working together

a health justice partnership to address elder abuse

first year report
March 2016

justice connect Seniors Law

cohealth

LA TROBE UNIVERSITY

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introduction

Justice Connect Seniors Law – a pro bono legal service – and cohealth – a community health organisation – have established a health justice partnership (**HJP**) to help older people experiencing elder abuse and other legal issues.

The partnership, which started in early 2015, is generously funded for three years by the Victorian Legal Services Board (**LSB**). By incorporating a lawyer into a health care team, the partners aim to improve legal and health outcomes for older clients by:

- minimising the incidence and impact of elder abuse
- articulating and demonstrating a HJP model of practice

the partners

Justice Connect Seniors Law

Justice Connect exists to help build a world that is just and fair – where systems are more accessible and accountable, rights are respected and advanced and laws are fairer.

In pursuing this vision, Justice Connect:

- provides access to justice through pro bono legal services to people experiencing disadvantage and the community organisations that support them
- builds, supports and engages a strong commitment to lawyers' pro bono responsibility
- challenges and changes unjust and unfair laws and policies, using evidence from our case work and the stories of our clients to bring about reform
- undertakes legal education and law and policy reform aimed at improving access to justice

A team of Justice Connect, **Seniors Law** provides free legal help to older people experiencing elder abuse and other legal issues associated with ageing.

Seniors Law provides free legal help to older people who are unable to afford a lawyer. Legal services are provided by Seniors Law lawyers and pro bono lawyers from Justice Connect member law firms.

The objective of Seniors Law is to improve the ability of older Victorians to age with dignity and respect.

Seniors Law assists clients with legal issues including guardianship and administration, housing, credit and debt, grand parenting, powers of attorney (**POAs**) and making arrangements to live with family. While these legal issues are experienced by many older Victorians, they also tend to arise in the context of elder abuse.

As Seniors Law can draw on the capacity and resources of pro bono lawyers, we can assist older people with these extremely complex matters that can involve extensive negotiations and protracted higher court litigation.

collaboration with the health sector

In delivering its service, Seniors Law has developed a close connection with the health sector.

Previously, pro bono lawyers provided free legal appointments at hospitals and health centres across Melbourne. Complementing this, Seniors Law delivered training on elder abuse and other legal issues associated with ageing to health and community professionals as well as its pro bono lawyers. These sessions aimed to increase the capacity of health professionals and pro bono lawyers to work with older people experiencing abuse.

However, co-located legal clinics and ad hoc training sessions did not necessary translate into enduring relationships with different professionals and the necessary change in practice to address elder abuse.

It was believed a more integrated service, like a HJP, would achieve better health and legal outcomes for clients.

cohealth

cohealth, previously Western Region Health Centre, hosted one of Seniors Law's clinics.

cohealth is a rights-based community organisation of more than 850 staff, delivering health services from over 40 sites across 14 local government areas in northern and western metropolitan Melbourne.

Each year cohealth delivers almost half a million medical, dental, mental health, allied health, and community support services to over 110,000 people. At the core of these services are principles of human rights, client participation in the design of services and a social model of health.[1]

cohealth was the ideal partner for the HJP because of its commitment to social justice and human rights.

For example, cohealth is committed to:

- identifying, building and strengthening strategic partnerships that support cohealth's work across service types and settings
- strengthening an understanding of the relationship between inequity, the social determinants of health and health outcomes
- creating a stronger voice in public debates that can be a catalyst for health equity and system reform
- cultivating innovative practice

The partners found a culture that recognises the importance of collaboration to address complex social determinants of health on both an individual and systemic level is ideal when trying to integrate a legal service into a health care setting.

cohealth is also recognised for its capacity to work with groups and communities who are often regarded as hard to reach and difficult to service. This is consistent with Justice Connect's priority to improve access to justice for people facing disadvantage, especially those in CALD communities.

elder abuse

ageing population

Australian's are expected to live longer, healthier lives. This is a triumph of modern medicine. In 2055, life expectancy at birth is projected to be 95.1 years for men and 96.6 years for women, compared with 91.5 and 93.6 years today.[2] It is also anticipated that 'health expectancies' will likewise increase; meaning people are not only living for longer, but they are enjoying good health for a longer period of time.[3]

A likely consequence of the increase of the number of older Australians is, sadly, an increase in the incidence of elder abuse.

definition and form

The World Health Organisation (**WHO**) has defined elder abuse:[4]

> **elder abuse:** *a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person.*

The different ways elder abuse can manifest are:[5]

physical	Non-accidental acts that result in physical pain, injury or physical coercion.
financial	Illegal use, improper use or mismanagement of a person's money, property or financial resources by a person with whom they have a relationship implying trust.
psychological	Inflicting mental stress via actions and threats that cause fear or violence, isolation, deprivation or feelings of shame and powerlessness. These behaviours – both verbal and nonverbal – are designed to intimidate, are characterised by repeated patterns of behaviour over time, and are intended to maintain a hold of fear over a person.

[1] cohealth, strategic plan 2015-18.
[2] Australian Government, *2015 Intergenerational Report* (2015) 5, 7 and 8.
[3] Above n 2, 8.
[4] World Health Organisation, *The Toronto Declaration on the Global Prevention of Elder Abuse* (17 November 2002) 3.
[5] Victorian Government, Department of Health, *Elder Abuse Prevention and Response Guidelines 2012-2014* (2012) 3

social	The forced isolation of older people, with the sometimes additional effect of hiding abuse from outside scrutiny and restricting or stopping social contact with others, including attendance at social activities.
sexual	Unwanted sexual acts, including sexual contact, rape, language or exploitative behaviours, where the older person's consent is not obtained, or where consent was obtained through coercion.
neglect	Failure of a carer or responsible person to provide life necessities, such as adequate food, shelter, clothing, medical or dental care, as well as the refusal to permit others to provide appropriate care (also known as abandonment). This definition excludes self-neglect by an older person of their own needs.

Typically, these different forms of abuse co-occur, with financial and psychological abuse being the most common.[6] While financial abuse may be the fastest growing form of elder abuse in Australia, it can also be one of the most detectable, often leaving a clear trail of financial transactions through banking records.[7]

prevalence

There is limited data on the prevalence of elder abuse, with most studies offering a range. For example, Boldy *et al*, suggests up to 5% of older people have experienced elder abuse, correlating to approximately 42,000 Victorians.[8]

Up to 80% of perpetrators of elder abuse are family members, such as a spouse, adult children, grandchildren, siblings or other family members, friends or carers.[9] Elder abuse is, therefore, a form of "family violence".

The abuse may be perpetrated as a result of ignorance, negligence or deliberate intent.[10]

Adult children are most commonly the perpetrators of abuse, with intergenerational relationships established as those most likely to lead to abuse: [11]

> Overall, 40% of alleged perpetrators are sons, and 26.8% are daughters: therefore 66.8% of abuse is perpetrated by a child of the older person.
>
> 92.3% of alleged perpetrators are related to the older person or in a defacto relationship

Neighbours, carers, and boarders or lodgers made up a small percentage of those perpetrating abuse.

Elder abuse is under-recognised and under-reported. While some forms of elder abuse are obvious and involve criminal acts, in many cases the problem is subtle and hidden, occurring between older people, their families, neighbours, friends and carers. For this reason, elder abuse has been referred to as "a hidden problem, under-recognised and under-reported due to a stigmatisation and a lack of community awareness".[12]

impact

The WHO describes elder abuse as "a violation of human rights and a significant cause of injury, illness, lost productivity, isolation and despair".[13]

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[6] Peteris Darzins, Georgia Lowndes and Jo Wainer, 'Financial abuse of elders: a review of the evidence' (2009) 8 citing Dong *et al*, 2008; Chokkanathan and Lee, 2006; Anme *et al*, 2005; Boldly *et al*, 2005; McCawley *et al*, 2006; Kemp and Liao, 2006; Rabiner *et al*, 2004; Choi and Mayer, 2000; Malks *et al*, 2003.

[7] Above n 6, 8 and 10 citing Boldly *et al*, 2005; Elder Abuse Prevention Unit (EPAU), 2005; Rabiner *et al*, 2004; Bomba, 2006; Rodney Lewis, 'Taking action against abuse of older people: pathways out of the maze' (2013), 10 quoting Clare, Prof M, Blundell, Dr B, Clare, Dr J, Examination of the extent of elder abuse in Western Australia, Crime Research Centre, University of Western Australia with Advocare Inc, pp82-83, April 2011; Human Rights and Equal Opportunity Commission (HREOC), Submission to the House of Representatives Standing Committee on Legal and Constitutional Affairs, *Inquiry into Older People and the Law*, December 2006, 15.

[8] Victorian Government, Department of Human Services, *With respect to age* (2009) 3 citing Duncan Boldy, Barbara Horner, Kathy Crouchley, Margaret Davey and Stephen Boylen, 'Addressing elder abuse: West Australian case study' (2005) 24(1) *Australasian Journal on ageing*: 3-8.

[9] Wendy Lacey, 'Neglectful to the Point of Cruelty? Elder abuse and the rights of older persons in Australia' (2014) 36(99) *Sydney Law Review*, 99-130, 99-100.

[10] Above n 5, 2.

[11] Seniors Rights Victoria (SRV) and the National Ageing Research Institute Ltd (NARI), *Profile of Elder Abuse in Victoria – Analysis of data about people seeking help from Seniors Rights Victoria – Summary Report*, June 2015, 36.

[12] Elder Abuse Prevention Project, *Strengthening Victoria's Response to Elder Abuse* (2005) 12.

[13] World Health Organisation, *Active Ageing: A Policy Framework* (2002) 29.

The impact of elder abuse on older Victorians can be life changing, leading to:[14]

adverse impact of elder abuse
depression and anxiety
psychological harm
declining physical health compounded by a decrease in resources available for healthcare
increased mortality
relocation to an aged care facility
fear and lack of trust
poverty and homelessness
behavioural problems

contributing factors

ageism

Perhaps most significantly, it is prejudicial attitudes, discrimination and unhelpful stereotypes with respect to ageing and older people – known as "ageism" – that are commonly regarded as a significant contributing factor of elder abuse.[15]

This ageism can manifest as a perpetrator's strong sense of entitlement to an older persons' assets because of: [16]

- their care-giver status
- an expectation of inheritance
- an attitude that the older person cannot manage their own affairs
- the need to qualify the older person for government funded long term care.

This sense of entitlement can conflict with an older person's desire to pay for care.

risk factors

Beyond community attitudes, research has identified key characteristics of older people and potential perpetrators that can increase a person's vulnerability to elder abuse.[17]

risk factors of elder abuse	
older person	**perpetrator**
dependency	family member or friend
social isolation and loneliness	sense of financial entitlement
accumulation of substantial assets	carer stress
reduced capacity	substance abuse
poor health	mental illness
disability	disability
family violence	access to finances
death of a partner	financial reliance
poverty	lack of social integration
divorce	living in close proximity to the older person
language or financial literacy barriers	overbearing demeanour

Evidence suggests the accumulation of significant savings and assets, *itself*, can increase an older person's vulnerability to financial abuse, irrespective of the presence of other aggravating characteristics or conditions.[18]

[14] Above n 6, 8, 12 and 18; Claudia Cooper, Amber Selwood, Gill Livingston, 'Knowledge, detection and reporting of abuse by health and social care professionals: a systematic review' (2009) 17(10) *The American Journal of Geriatric Psychiatry* 826-838, 827 citing Lachs MS, Williams CS, O'Brien S *et al* 'The mortality of elder mistreatment' (1998) *Journal American Medical Association* 428-432 and Ogioni L, Liperoti R, Landi F *et al*, 'Cross-sectional association between behavioral symptoms and potential elder abuse among subjects in home care in Italy: results from the Silvernet Study' (2007) *American Journal of Geriatric Psychiatry*, 70-78.

[15] Above n 9, 99 and 101; HREOC, above n 7, 17 and 20-21; NACLC, Submission to the Office of the High Commissioner for Human Rights, *Public Consultation on the Human Rights of Older Persons*, 2013, 4 citing Christine Walsh, Jennifer Olson, Jennifer Ploeg, Lynne Lohfield and Harriet Macmillan, 'Elder abuse and oppression: voices of marginalized elders', 23(1) *Journal of Elder Abuse & Neglect*.

[16] Above n 6, 8 and 16 citing Dong *et al*, 2008; Chokkanathan and Lee, 2006; Anme *et al*, 2005; Boldly *et al*, 2005; McCawley *et al*, 2006; Kemp and Liao, 2006; Rabiner *et al*, 2004; Choi and Mayer, 2000; Malks *et al*, 2003. 15-17;

[17] Above n 6, 6, 8 and 14-16 citing Peri *et al*, 2008; Hafermeister, 2003; Malks et al, 2003; Choi and Mayer, 2000; Quinn, 2000; Tueth, 2000; Bond *et al*, 1999; Comijs *et al*, 1998; Wilber and Reynold, 1996; Above n 11, 17-18 ; Rodney Lewis, above n 7; A Almogue, A Weiss, E-L Marcus, Y Beloosesky, 'Attitudes and knowledge of medical and nursing staff towards elder abuse' 51 (2010) *Archives of Gerontology and Geriatrics* 86; SRV, Submission No 71 to the Victorian Law Reform Commission, *Guardianship*, 3 June 2011; Lynette Joubert and Sonia Posenelli, 'Window of opportunity: the detection of management of aged abuse in an acute and subacute health care setting" 48 *Social Work in Health Care*, 706.

[18] Above n 9, 112 and 120.

gender

The recent research by Seniors Rights Victoria (**SRV**) and the National Ageing Research Institute based on advice sought from SRV, found that women are more likely than men to be the victims of abuse:[19]

> *"In all categories of abuse (apart from neglect), the older person who suffers abuse is more likely to be female than male, and the total number of older women reporting abuse was approximately 2.5 that of older men".*

For example, 70% of the victims of financial abuse were women. [20] In addition to this, the evidence shows that the combination of age and gender is relevant, with reports of abuse more frequent for women once over the age of 65 years.[21]

living arrangements

An older persons' living arrangements play a further part in determining their risk of elder abuse.

Around 43% of older people reporting abuse as part of the SRV study were living with the alleged perpetrator, while around 35% lived alone.[22]

These figures indicate that older people living as part of a couple are most protected from abuse.

[19] Above n 11, 12.
[20] Above n 11, 27.
[21] Above n 11, 32
[22] Above n 11, 37.

why do this?

There are many barriers to addressing elder abuse. Elder abuse may be subtle and, in the absence of disclosure, can be difficult to detect or anticipate. An older person's experience of elder abuse might involve interconnected health, social and legal issues. Resolving the underlying legal problem can improve clients' health and wellbeing.

Health professionals are best placed to identify elder abuse. Because they have developed an ongoing relationship of trust, they can identify the risks and warning signs and an older person may be more likely to disclose abuse.

If health professionals can identify legal risks early on, they can discuss available legal services with their clients, thereby avoiding a more complicated legal issue in the future. Lawyers rely on trusted health and community professionals to identify relevant legal issues and, if necessary, support the person in seeking legal help.

the challenge of addressing elder abuse

the hidden problem of elder abuse

Elder abuse remains "societally hidden". When compared with child abuse and domestic violence, it has taken longer to develop a body of research on the nature and prevalence of elder abuse, with the issue remaining "under-researched, under-reported and under-funded".[23]

Wendy Lacey attributes this to the following:[24]

> *"The abuse, exploitation and neglect of vulnerable older persons involves the serious denial of a person's basic human rights, however, a lack of community awareness, ageism and the frequent invisibility of our elderly mean that elder abuse remains a hidden problem within society."*

Prevailing ageist attitudes and the subtle exclusion of older people from society further compounds the problem preventing older people from engaging in their communities and leaves open "the potential for their basic rights and freedoms to be easily ignored, overlooked or downplayed".[25]

barriers: disclosing abuse

There are many reasons why an older person may be reluctant to seek assistance. Two common reasons are: (a) the need to preserve family relationships; and (b) the wish to avoid exposing family members to legal sanctions.

barriers to disclosing elder abuse [26]
isolation and reliance on the perpetrator for care and companionship
fear of institutionalisation
fear of family members being penalised or prosecuted
desire to preserve family relationships
shame
blaming themselves or feeling responsible for perpetrators actions
fear loss of independence
poor health impacts on energy and motivation to manage emotional conflict and physical change

elder abuse as a 'life problem'

An older person's experience of elder abuse might involve interconnected health, social and legal issues.

For example, elder abuse might manifest as a health issue – such as depression or chronic pain – or a social issue – such as homelessness – but the underlying cause might be legal – a failed agreement with their family to provide care. These problems are likely to be presented as part of a complex "life problem".

[23] Above n 9, 106-107 citing World Health Organisation, Missing Voices: Views of older persons on elder abuse (2002) 2 and John B Breaux and Orrin G Hatch, 'Confronting Elder Abuse, Neglect and Exploitation: The Need for Elder Justice Legislation' (2003) 11 *Elder Law Journal* 207, 208.
[24] Above n 9, 100-101.
[25] Above n 9, 114 citing John Williams, 'An International Convention on the Rights of Older People' in Marco Odello and Sofia Cavandoli (eds) (2011) *Emerging Areas on Human Rights in the 21st Century* 128, 140.
[26] Above n 6, 10; Rodney Lewis, above n 7, 2-3; A Almogue *et al*, above n 21, 86; SRV, above n 21; Lynette Joubert and Sonia Posenelli, above n 21, 711.

the role of trusted health professionals

Given the subtlety of elder abuse and a reluctance of those experiencing the abuse to disclose it, trusted health professionals are in the best position to identify elder abuse. Often they have developed an ongoing relationship trust, making clients feel more comfortable disclosing what is going on at home.

In Australia, nearly 30% of people will initially seek the advice of a doctor, or another trusted health professional or welfare adviser, in relation to a legal problem.

Further, because of the length of time spent with clients and with the questions they may ask in an assessment, health professionals also have more of an opportunity to pick up on any risks and signs.

If they do detect any potential legal risks, they can discuss the possibility of getting legal help earlier on, thereby increasing the possibility of resolving the legal matter.

Some legal issues arising in the context of elder abuse can remain unresolved for extended periods of time and, generally, it is only when significant consequences transpire – such as the sale of the family home – that the older person seeks help. At this stage the legal avenues to resolve the matter, if any, can be lengthy, stressful and costly.

Therefore, lawyers not only rely on health professionals to identify abuse, but also to help support clients while they are seeking legal help.

barriers: responding to abuse

Elder abuse can be subtle and, without disclosure, may be difficult to detect. Health professionals may be constrained in their ability to address elder abuse, citing the following reasons for this:[27]

factors constraining health professional's identification of, and response to, elder abuse
limited consensus and understanding of what constitutes elder abuse
lack of knowledge of reporting or referral frameworks
concerns about confidentiality
concerns referral may compromise therapeutic relationships
consequences for the older person
impact of the legal process on the older person
reluctance to become involved in legal process
outside scope of professional responsibility
dissatisfied with authorities response to elder abuse
lack of conviction that referral would improve outcomes
older person has denied mistreatment
abuse only involved subtle signs
difficulties in obtaining necessary evidence

working together

Given the barriers, sensitivities and complexities associated with elder abuse, it makes sense for lawyers and health professionals to work together, rather than in isolation.

Lachs, *et al* agrees:[28]

> *"The most promising response to the complex nature of cases of elder abuse has been the development of interprofessional teams. Evidence suggests that interprofessional teams, also referred to as multidisciplinary teams, consisting of physicians, social workers, law-enforcement personnel, attorneys, and other community participants working together in a coordinated fashion, are the best practical approach to assisting victims."*

The authors also suggest a possible approach to successfully intervene in a case of elder abuse:[29]

> *"Successful treatment rarely involves the swift and definitive extrication of the victim of abuse from his or her predicament with a single intervention. Instead, successful interventions in cases of elder abuse are typically* ***interprofessional, ongoing, community-based, and resource-intensive****."*

[27] Above n 6, 6 and 29; Almogue, A *et al* above n 21, 86; Lynette Joubert *et al* above n 21, 710; Claudia Cooper above n 15, 833 and 837; John Chesterman, *Responding to violence, abuse, exploitation and neglect: improving our protection of at-risk adults* (2013), 51.

[28] Mark S Lachs and Karl A. Pillemer, 'Elder abuse' (2015) *The New England Journal of Medicine*, 1947-1956, 1954.
[29] Ibid, 1951. (emphasis added)

health justice partnerships

HJPs embrace inter-disciplinary collaboration as a core component. It focusses on creating a systemic change of practice to address the social determinants of health, providing more immediate legal assistance within a healthcare setting and promoting joint advocacy efforts.

There is an emerging body of knowledge in the US and, more recently, in Australia illustrating the benefits of the HJP model to both the clients and the partners. We will contribute findings from an evaluation by LaTrobe University of this HJP to this growing evidence base.

the model

Based on the United States' Medical-Legal Partnership (**MLP**), a HJP is a healthcare delivery model integrating legal assistance as an important element of the healthcare team.

According to the HJP Network:[30]

> *"The model is built on an understanding that the social, economic, and political context of an individual's circumstances impacts upon their health, and that these social determinants of health often manifest in the form of legal needs or requirements."*

HJP's have three core components and activities:[31]

inter-disciplinary collaboration	lawyers guide health professionals in identifying legal issues that may impact on health, and work together in providing a holistic service
legal assistance within healthcare setting	provide more responsive legal assistance for acute legal issues, while also promoting early intervention and prevention strategies to avert legal crises
policy change	Legal and health professionals jointly advocate for policy reform to systematically improve the health and wellbeing of clients

With more seamless integration, the HJP model of service delivery is expected to address some of the limitations of ad hoc professional training, by:

- influencing systemic change of practice in the identification and response to elder abuse – facilitating the exchange of knowledge and trust between the professions
- providing more immediate legal assistance
- encouraging a holistic service for the client – where legal assistance may resolve health issues or the availability of social services may resolve legal issues

the evidence

United States

There is an emerging body of knowledge supporting the expansion of the MLP model in the United States. The National Centre for Medical Legal Partnership (**NCMLP**) conducted a literature review of MLPs, which demonstrated MLPs are having a positive impact in these three areas: [32]

- financial benefits to clients and partnering organisations
- improved health and wellbeing of clients
- increased knowledge and confidence of health professionals to address legal issues

The NCMLP concluded MLPs are "a promising innovation for addressing social, legal and health challenges for undeserved and vulnerable patients, and should be scaled up to improve care at the patient, institution, and policy level".[33]

Australia

Literature detailing the impact of HJPs in Australia is only just beginning to emerge. LaTrobe University will undertake an evaluation of the HJP, contributing to the body of evidence in respect of the model in Australia.

Another exciting initiative in the expansion of HJPs in Australia is the establishment of a National Centre for Health Justice Partnerships. Clayton Utz has provided initial funding for the establishment of the Centre, which is auspiced by Justice Connect.

[30] Health Justice Partnership Network, Health Justice Partnerships (21 May 2015) <http://www.justiceconnect.org.au/what-we-do/what-we-are-working/health-justice-partnerships> citing Elizabeth Tobin Tyler *et al* (eds) *Poverty, Health and Law, Readings and Cases for Medical-Legal Partnership* (Carolina Academic Press, 2011), 74.

[31] National Center for Medical-Legal Partnership, 'Making the case for MLP's: a review of the evidence' (February 2013) 3.
[32] Ibid, 5-6.
[33] Ibid, 7.

how was this HJP developed?

As part of its ongoing commitment to HJPs, in 2014 the LSB committed $2.6m to nine HJPs, including the three-year HJP with cohealth.[34]

This partnership commenced in early 2015 with a lawyer from Seniors Law based at cohealth four days a week.

Both partners agreed on the shared aims and objectives of the partnership.

To achieve these objectives, the partnership involves six key areas of work: governance, evaluation, communication, professional development (**PD**), community legal education (**CLE**) and legal help.

Since the commencement of the HJP, the partners have delivered:

135+ instances of legal help

100+ attendees at PD sessions

420+ attendees at CLE sessions

Over the course of the year, the partners recognised cohealth has a culture that is conducive to integrating a legal service into its healthcare team. This was evident from existing attitudes, and a few key initiatives already underway, at cohealth. Refer to page 19.

aim and objectives

As detailed on page 11, both partners developed the shared aims and objectives of the HJP. This was an important element of the HJP.

The agreed aim of this HJP is to enhance the social model of health on North West Melbourne to include, for the first time, an integrated legal service. This model aims to create better health and legal outcomes for older people in North West metropolitan Melbourne.

The long term objectives of the HJP are to:

1. reduce the incidence and impact of elder abuse
2. articulate and demonstrate a HJP model that is: feasible, sustainable, client-centred, collaborative, embedded and strengths-based

While the medium term objectives are to:

1. increase health professionals' capacity to identity and respond to legal issues for older people
2. increase lawyers' ability to communicate with clients and respond to their health and legal needs
3. improve engagement with disadvantaged community groups and a better understanding of their legal needs
4. demonstrate a HJP model in practice and through a functioning governance structure
5. improve laws, policies and systems that are just and fair for older people

These objectives align with the strategic outcomes in the Victorian Government's elder abuse and prevention guidelines, emphasising the importance of:[35]

- increased community awareness of elder abuse
- increased active engagement by professionals through an increased ability to identify and respond to elder abuse
- a coordinated multi-agency support provided by relevant services

outputs and deliverables

To achieve these objectives, the HJP involves six key areas of work:

- governance
- evaluation
- communication and stakeholder engagement
- PD for health professionals
- CLE and community development (**CD**)
- legal help: information, advice, casework and referrals

[34] Legal Services Board, *$2.6 million funding awarded in the 2014 Major Grants round* (22 May 2015) <http://www.lsb.vic.gov.au/documents/Newsletter_11_Grants_Program_2014.PDF>.

[35] Above n 5, 9-15.

As detailed in the project schedule, these areas of work were prioritised over the three years of the HJP. See appendix a for a copy of the project schedule.

In the first year, the partners agreed it was important to develop the appropriate governance and evaluation frameworks, identify and engage high-priority teams at cohealth and deliver PD sessions to those teams. Evaluation would focus on health professionals.

Once the foundations of the HJP are established in year one, year two would focus on the provision of legal help, expanding the promotion of the service and further PD for health professionals. Evaluation activities would extend to clients.

In the third year, the HJP lawyer and various health professionals would engage high-priority CALD community groups to understand relevant legal issues for their older populations and work together to develop tailored legal health checks accordingly.

flexible delivery of outputs

The partners found, while it is important to have an agreed outputs from the start, such as polices, PD and CLE sessions, these should be delivered according to the needs of cohealth and its clients. There were a few instances where the project schedule had to be changed to ensure outputs complemented the existing initiatives at cohealth.

For example, a priority for the first year was to deliver PD sessions to a number of teams by mid-year. However, a PD program on goal-directed care planning had already been scheduled during this time. To avoid inundating teams with PD, we delayed the planned sessions until later in the year.

At the same time, various CD workers had received requests from community groups to receive CLE on the new powers of attorney laws. Consequently, the HJP lawyer delivered CLE sessions on elder abuse and POAs to over 420 community members, as outlined on pages 16 and 21.

Work on the intake and assessment procedures for elder abuse and other legal issues also had to be adjusted according to a broader initiative at cohealth to review its organisation-wide intake procedures. See page 12 for more information on this.

(a) governance

The initial stages of the HJP involved reviewing existing, and establishing new, governance arrangements to support the HJP. For example, the partners looked at:

- decision-making for the HJP
- formalising the HJP in a deed
- privacy, confidentiality and legal professional privilege (**LPP**) implications for multi-disciplinary practice
- intake, assessment and referral procedures

HJP decision-making

It was important to the partners that respective roles, responsibilities and expectations were established from the start. For instance, cohealth staff played a vital role in identifying and influencing key personnel and promoting the HJP at all levels of the organisation. This was critical to generate senior management 'buy-in' who in turn encouraged and supported professionals to attend PD sessions.

Ideally, there should be dedicated capacity from both partners to reflect the shared commitment and resourcing required for the establishment and maintenance of the HJP.

In the initial stages key stakeholders for the HJP – from Justice Connect, cohealth, LaTrobe University, the LSB as well as a pro bono representative – conducted a workshop to:

- understand expectations
- clarify roles and responsibilities
- define aim and objectives, as outlined on page 10
- prioritise outputs and deliverables, as outlined on page 10
- develop broad governance and evaluation frameworks
- understand available resources

In developing the appropriate governance arrangements, participants agreed three groups should be established to assist with decision-making:

executive committee: comprising one manager from each partner and responsible for guiding the development of the HJP and making decisions regarding operational matters with respect to the HJP. It receives advice and guidance from the advisory group and working group.

advisory group: comprising key stakeholders from the partners, government, the LSB, other health and legal services, pro bono partners and the HJP evaluator. The group is responsible for providing advice and guidance on: governance, evaluation, reporting, communications as well as PD and CLE sessions.

working group: comprising key cohealth senior managers and various health professionals, is responsible for providing advice and guidance to inform the executive committee's decisions on operational matters and to promote the legal service, PD and CLE sessions to colleagues and clients.

formal agreement

Initially, the partners considered entering into a standard agreement that contemplated colocation and delivery of a service. However, the partners formed the view that it did not quite reflect the nature of the relationship. As a result, a pro bono firm generously agreed to draft a "collaboration deed" specifying the:

- parties' shared vision and objectives as well as their relevant expertise
- nature of the relationship, confirming that whilst the relationship is very much a partnership in the ordinary sense of the word, neither party intends to create a partnership or joint venture in the legal sense
- parties' respective obligations
- role of the executive committee, including a "shared management structure" to ensure continuation of the HJP following the departure of key staff
- HJP deliverables along with the requirement that each party act consistently with the HJP objectives and use all reasonable endeavours to comply with the HJP schedule and targets
- parties' relevant insurance obligations, indemnities, intellectual property rights, confidentiality and privacy obligations
- process for dispute resolution, complaints and termination

privacy, confidentiality and LPP

Seniors Law changed its own policies and procedures to address the privacy, confidentiality and LPP implications of legal and health professionals working together.

In particular, these policies and procedures had to balance a client's right to privacy, confidentiality and the protection of LPP, while also facilitating trusting relationships between different professions and a more seamless service.

For example, the policies and procedures were changed to address:

- having a lawyer present at multi-disciplinary assessment meetings for complex clients
- the implications of having a legal and health professional present at a client appointment
- how to promote an ongoing "feedback loop", whereby the HJP lawyer, pro bono lawyers and health professionals can keep each other updated on the progress of the client's respective matters
- how lawyers can communicate with third and fourth parties when coordinating legal and non-legal services for clients

  For example, if the HJP lawyer is helping a client whose ability to remain in their property is dependent on a successful legal outcome, how to communicate with cohealth staff and external housing providers to arrange alternative accommodation, if need be.

intake, assessment and referral

A priority for the first year was to establish intake, assessment and referral procedures for the legal service. However, there was a broader initiative at cohealth to review its organisation-wide intake procedures. Consequently, it was decided that any long-term screening and assessment for elder abuse and other legal issues must be incorporated into these new procedures.

As an interim measure, the HJP lawyer would:

- meet with high-priority teams at cohealth to talk about the legal service and the referrals process, which was an informal telephone call
- develop a screening tool for elder abuse and other legal issues for health professionals to use
- deliver training on identifying and responding to elder abuse and other legal issues, and how to access the legal service
- list the legal service in cohealth's internal service directory

However, in the long-term, screening and assessment for elder abuse should be incorporated into cohealth organisation-wide procedures and practice, rather than being a standalone screening tool. The partners believe this approach would be

more convenient for health professionals and would encourage the necessary change in practice to ask about abuse and make appropriate referrals.

(b) evaluation

The LSB is working with grant recipients to develop some consistent indicators of success to be reflected in each HJP's evaluation framework. The evaluation findings of these HJPs are expected to significantly contribute to the evidence base of the utility of HJPs in Australia. Seniors Law must also report the impact of the HJP to the Justice Connect board.

La Trobe University will undertake an evaluation of the HJP, contributing to the body of evidence in respect of the model in Australia.

Given the HJP is a relatively new model of service delivery, the partners found the expertise and capacity of an independent evaluator is a key component of a HJP.

framework

The agreed aims and objectives of the HJP informed the development of a theory of change, illustrating the intended impact of the HJP. Refer to annexure b for a copy of the theory of change. A monitoring and evaluation plan was then developed based on the theory of change, outlining what is to be measured and how.

The partners found it is important the evaluation framework is established in the initial stages so that:

- the partners and relevant stakeholders know what can be reported on
- relevant information can be collected over the course of the HJP
- ongoing evaluation can continuously inform the development of the HJP

Once the partners knew what information needed to be collected, they could adapt their systems accordingly. For example, one of the intended impacts of the HJP model is that, with better collaboration between the partners, the HJP lawyer will be seeing clients with legal matters *sooner*.

To measure this Seniors Law wanted to classify the legal outcome: resolved by formal decision, agreement or preventative measures; or no legal remedy available. This involved making changes to Seniors Law's database to systematically collect this information at intake and file closure.

surveys and informal feedback

Other evaluation indicators require new data to be collected directly from stakeholders including cohealth staff.

Two key evaluation activities undertaken in the first year were surveys of health professionals in high-priority cohealth teams (a) before complete colocation of the lawyer at cohealth (**baseline survey**); and (b) following PD sessions (**post-PD survey**). The surveys aimed to measure the change in health professionals' attitudes, confidence, capacity and practice with respect to elder abuse and legal issues. Refer to appendix c for a copy of the distributed surveys.

The partners wanted staff to complete the baseline-surveys before they had any significant involvement with the HJP lawyer in order to capture the relevant indicators before the commencement of the HJP.

This meant the evaluation framework, which informed the baseline surveys, had to be developed first. Once the framework was established, the baseline surveys could then be developed, approved by cohealth's ethics committee and distributed to the teams. In the meantime, the HJP lawyer was limited in her ability to raise awareness about elder abuse, legal issues and the service.

As a result, a key learning is the importance of distributing the baseline surveys as soon as possible, so the HJP lawyer can quickly establish relationships with the relevant teams. However, as these surveys allow the partners to measure changes in attitudes, confidence, capacity and practice over time, these relevant indicators must be agreed from the start and captured in the baseline surveys.

The results of the surveys and informal feedback helped to inform subsequent PD sessions. For example, the baseline survey indicated reasonably high levels of consensus that health and legal professionals should work together to address elder abuse and that it was a good idea for a lawyer to be at a community health centre. This indicated a reasonably high level of "buy in" from cohealth staff as to the value of the HJP.

However, findings supported the need for training on identifying elder abuse and making referrals to legal professionals. This meant PD sessions should be focused on elder abuse, other legal issues, working with lawyers and how to make referrals. Discussion of the relationship between health and legal issues generally and the rationale for the HJP only needed to be briefly touched on.

The results of the baseline survey also outlined common legal issues experienced by older clients accessing cohealth's services – financial abuse and POAs – which account for a significant proportion of Seniors Law cases. This confirmed cohealth as an appropriate partner for the HJP.

Post-PD survey results and informal feedback from health professionals informed subsequent sessions. During the sessions, health professionals were given the opportunity to share their own experience and insights with colleagues. This was particularly useful for topics where health professionals play a key role in addressing elder abuse, for example:

- identifying abuse – common risk factors and signs
- recommended questions and strategies when asking about abuse
- strategies in the immediate response to suspected or disclosed abuse
- successful non-legal interventions to support people experiencing elder abuse – for example, finding available community groups to reduce isolation and dependence on the perpetrator

Interestingly, colleagues who had developed a good working relationship with the HJP lawyer shared frank suggestions on how to improve the PD sessions for the future. There are generally no opportunities for these types of discussions after external PD sessions arranged on an ad hoc basis.

Guided by the results and feedback, the HJP lawyer:

- refined the PD content
- captured insights and information provided by experienced professionals during the session to be included in training materials and resources
- allowed more time for case studies
- adjusted the format of the handouts

Findings from the post-PD surveys showed subsequent improvements from the initial session, which had a statistically significant variation.

(c) communication

While the HJP lawyer is formally based in an allied health team, the partners also wanted to engage with health professionals in teams who would be expected to work older people who may be at risk of elder abuse and other legal issues (**high-priority teams**). These teams included allied health, intake, aged residential outreach, HARP, homelessness, mental health and adult day centre staff.

Input from cohealth management was invaluable in identifying the relevant teams and encouraging engagement with the legal service, including arranging for the HJP lawyer's attendance at team meetings, encouraging attendance at PD sessions and directing referrals to the service. This "buy in" from management is integral to the HJP's viability and sustainability.

Initially, the HJP lawyer met with each high-priority team to discuss:

- the relationship between health and legal issues
- the role of health professionals in addressing elder abuse
- elder abuse, especially financial abuse
- other legal issues
- the legal service and how to make referrals

The HJP lawyer distributed a brochure for the service at these meetings. It was decided the HJP would be communicated as cohealth's legal service for older people, with the lawyer regarded as another member of the health care team, rather than a HJP between cohealth and Justice Connect. This was intended to provide a clearer message for health professionals and their clients and promote cohealth's ownership of the service thereby encouraging its long-term sustainability.

We also created flyers for specific communities with the assistance of health professionals who specialise in working with CALD community groups.

Various mediums were used to raise awareness of elder abuse and the legal service throughout the year. These ranged from formal settings – like team meetings, PD sessions, newsletters and social media – to more informal interactions – casual coffee catch-ups or lunches, tea room conversations or emailing a colleague an interesting article.

While these more formal settings were beneficial, especially in the initial stages, it was the incidental interactions that provides the lawyer with the opportunity to build trust and feel more part of the "health care team". Therefore, a key role of the HJP lawyer is to make themselves physically available to these incidental interactions. Page 20 details how relationships between the HJP lawyer and health professionals improved due to colocation.

Outside cohealth, the HJP lawyer also met with:

other health organisations where unmet legal need was apparent: for example, a nurse in the emergency department of a local hospital, who had been tracking instances of physical abuse over the past two years, approached Seniors Law to discuss how to best help his patients. Given the potential unmet legal need, we made an informal referral pathway for this team to access the legal service.

local networks for family violence, aged and disability services: through the promotion of the service, the HJP lawyer was invited to attend various local networks to discuss elder abuse and the legal service. With referrals being generated from these meetings, this targeted approach has proved to be an effective way to connect with local services working with people who may benefit from the legal service.

other legal services: invariably, the HJP lawyer was approached for legal help that was outside the scope of the older persons' legal service. It is, therefore, important that the HJP lawyer has extensive knowledge of other legal services to make appropriate referrals and empower health professionals to navigate the legal system for their clients.

These legal referrals are an important part of the role of the HJP lawyer as they help the HJP lawyer (a) build trust and credibility with colleagues and (b) monitor legal demand and identify any systemic legal issues that might be resolved through PD or CLE. These local legal services may also be a referral source for the HJP.

During year two, the partners will monitor demand for the service, so as to inform the nature and extent of engagement with different health care teams and services.

(d) professional development

health professionals

In the first year over 100 health professionals were involved in an intensive PD program addressing four key areas:

- the relationship between health and legal issues
- elder abuse
- legal issues for older people
- working with lawyers

Appendix d details a more comprehensive list of topics.

Participants also received an elder abuse risk assessment framework and screening tool for legal issues.

Where possible, the sessions were co-presented by the HJP lawyer and a social worker from cohealth who specialises in working with older people in the Chinese community experiencing elder abuse. The social worker was able to provide practical strategies on:

- how to ask questions about abuse
- common signs – for example, if a client advises a worker not to speak to a certain family member, this may indicate a level of family distrust, fear or conflict
- building an older person's capacity to seek legal help
- non-legal interventions that may help mitigate harm if the person does not want to seek legal help, including case studies highlighting successful non-legal interventions

These insights provided a more complete discussion on what each professional can do to help older people experiencing elder abuse. Involvement of health and legal professionals in delivering PD session is a vital component of the HJP model.

The HJP lawyer discussed the proposed PD plan with cohealth management and the advisory group who provided two valuable pieces of advice on the practical implications of delivering the PD program:

different teams and professionals have varying capacity to assess risk, make referrals and provide ongoing support

Consequently, the HJP lawyer met with the team leaders of each high-priority team to understand their expectations of what role team members should play in working with clients experiencing elder abuse.

For example, social workers, counsellors, outreach workers and care coordinators may have an ongoing relationship with the client and are more likely to have capacity to screen for abuse, develop interventions and provide ongoing support. In comparison, the capacity of intake staff, podiatrists, dentists, doctors, etc may be

limited due to brief consultation times, busy wait-lists and sporadic or once-off interactions.

The PD sessions were then tailored to accommodate the varying needs of these professions. For example, workers that are likely to have a more involved role in working with the client received training on how to develop interventions and work with lawyers. In contrast, PD sessions for workers who may have a more limited role focussed on how to quickly screen for elder abuse and other legal issues and how to make appropriate referrals.

Further, the team leaders also provided feedback on what case studies would resonate with their team members, which was reflected in the PD presentation and handouts.

if health professionals are trained on asking about elder abuse, there must be clear guidance on what to do if abuse is suspected or disclosed

The partners were advised, if elder abuse is suspected or disclosed during intake or a client appointment – especially with high-risk clients – there must be capacity in a health service to conduct an assessment internally or make an appropriate referral. Ideally, given the sometimes narrow window of opportunity to help clients experiencing elder abuse or family violence, the response must be timely and client-centred.

Policies and procedures that outline expectations of health professionals and management, define roles and responsibilities and provide clear referral pathways are useful to support staff in the event of suspected or disclosed elder abuse.

Consequently, the HJP lawyer joined a working group to develop cohealth's response to family violence, elder abuse and child abuse (**violence and abuse**). It comprised cohealth managers from different teams who had expertise in violence and abuse. It was agreed that, where possible, cohealth would have a consistent response to clients experiencing violence and abuse. The group agreed on some general principles and practices, which were used as a basis for the PD sessions in the first year. It is anticipated the relevant policies and procedures will be finalised by mid-2016, which will form a basis for additional PD sessions in year two.

pro bono lawyers

Seniors Law is also committed to training its pro bono lawyers who undertake the more significant, resource-intensive matters referred from the HJP lawyer. The legal need of cohealth's clients will inform the ongoing training for pro bono lawyers. As we continue to see financial abuse involving significant property transactions, we provided training on "assets for care" arrangements and restraint of assets for property law.

(e) community legal education

Originally, CLE and community engagement was not a focus for year one, but various health professionals and their community groups requested CLE sessions, especially on the new powers of attorney law. As a result, the HJP lawyer delivered CLE sessions on elder abuse and POAs to over 420 community members. For more information on how the HJP lawyer and health professionals developed these CLE sessions see page 21.

(f) legal help

The HJP lawyer provided a range of legal help: legal information and referrals, advice and casework.

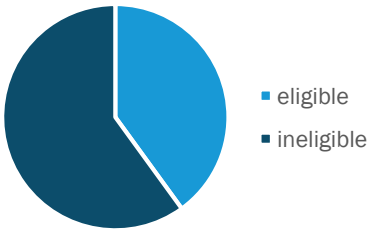
Since it's commencement, the HJP has helped address 136 legal issues.

secondary consults: legal information and referrals

The most common form of legal help provided was secondary consultations with health professionals for their clients. The HJP lawyer provided 96 secondary consultations to health professionals from different teams on a variety of legal issues.

Of these 96 secondary consultations, 38 matters (40%) were eligible for the legal service, while the remaining matters were referred to legal or non-legal services. See graph 1.

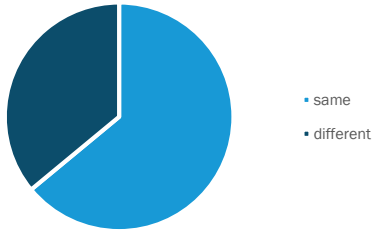
graph 1: consults for eligible issues



The partners are monitoring the proportion of eligible matters over the course of the HJP. It is hoped, as health professionals develop a better understanding of the community legal sector, the "strike rate" for eligible matters will improve.

As illustrated in graph 2, health professionals at the same site as the HJP lawyer accounted for a significant majority of secondary consultations, being 64%.

graph 2: sites requesting consults



legal advice, casework and referrals

The legal service is for older people who are experiencing elder abuse or another legal issue associated with ageing. Seniors Law reduced the minimum age limit of the service, from 65 to 55, bringing it in line with cohealth's eligibility criteria for many aged services.

The service is available to health professionals at cohealth, as well as external organisations within cohealth's catchment area that have indicated apparent unmet legal need, including Western Health and local family violence, aged and disability networks.

Legal help can be provided by the HJP lawyer or Justice Connect's network of pro bono lawyers.

pro bono capacity

A distinctive element of this HJP is Justice Connect's ability to utilise the capacity and resources of its pro bono member firms. It is hoped the availability of these pro bono resources provided by Justice Connect member firms will mean:

- more clients will be seen, *sooner*
- more complex legal issues can be addressed, in a timely manner
- specialist knowledge can be developed to address systemic issues, such as "assets for care" arrangements

To achieve this, there must be a relatively seamless process between the HJP lawyer's eligibility assessment and the engagement of a pro bono firm. A timely response from pro bono firms helps to engender trust with health professionals and their clients.

defining the scope of the service

The partners found defining the eligibility for legal services provided as part of a HJP, can be complex. In this HJP, the partners were careful to balance the desire to extend the reach of the service with the need to ensure the HJP lawyer and pro bono lawyers have sufficient capacity to meet the needs of cohealth staff and its clients.

Especially in the initial stages, the partners wanted to ensure the HJP lawyer was available to develop relationships with cohealth staff, particularly those in high-priority teams. Therefore, the HJP lawyer focused on meeting with, delivering PD sessions for, and receiving referrals from these teams. However, the HJP lawyer was also available to engage with health professionals outside cohealth, in response to apparent unmet legal need.

With PD sessions for high-priority teams concluding towards the end of 2015, the partners will be reviewing what impact it has in referrals to the service. Depending on the capacity of the HJP lawyer and pro bono firms, the partners will decide whether the promotion of the service could be expanded to other sites at cohealth and other agencies outside cohealth. A potential challenge of the HJP model is the need to adapt to fluctuating demand for legal services from various organisations. This is made easier with the availability of pro bono resources.

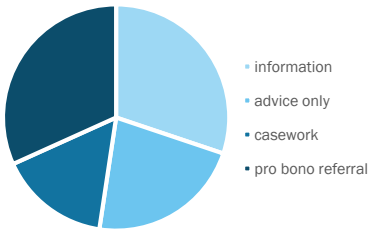
how we helped

The HJP lawyer assisted with one-off or discrete legal issues – such as powers of attorney or intervention orders – and referred more significant, resource-intensive matters to pro firms – including property disputes or "assets for care" agreements.

Graph 3 shows the different ways the HJP assisted eligible clients, receiving one or more of the following from the HJP lawyer:

- legal information in 24 instances
- one-off advice in 14 instances
- casework in 10 instances
- referrals to pro bono lawyers in 20 instances

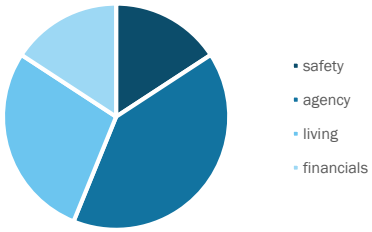
graph 3: legal help for eligible clients



The legal service helped with a wide variety of legal issues, relating to an older person's:

- **safety:** intervention orders
- **agency:** guardianship and administration (**G&A**), POAs and wills
- **housing:** property, building, family agreements, tenancy and family law property settlements
- **financials:** credit and debt, employment, Centrelink, fines, administrative law, criminal

graph 4: types of legal issues



Examples of the types of significant matters referred to our pro bono firms include:

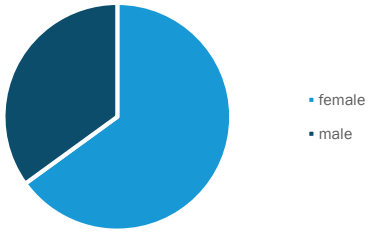
- G&A advice and disputes
- unauthorised cash withdrawals
- property advice and disputes
- wills advice and disputes
- resolving "assets for care" arrangements
- personal loans between family
- drafting wills and POAs

clients experiencing elder abuse

Of the legal issues we helped with, almost half (49%) arose in the context of elder abuse. These included: G&A, POAs, family law, property, family agreements family violence intervention orders and wills.

Of these clients identified as *experiencing* abuse, 65% were female, while 35% were male.

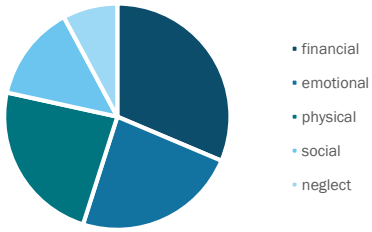
graph 5: clients experiencing elder abuse



Just over half (52%) of the identified *perpetrators* of abuse were male, while the remaining (48%) were female. Abuse was typically perpetrated by an adult child, which is consistent with the previous experience of Seniors Law.

In terms of the types of elder abuse clients experienced, the most common was financial abuse, followed by psychological and physical.

graph 6: types of elder abuse



Interestingly, physical elder abuse did not feature prominently in its casework. In contrast, since the commencement of the HJP, of the people identified as experiencing elder abuse who received legal help, physical abuse was flagged in almost two-thirds of the cases (59%).

These cases were generally reported in the process of secondary consultations or one-off advice sessions with the HJP lawyer, but did not necessary translate into the client wanting to take legal action. There main reasons for this were a reluctance to compromise their relationship with the perpetrator or insufficient capacity to instruct a lawyer.

Examples of the instances of elder abuse include:

- depleting the older person's bank account and then leaving them in an aged care facility
- evicting the older person from their own property
- pressuring the older person to sign documents
- gaining control of the older person's accounts and refusing access to their pension
- unauthorised transfers of property

- refusing to repay personal loans in the $100,000's
- selling drugs from the older person's property without consent
- refusing to release funds for care under an "assets for care" arrangement
- "boomerang" children – where an adult child remains living with their older parent – and refusing to leave when asked

what already existed at cohealth?

As highlighted on page 10, cohealth has a culture that is conducive to integrating a legal service into its healthcare team. Over the course of the first year this was evident in existing attitudes, and a few key initiatives already underway, at cohealth:

existing positive attitudes

cohealth staff responded to a baseline survey about the way they see legal issues impacting on older consumers, and the potential value of a collocated legal service. The findings of these baseline surveys indicated:

an appreciation of the connection between health and legal issues for older clients

100% agreed receiving help with legal problems and issues can improve the health of older people

very strong support for strengthening links between health and legal services to help clients

100% agreed health professionals have a role to play in addressing elder abuse

100% agreed legal and health professionals should work together in addressing elder abuse

98% agreed it is a good idea to have a lawyer as part of a community health service

client-centred services

cohealth has a broader commitment to move towards client-centred and client-directed services in line with the significant changes to the coordination of health care services, such as the NDIS and My Aged Care.

For example, the Community Health team held meetings during the year to discuss how inter-professional practice (**IPP**) could be implemented in the team, including through multi-disciplinary assessment meetings, PD on different professions and better coordination of services. Supporting this, staff were also trained on goal-directed care planning (**GDCP**), which coordinate services at cohealth according to the needs and priorities identified by the client.

These positive findings from the baseline results and broader commitment to provide client-centre services through IPP indicate there will be attitudes and structures that can promote the longevity and sustainability of the integrated legal service.

supporting policies and procedures

The partners are also collaborating on the development of policies and procedures that help sustain a better service for older people experiencing elder abuse and other legal issues, including:

a gender equality strategy and policies and procedures outlining cohealth's response to family violence, elder abuse and child abuse: including immediate response to disclosure, screening and assessments, safety planning, etc. This promotes an organisation-wide commitment to helping older clients experiencing abuse, building internal capacity for workers and managers to identify and respond to elder abuse and streamlines referrals to appropriate services.

a human-rights framework: which encourages health professionals to adopt a rights-based approach to health care. This framework will help guide workers in navigating their professional obligations relating to confidentiality, duty of care, respecting self-determination, etc when working with clients experiencing violence and abuse.

a review of its intake procedures: to create a consistent and coordinated experience for clients, streamlining the processes used at Western Region Health Centre, Doutta Galla Community Health and North Yarra Community Health, which amalgamated to become cohealth.

a diversity strategy: including a commitment to engage with older people who identify as LGBTI. This is consistent with the HJP's objective to promote access to justice for older populations that are isolated and difficult to reach. Older people who identify as LGBTI are one of these populations.

The partners want to ensure any screening for elder abuse, PD sessions and referral pathways to the legal service are consistent with organisation-wide frameworks and initiatives.

what is the impact?

In just the first year the partners have seen evidence of:

improved relationships between health and legal professionals, due to colocation of the services and the availability of secondary consultations

better collaboration in the development of PD and CD sessions and the provision of a more client-centred service

better understanding of the health and legal sectors

changes in policies, procedures and practice of the respective partners

improved capacity to address elder abuse and other legal issues on individual, team and organisation-wide levels leading to better reach of clients and improved engagement with the service

The partners have identified four key elements that make this service better for older people who are experiencing elder abuse and professionals who work with them:

- having an approachable lawyer colocated at a health service
- ensuring the lawyer is integrated into an existing client-centred service with coordinated client appointments and a seamless "feedback loop"
- promoting the use of secondary consultations
- supporting workers with ongoing professional development

what is the impact?

(a) improved relationships

colocation

Being on site four days a week, the HJP lawyer is in a better position to develop enduring relationships with health professionals over a longer period of time. This might be through lunchtime conversations, coffee catch-ups or it might come through invitations to meetings and events for clients and staff. These interactions provided an opportunity to raise awareness about elder abuse and other legal issues, but also to demystify the legal profession.

Several health professionals interviewed for the evaluation commented specifically on the approachability of the HJP lawyer. In addition to introducing herself to staff, "she has engaged with clients".

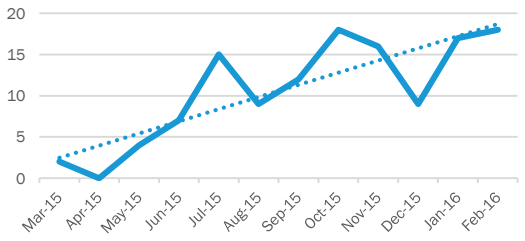
> *[The HJP lawyer] is very caring. She has a high level of empathy. Not all lawyers have this.*

The HJP lawyer increasingly felt more like a member of the health team, sometimes simply by having a locker in the kitchen and a cohealth lanyard, or through a better understanding of the health sector – ACAS assessments, HACC packages, housing policies, my aged care, etc.

After a while, professionals approached the HJP lawyer, having heard "there is a lawyer in the office". The value of having the HJP lawyer physically present at a cohealth site was evident in the number of requests for secondary consultations, a majority of which were provided to professionals based at the same site as the lawyer.

As word spread – both formally and informally – the number of requests for legal help per month increased over the year.

graph 7: instances of legal help



With colocation an essential element of this model, one challenge with this HJP was constraints on the lawyer's ability to develop relationships with health professionals based at different cohealth sites and on outreach, rather than having a centralised referral pathway through a social work team.

The partners decided, at least during the first year, the lawyer should remain at one site so as to maintain a sense of stability and certainty for health professionals. In the second year, the partners will review the location of the HJP lawyer, balancing the need to build new relationships, whilst also

maintaining relationships with health professionals who are already engaged with the legal service.

The partners were concerned that, if the lawyer is located at too many sites, it may be difficult to develop enduring relationships. The service may then be perceived as a "legal clinic" and the lawyer is not necessary seen as part of the "health care team".

secondary consultations

The availability of secondary consultations was a key element of the HJP for a variety of reasons:

better access to legal help, sooner: as detailed on page 7 there are many reasons why an older person does not want to seek legal help if they are experiencing elder abuse. With the availability of secondary consultations to health professionals, older people in this situation can still receive the benefit of legal information through a trusted worker who can continue to support them and build their capacity.

By being informed of a potential legal solution and any associated time limits, the older person may be more likely to seek legal advice in the future. If the older person still decided not to seek legal help, at least the decision is informed, which can still be empowering.

building trust and relationships: by providing a convenient and immediate source of legal information, the HJP lawyer can add value to the health service and build trust and credibility with colleagues, who may be more likely to make subsequent referrals to the service and encourage others to do so.

easier intake process: for eligible matters, the process of secondary consultations also made the intake process quicker and easier. If the client decides they do want to seek legal help, they do not have to repeat their story to the HJP lawyer, who has already received information on the background facts and key legal issues. Health professionals also do not have to comply with the formal intake process, which can at times be impracticable.

better navigation of the community legal sector: the HJP lawyer can increase health professionals' awareness of other relevant legal services for non-eligible matters. The lawyer can also monitor requests in order to identify systemic, recurring legal issues and engage a relevant legal service to provide legal help, CLE and PD to address unmet legal need.

(b) better collaboration

In the first year, this HJP provided more opportunities for health and legal professionals to collaborate in the design and delivery of PD and CLE sessions, the provision of a client-centered service as well as the development of policies and procedures.

PD sessions

As outlined on page 15, the HJP lawyer met with various health professionals at cohealth to develop and co-present PD sessions, according to the needs of each individual team.

CLE sessions

There were many advantages arising from better collaboration between the HJP lawyer and relevant health professionals in developing and delivering CLE sessions:

more tailored sessions: the HJP lawyer consulted with health professionals on what legal issues would be most relevant to their groups and the best format.

For example, the formats of the CLE sessions varied from more formal presentations – panel discussion for over 100 people – to informal interactions – a "community kitchen" lunch and afternoon teas.

easier follow-up and referrals: if a person required further information after the session, they had the option of calling their trusted worker who could support a referral as well as making a self-referral. If the person seeks legal help, their trusted worker can also provide ongoing support following on from the session.

better relationships with community groups developed through a program of ongoing activities, designed by outreach and CD workers.

For example, the HJP lawyer initially met with community groups in the older persons' high rises at a regular "community kitchen" lunch and afternoon tea run by cohealth's aged outreach services. Following on from this, colleagues also invited the HJP lawyer along to other initiatives – art exhibitions, Christmas dinners, etc – which allowed the residents to become more familiar with the HJP lawyer.

These incidental interactions – cooking classes, visiting the residents' gardens – were important as it helps build trust and helps to break-down stereotypes of a "typical lawyer".

client-centered service

The partners want to demonstrate a service that is flexible, transparent and responsive to the needs of cohealth staff and their older clients.

A client-centered service was achieved in the following ways:

responsive to urgent needs: health professionals interviewed as part of the evaluation highlighted how important being flexible and responsive is for cohealth clients, particular those likely to require legal assistance.

*Some clients are not OK on the 'phone…some of them are patient, but some are very demanding and want someone straight away. They calm down (*if the response is quick), *and it's fine.*

Older people present with more complicated issues than younger people.

If you say "you may hear from me in three days", their mobile phone may be out of credit or switched off. Things escalate if the response is slow. This way [the legal service] shows the client [their problem] can be resolved.

The approach is very crucial – how they [HJP lawyer] approach the person and the whole situation. If they're too strong, the client may close up and say I don't want to talk to you anymore. Or stop coming to the service altogether if they sense the approach is too rigid. It's the human approach – how they approach things.

coordinated appointments: the HJP lawyer does not have set "clinic times" to see clients. Rather, appointments with the lawyer are coordinated with health professionals' meetings or home visits, if possible.

For example, health professionals, would often say to the HJP lawyer "I have a client coming in this afternoon. I think they may have a legal issue. Do you mind popping in to speak to them?" This flexibility was highly valued by health professionals, with one exclaiming "you're just the best!" when the HJP lawyer was able to meet with the client and the HARP team member for an initial assessment.

Likewise, social workers would also come to support clients for court appearances, which was immensely useful especially when the lawyer was occupied speaking with other lawyers and the court staff.

Li's story on page 23, illustrates the value of coordinated appointments, especially for isolated older people experiencing elder abuse. As referrals to the legal service increase, however, this approach may have to be revised.

multi-disciplinary meetings: the HJP lawyer found the presence of a health professional during initial meetings invaluable. If the health professional has developed a long-standing relationship with the client, they are able to illicit, verify or even challenge information from the client about their legal matter to assist in the provision of more accurate advice.

For example, the HJP lawyer met with an older person who wanted her carer to cease her abusive behaviour but still wanted to maintain the caring relationship. During the meeting, the social worker was able to ask about specific instances of previously reported abuse to provide a more complete picture for the lawyer to conduct a risk-assessment and provide legal advice. In this instance, while the older person decided not to take legal action, the social worker was still able to discuss a range of strategies to improve the caring relationship and the older person's safety.

Over the course of gathering information about clients' legal matters from clients and their workers, the HJP lawyer tried to establish a consistent account of the relevant facts, on which her advice was based. To avoid inconsistencies, or resolve them in a transparent way, the HJP lawyer tried to meet with both the client and the worker simultaneously.

providing for the "feedback loop": systems and practices were changed so that the relevant file lawyer could, subject to obtaining client consent, update the relevant health professionals on how the legal matter is progressing.

Simply recording that there had been contact between the HJP lawyer and the client, without any subsequent detail, was considered helpful by one health professional interviewed. Both in terms of knowing that something had happened, and also for highlighting to other staff that legal solutions can be relevant across a range of situations.

For example, during intake, the HJP lawyer explained the role of the HJP lawyer and, if necessary, pro bono firms to inform client consent to communications between cohealth, Seniors Law and the pro bono firm for the purposes of facilitating: (a) the initial referral; and (b) ongoing updates over the course of the matter, which was recorded on file and on the referral from Seniors Law to pro bono firms.

The engagement letter from a pro bono firm also sought the client's consent to provide regular updates on the matter.

This is another key element of the HJP, as provision of updates engenders trust with the relevant health professionals, helps inform non-legal interventions and saves the client having to repeat themselves.

addressing systemic issues: when a systemic legal issue presented, the partners coordinated a more effective response.

For example, a cohealth CD worker and the HJP lawyer arranged a CLE session on POAs for a community group for older people who had been diagnosed with early-onset dementia, a recognised risk factor for elder abuse. No one at the CLE session had prepared a POA but, at the end of the session, participants indicated that they wanted to.

Subsequently, the CD worker and HJP lawyer arranged for pro bono lawyers and interpreters to attend at the group's centre to do a "POA clinic" for participants, who the CD worker had assessed as high-risk of losing legal capacity or experiencing financial abuse. This was easier for the clients, who would otherwise have to individually arrange their own interpreting services and POAs.

the value of pro bono contribution: as discussed on page 17, a distinctive feature of this HJP is the contribution and commitment of its pro bono firms, which can assist the legal service in accommodating fluctuations in demand, reduce waiting times and ensure the timely progression of the client's legal matter.

policies and procedures

Beyond individual clients, teams and community groups, the partners wanted to develop organisational change that will sustain a better response to older people experiencing elder abuse and other legal issues in the long term. This was best achieved through the development of policies and procedures, as detailed on page 19.

Li's story

The only time Li could speak to a lawyer was during her physio appointment. Health justice partnerships provide a small "window of opportunity" to assist older people experiencing elder abuse.

Social isolation and dependence on the perpetrator can be both a cause and a consequence of elder abuse. This makes it difficult for older people to access services to address elder abuse, especially legal services.

Li's story illustrates the potential of HJPs to promote access to justice for older people experiencing abuse.

Li, 58, has been married to her husband, Chen, for 35 years. When Li and Chen emigrated from China with their children they relied on her occupation as a teacher to support the family – she was the main "breadwinner".

Li's health has deteriorated – she had a stroke a year ago and now receives physiotherapy treatment. She now relies on Chen as her primary carer, while her children also provide support. As Li is unable to work, and Chen is her primary carer, they are reliant on government benefits. They also own their home but, with limited income, they are finding it hard to make repayments on their mortgage. While the house is in Chen's name, Li contributed $50,000 to the purchase price. If the mortgage repayments can't be made, Chen plans to sell the house but he denies Li's entitlement to her $50,000 contribution.

Li has superannuation and a small amount of savings. Chen has been pressuring her to access this money to make payments on the house. Instead, she would prefer to leave her remaining superannuation and savings to her children, thereby reflecting the contribution already provided to Chen...

continued

Chen is very controlling – he doesn't let her go out on her own and manages all the family's finances. He attends all her medical appointments. Because of this controlling behaviour, Li cannot visit a lawyer to help her with a will and to protect her interest in the family home.

Chen is also verbally and physically abusive. Unfortunately, with her complex health conditions and care needs, there are limited housing and care services available for Li to live independent of her main care-giver, Chen. The police have taken out an intervention order for Li against Chen, which allows him to remain living at the house but prohibits family violence. Since the police have taken out the order, his behaviour has improved, but Li believes that if Chen hears about any will he may become violent.

With Li's consent, her care coordinator contacted the HJP lawyer, who attended Li's next physiotherapy appointment. While Chen remained in the waiting room, the HJP lawyer advised Li on preparing a will and lodging a caveat. The lawyer also checked Chen's ongoing compliance with the intervention order.

The HJP lawyer then arranged for specialist pro bono lawyers to prepare the will and to attend Li's next physiotherapy appointment. Li signed the will and binding nomination form for her superannuation but she did not proceed with lodging the caveat because Chen would receive notice of the lodgement. She was fearful of how he might respond and didn't want to disrupt the family, especially since things had improved since the intervention order. The pro bono lawyers were able to store Li's will at their office so Chen would not be able to find it.

If cohealth staff, the HJP lawyer and pro bono lawyers were not able to work together, Li would not have been able to receive the legal advice she required without Chen knowing.

(c) better understanding of different sectors

the legal sector

Given the significant barriers to speaking to a lawyer about elder abuse, an important aspect of the CLE sessions was to acknowledge these barriers – that people don't want to get their families in trouble with the law – and explain what it means to speak to a lawyer – that the consultation is confidential and the client can decide whether or not to take legal action. Assuring participants that they can speak to a lawyer without anyone knowing, can help overcome some of these barriers to seeking legal assistance.

Further, a lawyer's professional obligations were an important aspect of the PD sessions developed for cohealth teams. A good understanding of these obligations helps to develop better relationships and clarity of why lawyers do things a certain way.

For example, when speaking about "conflicts of interest", the HJP lawyer explained why they need the parties' full name at intake and that, in the event of a conflict, they could not disclose the conflict due to the duty of confidentiality. This explanation guards against the potentially awkward situation where the HJP lawyer is unable to disclose the reason why they are unable to help an otherwise eligible client.

Another important topic is the importance of maintaining the protection of legal professional privilege, which may be compromised with the presence of non-legal professionals when legal advice is provided to a client. However, there are strategies that can be adopted to maintain privilege, including restrictions on recording notes of the meeting and on communications outside the meeting. Prior explanation of the strategies can hopefully allow for better collaboration on a client matter down the track.

The baseline surveys indicated:

support for training cohealth staff to help *refer* clients to a lawyer

53% indicated they had never referred a client to a lawyer in the last 12 months

30% indicated they were not confident that they had the skills and knowledge to refer clients to a lawyer

Whereas, findings from the post-PD surveys indicated:

an improved capacity to address legal issues and work with lawyers:

100% agreed, after PD, they are more – or were already – confident in their ability to *identify legal issues*

98% agreed, after PD, they have the necessary skills and knowledge to *refer to a lawyer*

100% agreed, after PD, they have a better understanding of – or already knew – how to *work with lawyers*

the health sector

The HJP lawyer increased their understanding of how health professionals assess, support and advocate for clients, which generally occurs before they have any interaction with a lawyer.

During the year, the HJP lawyer learnt about the various intake, assessment and screening processes at cohealth and resources required to identify these underlying issues impacting on a person's health.

Beyond cohealth, the HJP lawyer also learnt about broad sector reforms, such as NDIS and My Aged Care. This movement towards centralised intake and client-directed services will inform the policies, procedures and PD sessions developed over the course of the HJP.

Health professionals were also generous in sharing their expertise working with older clients experiencing elder abuse, including successful non-legal interventions used. For example, the importance of community groups and how to navigate housing services.

Several health professionals interviewed commented on the way the HJP lawyer had engaged with clients.

[The HJP lawyer] understands health. She is getting involved with clients—like going to a community kitchen event—and she's seen as a normal person.

(d) changes in policies, procedures and practice

Seniors Law

As discussed on page 12, Seniors Law changed its policies and procedures to address the privacy, confidentiality and LPP implications of legal and health professionals working together. The intention of these changes was to facilitate more seamless interactions between different professionals working with a mutual client, while also complying with a client's right to privacy and confidentiality.

The HJP lawyer had to be more mindful of these professional obligations as their interactions with the health professional became more like "being part of the same team" – for example, seeking and recording consent to provide updates, monitoring any record of legal advice, storage of client records and discussing client matters outside the appointment room.

Further, with the increased emphasis on providing legal information by way of secondary consultations, the HJP lawyer also had to make sure they did not provide legal advice in the course of these consultations.

cohealth

Initially, the partners wanted to understand current awareness of elder abuse and referral pathways for the high-priority teams.

Findings from the baseline surveys indicated:

a reasonably high level of awareness of legal issues for older clients

The top five legal issue for older clients were:

1. abuse, physical, family other violence;
2. family relationships;
3. homelessness, housing;
4. financial;
5. wills, property, POA;

which are issues that commonly arise in Seniors Law advice and casework

97% agreed older people experience issues and problems (financial and emotional) that could be addressed with legal solutions

a reasonably high level of awareness of the Seniors Law service

the three most common services to refer an older person experiencing elder abuse were: a counsellor; a CLC and Seniors Law

While the Seniors Law service was a recognised referral pathway for older people experiencing elder abuse, there was not a consistent approach for making referrals. Some workers cited reasons for not speaking to a lawyer, including:

- they were not sure what to do when a client discloses elder abuse but asks them not to tell anyone or do anything
- they do not want to compromise the therapeutic relationship – the worker does not believe the client is ready to speak to a lawyer; the client does not see the value of speaking to a lawyer because it is a "family issue"; the client does not want to get their family into trouble

Health professionals interviewed also raised an issue around perceptions of differences in the goals for elder abuse involving family members.

> *Staff are likely to raise [family elder abuse issues] with [the HJP lawyer] as long as the outcome wouldn't be as dramatic as saying "your kids have to move out". Workers want everyone to be happy. Unless [the client] really hates their kids and things are terrible, they don't want to break up relationships.*

The partners found the role of the HJP lawyer involved strengthening these pathways – through secondary consultations – and developing relationships with workers, PD sessions and policies and procedures.

Interviewees reflected on change in their practice. These comments were consistent with findings from the post-PD surveys, which indicated:

a change in practice to be more aware of elder abuse and other legal issues; to ask about abuse and to refer to the HJP lawyer

100% agree, in future, they will be – or are already – *alert to risk factors, signs and symptoms* of abuse

100% agreed, after PD, they will be more – or were already – *aware of urgent legal issues*

98% agreed, in future, they will *ask about abuse*

100% agreed, in future, they *will* – or already do – refer to the HJP lawyer

(e) improved capacity to address elder abuse, legal issues

individuals and teams

The partners found the combination of PD sessions and secondary consultations were important in building the capacity of health professionals to address elder abuse and other legal issues.

For instance, PD sessions outlined common legal issues Seniors Law can help with, but they were framed as "life issues" in the context of someone's care, agency, living arrangements and finances. After a PD session, common feedback was "I had no idea that was a legal issue – that happens all the time".

Combining these PD sessions with the availability of secondary consultations, the HJP lawyer and a health professional are able to work together to identify whether a client's "life problem" is actually a "legal problem" the legal service is able to assist with.

Findings from the post-PD surveys and interviews with health professionals also indicated an improved capacity amongst health professionals to address elder abuse as well as other legal issues and to work with older people who have diminished capacity for decision-making.

In particular, findings from the post-PD surveys indicated:

an improved capacity to identify and address elder abuse

98% agreed, after PD, they are more likely to – or already confident in their ability to – *identify* abuse

98% agreed, after PD, they feel more – or are already – comfortable *asking about emotional abuse*

96% agreed, after PD, they feel more – or are already – comfortable *asking about financial abuse*

100% agreed, after PD, they had a better idea of – or already know about – *the questions they can ask* about elder abuse

an improved capacity to address legal issues and work with lawyers:

100% agreed, after PD, they are more – or were already – confident in their ability to *identify legal issues*

98% agreed, after PD, they have the necessary skills and knowledge to *refer to a lawyer*

98% agreed, after PD, they have a better understanding of – or already knew – how to *work with lawyers*

an improved capacity to work with people with diminished capacity

98% agreed, after PD, they feel more confident working with *older people who have diminished capacity* for decision-making

Interviews with HCPs also reflected an improved capacity to address elder abuse as well as other legal issues, indicating:

improved capacity to address legal issues through advice and secondary consultation

Sometimes I use [the HJP lawyer] just to sound her out. Some situations haven't advanced to a referral, but [the HJP lawyer] has had good ideas about how to work with the situation.

It's a God-send. To be able to ring someone with a really knotty problem and talk those over.

Interviews with HCPs also reflected an improved capacity to address health issues because legal issues were being addressed, where formerly they would not have been.

improved capacity to address health issues

I couldn't work on [the client's] health issues with him because he could only focus on the conflict and potentially being homeless.

organisation-wide

As mentioned on page 19, there also needs to be organisation-wide capacity to support health professionals to take a proactive role in addressing elder abuse. This is important for the legal service to be sustainable. The partners tried to achieve this in a few ways:

clarifying the role and responsibilities of workers and managers to address elder abuse

The HJP delivered PD sessions and resources to support health professionals in ad hoc screening of elder abuse and how to facilitate a referral. However, this process of identifying and responding to abuse may require significant resources, including extensive conversations with clients, gathering and collecting evidence, safety planning, coordinating different services, etc. This investment can pose practical challenges for health professionals to balance against other competing client work.

Recognising this, the HJP lawyer joined a working group to promote an organisation-wide response to abuse and violence. The group has drafted policies and procedures outlining roles and responsibilities at all stages of the client journey – initial needs identification, assessment, safety planning, documentation, follow up, etc. The policy, due to be finalised mid-2016, aims to clarify the role and responsibilities of workers and managers. The policy recognises the importance of providing an immediate response as well as the importance of ensuring the capacity of individual workers and managers to respond. Once the policy and procedure is finalised following consultation with the senior management group, training will be provided to the relevant personnel.

empowering a diverse range of professionals to address elder abuse, not just a few specialists

While the first year of the HJP focussed on engaging high-priority teams, the partners want to encourage the collective knowledge and expertise of many different professionals and teams. This is essential to ensure the longevity of the legal service and, ultimately, improve cohealth's response to elder abuse. The partners have tried to achieve this through creating forums for different professionals to reflect on, and share, their own experiences working with people experiencing elder abuse.

For example, the partners developed a dedicated cohealth working group for the legal service to provide operational knowledge, develop champions and build internal capacity. This reduces the impact of losing key staff who have developed significant expertise in elder abuse. Further, the HJP lawyer invited participants at PD sessions to share learnings, strategies ad experience of risk-factors or signs of abuse with their colleagues which were incorporated into materials for subsequent PD sessions.

These forums allow for a more comprehensive understanding of elder abuse and how to promote best practice. These materials were also shared with teams external to cohealth – HARP teams in the region and emergency response team at Western Health.

better reach

As a result of the HJP, Seniors Law's capacity to reach vulnerable clients has also improved, especially the following recognised groups:

client experiencing elder abuse who do not want to speak to a lawyer: as mentioned on page 21, with the availability of secondary consultations to health professionals, older people in this situation can still receive the benefit of legal information through a trusted worker who can continue to support them and build their capacity.

isolated older people experiencing abuse: the client story on page 23 illustrates the importance of coordinating appointments between the client and different professionals to provide clients experiencing abuse a safe space to receive legal help independent of the perpetrator.

clients experiencing physical elder abuse: before the HJP, physical elder abuse did not feature prominently in Seniors Law's casework. In contrast, of the people identified as experiencing elder abuse who received legal help, physical abuse was flagged in almost two-thirds of the cases (59%).

older LGBTI clients: in accordance with cohealth's diversity strategy, cohealth has a commitment to engaging with older LGBTI clients and promoting LGBTI-inclusive practice. As the HJP lawyer is a member of the diversity working group responsible for these initiatives, Seniors Law hopes to improve its ability provide access to justice for older people who identify as LGBTI. Professionals at cohealth are able to connect the HJP lawyer with relevant groups who work with these clients to discuss potential CLE and PD sessions to encourage engagement with the service.

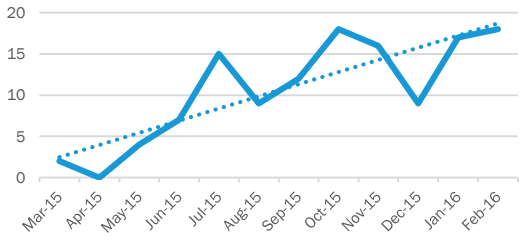
Essentially, the HJP affords partners the opportunity to address systemic issues – such as violence and abuse – and promote best practice in terms of rights-based and LGBTI-inclusive practice as well as promoting gender equality and diversity.

improved engagement

As detailed on page 16, the HJP has helped address **136 legal issues** since its commencement. The rate of requests for legal help have increased over the course of the year, as illustrated by graph 7.

The partners believe this increased engagement has been due to a combination of colocation, engagement and communication, PD, CLE and secondary consultations.

graph 7: instances of legal help



references

journal articles

A Almogue, A Weiss, E-L Marcus, Y Beloosesky, 'Attitudes and knowledge of medical and nursing staff towards elder abuse' 51 (2010) *Archives of Gerontology and Geriatrics* 86.

Claudia Cooper, Amber Selwood, Gill Livingston, 'Knowledge, detection and reporting of abuse by health and social care professionals: a systematic review' (2009) 17(10) *The American Journal of Geriatric Psychiatry* 826-838.

John Chesterman, *Responding to violence, abuse, exploitation and neglect: improving our protection of at-risk adults* (2013).

Lynette Joubert and Sonia Posenelli, 'Window of opportunity: the detection of management of aged abuse in an acute and subacute health care setting" 48 *Social Work in Health Care*.

Mark S Lachs and Karl A. Pillemer, 'Elder abuse' (2015) *The New England Journal of Medicine*, 1947-1956.

Peteris Darzins, Georgia Lowndes and Jo Wainer, 'Financial abuse of elders: a review of the evidence' (2009)

Rodney Lewis, 'Taking action against abuse of older people: pathways out of the maze' (2013).

Wendy Lacey, 'Neglectful to the Point of Cruelty? Elder abuse and the rights of older persons in Australia' (2014) 36(99) *Sydney Law Review*, 99-130.

other sources

Australian Government, *2015 Intergenerational Report* (2015) 5, 7 and 8.

cohealth, strategic plan 2015-18.

Elder Abuse Prevention Project, *Strengthening Victoria's Response to Elder Abuse* (2005).

Health Justice Partnership Network, Health Justice Partnerships (21 May 2015) <http://www.justiceconnect.org.au/what-we-do/what-we-are-working/health-justice-partnerships>.

Human Rights and Equal Opportunity Commission, Submission to the House of Representatives Standing Committee on Legal and Constitutional Affairs, *Inquiry into Older People and the Law*, December 2006.

Law and Justice Foundation of New South Wales, *Legal Australia-Wide Survey: Legal Need in Australia* (Sydney, 2012).

Legal Services Board, *$2.6 million funding awarded in the 2014 Major Grants round* (22 May 2015) <http://www.lsb.vic.gov.au/documents/Newsletter_11_Grants_Program_2014.PDF>.

NACLC, Submission to the Office of the High Commissioner for Human Rights, *Public Consultation on the Human Rights of Older Persons*, 2013.

National Center for Medical-Legal Partnership, 'Making the case for MLP's: a review of the evidence' (February 2013).

Seniors Rights Victoria (SRV) and the National Ageing Research Institute Ltd (NARI), *Profile of Elder Abuse in Victoria – Analysis of data about people seeking help from Seniors Rights Victoria – Summary Report*, June 2015.

SRV, Submission No 71 to the Victorian Law Reform Commission, *Guardianship*, 3 June 2011.

Victorian Government, Department of Health, *Elder Abuse Prevention and Response Guidelines 2012-2014* (2012).

Victorian Government, Department of Human Services, *With respect to age* (2009).

UN materials

World Health Organisation, *The Toronto Declaration on the Global Prevention of Elder Abuse* (17 November 2002).

World Health Organisation, *Active Ageing: A Policy Framework* (2002) 29.

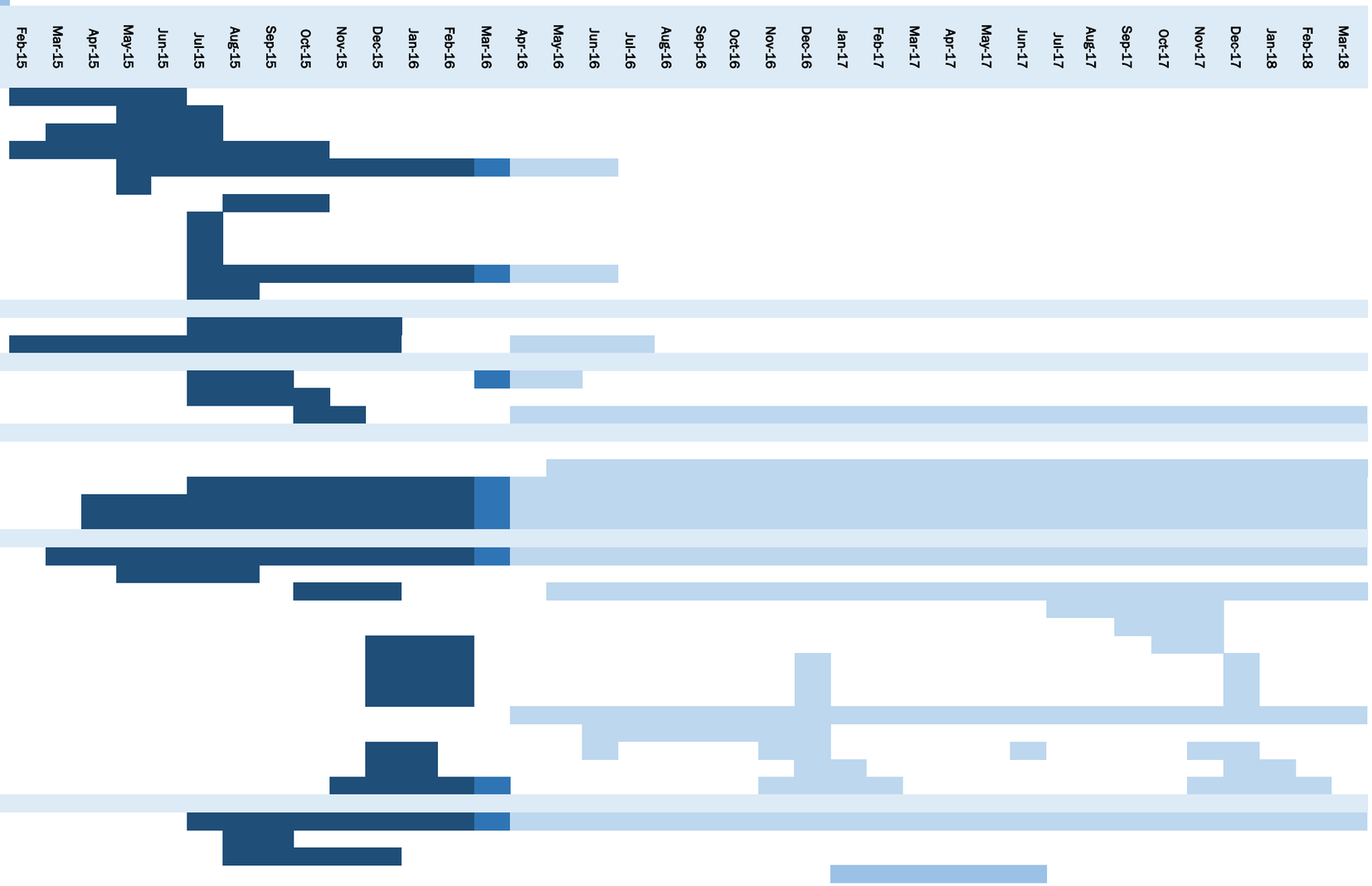
appendices

appendix a: project schedule

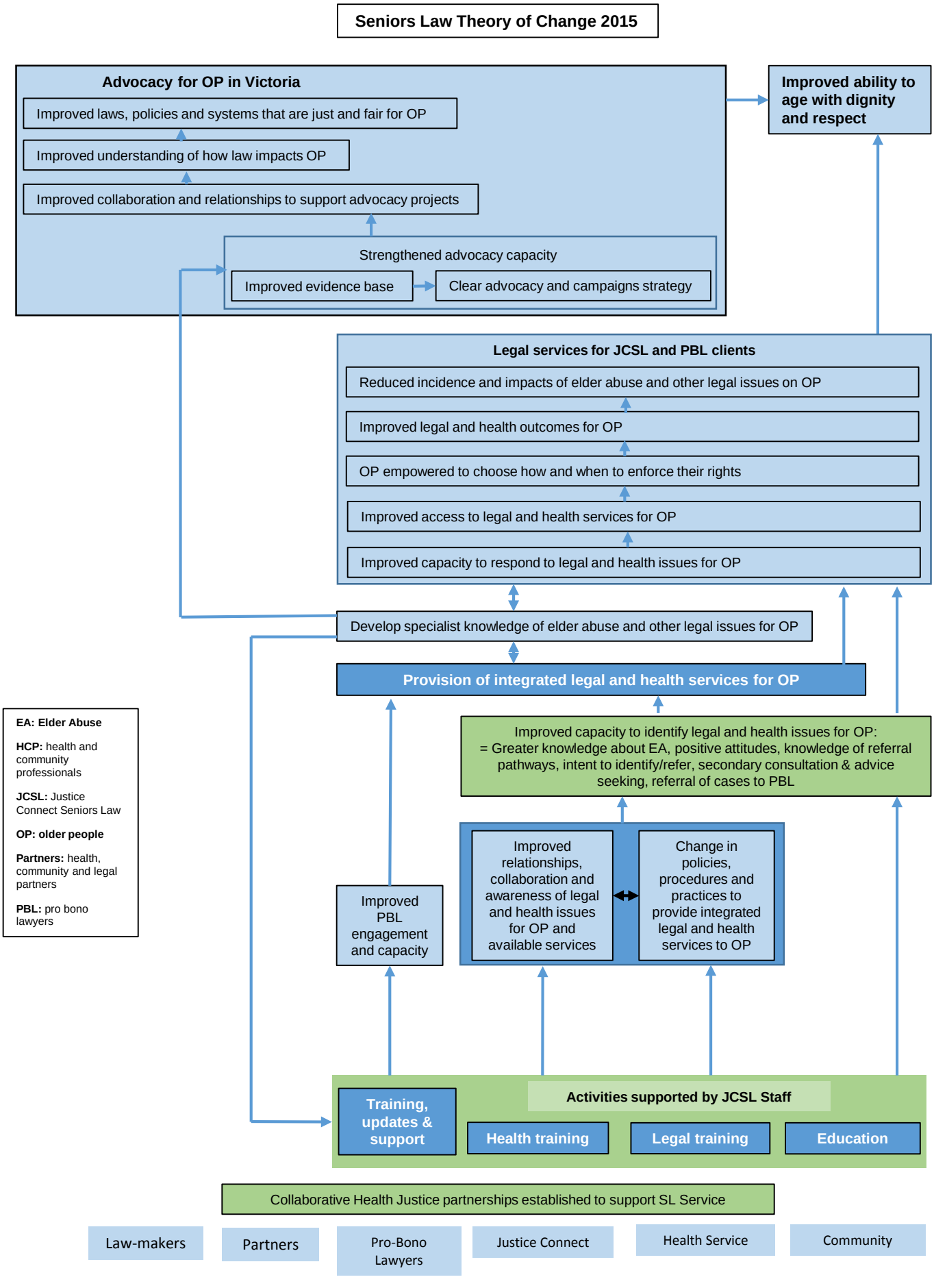
HJP - cohealth: project schedule

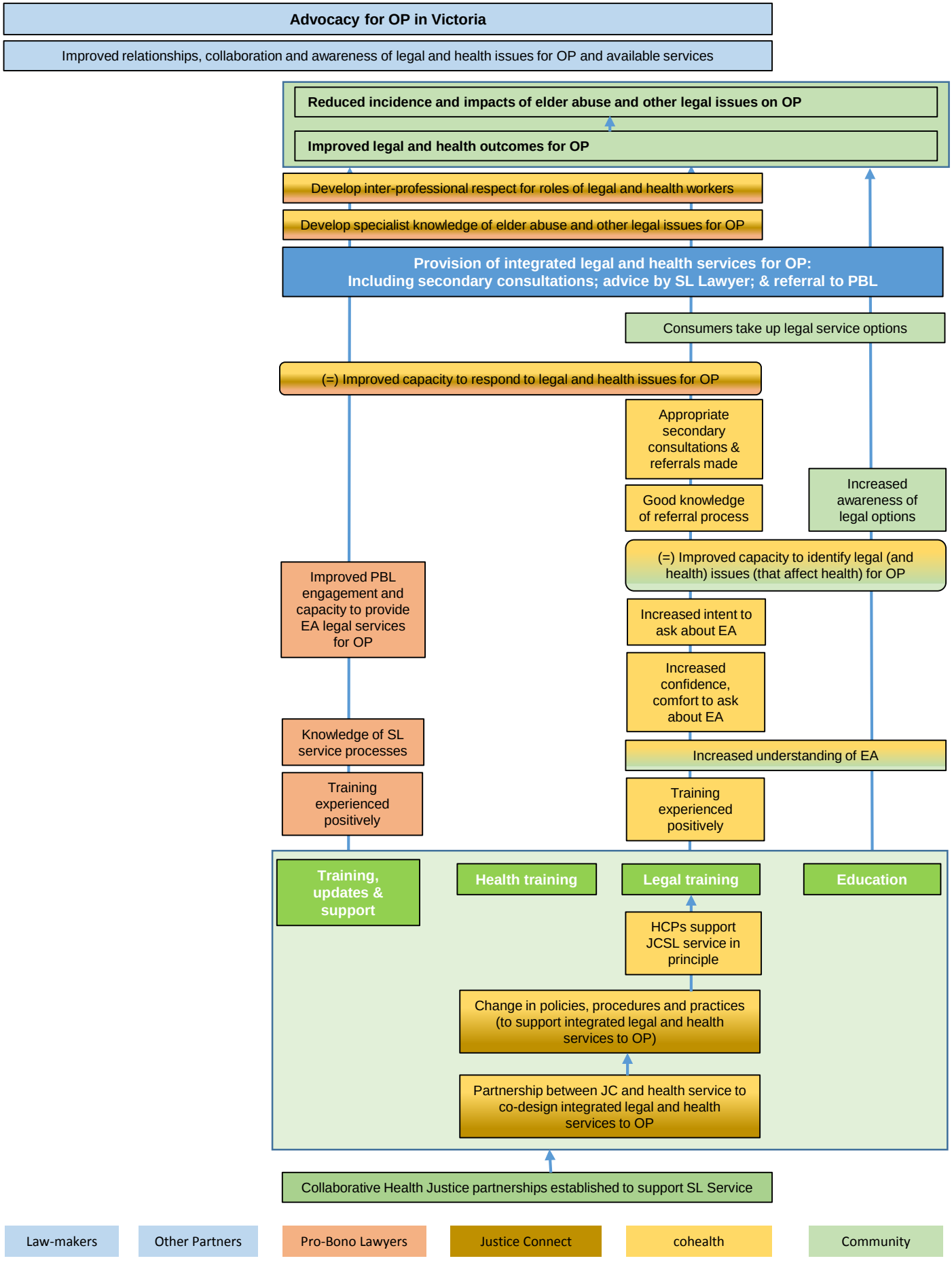
Complete
In progress
Not started

Description
Foundation stage
ME - JC theory of change and monitoring and evaluation plan
ME - develop evaluation framework with LaTrobe University
ME - systems to support evaluation framework
PP - develop JCSL P&Ps for project and work with cohealth
PP - work with cohealth to review intake procedures
GOV - determining governance structure of HJP
GOV - risk management and MOU
GOV - TOR for exective
GOV - TOR for reference group
GOV - TOR for working group
P&Ps - develop elder abuse policy for cohealth
COMMS - develop communications strategy for HJP
Stakeholder engagement
SE - JCSL to form working and reference group to guide HJP
SE - JCSL to meet with key HCP at cohealth and Western Health
Professional development
PD - in consulation with working group identify dates, strucutre, topics and presenters for training
PD - develop training package to relevant HCP
PD - deliver training package to relevant HCP
Legal services
GOV - obtain necessary authorities to attend allocation meetings
LS - attend allocation meetings to identify legal issues, provide support to caseworkers and facilitate referrals
LS - attend outreach sessions with caseworkers in Western and Northern regions
LS - provide legal information, advice, casework and referrals to OP
LS - provide necessary secondary consultations
Evaluation and reporting
ME - routine monitoring of secondary consultations
ME - identify baseline HCP awareness of JCSL, elder abuse and other legal issues, confidence to respond
ME - survey post training HCP
ME - focus groups with cohealth HCP
ME - survey of HCP - final
ME - interview with partners and stakeholders re value of model
ME - review and summary of cohealth administrative data (Trak)
ME - review and summary of JC administrative data (PIMS)
ME - summary of routine activity monitoring data (secondary consults, training, etc)
ME - client questions
ME - review of cohealth and JC P&Ps
ME - analysis of survey data in last 6 months
ME - summary of results
ME - prepare report to LSB
Community development stage
CD - identify key community groups and networks
CD - develop CLE package for groups
CD - deliver CLE package for groups
CD - work with key community groups in developing legal health check for the community



appendix b: theory of change


Seniors Law Theory of Change 2015
Advocacy for OP in Victoria
Improved laws, policies and systems that are just and fair for OP
Improved understanding of how law impacts OP
Improved collaboration and relationships to support advocacy projects
Strengthened advocacy capacity
Improved evidence base
Clear advocacy and campaigns strategy
Improved ability to age with dignity and respect
Legal services for JCSL and PBL clients
Reduced incidence and impacts of elder abuse and other legal issues on OP
Improved legal and health outcomes for OP
OP empowered to choose how and when to enforce their rights
Improved access to legal and health services for OP
Improved capacity to respond to legal and health issues for OP
Develop specialist knowledge of elder abuse and other legal issues for OP
Provision of integrated legal and health services for OP
Improved capacity to identify legal and health issues for OP:
= Greater knowledge about EA, positive attitudes, knowledge of referral pathways, intent to identify/refer, secondary consultation & advice seeking, referral of cases to PBL
Improved relationships, collaboration and awareness of legal and health issues for OP and available services
Change in policies, procedures and practices to provide integrated legal and health services to OP
Improved PBL engagement and capacity
Activities supported by JCSL Staff
Training, updates & support
Health training
Legal training
Education
Collaborative Health Justice partnerships established to support SL Service
Law-makers
Partners
Pro-Bono Lawyers
Justice Connect
Health Service
Community
EA: Elder Abuse
HCP: health and community professionals
JCSL: Justice Connect Seniors Law
OP: older people
Partners: health, community and legal partners
PBL: pro bono lawyers


Advocacy for OP in Victoria
Improved relationships, collaboration and awareness of legal and health issues for OP and available services
Reduced incidence and impacts of elder abuse and other legal issues on OP
Improved legal and health outcomes for OP
Develop inter-professional respect for roles of legal and health workers
Develop specialist knowledge of elder abuse and other legal issues for OP
Provision of integrated legal and health services for OP:
Including secondary consultations; advice by SL Lawyer; & referral to PBL
Consumers take up legal service options
(=) Improved capacity to respond to legal and health issues for OP
Appropriate secondary consultations & referrals made
Good knowledge of referral process
Increased awareness of legal options
(=) Improved capacity to identify legal (and health) issues (that affect health) for OP
Improved PBL engagement and capacity to provide EA legal services for OP
Increased intent to ask about EA
Increased confidence, comfort to ask about EA
Knowledge of SL service processes
Increased understanding of EA
Training experienced positively
Training experienced positively
Training, updates & support
Health training
Legal training
Education
HCPs support JCSL service in principle
Change in policies, procedures and practices (to support integrated legal and health services to OP)
Partnership between JC and health service to co-design integrated legal and health services to OP
Collaborative Health Justice partnerships established to support SL Service
Law-makers
Other Partners
Pro-Bono Lawyers
Justice Connect
cohealth
Community

appendix c: surveys

Evaluation of the Older Persons Legal Service

cohealth and Justice Connect have been funded by the Legal Services Board to develop and implement a new service for older people who may be experiencing legal problems but who have trouble accessing advice or help. It is important to cohealth and Justice Connect—and is a requirement of the funding agreement—that this service is evaluated. La Trobe University is supporting the evaluation.

Aim of the Evaluation:

The evaluation will consider the extent to which the service meets its intended reach (providing legal services to older clients) and achieves positive outcomes for clients. The evaluation will help cohealth and Justice Connect to determine the value of the service, and will contribute evidence to support consideration of whether this model should be replicated more widely.

What you are asked to do:

You are being invited to take part in the evaluation because you are a staff member who has contact with older clients of cohealth who may use the Older Persons Legal Service. We will ask you to answer some questions at key points during the roll-out of the service, including prior to its commencement (i.e., now), around training or information sessions, approximately 12 months after the service has been operating, and in the last phase of funding. You may also be invited to attend a focus group or one-on-one interview at some time in the future.

You are not obliged to take part in the evaluation. Participation is completely voluntary. You do not have to answer the questions if you do not want to; there will be no negative consequences for you if you choose not to respond.

What will happen to the information you provide?

Your responses to surveys will remain confidential; you do not have to record your name; information about your current role at cohealth will not be used to identify you; it is intended to help the project staff to target and improve their training and support.

All of the information that is collected from you will be combined with other information from administrative data sets, surveys of lawyers and surveys of clients to provide an overview of how the Older Persons Legal Service is going, and whether it is achieving the intended reach and positive effects for participants. Completed surveys and other de-identified data will be sent to La Trobe University where they will be kept in a locked office and/or on a password-protected computer system.

Feedback about the evaluation of the Older Persons Legal Service will be provided through a variety of mechanisms, including internally by cohealth and Justice Connect project staff and externally, in reports to the Legal Services Board. Results of the evaluation may also appear in publications or at conferences. At no time will any individuals be identified. The Project Team will not look at the survey responses.

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If you have questions:

If you have any questions about the evaluation, please contact Associate Professor Virginia Lewis, La Trobe University, on t: 03 9479 3924

If you have any questions about the Older Persons Legal Service, please contact Maureen Convey, cohealth, on T: 03 9334 6667

PLEASE KEEP THIS PAGE FOR YOUR OWN RECORDS.

Please indicate to what extent you disagree or agree with each of the following statements. There are no right or wrong answers – we are interested in your personal views.

	Disagree Strongly	Disagree Moderately	Disagree Slightly	Agree Slightly	Agree Moderately	Agree Strongly	Don't know
1. Older people experience issues and problems (financial and emotional) that could be addressed with legal solutions.							
2. I am confident I can identify problems that older people experience that could be addressed by consulting a lawyer.							
3. Health professionals have a role to play in addressing elder abuse. If you are not sure what constitutes "elder abuse", please select "Don't Know".							
4. The health of older people can be negatively affected by legal problems and issues.							
5. I feel comfortable asking older people questions that would reveal if they are being abused emotionally or are being neglected.							
6. I am confident I have the skills and knowledge to refer clients to a lawyer.							
7. It is a good idea to have a lawyer as part of a community health service.							
8. I feel comfortable asking older people questions that would reveal whether they are experiencing financial abuse.							
9. Having a lawyer for older people at cohealth would make my job easier.							
10. I am confident I can identify whether an older person is experiencing elder abuse. If you are not sure what constitutes "elder abuse", please select "Don't Know".							
11. Legal and health professionals should work together in addressing elder abuse. If you are not sure what constitutes "elder abuse", please select "Don't Know".							
12. Receiving help with legal problems and issues can improve the health of older people.							

Please continue and answer the questions over the page…

13. How many clients have you referred formally or informally to a lawyer in the last 12 months?	❒ None ❒ 1-2 ❒ 3-5 ❒ 6-10 ❒ More than 10
14. Have any of these referrals related to issues for older clients?	❒ Yes ❒ No ❒ Don't know
15. Where would you refer an older client/consumer who had a legal issue or problem?	
16. What kinds of legal issues or problems do you think older clients are likely to experience?	

Finally, can you tell us:

17. What team do you work in?	
18. How long have you worked at cohealth (including previous CHCs that merged to become cohealth)?	

Thank you for answering the questions. We appreciate your time.

Evaluation of the Older Persons Legal Service

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You are not obliged to take part in the evaluation. Participation is completely voluntary. You do not have to answer the questions if you do not want to; there will be no negative consequences for you if you choose not to respond.

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PLEASE KEEP THIS PAGE FOR YOUR OWN RECORDS.

How strongly do you agree or disagree with the following statements about the training?

	disagree strongly	disagree	neither agree nor disagree	agree	agree strongly
1. The training was well organised					
2. The content of the training complemented my other responsibilities					
3. The training went for an appropriate period of time					
4. The training was held at an appropriate time of the year					
5. The way the training was delivered supported my learning					
6. The depth and breadth of the training content was right for me					
7. Training resources and materials assisted my learning during the workshop					

8. What were the most useful aspects of the training?
9. What was the least useful aspect of the training? How could we improve the training? Can you make any specific suggestions?

	poor	fair	good	very good	excellent
10. How would you rate the training overall?					

	disagree strongly	disagree	neither agree nor disagree	agree	agree strongly
11. Undertaking the training was a positive learning experience					
12. I would recommend the training to colleagues					

Additional comments and suggestions

Please indicate to what extent you disagree or agree with each of the following statements. There are no right or wrong answers – we are interested in your personal views.

As a result of attending the workshop…	disagree strongly	disagree moderately	disagree slightly	agree slightly	agree moderately	agree strongly	I already felt/knew this	don't know
1. I feel more comfortable about asking older people questions that would reveal if they are being abused emotionally or are being neglected								
2. I feel more comfortable about asking older people questions that would reveal whether they are experiencing financial abuse								
3. I am more confident I will be able to identify whether an older person is experiencing elder abuse								
4. I am more confident I will be able to identify problems that older people experience that could be addressed by consulting a lawyer								
5. I will be more aware of the kinds of legal issues that need urgent attention								
6. I know what C.A.L.M. stands for								
7. I have a better understanding of what questions I can ask when developing strategies for older people experiencing elder abuse								
8. I feel more confident I will be able to work with older people who have diminished capacity for decision-making								
9. I have the necessary skills and knowledge to refer clients to a lawyer								
10. I understand the processes for referring clients to the cohealth older persons' legal service								
11. I have a better understanding of working with lawyers								

In future…	disagree strongly	disagree moderately	disagree slightly	agree slightly	agree moderately	agree strongly	I already do this	don't know
1. I will ask older people questions that would reveal if they are being abused emotionally or are being neglected								
2. I will ask older people questions that would reveal if they are experiencing financial abuse								
3. I will be alert to risk factors, signs and symptoms of abuse								
4. I will refer clients who have legal problems to the cohealth older persons' legal service								

Finally, can you tell us:

What team do you work in?

Thank you for answering the questions. We appreciate your time.

appendix d: list of topics for PD sessions

health and legal issues

elder abuse as a life problem

health impacts of elder abuse

the role of health professionals

barriers to addressing elder abuse

elder abuse

definition, types

ageism

case studies: identifying elder abuse

the client journey: identifying and responding

risk factors and signs

asking about abuse and dealing with disclosure

developing interventions: what do we need to know?

case studies: “assets for care” arrangements, “boomerang children”, misuse of powers of attorney

emergency situations

capacity: definition, warning signs, principles

consent

confidentiality and privacy

legal issues for older people

family violence intervention orders

powers of attorney

guardianship and administration

“assets for care” arrangements

“boomerang children”

renters’ right

hoarding and squalor

consumer rights

age discrimination

case studies: neglect, repairs, harassment from tradesmen

working with lawyers

who is the client?

duty to follow instructions

duty of confidentiality

legal professional privilege

conflict of interest

duty to the court

case studies: maintaining privilege, avoiding a conflict