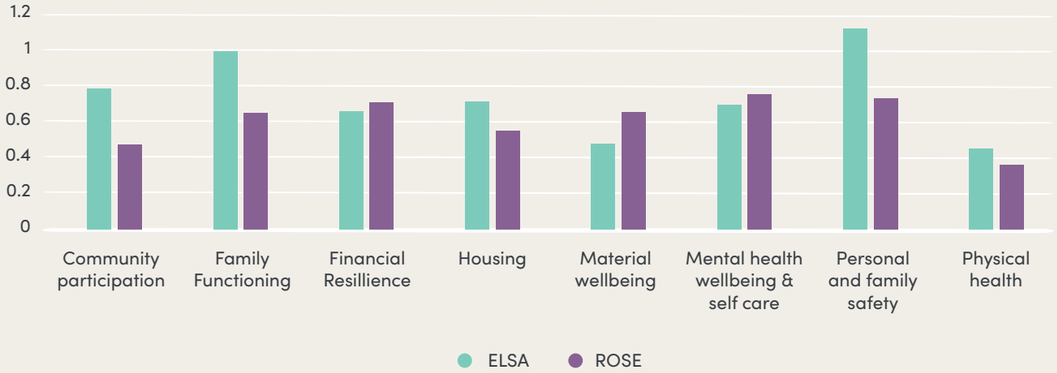
Figure 20 - Client outcomes



Despite the mixed outcomes data, Figure 21 which presents SCORE data pre/post change, shows dramatic improvement in all areas, with an average improvement of 15% for ELSA clients and 12% for ROSE clients. This is also consistent with the findings of the evaluation of all the Attorney-General's Department funded elder abuse service trials, which showed higher levels of improvement for health-justice partnerships (such as ELSA) than for specialist elder abuse units (such as ROSE).[22]

Attorney-General's Department guidelines require that the SCORE outcome and circumstance data are assessed by ELSA and ROSE staff, not self-assessed by clients, and so these should be interpreted with caution. SCORE satisfaction data are collected from clients by ELSA and ROSE staff through the client questionnaire following closure of the client file, so they are much more reliable. Future outcomes and circumstances assessments should be conducted by or with clients rather than unilaterally assessed by staff, with additional protections to protect the data from bias (Recommendation 26).

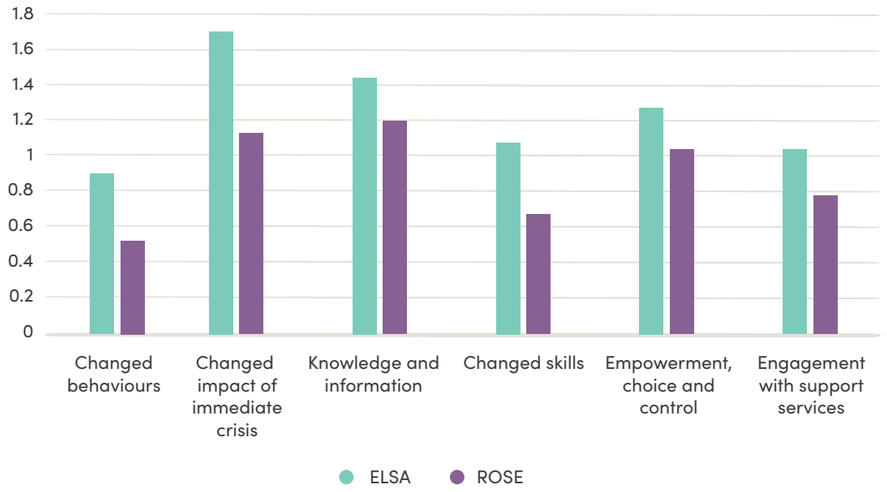
Figure 21 - SCORE average improvement (client circumstance)



A similar pattern is evident in Figure 22, where there is a substantial pre/post improvement in every domain and an average improvement of 25% for ELSA and 18% for ROSE. As with Figure 21, Figure 22 shows outcomes as assessed by ELSA and ROSE staff, not self-assessed client data, so they should be interpreted with caution.

[22] Inside Policy (n 6).

Figure 22 - SCORE average improvement (client goals)



The evaluation team also conducted a cross-tabulation analysis to determine if outcomes were impacted by demographic variables or the different experiences of abuse. These included gender, language spoken at home, interpreter use, abuse type and perpetrator type. Those speaking languages other than English, women and those experiencing physical abuse all had slightly greater SCORE improvement, but none of these analyses were statistically significant.

Taken together, the available data indicate that roughly half of clients achieve an outcome that either ends the abuse (such as eviction or separation) or resolves a consequence of the abuse (such as reclaiming money or property). Still others had some areas of improvement, but the abuse or other issues remained unresolved. For those who did achieve an outcome, these outcomes were often very substantial. The remainder of this section details these outcomes, considering legal, social and intangible outcomes.

2.3.2.1 Legal outcomes

As ECLC is a community legal centre, all ELSA and ROSE clients presented with a legal issue, although clients were not always seeking a legal outcome. Legal matters commonly related to policing and criminal justice, powers of attorney, intervention orders, evictions, Victorian Civil and Administrative Tribunal or Victims of Crime Tribunal, or legal letters to perpetrators. Will disputes and family law were also commonly raised, but often referred to other legal services as these are not generally within the scope of ECLC's practice areas. These were often complex cases, without clear documentation, and often involving substantial sums of money or other property. ECLC Staff 3 explained the variety of work they might do:

> *Empowerment in explaining clients' rights and, again, doing the case work for them. The situation where one client, a few years ago, gave her son and her daughter-in-law a loan and they were refusing to pay. We took that matter to VCAT on behalf of the client. Fortunately, the matter was resolved prior to the VCAT hearing. Some clients, well, quite a few, we have been able to have their son evicted from the property. We sent letters. In one case we were able to involve the police. It was a case where the client contributed a lot of money, about $500,000, whereby assisted the son to build a house and a granny flat behind. The son was going to use the house, mum use the bungalow. And the relationship broke down. So, we had to now assist the client. We got some money, were able to assist the client with a new agreement, because the initial agreement was just verbal. Nothing written down. So, we've had a few of those cases.* (ECLC Staff 3)

Often, legal outcomes resulted from the empowerment that came from having a better understanding of the legal system, as was the case for ROSE Client 10:

> *We're just waiting for the settlement to be finalised. The divorce has gone through. And then we're just waiting for the house to be settlement. He wants to only give me 30%. And he wants to take 70%. So [ROSE lawyer] said, "No, it has to be 50/50. You stand there and you wait and fight. We're going to stand there for you."* (ROSE Client 10)

In nearly all cases, without the intervention and support of ELSA and ROSE, a legal outcome could not have been achieved.

2.3.2.2 Non-legal outcomes

Many non-legal outcomes were financial, with substantial sums able to be reclaimed or protected following the intervention of the financial counsellor:

> *Initially, we tried to remove the access [to the online banking system]. The daughter's name and authorisation was removed although the card is in the lady's name then later on we find out she got access again. I couldn't figure out why but I did have suspicion that she has got the recovery number so she's kind of able to change the password and that sort of thing so she can regain access. Later on the access got permanently removed again, safe and sound and that time was make sure it was done right and making sure the bank manager was aware of the matter.* (External Stakeholder 2)

Other common outcomes which resolved client issues were social support and assistance. Rose Client 10 described this as "linking like a tree, like a branch":

> *ROSE program helped me to get more help through [family violence counselling and support service] to get a social worker, to get – in fact they even, through the ROSE program, financial assistance. And one linked to like a tree, like a branch. To every branch. And EDVOS if I wanted anything, they're over there and trying their best. The best which way – whichever way they could help us.* (ROSE Client 10)

Housing was a commonly raised issue, particularly for older people who technically owned their own homes and were often ineligible for housing assistance but, as a result of the elder abuse, were not able to live at those properties. A number of examples provided related to older people living in substandard outbuildings on their own properties while the perpetrator occupied the main house.

Positive outcomes included the eviction of the perpetrator, but in some cases, the older person had to move out to another property for their own safety, or into an aged care facility.

ELSA and ROSE also provided safety planning, such as with ROSE Client 5:

> *I certainly didn't know that I did need the type of help that I did get, with making myself safe and – I did also take their recommendations that they made to have a bag handy that I could grab and get out quickly, and a whole lot of things around that. Making sure that I knew where I could go in an emergency. Making sure I could lock my door securely.* (ROSE Client 5)

As discussed above, at 2.1.2, the integrated practice model does not just provide legal and non-legal services, but the services work together to support the person to achieve these outcomes. By providing these non-legal supports, legal outcomes could be achieved, and legal support could lead to non-legal outcomes. By supporting a person to be safe, supported and housed, ELSA and ROSE support the person to be in a position to be able to take action, including legal action, that they could not take otherwise.

2.3.2.3 Intangible outcomes

In addition to the tangible legal and non-legal outcomes, client participants identified improvements in their self-esteem and a general feeling of being supported, feeling less alone or feeling hopeful. These outcomes overlap with the positive client experience but are distinct outcomes which were often valued as highly by clients as legal or other more easily defined and measured outcomes. This was the case for ELSA Client 3:

> *She said, "Tomorrow I'll organise for a lawyer and advocate", and she did that and they actually – it was actually good because since then my life turned around with the advice I got from them, the advice I got from them, the support I got from them. It was pretty good. I mean, my self-esteem went up because at least I find someone who can help me.* (ELSA Client 3)

ELSA Client 2 had similar reflections:

> *It was just such a pleasure to talk to people who weren't bullying, weren't abusive, they just spoke as if I was a human being and that was so nice, so good. Just so good. So, it meant a lot to me, it meant a great deal to me and in the time I've spent speaking with [ELSA advocate] and the lawyers, it really gave me hope.* (ELSA Client 2)

ROSE Client 10 noted how important it was that ROSE was available when required, and the sense of safety that brought:

> *[ROSE lawyer] used to tell me that if you have anything that you want help, you can just call [ROSE advocate] and [ROSE advocate] the social worker was always there. So they're really a good team.* (ROSE Client 10)

External Stakeholder 6 had also observed the positive impact that ELSA and ROSE had on people's sense of well-being due to finally being heard and given a 'voice':

> *They've given people a voice, people somewhere to go and to have themselves be heard and being heard and being offered the help, their lives have changed. And the sad – and the happy part about that is that some people – I mean, they put up with this abuse for years and years and years, this abuse. And within perhaps a few weeks or a few months, this burden's been lifted because it's been shared, because it's been shared by people that care, professional people that care and they're not just paying lip service to you because that has happened quite a lot in the past. But you're being listened to and as I say, in a gentle and caring way, but you're being encouraged that your opinion counts, your life counts, your life experience counts. It's a – I think they're wonderful programs because of the opportunities that they give.* (External Stakeholder 6)

There are many examples of these kinds of outcomes in the qualitative data. They are important in their own right and are essential to older people feeling supported and understanding their options. They may also be necessary precursors for taking action to end the abuse in the future, even if they did not do so initially.

2.3.3 Factors impacting client outcomes

Without comparative data, it is not possible to assess if approximately 50% of clients having their issue resolved should be evaluated as "success". Instead, this needs to be understood in context through evaluating the outcomes data in light of the complexity of the lived experience of elder abuse and the lack of support and service options for older people and for perpetrators. The evaluation team conducted a cross-tabulation analysis to ascertain what, if any, quantitative indicators might be linked to outcomes data, but none could be determined with confidence intervals above the probability threshold for statistical significance. It does not appear that type of abuse, relationship to the perpetrator, gender of the perpetrator, or any other characteristic resulted in ELSA and ROSE being more or less likely to support the person to resolve the abuse or achieve other outcomes. Instead, the overwhelming complexity of the issues, which often include multiple perpetrators, multiple abuse types, and intersecting issues of gender, language, culture, historical and socioeconomic contexts, make drawing simple links difficult, if not impossible.

However, two issues consistent with the quantitative data repeatedly emerge in the qualitative data; the impossible predicament older people face when experiencing abuse perpetrated by close family members and the lack of supports and service options that might prevent or ameliorate elder abuse. In this section, we examine these two issues and explore how ELSA and ROSE build older people's capacity to make informed decisions.

2.3.3.1 The impossible predicament

Many evaluation participants raised the issue of 'reluctance' to take action or that older people might 'choose' not to take action. As the evaluation team interrogated this notion and heard from older people about their experience, it became clear that 'reluctance' and 'choice' were not reflected in this lived experience. Older people described impossible predicaments in which they were deprived of any notion of agency or choice, but instead forced to react to circumstances beyond their control. Often, the predicament had emerged over years, sometimes decades, of abuse as the older person's deteriorating health and function, or changing housing or financial circumstances, played a role in them seeking advice. Abuse was sometimes intergenerational, with children sometimes stepping into the role of abuser when their father passed away. This complexity often put older people into impossible predicaments where they felt they had no choice because the consequences of enacting the limited available options only compounded the difficulty of the situation.

Most often, the predicament was linked to the relationship with the perpetrator, care for that person, and concerns regarding implications of action for that person. This impossible predicament is described by ROSE Client 9 in their account of why they declined to take an intervention order out against her son:

> *I thought what am I talking to a lawyer for. The social worker was coming too from point of view of getting an intervention order. I said, "I won't do that." She said, "But why won't you?" I said, "Because if I do that, my son's work in the career, he does would be over. That'd be finished, his career."* (ROSE Client 9)

Nearly all ELSA and ROSE clients were experiencing abuse from a close family member or an intimate partner, as shown in Figure 23. The dynamics of power and control that characterise intimate partner violence were often present for clients who participated in the evaluation, but additional, more complex dynamics emerged when the perpetrators were adult children. Participants consistently identified more concern for their adult children than for themselves. ROSE Client 5 reflected on this predicament:

> *Especially in a situation that's a bit complex. Because when you're dealing with a mentally unwell person, it's not just yourself you've got to be concerned about; it's the other person. More than if it was, say, you're living with an abusive husband and you just want to get out, and you just need help around that – it's fairly – more straightforward. I'm not simplifying anybody else's. I've been in that situation too. But it is more complex with somebody who is also dependent on you.* (ROSE Client 5)

This can feel frustrating for staff, who see clients make what appear to be inexplicable 'choices' which leave them unsafe. The older people, however, were exercising a kind of agency by prioritising their adult children's welfare over their own. The older people were also very aware of the bind they were in:

> *They all did their jobs as far as I'm concerned. It just comes back to us.* (ROSE Client 1)

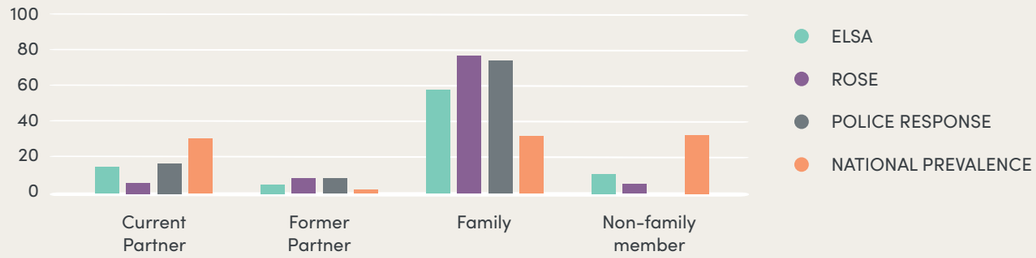
And:

> *The advice I've taken on board, but I haven't done anything that the lawyer suggested I do. Well, it was only a suggestion and it was there – he gave me his advice to help me through, working on – working for me, you see, in defence of me, I suppose. But, no, I haven't pursued anything or any advice that they had recommended.* (ELSA Client 1)

Shame also played a large part in constructing the impossible predicament. Clients were socially isolated, unable to take action because doing so would result in their communities knowing they had been abused:

> *And losing all my friends because I had them all with my ex-husband, and there was no way that I could feel I could trust some of them or most of them. So I just had to move away from all of them. Because everybody likes to talk.* (ROSE Client 10).

Figure 23 - Primary abuser by relationship



Safety was also a factor. Clients noted that taking action may result in retaliation from the perpetrator. ROSE Client 5 described taking the safety measure of doing the evaluation interview and accessing ROSE services from their car, away from their house, to avoid their daughter overhearing. Even this concern for her own safety was mixed with concern for the consequences for her daughter. As she reflected:

> *I had this fear that if I did anything like that, it would end up worse than ever. ... So I was fearful that things I did to look after myself in the short-term, would make it worse for both of us in the longer-term.* (ROSE Client 5)

Furthermore, when clients did take action, they were often left emotionally impacted by the consequences of the action they did take, often due to important relationships being lost:

> *I went to the police station and they interviewed me and they went to court and got an order that he had to vacate the house. .... So, when the due date came, my son and I came to the house and [Husband] was still there and he just refused to go so we just quietly left and we went back to the police and they came and removed him. It doesn't give me any joy to do that.* (ELSA Client 2)

Outcomes such as these, where the abuse ends but so does the relationship, were characteristic of the 'successful' outcomes identified in the data. Ultimately, as ECLC Staff 10 noted, the system does not provide the kind of resolution people often wanted, where the abuse would end but the relationship could continue:

> *We have... an adversarial system that is not designed to bring people together. It is designed to tear people apart, essentially. That model is where the problem lies for me, not in the model of ROSE and ELSA. We're operating within a framework that's requiring us to have that model.* (ECLC Staff 10)

This does not reflect poorly on ELSA or ROSE. In fact, given the limited options available, the high levels of client satisfaction with the service indicate that ELSA and ROSE are performing exceptionally well to achieve any outcomes for people in such apparently irresolvable predicaments.

2.3.3.2 Lack of support and service options

The impossible predicament outlined above was exacerbated by systems failure and lack of support and service options for both clients and perpetrators. Common examples related to lack of housing, mental health support and mediation services. Both ELSA and ROSE clients highlighted these service gaps when explaining the chronic nature of their abuse and the complex factors that contributed to it. As outlined above, this often contributed to inaction when the perpetrator was an adult child and the parent's concern for their wellbeing outweighed their concern for their own wellbeing. This complexity was very present for ROSE Client 1, who could not agree with their partner to evict their son, and so the son was still living with them:

> *They could come in and take him back to the police station or back to the hospital and talk to him, and then he'd be let out and he'll come back home again, and you've still got the same problem. It doesn't go away.* (ROSE Client 1)

ROSE Client 1 described a range of options that would resolve the abuse, including housing and mental health services, which are well outside the services provided by ELSA and ROSE. ROSE Client 5's abuse would also have been resolved if housing was available for their daughter:

> *I found that things like getting a restraining order or getting the police around, they weren't – that had a whole lot of other problems around it. Or kicking her out, a whole lot of other problems. Because there was actually nowhere for her to go, and that – so it was – I could have got emergency accommodation, but I couldn't get her into other accommodation. So there was problems around that.* (ROSE Client 5)

ECLC staff also noted this issue:

> *Her decision to say, "No, I don't want him to move out" was based on that. I think we should provide a lot of the services to make it easier for elderly clients to make a right decision, not to be thinking about "If my son is removed, he's going to be homeless." Because that's why they say, "I don't want my son or my daughter to be homeless." But if they were assured that their daughter or son is not going to be homeless, I'm sure they will easily make that decision, that, "Yes, I want him removed from my house."* (ECLC Staff 3)

A number of clients expressed a desire for mediation, but staff indicate that it is unlikely to work in many of these cases, given the point at which clients were referred to ELSA and ROSE. This suggests that mediation may be more effective as an early intervention strategy, although many evaluation participants identified that perpetrators would be unlikely to consent to participate. ROSE Client 7, however, still thought mediation would work to improve the relationship with the perpetrator:

> *It would have been better if there was some mediation or support to improve communications [with the perpetrator]. That's the problem. In a lot of ways it's like talking to a brick wall; you just don't get anything back.* (ROSE Client 7)

Mediation appropriate to elder abuse contexts is not widely accessible[23] Although the results of other Attorney-General elder abuse service trials that were funded to provide mediation services show that mediation was a viable option in those settings, mediation was the least valued of the service trial models, with legal advice, legal and social supports, connection to services, counselling and financial support all more highly valued.[24] Family group conferencing could be a viable option, [25] and family therapy may be useful even in cases where perpetrators did not consent to participate (Recommendation 18).

Services for older men were particularly lacking. While the family violence service system has well-developed responses for women experiencing intimate partner violence, these services were either not available to men or were unsuitable for older people:

> *I seek help from some other organisations like 1800RESPECT I went. I went to Safe Steps. I went to Relationships Australia, none of them would help me. ... Actually, one of them actually told me that it's only for women and kids there and I said, "What about us? The rest of us?" I appreciate the fact that women and kids are more vulnerable but there are some situations like mine that it was sort of pretty serious. I was lucky because one of the girls over there told me that, "Look, I'll give you a number and they can help you", and she gave me the number of ROSE.* (ELSA Client 3)

Vignette 2 – John, is the quintessential example of this gendered experience of family violence services. External Stakeholder 3 noted that, in the absence of other viable options, ELSA and ROSE are all that is available:

> *I think that's where ELSA and ROSE have that very strong part to play, but they are only one – as mentioned, they're not the only ones. They're one piece of the puzzle. But they're also an important piece of the puzzle. Because right now, I think they are playing multiple roles in the absence – because there's a vacuum around that. So until we fill that vacuum with other supports, other preventative measures, that's where we see ECLC will probably just have to be the standalone, the be all to everything in the elder abuse space, because there isn't anyone else. I can't think of anyone else undertaking elder abuse support or awareness or whatever.* (External Stakeholder 3)

Until appropriate services and supports are available, both for older people and perpetrators, ELSA and ROSE will be limited in the outcomes they can achieve. Elder abuse will not be resolved without resourcing for services to fill the gaps identified above, acknowledging that as a legal service ECLC is limited in terms of the scope of its services and its policy advocacy (Recommendation 19).

2.3.3.3 Building capability to make an informed decision

Despite the gaps in support and service options, the data clearly show that ELSA and ROSE are increasing access to supports and service options that are available and building capacity for clients to make informed decisions. Building on the high levels of client trust and satisfaction discussed at 2.3.1 and the intangible outcomes discussed at 2.3.2.3, ELSA and ROSE were able, over time, to support clients to take action to resolve abuse. ELSA Client 2 described this process:

> *They just advised, they gave me my options, the choices, my options so because I wasn't leaving my house, I didn't have anywhere else to go. ... It really gave me some hope and I was even building strength that whatever the outcome, if I had to leave or what, I was gaining the strength to be able to do that only because I had that support there, it was the support that I needed.* (ELSA Client 2)

[23] Annie Herro et al, 'Elder Mediation Services Among Diverse Older Adult Communities in Australia: Practitioner Perspectives on Accessibility' (2021) 61(7) *The Gerontologist* 1141.

[24] Inside Policy (n 6).

[25] Blundell and Clare (n 12).

Time was a key factor in this process, with clients describing a long journey to a place where they could take action:

> ***Knowing that the ROSE program is there for people like us, I never knew that. So I never had the ability and the courage prior to that to do what I did. Took me so long.*** **(ROSE Client 10)**

For others, time was a factor insomuch as the issue was not yet a crisis point, but it was important that ELSA and ROSE were available when the crisis came:

> ***Unfortunately, in our situation they can't really help. In the long run, maybe they can. … Only time will tell.*** **(ROSE Client 1)**

ELSA Client 3 described how this actually happened, so when the situation escalated to a crisis at which he did take action the ELSA lawyer was available to provide the support needed:

> ***And he even came to the court with me and helped me on that aspect. And I can tell you, since the intervention order was in place things changed around 100%. … In the past police advised me to do that as well but at that time I wasn't sure. I said, "It's my wife." I didn't want to put an intervention order against her. But thing became worse and worse so we ended up putting it in and it works out well.*** **(ELSA Client 3)**

External Stakeholder 7 reinforced the role ELSA and ROSE play in supporting people to take action and being ready to support their choice when and if the time came:

> ***In a lot of cases, we find that people don't want to take legal action. So, there can be a whole range of reasons why that's the case and so if you have an outcomes framework where – what is it that you're trying to achieve? Is it that people are aware of their options and have the support that they need to take that next step? To take action, if that's what they choose to do now, or they may choose to do it later.*** **(External Stakeholder 7)**

Within the limitations of context, it is clear that ELSA and ROSE are providing an essential service to people by increasing their access to options and supporting them when they do take action. It is clear from the qualitative data that but for ELSA and ROSE, many clients would not have taken the action they did, even at the point of crisis.

2.3.4 Unresolved issues

Despite the well-documented success in achieving outcomes for many clients and the key role ELSA and ROSE play in building capacity, some clients will navigate their impossible predicament through inaction. Many of these clients will remain unsafe or have their issues unresolved. For some, the actual abuse is no longer being perpetrated, but they are left with the consequences of the abuse. This could be financial:

> ***I doubt that I'll be getting any money back, that's for sure. All my super's gone and other money I – it's all gone. I'm literally on the pension. I've got two loans being held against the property I'm living in by the bank, so when I sell I won't get all that money back, so I'll be limited with what I get back. So, it's a situation – I thought retiring was going to be one of the best times of my life and it's actually turned out to be the worst time of my life.*** **(ROSE Client 9)**

Or emotional and psychological damage that could not be healed:

> ***They did sort of support me on their way and they actually referred me to the Victims of Crime and they worked with me for about a year with an advocate and a psychologist but the thing is nothing was changing.*** **(ELSA Client 3)**

For some, the abuse was ongoing, posing a direct threat to physical safety, in addition to financial and psychological harm. ROSE Client 1 shared this experience:

> ***The worry is, go to bed, you go to sleep. He's the person who's up all night smoking, and there's no way I'd know – if he came into our bedroom, I wouldn't know until it was too late. I started putting a block underneath the door so he couldn't get in.*** **(ROSE Client 1)**

For ROSE Client 10, this continued after the perpetrator was removed from the house by police:

> ***But we're still living in a property where we're still not 100% safe … And so there's no fences in the backyard. … anyone can just walk in our backyard. … But I have my dogs and I have to believe that – you just have to take it as it comes and we are safe.*** **(ROSE Client 10)**

Internal ECLC survey data show that 23% of clients reported feeling no safer as a result of using ELSA or ROSE, although it is not clear how many of these clients were unsafe when they came to the service. The evaluation team recommend implementing a follow-up process, where, with consent, ELSA or ROSE staff contact some clients at regular intervals after their cases have been closed. This would provide regular opportunities to offer support to take action and, if circumstances changed, provide additional referrals or links to other supports (Recommendation 11). The limitations of the service system to provide options and supports to keep older people safe from abuse may also lend support for proposals for a legislative regime for safeguarding adults such as that proposed by the Office of the Public Advocate[26] (Recommendation 25). These findings also reinforce the need for more services and supports for both older people and perpetrators (Recommendations 18 & 19) and for widespread availability of specialist elder abuse services based on the ELSA and ROSE models (Recommendation 16). There also appears to be a service gap in the provision of trauma counselling and other supports for survivors of elder abuse (Recommendation 18). Ultimately, elder abuse should be prevented before it occurs. The drivers of elder abuse are complex. Ageism is clearly a factor, but in many cases the abuse experienced by ELSA and ROSE participants had been ongoing for many decades and only became elder abuse as the victim/survivor became an older person. Intergenerational violence was also present, reflecting entrenched patterns of abusive relationships. Intersections of socioeconomic disadvantage, health, disability, housing insecurity and social marginalisation for both older people and perpetrators are also evident as drivers of abuse and neglect in the evaluation data and the prevalence data.

> ***It's about preventing elder abuse before it occurs. So really trying to learn more about the drivers, and then trying to create social and cultural change to address those drivers, including ageism is a known driver or an agreed driver, and working to influence policy and culture change particularly among our key partners.*** **(ECLC Staff 16)**

As discussed above, at 2.1.6, ELSA and ROSE support broader ECLC initiatives and other work in the prevention of elder abuse. The inability of the service system to respond to many cases of elder abuse reinforces the importance of this work (Recommendation 18).

2.4. Co-Design and community-led development

Going forward, ELSA, ROSE and other similar services can build on the lessons learned from implementing ELSA and ROSE by embedding co-design and community input into the service planning, design, delivery and evaluation (Recommendations 14 & 17). Such approaches are increasingly common in other service sectors, such as intimate partner violence, mental health and disability, but not yet widespread in elder abuse response services. The evaluation team were unable to identify any published literature that incorporated co-design into service delivery. However, recent attempts have been made to involve people with lived experience of elder abuse in research,[27] education[28] and prevention. An example is OPERA, a prevention project run by ECLC, in partnership with Swinburne University. [29]

The value of having lived experience evaluators on the evaluation team for this project was significant, providing otherwise inaccessible insights into the experiences of older people experiencing abuse and the development of recommendations. These insights would be equally valuable for ongoing service design and development, and for any service expansion. The evaluation identified substantial integration of external professional stakeholders into the development and implementation of ELSA and ROSE. Including older people with a lived experience of elder abuse would be a natural expansion of this approach. This will result in services that are immediately more reflective of the needs of clients and the community, and will particularly benefit service promotion and terminology so that people can see themselves in the programs provided to them.

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[26] Office of the Public Advocate (n 7).

[27] Bianca Brijnath et al, 'When Co-Design Works (Sort of): The Case of the Australian Elder Abuse Screening Instrument' (2022) 34(4) *Journal of Elder Abuse & Neglect* 302; Luke Gahan et al, 'Advancing Methodologies to Increase End-User Engagement with Complex Interventions: The Case of Co-Designing the Australian Elder Abuse Screening Instrument (AuSI)' (2019) 31(4–5) *Journal of Elder Abuse & Neglect* 325; Constance Lafontaine, Kim Sawchuk and Scott D Jong, 'Social Justice Games: Building an Escape Room on Elder Abuse through Participatory Action Research' (2020) 9(2) *The Computer Games Journal* 189.

[28] Deirdre O'Donnell, 'Keep Control: A Co-Designed Educational and Information Campaign Supporting Older People to Be Empowered against Financial Abuse' in Amanda Phelan (ed), *Advances in Elder Abuse Research: Practice, Legislation and Policy* (Springer International Publishing, 2020) 121.

[29] Diana Bossio et al, *The OPERA Project: Community Co-Design of Digital Interventions for Primary Prevention of Ageism and Elder Abuse Is an Output of the OPERA (Older People: Equity, Respect and Ageing) Project* (Report, Swinburne University of Technology, 2019) <https://www.opera.eclc.org.au/uploads/general/OPERA-Report_Swinburne_PhaseII_FINAL.pdf>.

This would need to be done carefully and resourced properly to ensure that lived experience experts were treated with dignity and respect and provided with the necessary supports to participate. Extant models from other sectors provide a range of blueprints that could be effectively adapted to the elder abuse context. Given the complexity of the ELSA and ROSE context, particularly concerning Aboriginal and Torres Strait Islander communities and Aboriginal community-controlled organisations, providing a detailed map of how co-design could be implemented is beyond the scope of this evaluation. Opportunities include lived experience advisory groups, lived experience designated staffing roles, and structured design processes which share power with community members. Future evaluations should also include lived experience researchers as part of the evaluation process.

Extant models from other sectors provide a range of blueprints that could be effectively adapted to the elder abuse context.

METHODOLOGY

The evaluation used a mixed methods approach to achieve the aim of the evaluation and to answer the evaluation questions. The second stage of the evaluation drew on co-design approaches, and included two lived experience evaluators, both with experiences of elder abuse, on the evaluation team.

3.1 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. All service delivery in the first three years of ELSA and ROSE is in scope, from inception in October 2019 to October 2022. This includes data collected during the midterm review. ECLC services other than ELSA and ROSE are not in scope.

3.2 Key evaluation questions

The key evaluation questions have been adapted from the Preparation for the Evaluation of the Elder Abuse Service Trials document 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?
   - **1.1** How are the health justice partnerships implemented?
   - **1.2** How are the specialist elder abuse units implemented?
   - **1.3** What were key features of the partnership and how did these contribute to client outcomes?
   - **1.4** 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?
   - **6.1** Older people feel supported and services meet their needs
   - **6.2** Older people receive justice and legal restitution
   - **6.3** Older people are satisfied their issues have been resolved appropriately
   - **6.4** 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:
   - **8.1** older people from CALD backgrounds
   - **8.2** older Aboriginal and Torres Strait Islander people
   - **8.3** older people experiencing cognitive decline
   - **8.4** older people experiencing social isolation
   - **8.5** older people with disabilities
   - **8.6** older people experiencing or at risk of homelessness
   - **8.7** 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?

3.3. Data collection

The evaluation drew on qualitative data collected by the evaluation team, and routinely collected quantitative service data collected by ECLC and third parties. All data were analysed and triangulated where possible.

3.3.1 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.

3.3.2 Qualitative data

3.3.2.1 Interviews with people who have used ELSA and ROSE

	REFERRED AT MIDTERM	INTERVIEWS AT MIDTERM	REFERRED AT FINAL STAGE	INTERVIEWS AT FINAL STAGE	TOTAL INTERVIEWS
ELSA	8	4	6	3	7
ROSE	3	2	12	11	13
TOTAL	11	6	18	14	20

ELSA referred 14 clients for interview, 7 of whom agreed to be interviewed, and ROSE referred 15 clients, 11 of whom agreed to be interviewed. One client participant was referred at both stages and was interviewed twice, resulting in 20 interviews with 19 clients.

3.3.2.2 ECLC staff interviews

In total, we conducted 23 interviews with 18 ECLC staff members, with 5 staff members interviewed at both the midterm and final stages. Interviewees included all ELSA and ROSE staff and key informants from ECLC management and executive. This is well above the initial target of 6 ECLC staff interviews.

3.3.2.3 External stakeholder interviews

In total, we conducted 26 interviews with 25 professionals external to ECLC, 18 at the midterm and 8 at the final stage, with one participating in both stages. External stakeholders represented a range of relevant organisations, including Eastern Health, Oonah Belonging Place, both private and community legal services, community organisations and statutory bodies. This is significantly above the original target of 10 external stakeholders.

3.3.3 Quantitative data

The evaluation drew quantitative data from a range of internal ECLC and external data. External data included unpublished data from the Australian Institute of Family Studies National Elder Abuse Prevalence Study[30] and family violence data from the Victorian Crime Statistics Agency for comparative purposes and drew on publicly published Australian Bureau of Statistics data from the 2021 Census and its Disability, Ageing and Carers, Australia: Summary of Findings (2018), Seniors Rights Victoria service delivery data[31] and other data as relevant.

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 have been drawn where appropriate.

The Victorian Crime Statistics Agency data are collected by police when responding to a family violence incident. We requested and were provided with data for incidents where the person was aged over 65 and living in the ELSA/ROSE catchment areas. This is whole of population data, insomuch as it includes all police responses to family violence, and so should be an accurate representation of police responses to family violence incidents but does not capture non-family violence related elder abuse.

The Seniors Rights Victoria data are service delivery data collected in the seven years 2012 to 2019 for all people who received advice and support. These data have been used for comparison purposes only, and only where appropriate to assess the performance of ELSA and ROSE and look for data trends in ELSA and ROSE data. No value assessment of SRV data or SRV services has been undertaken in using these data for this evaluation.

The National Elder Abuse Prevalence Study was conducted by the Australian Institute of Family Studies and represents the best available data on the prevalence of elder abuse in Australia, although it focused on people aged 65 and over dwelling in the community rather than on those living in aged care services. We requested and were provided with the deidentified results of this study. The narrowest analysis possible was of major Victorian cities, not the ELSA/ROSE catchment specifically. Where the Victorian major cities data are too small for useful comparison, the Australian data have been used instead.

3.4 Data analysis

The interviews and focus groups were audio-recorded, professionally transcribed and loaded into NVivo qualitative analysis software. All qualitative data were coded using well-rehearsed conventions of thematic analysis.[32] All client participant interviews were reviewed by four evaluators who had not conducted the interviews, including two evaluators with lived experience of elder abuse. Other transcripts were analysed by two evaluators. The analysis informed the broader thematic analysis and directly influenced the evaluation recommendations.

Qualitative data were analysed explicitly against the key evaluation questions (see 3.2) and implicitly for emergent themes not related to the key evaluation questions but which provide valuable insights into client experiences and service impact.

This resulted in two coding frameworks; one corresponding to the evaluation questions and one induced 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. Identified themes and recommendations were developed, tested, and refined. This thematic analysis forms the basis for the structure of the findings of this report.

The evaluation team employed a range of statistical techniques to analyse the quantitative data. This included descriptive statistics for demographic data and cross-tabulation analysis with t-tests for significance. Where the data collected from the data sets did not correlate (i.e. different categories for perpetrators, types of abuse, inconsistent age ranges, etc.), only data sets that did correlate with ELSA and ROSE data set were used.

A case study technique was used to develop the vignettes in Appendix 3. The two lived experience evaluators reviewed all transcripts and developed amalgam composites with reference to the key themes which emerged from the qualitative analysis. Identifying characteristics have been changed, but themes relating to the client experience and service responses are retained as faithfully as possible. Two other evaluators revised the vignettes based on data from interviews with ECLC staff and external stakeholders to accurately portray how ELSA and ROSE typically responded.

Only qualitative data from the final evaluation stage is included in this report. However, quantitative data from the full three-year period of both programs has been included to allow an analysis of change over time, particularly in relation to pre- and post-COVID-19 restrictions.

[30] Qu et al (n 3).

[31] Melanie Joosten et al, *Seven Years of Elder Abuse Data in Victoria* (Report, National Ageing Research Institute in partnership with Seniors Rights Victoria, 2020) <https://seniorsrights.org.au/wp-content/uploads/2021/03/2020August26PolicySevenYearsEADataVictoria.pdf>.

[32] Virginia Braun et al, 'Thematic Analysis' in Pranee Liamputtong (ed), *Handbook of Research Methods in Health Social Sciences* (Springer Singapore, 2019) 843.

3.5 Limitations

The key limitations of this study are those associated with many service evaluations. The evaluation team relied on referrals for participants from ECLC, so participants are not a random sample. All available service data are routinely collected by service delivery professionals and not cross-checked, so are likely to contain incidental errors. All client satisfaction and outcome data are self-reported by clients or staff and not able to be confirmed by another source. All reasonable attempts were made to minimise these limitations, including triangulation of different data sets. The community education data is particularly limited, with pre/post survey dropout rates very high, and many surveys with small numbers, wording of questions and answers changing between sessions, and some data in inaccessible formats. Similarly, the SCORE outcomes and circumstances data are unilaterally assessed by staff, not clients, so should be used with caution.

3.6 Ethics and governance

This evaluation is approved by the RMIT Human Research Ethics Committee (#HREC22857).

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.

APPENDIX 1 QUESTION MAPPING

QUESTION NO.	QUESTION TEXT	REPORT SECTION
1.	How are the service trials implemented?	2.1.1, 2.1.2, 2.1.3, 2.1.4, 2.1.5, 2.1.6, 2.1.7
1.1.	How are the health justice partnerships implemented?	2.1.1, 2.1.2, 2.1.3, 2.1.4, 2.1.5, 2.1.6, 2.1.7
1.2.	How are the specialist elder abuse units implemented?	2.1.1, 2.1.2, 2.1.3, 2.1.4, 2.1.5, 2.1.6, 2.1.7
1.3.	What were key features of the partnership and how did these contribute to client outcomes?	2.1.3, 2.1.3.1, 2.1.3.2, 2.1.3.1, 2.1.4, 2.1.5
1.4.	How effective is the integrated, multi-disciplinary service delivery?	2.1.2, 2.3.2
2.	To what extent are the service trials reaching the desired cohort?	2.2
3.	What are the barriers or challenges to implementing the service trials?	2.3.3
4.	How are barriers to implementing the service trials being addressed?	2.3.3.1
5.	What are the features of the service trials that are of most benefit to primary clients?	2.1.2, 2.3.1
6.	To what extent have the service trials outcomes been achieved?	2.3
6.1.	Older people feel supported and services meet their needs	2.3
6.2.	Older people receive justice and legal restitution	2.3.2.1
6.3.	Older people are satisfied their issues have been resolved appropriately	2.3.2, 2.3.3
6.4.	Older people respect and trust services	2.3, 2.3.1
7.	To what extent did each service trial type achieve its immediate and intermediate outcomes?	2.3.2, 2.3.3
8.	How well did each service trial type meet the needs of older people at risk of experiencing elder abuse? Including:	2.2
8.1.	older people from CALD backgrounds	2.2.1, 2.3.2
8.2.	older Aboriginal and Torres Strait Islander people	2.2.1, 2.1.3.2
8.3.	older people experiencing cognitive decline	2.2.1, 2.2.5
8.4.	older people experiencing social isolation	2.2.4
8.5.	older people with disabilities	2.2.3, 2.2.5
8.6.	older people experiencing or at risk of homelessness	2.3.2.2
8.7.	older LGBTIQ+ people	2.2.1
9.	What (if any) were unintended outcomes resulting from the service trials?	None identified.
10.	What were the lessons learnt?	Recommendations
11.	To what extent did the service trials provide value for money?	Not possible to assess, discussed at 2.1.1. See 2.1.3.2 for mobilisation of pro bono legal services.
12.	Are the service trials the best use of resources?	Not possible to assess, discussed at 2.1.1. See 2.1.3.2 for mobilisation of pro bono legal services.

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 objectives	To trial three service models to understand strengths of each model and the condition in which they are successful

Inputs

$18.3 million

(1 July 2018 to 30 June 2022)

Attourney-General Staff Resourcing

Participants

Older people

Health care and social workers

Older persons network

Assumptions

The right mix of service types to trial have been selected

Grantees will draw on their networks and promote their services to reach older people

Appropriate services exist

Older people have a range of services to access

Partners	Activites	Outputs	Immediate Outcomes	Intermediate Outcomes	Ulitmate Outcomes
Grantees With experience in supporting older Australians	Deliver grants program	Grantees deliver three service model types	Grantees deliver capability in providing elder abuse support	Grantees provide quality service	
			Grantees develop referral network		
Service Model (Types)					
Health Justice Partnerships	Health care and social workers trained to identify and refer older people to appropriate services	Secondary consultations between legal, health and social worker staff	Health care and social workers have skills and confidence to refer to legal and/or support services	Health care and social workers refer to legal and/or support services	
	Provide specialised legal support services in partnership with the health system	Older people recieve specialised legal support	Health care and social workers make appropriate referrals	Older people receive legal and non-legal remedies	Older people feel supported and services meet their needs
Specialist Elder Abuse Units	Referral and support to access other services	Older people receive legal advice	Older people are empowered to take legal action if they choose	Older people are satisfied their issues have been resolved appropriately	**Uninteded Consequences** Excalate problems for older people Cost shifting Breakdown of family support structures Assistance and support causes more harm to older people
	Advice including legal advice	Older people access referrals and support	Older people have the support, tools and resilience to continue to deal with issues	Older people respect and trust services	
	Other services	Older people receive counselling			
	Counselling				
Case Management and Mediation Services	Case management and councelling services with older person	Older people access case management, counselling and mediation services	Older people and/or their network engage in discussions to support resolution	Older people are satisfied with the support provided to pursue solutions	**External Factors** Similar programs funded by state governments
	Case management and mediation services with older person and their network	Older person's network engage with case management and mediation services	Identify possible solutions to drivers of abuse/ potential abuse	Older people and/or their networks engage with services to implement solutions	

APPENDIX 2 PROGRAM LOGIC

APPENDIX 3 VIGNETTES

Vignette 1. Andrea

Background

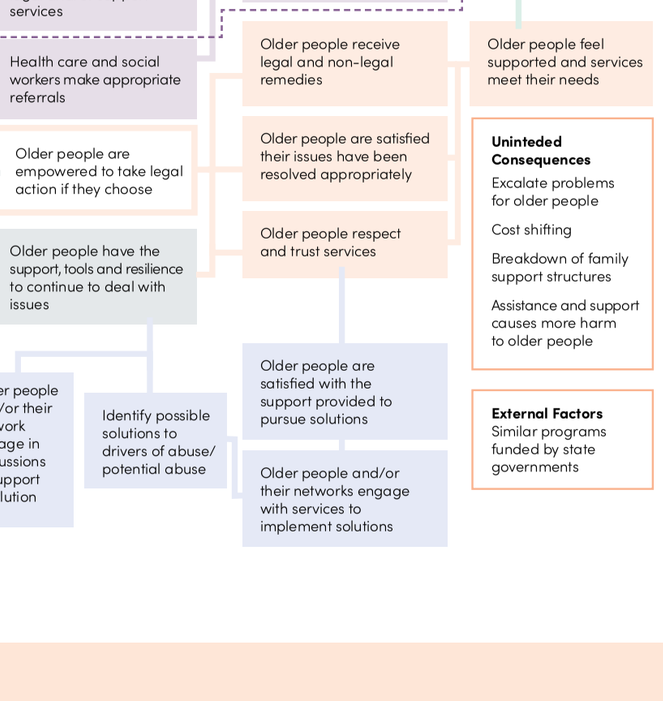
Andrea is 72 and has been living as a single parent on a property in the Yarra Valley ever since her husband died shortly after her son, Don, was born. Her now adult son has always lived with her. He previously accessed mental health services around ten years ago, which he found somewhat helpful at the time, but stopped engaging with mental health services after having a negative experience in an inpatient unit. He does not agree that he is unwell and refuses any treatment or medication. He is not interested in receiving any further mental health support. He often uses drugs to feel better, including in Andrea's house, which she has asked him not to do. He has refused to move out and Andrea does not want him to be homeless.

Andrea feels intimidated at times by Don, and he is not contributing financially or around the property. She finds his behaviour threatening, and it is escalating. Don is frequently angry and will stand over Andrea, yelling at her. Andrea is intimidated by Don's friends, who are often at the property. They eat her food and do not clean up after themselves, no matter how many times she asks them. Sometimes they get drunk and swear at her or bang on her door.

Recently Andrea needed to have surgery on her knee, and while in hospital she mentioned her concern about Don's ability to cope in her absence. Hearing Andrea talk about how apprehensive she was about talking to Don or returning home, the hospital social worker referred her to ELSA.

Response

The ELSA advocate visited Andrea in the hospital, as Andrea said she felt safe there and preferred to meet face-to-face. When Andrea described Don's behaviour, the advocate explained how this could be considered elder abuse. Together, they set up a video call with the lawyer, who outlined Andrea's legal options. Andrea was worried that if she got an intervention order, Don would be homeless. She decided to write a short letter with the lawyer, explaining to Don that she had spoken to the ELSA service and outlining what she found difficult about living together. Andrea left this letter on the kitchen table for Don to see.



After reading it, Don's behaviour changed, and he calmed down and backed off. The advocate spoke to Andrea about her concerns about managing the property, and they made a phone call to set up a My Aged Care assessment together. Andrea would not have known how to do this if not supported by the advocate.

When the ELSA and ROSE intake worker called Andrea to do an exit survey, Andrea said that she now had someone coming to help with home and garden maintenance, like cleaning the gutters. After receiving the letter, Don was worried about what would happen if he stayed living with Andrea and so he moved out and shared a house with a friend. The relationship between mother and son has been much improved, although Andrea is concerned that the share house arrangement will not last and about what might happen in the future if Don needs to move back home.

Vignette 2. John

Background

John, 73, and Elizabeth, 69, have been married for 20 years. This is a second marriage for both, and they both have adult children from previous relationships. Elizabeth has recently been diagnosed with mild dementia but is managing at home. Elizabeth's daughter Pamela lives nearby and holds enduring power of attorney for Elizabeth covering both financial and personal matters. While Elizabeth is still making her own decisions, this has caused considerable concern to John as he has noticed that when Pamela visits things go missing from the house. He has also observed that she has been using her mother's credit card for unknown expenses. This has led to a few thousand dollars of debt, which is a lot of money to the couple who are both on an aged pension. When John asked Pamela about this, she said she had been buying groceries and cleaning supplies for the couple. John has also been worried that Pamela has access to the couple's MyGov accounts, as she helped them set up online access to Centrelink. John is not confident or comfortable using the internet.

John had tried calling family violence services, as he felt that he and Elizabeth were being taken advantage of by Pamela. One service told him that as Elizabeth was the alleged victim, she had to make contact with the service. When John told them that Elizabeth had dementia, the service told him that she lacked capacity to make decisions and couldn't give instructions to a lawyer. Another service said that they could only help women and children, and suggested he call a men's helpline. When he rang the number, a worker explained they were a service for perpetrators, not victims. Finally, John noticed an advertisement in a local paper about ROSE, describing elder abuse. It resonated with him.

Response

John rang ROSE and set up a phone appointment with the advocate, financial counsellor and lawyer. He then spoke to Elizabeth, who agreed that it sounded like a good idea to find out more about their rights.

After speaking with John, the financial counsellor approached the bank, alerting them to the situation in a letter. The bank stopped any access from Pamela, waived the credit card debt on compassionate grounds and set up direct payments for bills. The financial counsellor also suggested reaching out to Centrelink about setting up phone self-service. John and the advocate spoke to Centrelink and were able to make access easier for the couple and prevent Pamela from accessing their account in future.

The lawyer explained a number of legal options to John. She offered to write a letter to Pamela about the things that had gone missing and financial abuse, to support him with going to court for an intervention order to stop Pamela from visiting the house, or to assist in applying to revoke and make a different power of attorney. While John wanted to get an intervention order, he wanted to make sure Elizabeth was on the same page. Elizabeth was reluctant, as she was worried about the impact this would have on her daughter's career and their relationship. Although she shared John's concerns, she also did not want to confront Pamela directly about the things that had gone missing. Elizabeth decided that she wanted support to give John and her other daughter Phoebe joint power of attorney, which John felt comfortable with. Once this happened, Phoebe helped her mother explain the change to Pamela.

John agreed that he was still concerned about Pamela's behaviour and decided that he wanted the ROSE advocate to follow up at regular intervals to check-in. ROSE referred John to a private lawyer for help drafting his will.

Vignette 3. Juanita

Background

Juanita and Pietro moved to Australia 45 years ago. Their son Elvis has left home and now has his own family. Juanita has always felt her English is poor, and now she has more time she has decided to do something about it. A few months ago, she started going to the local library for English classes and has made several friends. They meet after class for coffee and have been exchanging stories of their lives.

Juanita's friend Maria was concerned about some of the incidences of apparent abuse disclosed by Juanita, perpetrated by Pietro. Maria spoke to Elvis, whom she has met before, about this abuse but he brushed it off by saying, "Dad is just getting angry with Mum again and he will calm down like he always does." Maria volunteers with a community group advocating for seniors' rights, and recently attended a community event with speakers from ELSA and ROSE. She asked Juanita whether she knew what elder abuse is and received a negative response. She suggested Juanita could contact ECLC and discuss the situation, which seems to be getting more frequent and violent.

Response

After one particularly disturbing episode that included physical violence, Juanita had to go to the emergency department. When talking to the hospital social worker, she mentioned the services that Maria had described, and the social worker referred her to ELSA. They organised a meeting at the hospital, as a safe place away from Pietro. Juanita said she wanted Maria to go with her as a support person and that she would like ECLC to organise a translator to help with more complex information.

In the meeting with the ELSA advocate and lawyer, everyone introduced themselves and then ELSA asked to speak with Juanita one-on-one and Maria left the room. They explained to Juanita that usually they like to speak to clients alone so they can make sure they feel safe and comfortable to tell the team what has been happening. Juanita said she'd like Maria there and she trusted her. ELSA said that is okay, but asked permission to say to Maria that they might need to speak with Juanita one-on-one during the meeting or in future. Juanita said that is fine. Maria re-joined them, and they had a long discussion. Juanita described how scared and isolated she is feeling at home and discussed previous incidences of violence at home over the course of their marriage.

Juanita decided that she wanted to go to court for an intervention order, and that she wanted to separate from Pietro. She went to stay at Maria's house while the police removed Pietro from the family home.

Pietro became very angry and aggressive about the intervention order, and although there have been no breaches so far, he has been saying cruel things about Juanita to all their friends and community members. This has impacted Juanita's relationship with Elvis, and she is seeing her grandchildren less frequently than before, which is extremely difficult for her. She wishes there was some kind of mediation service that could help her communicate with Elvis, as her main hope is to be able to see the children more often again.

As the order is only for twelve months, Juanita is feeling vulnerable and looking for somewhere else to live, as Pietro knows where she is. She has a safety plan that she made with the ELSA advocate and Maria, but she worries that if Pietro tries to hurt her nobody will be able to respond quickly enough.

The ELSA team made a referral to a pro-bono family lawyer, who has been representing Juanita through her separation. The ELSA advocate has been providing support throughout this process, which Juanita feels is giving her the strength and confidence to continue with the difficult legal proceedings. Juanita is hoping that once they reach a divorce settlement, she will be able to have money to afford a small unit near to her friends from the library.

Vignette 4. Kyaw

Background

Kyaw is 65 and lives on her own in Croydon South, where there is a large Burmese community. Her daughter Mikki has her own family. Mikki has two children who are adored by their grandmother. Mikki and her mother are very close, and they come over frequently.

Kyaw finds English difficult to understand and often relies on Mikki to help her. Mikki was quite young when the family came to Australia and is happy to help her mother to translate things, but worries about not always being available. Kyaw recently had a stroke and has a paid carer to help in the home.

Mikki became upset after a visit and trying to arrange an outing. Kyaw mentioned in passing that the carer makes food she does not like, and Mikki thought she would take her shopping. She found her mother had lost considerable weight. When Mikki asked her mother about what was going on, Kyaw described how the carer is increasingly controlling visitors and family from seeing her. She said she has been feeling more and more isolated but did not know how to talk to Mikki about what was happening.

Mikki did not know what to do. Desperate, she called her local council, who referred her to ROSE.

Response

Mikki called ROSE, and the intake worker explained that elder abuse included abuse from trusted people, like carers, and described the service. Mikki spoke to her mother, who decided that she would like a call from ROSE to organise a meeting.

When the ROSE advocate called Kyaw with an interpreter and asked to speak with Kyaw without identifying where she was calling from, the carer answered the phone and said that Kyaw could not take calls as she did not speak English and was too unwell to talk on the phone. Before the advocate could respond, the carer hung up. The advocate called Mikki, who was able to set up a time for an appointment with her mother when the carer was not there.

Kyaw had an initial video call with the ROSE advocate and lawyer and an interpreter, without Mikki present. Kyaw explained that she felt better having meetings at certain times of day, and that she would like Mikki's support when working with ROSE. She said that she would prefer to meet face-to-face, and Mikki organised to drive her to the Boronia ECLC office.

The ROSE advocate met with Kyaw and Mikki a number of times in person, as Kyaw wanted to take time to understand her options. The advocate also wrote down notes to give to Kyaw and Mikki. With the advocate's support, Kyaw and Mikki were able to make a formal complaint about the carer's behaviour and to receive support from a different carer.

Kyaw decided that she wanted to give Mikki power of attorney in case anything happened in future, and she was not able to make decisions herself, and ROSE drafted an Enduring Power of Attorney document. Throughout all these processes, ROSE spoke with Kyaw one-on-one to check in with her and confirm her instructions without her daughter present, to make sure she was not feeling any pressure from her daughter. When the intake worker did an exit survey with Kyaw, she described feeling worried about what might happen to other people who did not have a supportive family member like Mikki to advocate for them.

Vignette 5. Linda

Background

Michael, 74, and Linda, 75, live in North Balwyn. Five years ago, they sold their farm in regional Victoria and moved into a small unit on the back of their daughter Samantha's property. This was a difficult decision, as the couple were strongly connected to their rural community. As Michael was experiencing chronic extreme back pain from an old injury and would eventually need surgery, the couple decided to move somewhere nearer to support, treatment and their grandchildren. As part of this move, Michael and Linda had provided Samantha with a house deposit, made up of most of their savings and the proceeds from selling the farm.

The family initially lived together peacefully, until two years ago when Samantha started dating Jesse. Jesse found it frustrating that Samantha spent so much time with her parents, supporting with shopping and maintaining the unit. When he moved in, tensions escalated. Over time, Jesse's arguments with the couple increased, until he started limiting their time spent with Samantha and her children. Eventually, he prevented them from accessing the main house, leading to Linda having to cook all the couple's meals on a camping stove in the unit. When Linda tried to enter the main house, Jesse would physically push her away.

After school one afternoon, when Linda attempted to enter the main house to see the children, Jesse called the police. When the police arrived, Linda was extremely distraught. The police placed an intervention order preventing her from going near Jesse, Samantha or the children. Linda was heartbroken, and a trusted member of her church community suggested she call ROSE.

Response

Linda rang ROSE and organised to meet with the lawyer and advocate. The lawyer offered to provide help representing Linda in her upcoming intervention order hearing. With this support, Linda was able to have the intervention order overturned. The lawyer offered to help her place an intervention order against Jesse. Still, Linda refused as she was concerned about the impact this would have on her ability to visit her grandchildren.

When Linda described the limited food and amenities at home, the advocate provided phone numbers for emergency accommodation and housing support. Linda said that she only wanted to do this if she could go with Michael and that she would have to speak to him.

When Linda spoke with Michael, he was firm that with his worsening health and upcoming surgery he wanted to stay where he was. Seeking to repair the couple's relationship with Samantha and Jesse, he spoke to Samantha about Linda seeing ROSE. In response, Samantha said that Michael should move into the main house, where she could better support him through his upcoming surgery. Michael did not want to leave Linda but thought that maybe this could provide an opportunity to recover and mend things with the family. Jesse and Samantha came into the unit and removed many of Michael and Linda's shared possessions. When Linda protested, Jesse pushed her aside and she fell.

Linda called the ROSE advocate, who made a referral for emergency accommodation. From there, Linda moved into her son Henry's house in Keilor, where she is sleeping on the couch. She feels safer but is worried that this is not a long-term solution as the house is crowded, and Michael is unsafe. She deeply misses Michael and her grandchildren and is too far away to regularly attend her church.

Michael sometimes calls Linda late at night when the household are asleep. He describes feeling stressed but does not want to speak to ROSE or move out, as he feels this will only make things worse. Jesse and Samantha have organised for the couple to be separated with Centrelink, so that Michael can have a higher pension payment which they use for their own bills and groceries. They have been encouraging him to formally separate from Linda.

eastern community legal centre

BOX HILL OFFICE

Suite 3, Town Hall Hub
27 Bank Street
Box Hill VIC 3128

Inner East: serving the communities of Boroondara, Manningham and Whitehorse

BORONIA OFFICE

Suite B, 6 Floriston Road
(PO Box 747)
Boronia VIC 3155

Outer East: serving the communities of Knox and Maroondah

HEALESVILLE OFFICE

Healesville Community Link
110 River Street
(PO Box 79)
Healesville VIC 3777

Yarra Ranges: serving the communities of the Yarra Ranges

ECLC acknowledges the Wurundjeri people of the Kulin Nation, the traditional custodians of the land across ECLC's region. We pay our deep respects to the Elders, both past and present.

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