Building the evidence to stop violence before it starts

NARI NATIONAL AGEING RESEARCH INSTITUTE
Bringing research to life

Primary prevention of family violence among older people living in Victoria

A report prepared by
the National Ageing Research Institute (NARI)
for Respect Victoria.

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NARI Volunteers Prue Molnar and Jacinta Young who participated in this intergenerational program.
Credit: Jacinta Young.

Respect Victoria
Preventing Family Violence

This report is dedicated to
Zelma Riddell and Mehmet Varol.

Both were longstanding volunteers at the National Ageing Research Institute (NARI) and part of this project, as well as many other studies at NARI. They were staunch advocates for the rights of older people, themselves exemplifying the best parts of being an older volunteer: intellectually generous, kind, and deeply empathetic. Sadly, they both died in 2020, during the COVID-19 pandemic, when this research was undertaken.

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Executive Summary

Background

Violence against older people has long been underreported, under-researched, and often undocumented in services. Yet, abuse of older people is a significant global criminal justice, public health, and human rights issue, with devastating consequences for the health and wellbeing of older people. It also has enormous social and economic costs, and attention is needed from policymakers, services, and researchers to solve this highly complex social problem.

Aim and Objectives

Primary prevention aims to stop abuse from occurring in the first place by changing the attitudes and social conditions that drive it. However, there is currently very little evidence about the drivers of abuse of older people and, as a result, how to address them effectively.

In response, researchers at the National Ageing Research Institute (NARI) undertook research to increase knowledge about the drivers of intergenerational family violence among older people and local strategies for prevention. The specific objectives were to:

1. Generate new knowledge on the drivers of family violence against older people.
2. Co-design and pilot a primary prevention initiative or suite of initiatives to address the problem.
3. Make recommendations for uptake of findings in policy and practice.

Approach

To achieve the objectives, the following were undertaken:

- **Phase 1: A systematic, rapid review** of the effectiveness of primary prevention interventions targeted at the drivers of abuse of older people, and identification of the factors that influence the effectiveness of these interventions.
- **Phase 2: Co-design workshops** with key stakeholders including older people, family carers, and service providers. The aim of these workshops was to co-design an intervention, based on the evidence review and the lived experience of workshop participants, piloted in Phase 3.
- **Phase 3: A pilot of an intergenerational program** to prevent the abuse of older people by reducing the known drivers and/or risk factors including ageism, loneliness, and depression and anxiety, as well as increasing potential protective factors such as social connectedness.

- **Phase 4: Translation of knowledge** gained from Phases 1-3 to produce recommendations to address the drivers of abuse as well as *identification of the elements for and challenges to successful implementation.*

Findings

Rapid Review

The full review is published on the Respect Victoria website:

- https://www.respectvictoria.vic.gov.au/sites/default/files/documents/202010/Evidence%20Review%20NARI.PDF

The key points are:

- There is very limited evidence on the effectiveness of primary prevention interventions targeting the abuse of older people.
- From the available evidence (n=12 studies), intergenerational programs that address ageism show the most promise.
- Effective implementation techniques include social interactions, motivational interviewing, and multi-component tailored interventions with boosters delivered by a multi-professional team.
- To maximise intervention impact: (i) partnership across organisations, professionals, and older people and caregivers, and (ii) co-design and person-centred approaches are crucial.

Co-design Workshops

- Participants wanted to tackle ageism as a driver of abuse of older Victorians by strengthening intergenerational bonds between younger and older people.
- Participants preferred a face-to-face intervention that involved younger and older people completing a shared activity (e.g. cooking and/or exercise).
- Participants preferred the intervention address social isolation and loneliness.
- Due to the outbreak of COVID-19 and the associated lockdown in Victoria, the pilot intervention was re-designed to be conducted online or by phone to comply with federal and state government directions.
- An intergenerational program was developed pairing older people and younger people to have a one-hour conversation per pair per week for six weeks.

- Three methods were used to measure the outcomes of the program and if it was effective in reducing the drivers and risk factors of abuse: quantitative methods via a series of surveys and validated tools, qualitative interviews, and collection of auto-ethnographic (creative) outputs.

Pilot Intervention Results

- Surveys found that ageist attitudes towards older people were lower for younger people (compared to older people).
- Surveys found that levels of loneliness were higher in the younger cohort (compared to the older cohort).
- Interview data demonstrated that the older participants felt undervalued and lacked opportunities to contribute their skills and experience, particularly post-retirement.
- During the interviews, younger participants said the stereotypical assumptions they made about older people decreased. For example, younger participants expected older people to have conservative views and were surprised to find similarities on topics such as gender and sexuality.
- From qualitative data, older participants expressed a change in attitude towards younger people, acknowledging the unique challenges they face. This was not measured by quantitative surveys, which focused on ageist attitudes towards older people.
- Careful attention to pairing older and younger people, conversation guides, booster check-in calls, finite start and end dates to the program, and clear communication around 'closing off' the program enhance implementation.
- Onerous paperwork, including for police checks and survey measures, recruiting participants with low digital literacy, and asking participants for creative outputs can pose challenges to the program's success.
- Program staff must be skilled to deal with un/expected events such as disclosure of family violence, participant illness, and death.

Recommendations

Primary Prevention of Abuse of Older Victorians

• Scale up existing or further intergenerational programs, specifically addressing:
  - Formalised mentoring programs working with youth and older people's groups.
  - LGBTIQA+ communities with a particular focus on alleviating loneliness and psychological distress.
• Gender inequality and racism must be considered alongside ageism as a key driver of abuse of older people with regard to intersecting forms of marginalisation.

Implementation Strategy
• An implementation toolkit should be developed so that other agencies who wish to pursue such initiatives can use evidence-based techniques methods to realise their program outcomes. To ensure consistency in primary prevention messaging, funders of the toolkit should ensure such messaging is embedded in the toolkit.

Abbreviations

AIFS	Australian Institute of Family Studies
COTA	Council on the Ageing
FSA	Fraboni Scale of Ageism
GP	general practitioner
K6	Kessler Psychological Distress Scale
LGBTIQA+	Lesbian, Gay, Bisexual, Transgender, Gender Diverse, Intersex, Queer, Asexual and Questioning
NARI	National Ageing Research Institute
PAG	Project Advisory Group
SCS-R	Social Connectedness Scale Revised
SD	standard deviation of scores, describes the variation of a set of scores
TIL	Three Item Loneliness Scale
U3A	University of the Third Age
UCLA	University of California, Los Angeles
WHO	World Health Organization

A note on language and terminology

The way language is used is critical to understanding the abuse of older people and the prevention of abuse. Below are definitions of key terms used in this report.

Older people: Aligning with Victorian and national Government policies, older people are defined as people aged over 65. For Aboriginal and Torres Strait Islander Peoples, those aged over 50 are considered as older people [1].

Ageism: Ageism is stereotyping or discriminating against a person because of their age [2-4].

Age inclusive language: Terminology such as “older adult”, “older persons”, or “older people” are used as the preferred terms for describing individuals aged 65 years and older, as opposed to denominating them as “seniors”, “the elderly”, or “the aged”.

Although ‘elder abuse’ is the locally used and internationally accepted term, there is unease with the continued application of this term in Australia. Older people and service providers prefer a shift in language from ‘elder abuse’ to ‘abuse of older people’. Language consistent with their preferences and the National Plan to Respond to the Abuse of Older Australians is adopted in this report [5].

Abuse of older people: The World Health Organization defines the abuse of older people (elder abuse) as ‘a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person’ [6]. There are various forms of abuse within this broad categorisation including physical, emotional/psychological, sexual, financial/economic, social, and neglect [7, 8]. Abuse of older people can be perpetrated by family members, a formal or informal caregiver or acquaintance, and can occur in the home, community, or institutional settings [9-11].

Family violence: In the state of Victoria, the abuse of older people is recognised as a form of family violence that may occur between the older person and an adult child, intimate partners, family carers, and/or other family members [12]. The abuse of older people was also considered as an issue of importance in the Victorian Royal Commission into Family Violence [13]. However, there remain issues in terms of appropriate response due to a lack of agreement as to whether such abuse should be seen as a subset of family violence, or an area requiring separate policy/service responses [14]. This is particularly problematic if there are overlaps with other forms of family violence, including cases of intimate partner violence where violence against

older women by their partners may also be classified as the abuse of older people. In such instances, victims can fall through gaps in service provision.

For the purposes of this report, the abuse of older people is understood as a form of family violence, occurring within communities and private dwellings. It is separate from violence that occurs in community- and residential-aged care settings, which involves only non-biological family members and/or persons of trust [15]. These definitional parameters align with the current Victorian Government's Elder Abuse Prevention and Response Initiative but not necessarily with the frameworks and policies of other states in Australia or all other countries [14].

Intersectionality: 'Intersectionality' refers to the ways in which different aspects of a person's identity can expose them to overlapping forms of discrimination and marginalisation [16].

Aspects of a person's identity can include social characteristics such as: Aboriginality, gender, sex, sexual orientation, gender identity, ethnicity, colour, nationality, refugee or asylum seeker background, migration or visa status, language, religion, ability, age, mental health, socioeconomic status, housing status, geographic location, medical record, and criminal record. Attitudes, systems, and structures in society and organisations can interact to create inequality and result in exclusion. These include: sexism, racism, homophobia, biphobia, transphobia, intersex discrimination, ableism, ageism, and stigma.

When these aspects or characteristics combine: there is a greater risk of people experiencing family violence; people find it harder to get the help they need due to systemic barriers; and there is increased risk of social isolation [16].

Drivers of the abuse of older people include the 'social norms, practices and structures that influence individual attitudes and behaviours' [17]. Ageism, gender inequality and other intersecting forms of discrimination such as racism, classism, homophobia and ableism are implicated [14, 18].

Risk factors for abuse refer to the characteristics of individuals or groups that make them more likely to experience or perpetrate abuse [19].

Prevention of violence against older people: For the purposes of this report, primary prevention can be defined as work (including interventions) that addresses the "underlying causes – or drivers – of violence. These include the social norms, practices, and structures that influence individual attitudes and behaviours" [17].

Secondary prevention, by contrast, “aims to ‘change the trajectory’ for individuals at higher-than-average risk of perpetrating or experiencing violence” and generally targets risk factors (since these can be defined as putting one at higher risk of perpetrating or experiencing violence) [19]. These risk factors can also be addressed as part of a primary prevention response [19].

Finally, tertiary prevention (or response) supports survivors of family violence and holds perpetrators to account, aiming to prevent the recurrence of such violence [19].

1. Introduction

Violence against older people is a highly complex social problem that encompasses many forms of abuse perpetrated in a variety of contexts.

It has been a hidden problem often underreported, under-researched, and undocumented in services. Yet, abuse of older people is a significant global criminal justice, public health, and human rights issue. Such abuse has harmful consequences for the health and wellbeing of older people, as well as enormous social costs, including decreased quality of life; morbidity; mortality; depression; anxiety; fear; other psychological stress such as feelings of unworthiness; substance abuse and even suicide [20]. This warrants the attention of policymakers, healthcare providers and researchers as a serious public health issue.

In response, Respect Victoria commissioned researchers at the National Ageing Research Institute (NARI) to undertake research that **increases knowledge about the drivers of intergenerational family violence among older people and local strategies for prevention**.

This project builds on local work on family violence against older people including the Australian Institute of Family Studies' (AIFS) work on defining the abuse of older people [21], Seniors Rights Victoria's report: *Older, Better, Together: The Primary Prevention of Elder Abuse by Prevention Networks'* [22], NARI's *Elder Abuse Community Action Plan for Victoria* [23], and the Victorian Government practice guidelines for health services and community agencies for the prevention of elder abuse [24]. The project also shares synergies with the Commonwealth Government's *National Plan to Respond to the Abuse of Older Australians (Elder Abuse) 2019-2023* [5].

To fulfil the overall aims of the project, the specific objectives were to:

1. Generate new knowledge on the drivers of family violence against older people.
2. Co-design and pilot a primary prevention initiative or suite of initiatives to address the problem.
3. Make recommendations for uptake of findings in policy and practice.

This report presents the findings. Chapter 1 provides an overview of the prevalence, drivers and risk factors of abuse of older people, a conceptual framework, and discussion of the primary prevention of abuse of older people. This is followed by a brief overview of the approach used in this project (Chapter 2). As an iterative mixed methods approach was applied, detailed descriptions of the methods and findings are consolidated and presented in Chapters 3–6. The key implications and recommendations for prevention are set out in Chapter 7, and then recommendations to enhance the implementation of primary prevention interventions are offered in Chapter 8.

Prevalence of abuse

A systematic review estimates the global prevalence of abuse of older people in community settings at 15.7% [25]. This is compared to the figure of 64.2% for institutional settings, and is based on a meta-analysis of 52 prevalence studies across 28 countries [25]. The breakdown in types of abuse experienced by older people in community settings includes 11.6% for psychological abuse, 6.8% for financial abuse, 4.2% for neglect, 2.6% for physical abuse and 0.9% for sexual abuse [25].

Until the results of the current population-level prevalence study undertaken by the Australian Institute of Family Studies (AIFS) are reported, the extent of the abuse of older Australians will remain unknown. Smaller-scale studies, including previous studies by AIFS, estimate the prevalence to be anywhere between 2% and 14%, with the rates of neglect possibly higher [11, 25, 26].

It has also been noted that particular communities may be more likely to experience different kinds of abuse, such as people from migrant and refugee backgrounds being particularly vulnerable to financial abuse due to language and literacy barriers [27] and increased social isolation [28, 29].

Further, Australian data reveals that violence experienced by older people is gendered, and most commonly occurs within the family context. Analysis of seven years of Senior Rights Victoria helpline data from 2012–2019 by NARI provides some insight into the nature of the problem in Victoria – but should be read with caution given the dataset is limited to those who sought help through this particular service [30]. This data shows that an extremely high percentage (91%) of abuse experienced by older people is perpetrated by a family member, most commonly sons (39%) or daughters (28%). The same data shows that women are most often the victims of abuse (as 72% of callers seeking advice), and that men are most often the perpetrators of such abuse (at 54%) [30].

Drivers of abuse

Ageism is widely considered to be a key driver of abuse against older people [31]. Gender inequality is likewise considered a key driver of abuse as older women are disproportionately impacted by abuse and the majority of perpetrators are men [30]. Although outside the scope of this report, it must also be acknowledged that there is an unacceptably high rate of sexual assault of older women, especially in residential aged care. The recent Royal Commission into Aged Care Quality and Safety (concluding in 2021) found over 4% of reportable incidents comprised unlawful sexual assault, including behaviours of rape, sexual assault, and touching genital areas without consent. In real numbers, these percentages equate to 1700 assaults per year or 33 per week [31].

Other possible drivers based on work done in the Victorian context include intersecting forms of discrimination such as racism, homophobia, transphobia, and ableism [31]. Capitalism – or a society where a person's worth is defined by their capacity to contribute financially – has also been considered as a potential driver of abuse of older people [2].

Preventing and responding to the abuse of older women requires disentangling the complex and multidimensional relationship between gender and abuse. This is because there are several different relationship dynamics at play; older women may be abused by (one or several) adult children, may experience longstanding intimate partner violence, abuse by a carer, abuse by another older person, and/or abuse whilst in institutional care [20]. Effective prevention and response efforts must therefore not only heed the lessons of successful family violence initiatives targeted at younger women and children, but also adapt these insights to deliver a person-centered response that meets the needs and wishes of older people.

Alongside the high number of women experiencing abuse there are also a high number of women perpetrating abuse (46%) (though at 54%, men remain the majority of perpetrators) [30]. These local studies concord with the existing literature that suggests that ageism, gender, poverty, community level factors (e.g. geographic location), and organisational factors (e.g. residential care culture) are significant drivers of the abuse of older people [19, 32, 33]. However, it should be noted that overall there is currently little evidence about the drivers of abuse. Thus, in this report, the focus is on the primary prevention of intergenerational abuse.

Risk factors of abuse

While significant gaps remain in determining the drivers of the abuse of older people there are known risk factors that increase the likelihood of abuse being experienced or perpetrated. For the older person, these include functional dependence and disability, poor physical and mental health, poverty, and social isolation [14]. For perpetrators, risk factors can include psychological or social factors, such as poor mental health, gambling or drug dependence, social isolation, dependency on the older person, homelessness, and poverty. Caregiver stress can also be a risk factor for abuse [32].

Risk factors differ according to the type of abuse, and can vary, or be heightened, depending on an older person's family circumstances or care relationships, as well as their cultural background and proficiency in English. For example, for financial abuse, living alone is a risk factor, especially for older men [33]. A phenomenon widely characterised as 'inheritance impatience' is another risk factor for financial abuse. This may involve having a family member with a sense of entitlement to the older person's property [34].

Primary prevention

Primary prevention aims to stop family violence from occurring in the first place by changing the attitudes and social conditions that drive it. This means tackling the underlying drivers of abuse, including ageism and gender inequality, as well as other forms of discrimination and marginalisation in order to create a culture that promotes respectful relationships. Such efforts require multiple methods and a whole-of-community approach that includes engaging older people, children, families, and the public. By providing diverse communities with evidence-based tools, including role-modelling respectful behaviour and strategies for how to safely

call out disrespectful behaviour, the cultures that underpin family violence may be changed over time.

To date much of the primary prevention efforts in Victoria vis-à-vis family violence have focused on the violence experienced by (younger) women and children, particularly in the context of intimate partner violence. Valuable insights have been learned from these efforts such as how to establish a culture of gender equality, call out disrespectful behaviours such as sexist jokes, and call out intersecting forms of discrimination such as racist comments and homophobic attitudes. Similarly, intergenerational efforts to promote conversations between parents and children, leverages the parent-child bond to imprint on boys, in their formative years, the need for respectful attitudes towards all women.

Such techniques may also apply to the abuse of older people where the fundamental driver is ageism. Similar to sexism and racism, ageism is manifested through negative stereotypes and beliefs, and in this case includes perceptions that older people are frail, cognitively slow, helpless, or weak, and a burden on society or the economy [35]. Such beliefs may significantly affect older people who may be prevented from actively participating in everyday life in their communities [36]. These beliefs may also intersect with gender inequality outside the paradigm of intimate partner violence; for example, recent research from the US reveals that older mothers, whose adult children fail to meet norms of autonomy and self-sufficiency, experience considerable maternal guilt and shame. This can contribute to the underreporting of abuse where children are perpetrators and mothers victims [37].

Whilst there is little evidence about effective primary prevention interventions to stop the abuse of older people, the WHO *Missing Voices* report [38] identified a number of possible strategies that could be trialled for preventing abuse. These included:

- Awareness and education strategies to promote positive views of older people.
- Promotion of positive intergenerational relationships with older people.
- Empowerment of older people, including via advocacy organisations.
- Addressing the role of media in promoting positive images of older people.
- Creation of recreation facilities for older people to reduce social isolation.

A conceptual framework

To date, no Australian Government has developed an evidence-based primary prevention framework for addressing the abuse of older people. However, at the time of writing, such a framework is under development by the Victorian Government's Department of Families, Fairness, and Housing.

Building on the available literature on the abuse of older people, in 2018, NARI developed its own conceptual framework (see Figure 1) [23]. This framework identifies some of the drivers and risk factors of abuse (for both the individual and person of trust) as well as potential interventions at the individual, community,

and societal levels. While the framework helps to understand some of the possible drivers of abuse, it also provides a useful conceptualisation of the various types of interventions targeted at the individual, person of trust, interpersonal, community, and society levels that could be used to address the drivers and risk factors of the abuse of older people.

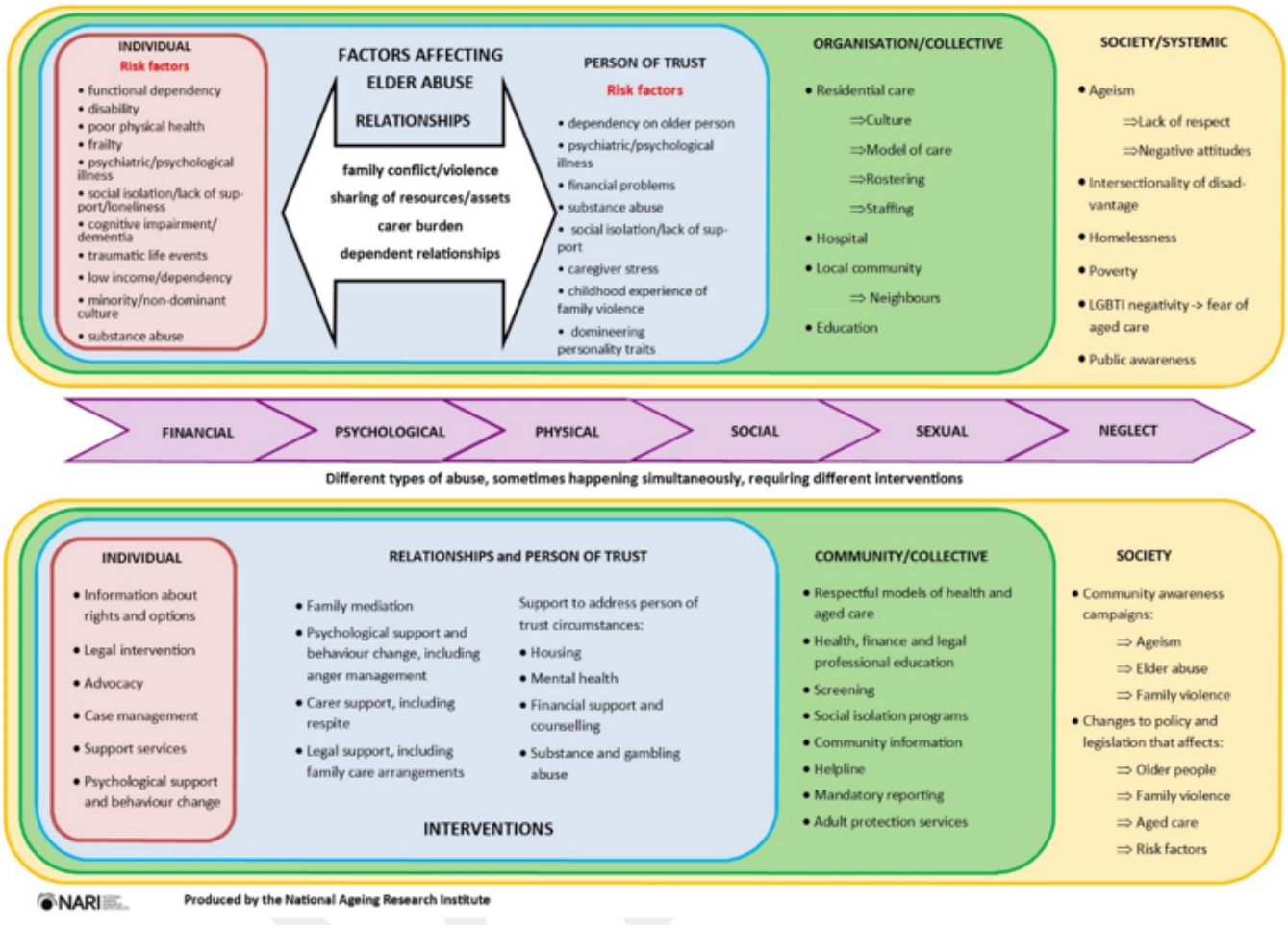

Figure 1: Conceptual framework for the abuse of older people and possible interventions

In line with this conceptual framework, prevention on interventions can plausibly be targeted at different levels reflecting the socio-ecological approach, that is, at an individual, a relationship, as well as community and societal levels. This approach also aligns with De Donder's [39] classification of primary prevention interventions as targeting:

- The macro level through public information campaigns on the abuse of older people and public anti-ageism campaigns,
- Exo-level through intergenerational programs and awareness and education programs and,
- Meso-level (such as social network strengthening programs).

Of importance to both policy and practice is the need to pay attention to the development, implementation, and evaluation of macro-level primary prevention interventions such as programs fostering positive attitudes to ageing and challenging systemic forms of discrimination and marginalisation, all of which are fundamental for preventing the occurrence of abuse of older people.

As part of this project, NARI conducted a rapid systematic review of available literature on primary prevention interventions for abuse of older people (see Section 3 for the full executive summary). This review found that there is extremely limited evidence on effective primary prevention interventions, with only intergenerational programs focused at the "macro" level (most accurately pitched at "society" as listed in the diagram above). The review also found evidence of only four existing intergenerational programs, targeting ageism at the primary prevention level and social isolation at the secondary prevention (or early intervention) level. These appeared to show the most promise when it came to addressing the underlying drivers of elder abuse. However, the review also stresses that implementation practices are critical to any intervention's success.

2. Methods

To build the knowledge and evidence base as well as strengthen interventions around primary prevention of violence against older Victorians, this project utilised a mixed methods design with an iterative approach, where each phase informed the subsequent phase.

The project comprised:

- **Phase 1:** ***A rapid review*** of primary prevention interventions targeted at the drivers of abuse of older people, and identification of the factors that influence the effectiveness of these interventions.
- **Phase 2:** ***Co-design workshops*** with key stakeholders including older people, family carers, and service providers. The aim of these workshops was to co-design an intervention, based on the evidence review and the lived experience of workshop participants, piloted in Phase 3.
- **Phase 3:** ***Pilot of an intergenerational program*** to prevent the abuse of older people by reducing the known drivers and/or risk factors including ageism, loneliness, and depression and anxiety, and/or increasing potential protective factors such as social connectedness.
- **Phase 4:** ***Translation of knowledge*** gained from Phases 1–3 to produce recommendations for approval and sign-off by the Project Advisory Group, Respect Victoria, and other key stakeholders. As part of this process, *the elements for and challenges to successful implementation* were also identified.

Epistemological approach

To ensure that project outcomes were relevant, acceptable, and feasible to implement for the target population, older people, family carers, service providers, and other key stakeholders were engaged from project inception. These stakeholders participated in the project's conceptualisation, design, pilot, knowledge translation, and implementation planning.

To facilitate their active inclusion, an approach called 'knowledge exchange' (or cultural exchange when applied to different cultural groups) was used [40]. This approach required the research team to be explicit about our aims, knowledge, expertise, and values while seeking to understand the same about the people we worked with, particularly how they viewed and understood family violence as it affects older people.

This approach aligns with action research methodology, in that it seeks to empower research participants to fully engage and influence the research process from inception to conclusion. Action research is an approach in which the researcher/s and participants work together to understand the problem they are trying to address and develop solutions together, which are then tested, evaluated, and refined using the action research cycle [41]. Such an

approach ensures that older people are supported to be active participants in the cycles of action research, and that outcomes are applicable and meaningful to the individuals and communities who take part.

Project Advisory Group

A Project Advisory Group (PAG) guided the research team throughout the project. The PAG was tasked to support the study throughout all stages of the project, and advise the research team on the views of stakeholders to ensure that they were recognised and reflected in the research design, process, and dissemination.

The PAG included representatives from:

- The NARI project team, including Director of NARI, Professor Briony Dow, Chief Investigator, Associate Professor, Bianca Brijnath, and the Project Manager, Dr Kate O'Halloran.
- Respect Victoria, initially represented by Dr Anne Stephens, and later replaced by Dr Suzette Mitchell.
- Carers Victoria, represented by Ms Anne Muldowney until her employment with Carers Victoria ceased.
- The North Metro Elder Abuse Prevention Network, fulfilled by Ms Julie Watson until her employment with Merri Health ceased.
- Seniors Rights Victoria/COTA Victoria, represented by Ms Melanie Joosten and Ms Alexia Huxley.
- Pronia Australian Greek Welfare Society, represented by Ms Mary Sophou.
- Better Place, represented by Mr Graeme Westaway.
- Elder Rights Advocacy, represented by Ms Philippa Campbell.
- Our Watch, represented by Ms Libby Blake until her employment with Our Watch ceased.
- A family carer representative and older person from a culturally and linguistically diverse background, Mr Sukhwinder Rakhra.
- A family carer representative and older person representative, Ms Fay Brassington.
- An older person representative, Ms Zelma Riddell, who died in 2020, before the project was complete.

The PAG met approximately every three months across the course of the study, with meetings held at either NARI's offices or via video-conferencing.

Impact of COVID-19

Phases 1 and 2 were run prior to the WHO declaration of a COVID-19 pandemic. The ensuing lockdown in Australia, especially the 'hard' second lockdown in Victoria, created significant uncertainty for the project's initial design and necessitated a change in approach to the pilot program to ensure the safety of the program participants and staff.

While this project was under consideration by the Austin Health Ethics Committee, NARI conducted a thematic literature review funded by Respect Victoria on the abuse of older people in the context of disasters [42]. This review informed the re-

design of this pilot, as well as NARI's approach to ensuring the health and wellbeing of its older volunteers involved in *The Impact of COVID-19 Pandemic Response on Older People Project* [42].

As was found in the review [42], older people are disproportionately affected by disaster, including in death and injury tolls, and in terms of the psychosocial impacts of disaster. These impacts extend to the medium and long-term. However, older people also show significant resilience in the face of disaster, and it is too simplistic to say that age alone makes someone vulnerable to disaster. Instead, age must be considered alongside functional capacity, physical impairments, and other intersecting factors, including, but not limited to, gender and race/ethnicity. Research is limited on protective factors, but support networks appear to be particularly important.

Disturbingly, what research is available suggests that older people experience financial, physical, and sexual abuse, as well as neglect (including abandonment) during times of disaster. However, much of this evidence is anecdotal. The strongest evidence exists for financial abuse, suggesting that older people are at greater risk of fraud and scams during disaster.

The review could not find any specific research on the prevention of elder abuse in the context of disaster. However, the literature surveyed suggested that the following steps could be taken to enhance disaster mitigation and preparedness with respect to older people:

- further training of and/or education for relevant health workers and family/friends on the specific needs of older people in disaster;
- fostering intergenerational connections and social support networks in communities prior to disaster (as well as during, and after), and;
- involving older people in disaster planning processes.

Importantly, COVID-19 appears to have exacerbated ageism as well as several risk factors for abuse relevant to both older people and family carers. In the early days of the pandemic, examples of ageism were evident in: media coverage; public and political discourse about the worth of older people's lives relative to the economy; the global incidence of older people being denied life-saving medical care due to their age (although this did not occur in Australia); the disproportionate death rate of aged care residents across the globe; and; policy responses that could be considered ageist, such as that of 'herd immunity' through population exposure to COVID-19.

Risk factors for older people that increased in the context of COVID-19 (particularly during extended 'lockdowns' in 2020) included: social isolation; decreased access to health care and exercise; increased reliance on and use of technology, and; financial instability. Risk factors specific to carers also increased, including social isolation and financial hardship, as well as anxiety and stress.

It is likewise important to note that the COVID-19 pandemic has had disproportionate impacts on, and poses increased risks to many marginalised groups, including women; Aboriginal and

Torres Strait Islander communities; migrant and refugee communities; people with disabilities; LGBTIQA+ communities; and those of lower socio-economic status. For many of these groups, age disaggregated data is lacking and it remains unknown how older people in these communities have been affected relative to younger members in these communities. Extrapolating from what is known about the impact of COVID-19 on younger women to older people, it may be hypothesized that there are increases in violence against older women; disproportionate economic and employment impacts; increases in unpaid caregiving, education and household chores; and disproportionate effects on mental health and wellbeing.

With all of these factors in mind, and in conjunction with Respect Victoria and the PAG, the research team made a decision to re-design the pilot program to be specifically applicable to the circumstances of the federal and Victorian state government's 2020 direction for people to "physically distance" during the COVID-19 pandemic, and the likelihood that this would increase social isolation and loneliness for both younger and older people (and as such increase the risk factors of abuse against older people).

Indeed, in 2020, the abuse of older people received further attention due to the COVID-19 pandemic. Data from the Victorian Crime Statistics Agency in October 2020 noted increases in family violence incidents and service use among people aged 55 and over following the introduction of COVID-19 restrictions [43]. Compared to 2019 data, this included a 20% increase in reports of family incidents to Victoria Police between April and June 2020, a doubling of Ambulance Victoria callouts for a family, domestic or sexual violence incidents, and a 50% increase in the number of older people receiving accommodation from a specialist homelessness service for family violence reasons in June 2020. The Australian Institute of Criminology also reported that two-thirds of older women who had experienced intimate partner violence by a current or former cohabiting partner said the violence had started or escalated during the pandemic. [44]

These figures resonated with what was also occurring internationally. For example, in the UK, abuse helplines for older people reported a 74% increase in calls compared to the same time in the previous year [45] and increases in the abuse of older people were also reported in the US and Brazil [46-48]. This is in keeping with Gutman and Yon's [49] systematic review, which shows more older people experience financial, physical and sexual abuse, as well as neglect (including abandonment) during times of disaster.

COVID Poem

Covid
Covid what?
COVID fear
Covid learning
Covid growing
Covid delight
Covid despair
Covid exercise
Covid torpor
Covid renewal
That's it
Renewal
Forced out of daily life
Locked up
Time at last
What to do with time
A gift or a challenge?
Suddenly there was time for new things
Time to stop and talk
To say hello and find the next sentence
To see things hitherto unseen
To say things hitherto unsaid
To discover people's insides
To hear their stories
To invite them home
To come out into the fresh air, to the newness,
towards a larger human family.

Ethics approval

Cognisant of the likelihood of increased family violence, Austin Health Human Research Ethics Committee rightly took a very cautious approach to the approval of this study. It took approximately five months to thoroughly assess the application, request changes, and subsequently approve the final protocol for the pilot study. This meant that the timelines of the project were amended (see Table 1) and that the pilot intervention occurred from mid-October 2020 to mid-February 2021. This period coincided with summer holidays in Victoria, with the state gradually emerging from a stringent second lockdown, which also affected the project. The impacts of these contextual factors and how they shaped the pilot are discussed in Chapter 8

.

Table 1: Impact of COVID-19 on the project timelines

Original timeline	Amended timeline
Ethics application outcome for proposed intervention type (May 2020)	Ethics application outcome for proposed intervention type (September 2020)
Six-week intervention pilot recruitment (May – June 2020)	Six-week intervention pilot recruitment (September – October 2020)
Six-week intervention pilot (June 2020 – September 2020)	Six-week intervention pilot (October 2020 – January 2021)
Intervention evaluation (June 2020 – October 2020)	Intervention evaluation (October 2020 – February 2021)
Draft research report (October – November 2020)	Draft research report (February 2021 – March 2021)
Final research report (November – end of December 2020)	Final research report (March 2021 – April 2021)

This project was approved by the Austin Health Human Research Ethics Committee and the NARI Governance Committee in two steps[1]:

- Co-design workshops (HREC/57353/Austin-2019).
- Pilot intervention (HREC/63637/Austin-2020).

[1] We did not consolidate the ethics applications because the pilot intervention was developed as a result of the co-design workshops. Therefore, seeking approval without clearly identifying the pilot methods, outcomes, measures, and consent procedures was not possible. This is one of the known drawbacks of a co-design approach [51].

3. Rapid review of the evidence

The abstract of the rapid review is included below. The full rapid review is published on Respect Victoria's website:

Key points

- There is very limited evidence on the effectiveness of primary prevention interventions targeting the abuse of older people.
- From the available evidence (n=12 studies), intergenerational programs that address ageism are most effective.
- Effective implementation techniques include social interactions, motivational interviewing, and multi-component tailored interventions with boosters delivered by a multi-professional team.
- To maximise intervention impact: (i) partnership across organisations, professionals, and older people and caregivers, and (ii) co-design and person-centred approaches are crucial.

https://www.respectvictoria.vic.gov.au/sites/default/files/documents/202010/Evidence%20Review%20NARI.PDF

Background

Although a number of systematic reviews and/or meta-analyses have to date been conducted assessing the effectiveness of interventions, these have not had a specific focus on primary prevention programs targeted at the drivers of abuse of older people.

While this review was initially limited to primary prevention programs, this ultimately resulted in too few results to analyse. A decision was therefore made to include some secondary prevention or early intervention programs in order to consider the factors that influence the effectiveness of interventions (regardless of whether their focus is primary or secondary prevention).

This also meant that – despite this project's focus on family violence - the inclusion criteria were expanded to incorporate some

studies focused on institutional settings where these learnings were relevant for primary prevention, or more broadly impacted the effectiveness of prevention programs. Thus, the review aimed to synthesise evidence on the effects of primary (and some secondary) interventions in tackling the drivers or risk factors of abuse experienced by older people, and to identify the factors that influence the effectiveness of programs or interventions (both primary and secondary). The review was guided by the following questions:

1. Which drivers (and risk factors) influencing the abuse of older people have been the focus of primary (and secondary) prevention programs/interventions?
2. What are the effects of primary (and secondary) prevention interventions in tackling the drivers and risk factors of abuse?
3. What are the factors that influence the effectiveness of abuse interventions?

Summary of methods

The review was guided by the conceptual framework developed by Dow and colleagues [23] discussed in Chapter 1. This framework identifies both drivers and/or risk factors as well as potential interventions at individual, community, and societal levels. The search for literature was performed in the following databases: Ovid Medline, Ovid Embase, AgeLine, PsycINFO, Web of science, and Sociological abstracts. A targeted search was conducted in WHO's online portal *Violence Info* (an information system that collates published scientific information on the main type of interpersonal violence) as well as the following journals for relevant articles: Age and Ageing, Journal of Elder Abuse and Neglect, The Gerontologist, The Journal of Gerontology: Social Sciences and Psychological Sciences, and Gerontology. The reference lists of retrieved articles and systematic reviews were manually searched for additional studies. Studies published in peer reviewed journals and grey literature between 2000 and 2019 were included. The literature search yielded 10,987 articles of which 172 full-text articles were screened for eligibility. Thirteen articles reporting on 12 interventions/studies were finally included in the review.

Main findings

Study characteristics

Twelve studies evaluating the effects of primary or secondary prevention interventions met the review inclusion criteria. Two of these were randomised controlled trials. A total of 2126 participants were involved in the twelve studies. Of these, 1153 were older people, 479 were caregivers, 255 were young adults and 238 were professionals/service providers. Six of the studies were targeted at older people, four each focused on caregivers and young adults/were intergenerational in nature, three were targeted at professionals/service providers, and one was a dyadic intervention (pairing caregivers and older adults with dementia). Five of the studies took place in institutional settings while eight took place in community settings.

Types of interventions

The review covered four types of primary and secondary prevention interventions: intergenerational programs; educational/psychological interventions for caregivers; educational interventions for practitioners/professionals; and multidisciplinary team interventions. With the exception of the intergenerational programs that act as primary prevention strategies at the community and societal level, no other macro-level primary prevention strategies were found. Except for two studies - one focused on psychological abuse and the other on financial abuse - all other interventions focused on multiple forms of abuse.

Drivers of abuse addressed by included studies

Five of the interventions focused on tackling carer risk factors. All four intergenerational interventions included in the review addressed ageism and social isolation, with one having an additional focus on the marginalisation of LGBTIQA+ older people. Two interventions focused on addressing organisational level risk factors for the abuse of older people (i.e. reducing the incidence of abusive care environments). Three interventions focused on addressing risk factors specific to older people. No interventions addressing structural drivers such as gender inequality or other forms of marginalisation or discrimination (aside from homophobia and transphobia) were found.

Factors influencing implementation and intervention effectiveness

While implementation approaches varied, strong evidence was found for the significant role of partnership across organisations, collaborative partnership (alliance among professionals, and alliance between health professionals, and older people and carers), co-design and person-centred approaches in optimising programs' impacts. In relation to the drivers of change that explain how and why interventions worked or failed to work, the most compelling evidence was for social interactions (largely engendered in group-based interventions), multi-component interventions, tailoring of interventions, motivational interviewing, booster sessions, and multi-professional team approach to program design and delivery. In conjunction with the use of participatory approaches, the operation of these factors played a key role in increasing program uptake and improving program effectiveness.

Gaps in the evidence

The gaps in the evidence identified relate firstly to the lack of primary prevention programs available to review. Other issues included limited focus of interventions on macro/structural drivers influencing the abuse of older people; limited outcome measures; lack of quality evaluations including limited use of theoretical frameworks; and limited description of interventions and implementation processes.

Conclusion

This review has shown that there is limited high-quality evidence regarding the implementation, evaluation, and effectiveness of primary prevention interventions targeted at older people who may experience abuse. The review has identified four primary or secondary prevention strategies that appear to have

the potential for targeting the drivers or risk factors of abuse:

- Intergenerational programs
- Carer psycho-educational programs
- Educational programs for professionals, and;
- Multi-sectoral/disciplinary team interventions

The review has also shown that the effectiveness of interventions to prevent the abuse of older people is contingent on a number of factors including the type of implementation approaches used, and the specific mechanisms that may be at play during the implementation process. The gaps in the evidence identified in this review provide further direction to policy makers, researchers, and evaluators regarding the development, adaptation, implementation and evaluation of interventions aimed at the primary prevention of abuse of older people. Of importance to both policy and practice is the need to pay attention to the development, implementation, and evaluation of macro level primary prevention interventions such as policies fostering positive attitudes to ageing, addressing gender inequality, and other forms of discrimination or marginalisation, which are identified drivers of abuse.

Matching the two reviews

Findings from the rapid review concord with results from NARI's thematic literature review on abuse during disaster (see "Impact of COVID-19" above for a summary of these findings) [42]. Indeed, as the team concluded in the report, very little research exists on the prevention of abuse of older people during disaster, and most evidence is anecdotal. Perhaps most worryingly, as Cornell et al. argue [50]:

> *The opinions and thoughts of older people… have rarely been canvassed. It has been more the case of doing things to and for older people [i.e. disseminating personal safety plans] rather than asking older people what they want [i.e. engaging with older people]" (p. 50).*

There is an urgent need for both quantitative and qualitative data that centres the experiences of older people – especially before and during disaster, as opposed to only in the aftermath. To date, the research focus has largely been on the post-disaster context of recovery and response. Relatively little exists in the way of pre-disaster work especially on mitigation and preparedness [51]. This is problematic as effective disaster management is "preventative rather than reactive" (p. 269) and includes planning for the conditions that best enable older people's resilience and recovery [51]. Therefore, the findings contained within this report should be taken into account when planning prevention activities in the future, particularly with the increasing likelihood of further disasters occurring.

4. Co-design workshops

Key points

- Participants wanted to tackle ageism as a driver of abuse by strengthening intergenerational bonds between younger and older people.
- They preferred a face-to-face intervention that involved younger and older people completing a shared activity (e.g. cooking and/or exercise).
- They wanted the intervention to address social isolation and loneliness experienced by older people.

The aim of these workshops was to co-design a primary prevention initiative or suite of initiatives involving older people, based on the evidence review and the lived experience of workshop participants, which would be piloted in Phase 3.

To achieve this outcome, the team ran two co-design workshops with professional stakeholders, older people, and people who care (or had cared) for older people one or more generations older than themselves. The workshops were each held for a half-day, approximately one week apart, and conducted using a World Café method [52].

World Café method

The World Café method is a type of focus group that enables participants to be part of evolving rounds of dialogue with three or more people while simultaneously being a part of an interconnected conversation with the other groups at the workshop [52]. This approach allows for a conversational greenhouse in which there is a rapid propagation of actionable knowledge and collective solutions [52].

The basic principles of this approach are:

- A welcoming and visually appealing environment with a facilitating host.
- Café type atmosphere – tables, table cloths, flowers, posters on walls.
- Ensuring everyone has the opportunity to contribute.
- All ideas are valued and respected.
- Using a range of media for expression of ideas.
- Small group format with experienced facilitators.
- Build on ideas generated from one café group to another.
- Using the information collected with integrity.

Figure 2: Co-design workshops using the World Café method

Each table comprised five to six professionals, carers, and older people, plus one facilitator from the research team or an experienced NARI staff member. NARI staff also provided additional support to people who may not be familiar or comfortable with public expression of their views. For example, some of the consumer participants were older people who had experienced abuse themselves and others had hearing or visual impairments. NARI staff spent time with these specific participants before the café workshops to ensure they understood the purpose and their role in the workshop, and a NARI staff member served as their individual support person during the workshop.

Participants

Inclusion criteria:

- Professional stakeholders had to be representatives of agencies who work directly with older people and/or their carers in a community care or advocacy capacity, or representatives of agencies who work in the field of family violence and/or the abuse of older people.
- Older people must have been aged 65 years or older, with the exception of people who identify as Aboriginal and/or Torres Strait Islander, who must have been aged 50 years or older.
- Carers must have been the primary carer for a person aged 65 years or older, with the exception of carers for people who identify as Aboriginal and/or

Torres Strait Islander who are aged 50 years or older.

- Carers also had to be one or more generations younger than the older person they care for, for example child, grandchild, son- or daughter-in-law, niece, nephew.

All participants attended the workshop sessions at a disability-friendly venue at NARI, in the suburb of Parkville, Victoria. Travel assistance was available for older people and carers who needed it.

Potential participants were ineligible if they were not able to provide informed consent, could not perceive or understand English language in aural or written form, or were under the age of 18 years.

Recruitment

Purposive sampling was used to recruit community care professionals and professionals working in the field of family violence and abuse of older people who could best inform development of intervention protocols. Sources included for example Carers Victoria, Seniors Rights Victoria, Elder Rights Advocacy, and prominent health and community care services such as aged care assessment teams, family mediation, and legal services. In addition, the team drew on their networks to identify relevant agencies or individuals. Professional stakeholders were recruited via means of a letter of invitation. Non-responders received one reminder via a phone call/email/or fax.

Purposive and snowballing recruitment methods were also employed to recruit older people and carers. Invitations to participate were sent in electronic and paper-based formats to members of the NARI volunteer database, which comprises more than 400 people. The project was also promoted through key stakeholder groups such as Carers Victoria, COTA, and carer support groups such as Manningham Senior Carers group.

Workshops

Following written informed consent from all participants, the first co-design workshop was held on 20 February 2020 and the second was held on 27 February 2020. There were 22 participants in Workshop 1, who were a mix of older people, carers and professional stakeholders, and 24 participants in Workshop 2 (see Table 2). Seven different people attended Workshop 2 (who did not attend Workshop 1), and three participants from Workshop 1 did not attend Workshop 2, thus, yielding a sample of 19 participants (65.5%) who attended both workshops.

Table 2: Workshop participants' demographics

Participant demographics	Workshop 1	Workshop 2
Total no. of participants	22	24
Older people/carers	11	15
Service providers working within sector	11	9
Age range	31 – 97	
Gender identity	26 women 3 men 1 non-binary	
Metropolitan Melbourne	29	
Regional Victoria	2	
Worked or volunteered in the ageing, family violence or related sectors	16	
Currently or previously cared for person 65 years or older Generation or more younger than person cared for Same generation as person cared for	22 14 7	
LGBTIQA+	1	
Refugee and/or migrant background	4	
Aboriginal or Torres Strait Islander	0	
Living with a disability	6	

Workshop 1

The aims of Workshop 1 were to further understand the possible drivers of abuse, brainstorm types of primary prevention interventions, and decide on a preference for the type of intervention to pilot. To assist participants in their efforts, they were provided with:

- A definition of the abuse of older people, types of abuse, its prevalence (Australia and worldwide), and impacts.
- Background to the project, and how the abuse of older people constituted a form of family violence in Victoria.
- Definitions of primary prevention and co-design, and an overview of the

drivers and risk factors of abuse of older people.

- A summary from the rapid review identifying local and international work done to address the drivers of abuse of older people based on the rapid review.

Participants were also asked to brainstorm what they thought were the drivers of abuse of older people, risk and protective factors, and suggest primary prevention programs. They were also asked about their preferences for primary prevention program(s).

Workshop 2

Findings from Workshop 1 were collated and presented back to participants in Workshop 2. As the purpose of this workshop was to design, in detail, the intervention to be piloted, participants were also asked in this workshop to brainstorm how to design the intervention, select primary outcome measures, and identify components for evaluation.

Findings

Drivers, risk factors, and protective factors

Drivers of abuse as identified by participants concords with the literature and are displayed in Figure 3. They also reflect NARI's 2018 conceptual framework, with the addition of gender stereotyping/gender inequality as an important driver of elder abuse (which is also reflected in the literature).

Figure 3: Word cloud demonstrating drivers of abuse identified by workshop participants

Participants reported that factors that increase the likelihood of experiencing or perpetrating abuse, or increasing the frequency/severity of abuse included: health vulnerabilities, social isolation and loneliness, family history and dynamics (e.g. parent/child relationship, reciprocity, sense of entitlement to inheritance), and major transitional life events such as bereavement or admission into aged care, which could disrupt one's value systems.

Protective factors named included having friends, connection to community and chosen/biological family, capacity to blossom, ability to advocate for one's rights, confidence, and a society where older people are valued and are worked *with.*

Both of these lists accord broadly with NARI's 2018 conceptual framework, which lists risk factors for the older person including: functional dependency, disability, poor physical health and frailty; social isolation/lack of support/loneliness and family dynamics such as conflict; sharing of resources/assets and carer burden. The culture of aged care is also mentioned as a contributing factor as the organisation/collective level in this model.

Although NARI's conceptual framework does not overtly list protective factors, it does list a range of "interventions" that may help the older person or person or trust such as family mediation; carer support (including respite); information about rights and options; respectful models of health and aged care; community awareness campaigns around ageism; and changes to policy and legislation that will in turn impact older people. These are broadly similar to the protective factors listed by workshop participants, although could be enriched by the comments made in workshops in an updated version of this conceptual framework that also includes gender inequality as a driver of elder abuse.

Co-designing a primary prevention program

Suggested primary prevention programs included:

- Intergenerational programs (e.g. with children, adolescents, middle aged and older people) – involving a shared meal, physical activity (e.g. dancing) or cause (e.g. advocating for action on climate change).
- Programs that bring together "chosen" or new families and encourage sharing lived experiences/storytelling, regardless of age. One example includes facilitating LGBTQI+ social connection programs.
- Educational or training programs focused on carers (including coping skills, information sharing, preparing 'future' carers).
- Education/training for financial planners (e.g. challenging inheritance impatience/importance of informing older people of financial rights).
- Media campaign targeting ageist stereotypes or raising public awareness of the abuse of older people.

- Community visitation programs (e.g. helping older people with digital literacy, letter writing).
- Programs for increasing social connection (e.g. friendship apps).
- Capacity building or training for older people (e.g. planning for ageing/advocacy skills).

Participants expressed a preference for an intergenerational program/intervention (13 votes), followed by educational programs (eight votes), and then community visitation, volunteer or 'networking' programs (three votes).

Participants indicated that preferred components of an intergenerational program should:

- Include activities such as a shared physical activity/interest/meal; and/or which helped people plan for their own ageing, including financial planning.
- Be inclusive of all cultures, and intersectional in approach.
- Involve carers.
- Be set in communities, including in regional/rural Victoria.
- Leverage digital media platforms including co-creation through films and apps, and dissemination via mainstream and social media.
- Generate outcomes that address ageism, create connection, empathy and understanding, and build capacity (e.g. advocacy skills, understanding, referrals).

Conclusion

After two half-days of interactive activity, participants expressed a preference to run an intergenerational program, preferably face-to-face, and involving a shared activity (suggestions included different forms of exercise, cooking, and more). The group endorsed the hypothesis that the program could, like some found in NARI's literature review [53], tackle ageism as a driver, by strengthening intergenerational bonds between younger and older people. Participants also expressed a desire for the program to address high levels of social isolation and loneliness for older people in particular – both known risk factors for the experience and perpetration of abuse of older people.

5. Pilot intervention: approach

Key points

- The pilot intervention was re-designed to be conducted online because of the COVID-19 pandemic to comply with federal and state government directions.
- An intergenerational program was developed pairing older people and younger people to have a one-hour conversation per pair per week for six weeks.
- Three methods were used to measure the outcomes of the program and if it was effective in reducing the drivers and risk factors of abuse: quantitative methods via a series of surveys and validated tools, qualitative interviews, and collection of auto-ethnographic outputs.

The co-design workshops carried out in Phase Two were run prior to the WHO's declaration of a COVID-19 pandemic and the ensuing 'lockdowns' in Australia, both of which necessitated a change in approach to the pilot program to ensure the safety of the program participants. NARI subsequently made a decision to re-design the program in an online context to be specifically applicable to the circumstances of the federal and state government's direction for people to "physically distance" during the COVID-19 pandemic, and the likelihood that this would increase social isolation and loneliness for both younger and older people.

Intergenerational program

The aims of the intergenerational program were to investigate if the pilot intervention was effective in:

1. Reducing ageism as a driver of abuse.
2. Reducing known risk factors for the perpetration and experience of abuse such as loneliness, depression and anxiety.
3. Increasing protective factors such as social connectedness.

The intervention worked by pairing older people over the age of 65 (or 50 for Aboriginal and Torres Strait Islander people) with younger people (aged 18–50, or 18–35 for Aboriginal and Torres Strait Islander people) to have a one-hour conversation per pair per week for six weeks. The program had 35 total

participants; 16 older people and 19 younger people. Pairs, where possible, were determined by participants' expressed preferences for a communication partner (such as their hobbies, or interests) and were not previously known to each other. The team provided a suggested structure for their weekly conversations, recognising that they may naturally drift to other topics. The broad-based topic suggestions for each week were based on those suggested by participants at the co-design workshops (adapted specifically for the COVID-19 context). These topics are listed in Appendix 1.

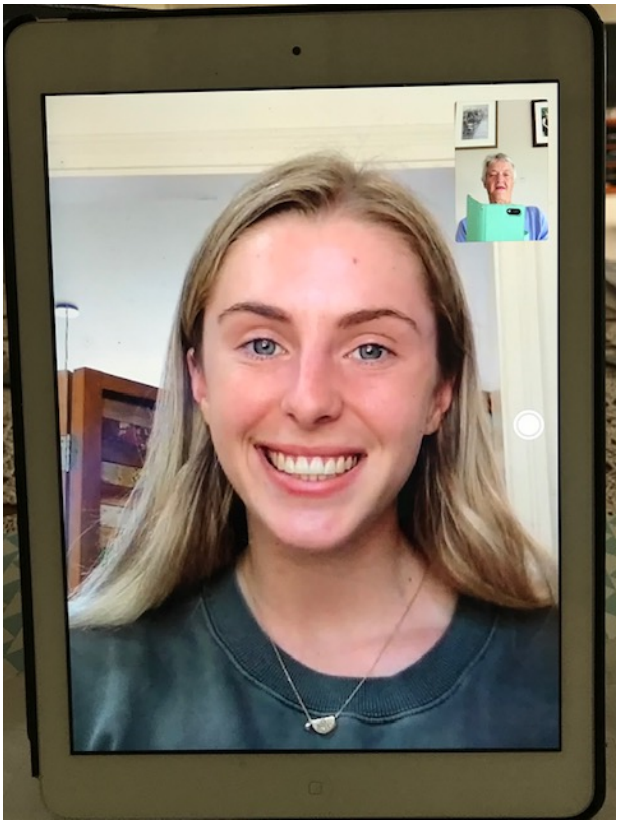

Figure 4: An intergenerational pair talk over FaceTime

Booster calls were made once per week by the research team to check in on participants. Detailed notes from each of these conversations were made and these additional insights have been used to inform the analyses. All participants were also provided with a number of resources including referral information for relevant services, should the need arise. While participants were discouraged from discussing abuse or other potentially distressing topics, it was recognised that this might happen. The team therefore also provided specific tips and information relating to the COVID-19 pandemic and the suggested topics above; for example, tips on 'staying connected' and 'exercise and physical activity' during the pandemic and requirements to physically distance. While the program formally 'ended' after six weeks, participants were given the option to continue to converse if they mutually agreed to do so. Those who were interviewed were asked if they stayed in touch, while many others updated the research team if they had stayed in contact.

Recruitment

Purposive and snowballing methods were used to recruit older program participants (over the age of 65, or 50 for Aboriginal and Torres Strait Islander people). Invitations to participate were first sent in electronic and paper-based formats to members of the NARI volunteer database. Recruitment was also broadened to the team's existing networks with key stakeholder groups in the ageing and family violence sectors.

Purposive and snowballing methods were also used to recruit younger program participants (over the age of 18 but below the age of 50, or 18–35 for Aboriginal and Torres Strait Islander people). Again, the

recruitment was conducted through NARI's existing volunteer database and trusted networks including key stakeholder groups in the ageing and family violence sectors. In the first instance, the team approached those younger people who have previously expressed interest in other related NARI research projects such as those that have involved 'befriending' older people living in aged care facilities [54, 55].

Sample diversity by gender, cultural background, and sexuality was sought where possible. However, the team prioritised not turning away participants in an unprecedented time of social isolation.

Potential participants contacted the research team to express interest in the study. Once contact had been made, the researchers described the program and

study procedures in plain language, and if the participant agreed to the study, the researchers confirmed the participant's eligibility (see Table 3).

Upon confirmation of eligibility, the researchers obtained consent and undertook a comprehensive, 30-minute screening call with the interested participant. This screening call asked participants demographic information, as well as their hobbies and interests and any preferences the participant may have for who they are paired with. The research team also took their own notes about their impressions of the participant's personality and the type of person they may be best paired with as a conversation partner.

Discovering Connections

I originally said no to the request but then changed my mind and thought "Why not?" Kate did a marvellous [sic] job in matching me with a lovely young lady, and though Kate (and we), did not realise it at the time, in our first conversation, we found that [she] and I had a connection. It turned out that [her] mother and my daughter went to school together and they still have a little contact through Facebook! I also know her grandma and knew who her late Grandpa was though I don't think I ever actually met him. What a coincidence!!! Another of my daughters was in the same HSC class as [her] brother and I actually taught her Auntie!

Table 3: Eligibility criteria for study participants

Inclusion Criteria	Exclusion Criteria
Older people must be: • Aged over 65 (or over 50 for Aboriginal and Torres Strait Islander people). • Proficient in English. • Able to provide informed consent. • Able to complete a police check or working with children check. **Younger people must be:** • Aged 18–50 years (or 18–35 years for Aboriginal and Torres Strait Islander people). • Proficient in English. • Able to provide informed consent. • Able to complete a police check or working with children check.	Participants will be deemed to be ineligible for participation if they: • Are under the age of 18 years. • Are not able to provide informed consent. • Are deemed to have severe cognitive impairment. • Have very low to no English proficiency. • Are unwilling to undertake or pass a police check or working with children check.

Measures

Three methods were used to measure the outcomes from the intergenerational program. This included quantitative methods via a series of surveys with validated tools, qualitative interviews with participants, and the collection of auto-ethnographic outputs. The success of the program in shifting either a driver of abuse (ageism) and/or risk and protective factors were key to determining its possible effectiveness as a primary prevention (or secondary prevention) intervention, or a combination of both.

Quantitative measures

Five quantitative measures (identified in Table 4 below) were chosen to determine the pilot's effectiveness as a primary prevention program; in the first instance by measuring the program's capacity to shift a key driver of abuse experienced by older people – i.e., ageism. The focus on ageism as a driver was deliberate because this was the driver raised most often at co-design workshops, and it also has the most evidence in the literature (including the team's own rapid review).

As this was a pilot intervention, risk and protective factors were also measured to determine if the program would prove effective as a primary prevention intervention (as opposed to a secondary prevention intervention, or a combination of both). To this end, scales measuring

constructs[2] that reflected the issues raised by participants in the workshops were selected. These constructs included the following risk factors:

- Depression and anxiety, which often go hand in hand with loneliness and/or social isolation. Co-design workshop participants also mentioned bereavement and other potentially traumatic life events such as admission into aged care as contributors to loneliness, depression, and anxiety.
- Loneliness – participants specifically referred to "social isolation and loneliness".

Finally, the protective factors which were raised by older people in the co-design workshop were also measured, such as:

- Social connectedness – participants raised "friendship" and "connection to community and family (chosen and/or biological).
- Flourishing – participants used the word "blossoming" in later life.

These five constructs also align with some of the drivers and risk factors identified by NARI [23] in its conceptual framework (see Table 4).

Table 4: Alignment of drivers, risk factors and protective factors between the NARI conceptual framework [23], Rapid review, Co-design workshops and Quantitative measures.

Description in the NARI conceptual framework	Description in the Rapid review as	Description in the Co-design workshop as	Quantitative scales used in the pilot intervention
Ageism	Ageism	Ageism	Fraboni Scale of Ageism
Psychiatric/Psychological illness	Educational/ psychological interventions targeted as carers	Depression and anxiety	Kessler Psychological Distress Scale 6-item (K6)
Social isolation/lack of support/loneliness	Social isolation	Social isolation and loneliness	Three-item Loneliness Scale
Addressing social isolation programs in communities	Connecting the older person to support services	Friendship and connection to community and family	Social Connectedness Scale Revised
Not discussed	Not discussed	Blossoming in later	Flourishing Scale

[2] In survey research, a construct is the abstract idea that is measured using survey questions. Complex constructs contain multiple interconnected dimensions that, as a whole, compose the construct. For this reason, a scale can neither be disaggregated nor individual items separately analysed.

Participants completed the five validated scales at three stages: 1) at baseline when they signed up for the program; 2) immediately after the program and 3) one month following the completion of the program. The validated tools were selected to measure whether the intergenerational program was effective in reducing ageism, increasing potential protective factors for abuse (e.g. social connectedness and flourishing), and decreasing established risk factors for both the experience and perpetration of abuse of older people, including loneliness and psychological symptoms such as depression and anxiety. The validated tools are detailed below as is the scientific justification for why each of these scales were selected.

Measurement scales used to identify changes in the drivers, protective and risk factors of elder abuse

Drivers of abuse: ageism

To measure ageism the *Fraboni Scale of Ageism (FSA)* (Appendix 2*)* was selected. The FSA was developed primarily to measure ageist attitudes in younger people [56]. This 29-item scale has a range of possible scores from 29 to 116, with higher scores indicating greater levels of ageism. It has been found to have adequate construct validity as well as high internal reliability, measuring three factors: antilocution (similar to talking behind one's back), discrimination, and avoidance. Social desirability or respondent's desire to provide a social acceptable answer has not been found to influence results. The scale also differs notably from others by measuring both cognitive and affective components of attitudes towards older people [56].

Risk factors for abuse

Depression and anxiety

To measure depression and anxiety the *Kessler Psychological Distress Scale* 6 items (K6) was used (Appendix 3) [57]. Please list the six items This scale has been well-validated, is reliable and widely used to assess psychological distress in both clinical and general populations, as well as with people of varying ages and cultural backgrounds [57]. Scores range from 6-30 and a total score above or equal to 19 is considered indicative of clinically relevant anxiety or depression. Therefore, participants who scored 19 or above on the K6 were followed up with an email and/or phone call to communicate their score to them, and to recommend that they contact a general practitioner (GP) or mental health specialist, if they were not already in contact with someone, for further support.

Loneliness

To measure loneliness, the Three-item Loneliness Scale (TIL) (Appendix 4), please list the three items adapted from the 20-item UCLA Loneliness Scale, was used [58]. The range of possible scores is 3 to 9. Higher scores indicate greater loneliness. The broad cut-off points are: 3 to 5 = not lonely; 6 to 9 = lonely. Both the 20-item UCLA Loneliness Scale and the three-item alternative have been widely used and shown satisfactory reliability and validity. Importantly, the short, three-item version was developed for use with older adults [58].

Potentially protective factors:

Social connectedness

To measure respondent's levels of social connectedness the *Social Connectedness Scale Revised* (SCS-R) 20 items was selected (Appendix 6) [59]. This scale measures the emotional distance or connectedness between the self and others, including friends and society more broadly some examples. It has been found to be reliable with high internal item consistency and test-retest reliability [60]. There are three versions of the Social Connectedness Scale (Original; Revised and College). NARI confirmed with the scale developer that the revised scale was the most appropriate to use with this particular cohort of participants.

Flourishing

To measure respondents' perceived success in relationships, self-esteem, purpose and optimism, the *Flourishing Scale* was used (Appendix 5) [61]. This 8 item scale please list or summarise has good psychometric properties [61] and has been found to have acceptable reliability in various cultures and a wide range of age groups [62].

The construct of "flourishing" (as it relates to the scale used in this project) can be equated to a measure of a person's "psychological resources and strengths". More specifically, it measures one's perceived success in relationships, self-esteem, purpose and optimism. As above, this scale was chosen because older people, carers and stakeholders mentioned "blossoming" as a protective factor for the experience of abuse at the co-design workshops. The NARI research team interpreted this to mean something akin to the concept of flourishing, hence choosing this scale.

Qualitative measures

Interviews

All participants were offered the option of an interview after the program. The project manager interviewed those who had an interest in taking part in an interview, with a preference for a mix of older and younger participants, as well as those who she was aware had differing experiences of the program. In-depth interviews were chosen as they often unfold in a conversational manner, which offers participants the chance to pursue issues they feel are important [63]. In-depth interviews also enable the researcher to deviate from the "official" interview schedule where appropriate, to pursue important (sometimes tangential) themes or topics. This empowering approach proved an appropriate fit with the action research methodology employed in this project. The interviews explored participants' experiences of the program as well as any associated impacts.

It should be noted that in most cases the researcher who conducted the interviews had also been the participant's "check-in" person who called them each week for six weeks to discuss their progress. In many cases, this meant there was a high degree of familiarity between the researcher and the participant, including knowledge about how they felt about the intervention.

One-on-one, approximately one-hour, in-depth interviews were conducted with five younger and five older participants after the program had concluded. The interview schedule is listed in Appendix 7. Regrettably, one of the interviews with a younger person failed due to a technical error that meant the recording was impossible to transcribe. This interview was therefore excluded from analysis. Thus, nine interview transcripts were analysed in NVivo.

Auto-ethnographic output

Participants were also asked to produce an optional auto-ethnographic and creative output during the program, such as a photo or video diary. Such outputs are a less frequently used and innovative qualitative method that has the capacity to provide different insights into the participants' experience of the program [64]. For those who were unable to, or preferred not to use technology for this task, the team asked for a similar output such as a drawing(s) or journal entry. Seven participants provided a creative output with one completed as a pair by the older and younger participant. These were in the form of journal entries or poetry.

In the qualitative interviews, participants were interested in how the outputs would be used and suggested they could be shared via newsletters or websites. However, not all participants enjoyed the creative output, with some admitting it was a barrier to their participation (including one older person who initially declined to be involved in the program). Hence, while this activity was initially compulsory, it was later changed to optional. All of the creative outputs have been integrated into this report and are presented throughout. Consent was obtained from participants providing permission for the anonymous sharing in the report.

Limitations of the research

There are several limitations to this pilot.

First, the program was designed to run during the second, prolonged COVID-19 lockdown in Melbourne, but due to delays obtaining ethics, it started just after this period.

The project could not be advertised on social media or in other public forums due to constraints imposed by the ethics committee. As a result, participants were recruited through existing contacts and thus had an interest in the topic. This may have biased results given many of the younger participants were enrolled in social work degrees (hence may have been more likely to have an interest in social justice issues).

The requirements of a police check as an eligibility criteria may have skewed the sample towards those who were more computer literate and able to complete the check online. Relatedly, as the program was delivered exclusively online or by

phone, the sample was comprised of largely digitally literate participants;

A limited number of creative outputs were returned to the research team, with some reluctance reported by participants;

The pilot program was resource intensive, both in terms of supporting participants to obtain police checks as well as sustain participation in the program through weekly booster calls.

In terms of representation, none of the participants in this study identified as Aboriginal or Torres Strait Islander. There was also only one pair from regional Victoria.

6. Pilot intervention: findings

Key points

- Quantitative methods found that ageism was lower and loneliness higher in the younger cohort.
- Qualitative data demonstrated that the older participants felt undervalued and lacked opportunities to contribute their skills and experience.
- Younger participants expressed a notable shift in their assumptions regarding older people. Younger participants expected older people to have conservative views and were surprised to find similarities on topics such as gender and sexuality.
- Older participants also experienced a change in attitude towards younger people, acknowledging the unique challenges they face.

Quantitative findings

A total of 35 participants completed the measures at baseline, comprising 16 older people aged between 67 and 86, and 19 younger people aged between 20 and 48. The numbers of younger and older people are unequal due to the death of one older participant, plus the consecutive pairing of two younger people with an older person in two cases. See Table 5 below for sociodemographic data of participants.

Table 5: Survey participants' sociodemographic data

		Older participants	Younger participants
Total no. participants		16	19
Age		67 – 86	20 – 48
Gender	Female	12	18
	Male	4	1
	Non-binary	0	0

From refugee/migrant background		3	7
Living with a disability		2	1
LGBTIQA+		1	5
Aboriginal or Torres Strait Islander		0	0
Geographic location	Metropolitan Melbourne	10	7
	Regional Victoria	1	0
	Unknown	5	12

The data presented indicates the average (mean) scores for all participants and for older and younger age groups separately. The tables also show the standard deviation of scores (SD), whereby 95% of all individual scores fall within the SD number either side of the average score.

Drivers of abuse

Fraboni Scale of Ageism (FSA)

The range of possible scores for the FSA is 29 to 116, with higher scores indicating greater levels of ageism. Our data shows that the average scores for participants indicating ageism were relatively low in both cohorts at 49.69 at baseline, 45.65 at the end of the program, and 47.16 at follow-up (see Table 6). These rates are lower than what has been reported in other works; for example, an Australian study conducted in 2011 found a mean score of 61.5 (SD 11.0) for a sample of Victorian public hospital doctors working in general medicine or aged care [65].

A key finding around ageism is that overall, older people had higher ageism scores compared to younger participants. This may be due in part to selection bias in the younger sample who were predominantly social work students as well as in the opt in nature of the study, indicating young people were more likely to want to engage with older people in a positive way using their volunteer time. However, higher ageism scores in older people may also suggest that there is internalised ageism in this cohort.

Table 6: Fraboni Scale of Ageism

	Baseline	End program	Follow up
all participants average	49.69	45.65	47.16
SD	10.93	7.75	9.06

older average	54.56	49.50	49.92
SD	9.33	6.41	7.42
younger average	45.58	42.36	44.62
SD	10.47	7.26	9.68
n	*35 (16OP/19YP)*	*26 (12OP/14YP)*	*25 (12OP/13YP)*

Risk factors for abuse

Kessler Psychological Distress Scale (K6)

Responses to the summed six items on the K6 yield a score between 6 and 30, with higher scores indicating a greater tendency towards depression and anxiety. A total score above or equal to 19 is considered indicative of clinically relevant anxiety or depression.

Participants' scores on this scale were relatively low at baseline (9.50 for older people and 11.47 for younger ones). Through the pilot, these scores further decreased in both cohorts, signalling further reductions in levels of distress. The effect was slightly more pronounced in the older cohort.

Overall, the average scores in both cohorts were well below the cut-off point (19+) for cause for concern, and edging towards the healthiest score possible in the older cohort. This again may be indicative of the self-selection opt in process. As such, there were no meaningful results on this measure.

Table 7: K6 Scores

	Baseline	End program	Follow up
all participants average	10.57	9.92	9.20
SD	3.67	4.15	3.74
older average	9.50	7.92	8.08
SD	2.69	2.33	2.96
younger average	11.47	11.64	10.23
SD	4.12	4.58	4.08
n	*35 (16OP/19YP)*	*26 (12OP/14YP)*	*25 (12OP/13YP)*

UCLA Three Item Loneliness Scale

The range of possible scores on the TIL scale is 3 to 9 with higher scores indicating greater levels of loneliness. The broad cut-off points are 3 to 5 = not lonely; 6 to 9 = lonely.

In our study, younger people rated lonelier than older people at all time periods but were still within the 'not lonely' classification (see Table 8). Overall, loneliness declined for older and younger cohorts between baseline and follow-up, but peaked at the end of the program as many participants were concerned about a loss of connection with their paired partner.

Table 8: The Three Item Loneliness Scale

	Baseline	End program	Follow up
all participants average	4.23	4.35	4.00
SD	1.29	1.24	1.33
older average	3.88	4.00	3.58
SD	0.99	1.00	1.11
younger average	4.53	4.64	4.38
SD	1.43	1.34	1.39
n	35 (16OP/19YP)	26 (12OP/14YP)	25 (12OP/13YP)

Potentially protective factors

Social Connectedness Scale Revised

Participants were scored on the Social Connectedness Scale Revised. A higher score indicates greater social connection. The range of possible scores for the revised scale is 20 to 120.

At baseline, both older and younger people showed similar social connectedness scores on the Revised 20-item scale (93.75 and 93.89 respectively). These rates are higher than the average scores of participants (a sample of undergraduate students) that was used to develop the instrument (mean score of 89.84, SD 15.44) [60].

Overall, older participants' social connectedness scores improved over the course of the study, suggesting that these felt more connected to their friends and society.

By contrast, younger participants showed a decline in social connectedness at the end

of the program (87.86), but this rebounded slightly at follow-up (91).

It should be noted that external factors may have influenced the data given that the study was conducted at the tail end of a protracted COVID-19 lockdown in Victoria. This may mean, for example, that participants' initially high levels of social connectedness reflected their capacity to re-connect with friends and family post-lockdown.

Table 9: Social Connectedness Scale (Revised)

	Baseline	End program	Follow up
all participants average	93.83	91.08	93.56
SD	15.49	13.25	16.18
older average	93.75	94.83	96.33
SD	15.03	12.02	16.16
younger average	93.89	87.86	91.00
SD	15.86	13.40	15.77
n	35 (16OP/19YP)	26 (12OP/14YP)	25 (12OP/13YP)

The Flourishing Scale

The range of possible scores is 8 to 58. Higher scores indicate greater flourishing. A sample of college students was used to develop the original instrument, with a mean score of 45.5 (SD 6.2). The scale's authors state that "A high score represents a person with many psychological resources and strengths" [66].

In this study, scores for older and younger people were similar to each other and similar to the scale's validation sample although with higher variation. The older cohort reported high scores for flourishing with little change (less than 2 points difference) over time.

By contrast, younger people's scores dipped at the end of the program (42.14) but had almost reached baseline levels at follow-up (46.84 vs 45).

These variations suggest that younger people's psychological resources and strengths varied more over the course of the study than older people's but these variations were overall very minor.

Table 10: The Flourishing Scale

	Baseline	End program	Follow up
all participants average	46.60	44.19	45.76
SD	5.00	9.29	6.77
older average	46.31	46.58	46.58
SD	5.76	6.25	6.05
younger average	46.84	42.14	45.00
SD	4.23	10.84	7.30
n	*35 (16OP/19YP)*	*26 (12OP/14YP)*	*25 (12OP/13YP)*

Qualitative findings

The following key themes emerged from the 11 qualitative interviews conducted.

Shifting ageism as a driver of abuse

Several participants discussed the barriers and lack of opportunities for older people to contribute their skills and experience, especially post-retirement. This was an observation made about older people generally, rather than in the specific context of COVID-19. For some younger participants, realising how undervalued older participants felt changed some of their thoughts and preconceived ideas about older people. They also reflected on how they would like to live as they age:

"It's interesting to see how someone that had such a fruitful career can be where they are now, to see that circle, and for me it's an eye-opener from a society perspective to have someone that's so rich in a career that doesn't have any input in society. I think she'd be a great mentor or something like that, instead of just not – there's no input for her".

"It's an eye-opener for me because I'm like that's going to be [me] – obviously we're all going to get to that age at some point, so it just makes me reflect on how am I going to live my life at that time".

Many participants felt one of the best outcomes of the program was the opportunity to share knowledge and discuss similarities and differences in generational life experiences. Some younger participants believed the intervention highlighted a prejudice towards older people they felt they might have unconsciously had:

"There is a little bit of presumption that it's easier to just stay with people in your own demographic, apart from family members. And not that I ever openly thought that or anything like that. It was more just this was a

real reminder that there is so much that you can learn from people who you don't even know"

"I think that I'm just scared to admit that maybe I am a bit ageist, but I don't think I am, I was just given another example of a really smart, cool, wise, on the ball person who is older".

Some older participants identified experiences from their lives in which they had experienced ageist discrimination. One participant – who also displayed some internalised ageism – discussed their frustrations in seeking social groups and activities:

"I mean this was meant to be an art group. And so there were all these old, old, old, old, really old people with their meals on wheels. And then there were people like myself, who were there to do – because I paint and I draw and I like to hang around in – it's good to have a group, an art group, and I thought it was an art group. And it could have been an art group, but it ended up being a hobby for the aged … And that's the whole thing, that it's all about filling in time, and the assumption is that nobody above a certain age is actually interested in studying art. So it's not going to be a serious undertaking".

Indeed, some older participants in the study also expressed ageist views:

"I don't seek out the company of people my age. I find people my age – and I've been around a number of contexts in the last eight, nine years – I've had a lot of people my age – I really find them awful, quite frankly".

Although the quantitative surveys only measured ageist attitudes towards older people, qualitative interviews indicated that the program may have also changed older people's views of younger people. This included older people having more empathy for the challenges experienced by younger participants:

"In some ways it's reminded me we have more in common than less, I suppose, about struggles about life and health and relationships. And it's helped me get – not that I didn't know – just more in touch with how hard it is for younger people in terms of what the future looks like job-wise, climate-wise, post COVID-wise. It's a pretty tough gig, I reckon, all round. Whereas, probably post-Second World War, baby boomers – which I'm in the middle of – society-wise was probably the boomiest [sic] time in Australia's history. In terms of jobs, I could drop one, one day and pick one up the next".

"I certainly experience ageism, and to some extent I have what you'd term 'youthism'. Ageism and youthism, probably. And talking with yourself and [conversation partner's name] has allayed some of those stereotypes I've probably taken on board. Because of the distance, the connection. And I don't have a lot of young people in my life. I don't have kids or grandkids; got a couple of nephews. But I don't have a connection, so it's really helped me see more of our similarities. Well, in a small way it probably has".

Changes in attitudes, preconceived ideas or stereotypes

Participants also noted changes in their preconceived ideas and assumptions regarding age. For example, younger

participants often expected older people to have conservative values. This was evident in the case of gender and sexuality:

"[I was surprised by conversation partner's openness around sexuality, given the church involvement] and some other stuff about the expectations of the roles of women. And she was really critically aware of how those expectations had shaped her life and shaped her kid's lives and really – I don't know. She was just really progressive with all of that stuff. She had probably the same feminist ideas that I do".

Several participants identified as LGBTIQA+, with all expressing a preference to be paired with someone else who was either also LGBTIQA+, open-minded/progressive, or at the very least not homophobic. As a result, two LGBTIQA+ people were paired together, as well as another pair where the younger person was LGBTIQA+ and the older person had an LGBTIQA+-identifying daughter. This older person had, in the screening process, indicated her willingness to be paired with a younger LGBTIQA+ person given her experiences with her daughter. One younger LGBTIQA+ person was paired with an older person who had expressed progressive political viewpoints at screening, while another younger LGBTIQA+ person was paired with an older person who did not explicitly state that they identified as LGBTIQA+, but hinted so at screening.

For the openly LGBTIQA+ pair, their shared sexuality was critical in terms of them forming a bond and a degree of trust that enabled them to discuss issues relevant to queer sexuality and community. Their conversations therefore covered a range of topics where there were perceived generational differences in approaches and understanding, such as: gender diversity; polyamory; different "waves" of feminism (including lesbian feminism in particular); and political belief systems (such as anarchism):

"[With younger participant we discussed] mainly [an] exploration of lesbian feminist thinking, and the current thinking about sexuality and gender. For example, fluidity of gender, non-binary, and all the issues for people who are trans. I don't have much of an understanding because I'm not out in the scene. As you get older, you're not as involved and move around, so [I am] interested in the plight and the challenges of trans people. And just all the gender and sexuality cultural and current discussion".

In check-in calls (as verified by NARI researcher notes), both these participants expressed that such conversations had been transformative in bridging generational gaps in understanding, and concluded that they had more in common than they may have previously imagined*. Both described the program as a rare opportunity for queer connection across generations, and enthusiastically expressed that if another intergenerational program could be trialled, an LGBTIQA+-specific program would be very valuable*. For the older participant, this was especially important given many queer people are alienated from biological family, and for their generation, rarely have children of their own:

"As you get older, you've got to expect that, that the system can only do so much, and it's

just the way it's going to be, and you've got to try and find your own thing. And if you're a busy older person, you've got whatever – grandkids maybe, they keep you pretty busy – you probably don't analyse it like I am because I don't have the grandkids and not in a heterosexual paradigm. I'm finding it quite a challenge … Could it have gone on a little longer as a participant? Yeah, probably for me it could have. That's how I feel. Because I've got the time and the space, and I was interested in the things I wanted to explore with the younger lesbian too, in terms of gender and sexuality and politics".

Several older participants identified as practising religious, primarily Christian. This included two older people who were paired with younger LGBTIQA+ people. Several younger people expressed concerns that they would not be able to get along with a partner who expressed strong faith – especially if the younger person identified as LGBTIQA+. However, their preconceived ideas about religious persons changed as a result of the program, notably with two younger LGBTIQA+ people who were surprised to find that the older person they were paired with shared a number of their progressive views:

"[My conversation partner] is like an elder in her church and yeah, I was taken aback by my own assumptions there about – I guess I did not expect her to be so cool with [my sexuality]… well she just told me about some of her life experiences with gay people and other issues that I would definitely peg someone who is older and religious to be a bit – less comfortable talking about than she was".

"I indicated before I was a little trepidatious when I found out how religious [my conversation partner] was, just because in my experience… religious people have to work to prove themselves a hell of a lot more than anyone else. They're starting from here [gestures down], whereas other people might start from here [gestures higher up]. But, despite that, our politics align, we're both unionists. Even though he does a lot of church singing, it's still arts in singing. So, there were these interesting little connections. It reminded me that interesting lives don't come from having the most travel and the biggest experiences".

Gender inequality

The majority of the older participants in the program identified as women. In the interviews, some of these participants highlighted experiences they had at the intersection of gender inequality and ageism. This included patronising language commonly used towards older women:

"[The volunteers] say things to me such as, "Did you have a good night, dear?" And then checking to make sure that I know how to take a shower. What kind – a discussion about showers, you know. "What kind of shower do you have?" Oh, yeah, a fucking shower. "And do you take care? Do you have rails, dear, because you must avoid having a fall?" And as soon as anybody starts referring to falling over as a noun, a fall, you know that you're being totally patronised. And you know that you're being slotted into this pathetic category of decrepit, frail old person. I never ever use the noun "a fall".

Another, as discussed previously, spoke about how she was subjected to controlling behaviour as a wife and carer. She had

found these experiences to be common among her peers:

“A: I think [controlling behaviour is] common to a lot of older couples and older women. And in my writing, I've written stories about this, which have really amused my U3A [University of the Third Age] class. When I'm on a tram, I never get into a conversation with a woman of my own age on a tram without unleash[ing] – Because I used to be a social worker, so I know how to unleash. I unleash this torrent of complaint about their husbands. So, I did write a story, I should send that to you as well. I'll send you two or three of just writing, you will probably laugh as well. The story, which is just a little short story, will show you exactly how it is for women like me.

Q: Yeah, well no-one should really have to put up with controlling behaviour, I think.

A: It's true, that is true, nobody should, but it is fairly deeply entrenched in our society, and surprisingly at other levels, even amongst highly educated people”.

Racism/cultural diversity

In general, intergenerational program pairs were matched for “similarities” and “preferences” (e.g. in hobbies/career, even sexuality/gender) but participants were not matched according to similar cultural background, ethnicity, or race. No participants asked to be matched with someone of the same cultural background.

Indeed, in one or two instances, participants expressed a preference to be matched with someone of a different cultural background, a preference that was honoured. In one of these cases, where an older Caucasian participant was paired with a younger person of Indian/Singaporean descent, the match was cited as being both interesting and “educational” for the older person.

"I found [young person's name] particularly interesting, because of her cultural background. And that was because at a time in my life, for a period of seven years, I had worked in the Middle East. And I'd worked … very closely with people from many different backgrounds, but in particular from India, and the Philippines and some of these people had become good friends. So, that added a – And it was just especially interesting and nice for me to have that other contact".

One older person also commented that the program had made her reflect on differences between “white” and diverse cultures and their attitudes to ageing.

“I love going to [Footscray] and having a great time with Vietnamese people of all ages. And the same with taxi drivers from other countries, especially ones I’ve worked in. Young taxi drivers from Afghanistan, I mean these people are terrific. They know how to talk to older people. They don’t mind that I’m older. They don’t give a damn. And get invited to their international days and some of those celebrations. It’s fabulous. And no one cares."

Changes in mood or behaviour

Seven participants interviewed reported that they felt a positive change in mood and/or behaviour due to the program, while two participants stated that they experienced no change. This supports

quantitative analysis showing a small decline in levels of distress after participating in the program (although this cannot be assumed to be a causative result). For a number of participants, their positive experience of the program led to feelings of wanting 'to do more' to bridge the intergenerational gap. For instance, younger participants regularly cited being too busy as a major stress in their life and felt that the program was helpful in grounding them:

"My life was so busy, it was a dedicated hour a week that I wasn't working, that I was committed to. So I would always take that hour regardless of what else was going on. And that was fine, because I had it scheduled in. I guess it's taught me the importance of trying to schedule in other stuff. But when somebody else isn't involved, I just sort of go, "Yeah, I'll do it later. I've got to keep working." So, I would like to think that in the coming weeks I would start to schedule more balancing things in my day. Because I need that. So, that was good. I was incredibly stressed at the time and often going into the conversation I was like, "I don't have time for this. I'm not in the right mood" and then at the end I was glad I'd done it."

While some younger people commented that their lives had become more busy and stressful during the pandemic (particularly those who remained employed), older people by comparison reflected on their loss of commitments:

"We had made plans to [meet up], and I probably will leave it up to her. Only for the fact that she has a majorly far busier life than me, as you would, probably, at 28. And I'm turning 68 in April, and I have a lot of time on my hands. But there's present intentions on both sides, and I'll let her lead the charge, because she's extremely busy. And for me, part of my experience is ageism, and I haven't got a lot on my plate, so I'd be more conscious to continue a connection, but sensitive to – if someone is really busy, it may not happen, and that's okay."

Importantly, one older participant disclosed in the interview that she felt she was experiencing something akin to abuse or on the "spectrum of" abusive behaviours:

"[My husband] made a few cracks about why I was doing this [program], and didn't see why I would want to do it, because he's trying to make me just utterly connected with him, and he wants to be the only person who has any say over what I do with my life. So, very difficult. It's not actually elder abuse, but it's on the spectrum, at the very, very early end. It's controlling behaviour."

The same participant also reflected on her experiences of carer stress and isolation due to the nature of her relationship with her husband, in particular how dependent he was on her. This participant felt the program was positive in giving her some independence:

"My husband is very, very dependent on me emotionally and physically, and becoming more so. So, it was quite nice to have fixed time that was my time, where I can say to him, "Look, I've joined this program, this is something I'm going to do," and be quite firm about it. And yes, a little opportunity to be a little bit pleasantly assertive about my own life and interests. So, that was helpful, it was actually quite helpful".

It should be noted that while this participant said her husband's behaviour was not "elder abuse", controlling behaviour is a form of coercive control (and therefore a type of family violence). This participant was therefore followed up as per ethical protocols and concern for the participant's welfare. The follow up was by the project manager, who is experienced in identifying and responding to family violence.

Impact of the pandemic on participants and their experience of the program

For many participants, the pandemic was considered a significant enabler to study participation. This is perhaps unsurprising, given the program was advertised as being about: (a) the prevention of abuse of older people and (b) a program to enable (safe, socially distanced) social connection across generations during a time of heightened social isolation. Both of these components were identified in previous reviews, undertaken by the team, as crucial to address during times of disaster, such as COVID-19 [42, 53]. Due to the pandemic, participants felt they had more time on their hands than usual. It also made the program more accessible as it was changed to a virtual format (with participants able to communicate by phone or computer e.g. video conference or computer-based audio call). Many participants stated that if it was face-to-face they may not have participated due to availability. Participants corresponded via phone (either landline, mobile) and/or using digital videoconferencing technologies (e.g. Zoom, Skype, WhatsApp) pending their preference, which was negotiated with their conversation partner. They also felt that this made the first conversation less daunting. Barriers caused by travel and physical health were also removed:

"If it was face-to-face, I think it could be more commitment because you actually have to go somewhere to meet the person, and sometimes, for [co-participant's name], she wasn't feeling well, so even if she wasn't, she'd be on her couch and having a conversation, so it was more adaptable in that sense. So I think having the flexibility of both [phone and face-to-face meetings] is good".

This also enabled the participation of one participant from a regional area whom otherwise may have been excluded. Many participants appreciated the flexibility of working from home but missed their regular commitments during the pandemic. As a result, several participants stated that the program was helpful to them in providing some purpose:

"It's been a positive, it's been really interesting, it has helped improve my life, in a way. [The program has] taken a bit of pressure off the partner who was quite happy in COVID and her voluntary work, and I really haven't had a lot to do, so it has been a positive".

One younger and one older participant cited feelings of social isolation during the pandemic and the resulting restrictions put in place by the Victorian Government. The majority of the participants stated that they were not lonely, in fact, the opposite. This finding, however, should be interpreted with caution as quantitative results indicate that young people were overall more lonely than older people at all time periods, and only four younger people consented to be interviewed placing a limitation on the qualitative data that was analysed.

As above, loneliness also declined for both cohorts between baseline and follow-up, which may indicate that the program was beneficial in addressing their levels of loneliness (although loneliness peaked at the end of the program). Interviews took place around the time of follow-up, which is when quantitative data indicates that loneliness was at its lowest for both older and younger cohorts. Lower levels of loneliness in this study may also be a bias as a result of recruitment. The two participants who did cite social isolation considered the intervention positive as a result.

Integrating the quantitative and qualitative findings

Tackling ageism as a driver of abuse

The intergenerational program pilot altered younger people's recognition of the problem of ageism - even in a sample where their levels of ageism were very low compared to average scores on the Fabroni Scale. The qualitative data more strongly supported a reduction in younger people's ageist attitudes than quantitative data (which suggested a "rebound" at one-month follow up). The program also inspired many of them to actively do something about the problem – although they were unsure of what action(s) would be best taken.

One solution might be to ***find ways to value older peoples' knowledge/experience/contributions and give younger people greater and/or easier access to this knowledge and experiences.*** During the intergenerational program, many older people became incidental mentors to their younger conversation partner when they worked in similar fields or shared similar interests. In qualitative interviews and check-in conversations, younger people often mentioned how much they learned from the older person's wisdom.

Bringing different generations together also disrupted younger people's assumptions that older people are more conservative politically – including when it comes to gender norms, sexuality and so on. Disproving these myths may prove important in garnering respect for older people as well as younger people, thus addressing critical drivers and risk factors for abuse of older people.

Concurrently, older people are not only aware of being patronised/disrespected once they hit a particular age (particularly post-retirement, but many also internalise ageism as evidenced by the survey results. Indeed, older people were more ageist than the younger sample in this study.

There may have also been latent ageist attitudes towards younger people; while the survey did not measure this, qualitative data suggests that these views also shifted during the program particularly for older people. Many reflected that there was "more in common" between generations than they realised. This is a positive sign that such programs may have potential to shift ageist attitudes in both directions. Future iterations of this pilot may wish to measure ageist attitudes towards younger people to confirm this finding.

Addressing the risk factors of abuse

Depression and anxiety

Quantitative and qualitative findings also aligned with regard to findings on depression and anxiety. In qualitative interviews, seven of the 11 participants described a positive change in their mood and/or behaviour. The quantitative analysis also showed that participants' scores on the Kessler Psychological Distress Scale (K6) (which measures symptoms of depression and anxiety) generally decreased for both older and younger cohorts, signalling an overall decline in already relatively low distress levels.

Loneliness

Quantitative data did suggest that younger people felt particularly lonely, especially when the program ended. This matches their stated difficulties, including sadness and reluctance, in ending their relationship with their conversation partners, although a causal connection cannot be assumed.

Older people also experienced a spike in loneliness at the end of the program. However, at one-month follow up both younger and older people were less lonely than before they started the program. It is hard to interpret whether this was a result of the program itself, the evolving COVID-19 situation, or something else, however both younger and people showed the same patterns.

Interestingly, almost none of the participants interviewed spoke about "loneliness" explicitly or by name. One younger and older participant cited feelings of social isolation during the pandemic and the resultant restrictions put in place. However, most participants did not say they were "lonely", instead simply noting changes in their life due to COVID-19 restrictions. A number of younger participants spoke about how the pandemic had prompted reflection on their lives prior to the lockdown, with several speaking about how high their stress levels were and how busy they were. Some stated that they were even busier during 'lockdown', particularly those who were working as well as studying.

However, as many younger participants were working from home, they spoke about appreciating the chance to connect with an older person virtually, contending that participating in a similar program in person (which would require them to travel) would not have been possible outside of 'lockdown' due to their busy schedules. Older people, while also very grateful for the program, by contrast spoke most often about how the pandemic had resulted in the loss of meaningful commitments (e.g. volunteering, connecting with family and friends).

Potentially protective factors

Social connectedness

The quantitative data on social connectedness showed similar scores for older and younger people before the program started. For older people, these scores improved over the course of the study, whereas younger participants showed a decline in social connectedness at the end of the program but this rebounded at follow-up. This could indicate that younger people initially found the end of the program harder than older people did, but after one month, those feelings may have resolved.

In the interviews, a number of younger people expressed their ambivalence about ending the program, including concerns for the older person's welfare and sadness at the loss of connection, or uncertainty about how to navigate the possible continuation (or break) of contact. It is not clear if this was what contributed to their sense of greater emotional distance or disconnectedness after the program. Interestingly, most pairs did mutually choose to stay in touch, which may have contributed to the "rebound" at one-month follow-up.

For older people, incremental increases could indicate that the intergenerational program shows promise in shifting levels of social connectedness. Or, again, they could be a reflection of other circumstances more broadly, including the increasingly more "normal" structure to life post Victoria's lengthy second lockdown.

Flourishing

Overall, the quantitative measures showed no discernible shift in flourishing levels for older people, while scores for younger people dipped at the end of the program and almost reached baseline levels at follow-up. These variations suggest that younger people's psychological resources and strengths varied more over the course of the study than older peoples'.

Given flourishing measures "psychological resources and strengths" as diverse as relationships, self-esteem, purpose and optimism, it is difficult to interpret this finding, especially given the relatively small changes recorded, and the fact that that Victoria's lengthy lockdown had lifted simultaneous to the program starting. It is unclear how these circumstances may have affected these participants' perceptions of their psychological strengths, although undoubtedly the pandemic would likely have affected participants' sense of optimism and purpose. An alternative reading of these numbers may be that the end of the program resulted in a sense of loss or pessimism for younger participants, which "recovered" somewhat at follow-up.

7. Implications and recommendations for prevention

Key points

- Scale up existing or further intergenerational programs, specifically addressing:
  - Formalised mentoring programs working with youth and older people's groups.
  - LGBTIQA+ communities with a particular focus on alleviating loneliness and psychological distress.
- Gender inequality and racism must be considered alongside ageism as a key driver of abuse of older people with regard to intersecting forms of marginalisation.

The aims of this research project were to generate new knowledge on the drivers of family violence against older people; co-design and pilot test a primary prevention initiative or suite of initiatives involving older people; and make recommendations for uptake of findings in policy and practice.

In this chapter, specific recommendations are made on how to address the drivers, risk and protective factors of abuse, and in the following chapter, specific insights are offered on how to replicate intergenerational programs for prevention of abuse of older people.

While the intervention sought to address ageism, racism and homo/bi/transphobia also became key issues in the study. This was an unintended impact and is seen as an additional strength of this approach. It remains to be seen whether this approach would work with Aboriginal communities, people living with disability, or people who live in rural and remote areas due to this pilot not having an adequate representation of people from these communities.

Recommendations

- Support further research and gathering of evidence to inform how programs such as these can be:
  - Adapted or redesigned for specific cohorts including Aboriginal communities, people living with disability, or people who live in rural and remote areas. Such research must include strong community engagement and co-designing/co-adapting any intervention with the relevant groups.
  - Directed at addressing not only ageism but also other forms of

discrimination such as gender inequality, racism, homophobia etc.

Addressing the drivers of abuse

Ageism

- Older people feel they have much more to contribute than current, dominant Australian social norms and systems allow.
- The evidence synthesis, co-design workshops, and pilot intergenerational program suggest that formalising a lasting, positive engagement between an older and a younger person may be one way to combat internalised ageism and also racism, homophobia/biphobia and transphobia and faith discrimination.

Recommendations

- Facilitate partnerships between organisations that service youth and older people in order to scale-up, or continue to fund further intergenerational, social connection programs. A greater focus on the youth end would address primary prevention as it tackles ageism – a key the driver of abuse of older people.
- From the small sample, intergenerational programs appear to show promise in addressing the drivers and risk factors for abuse of older people by:
    - Raising younger people's awareness of ageist discrimination;
    - Reducing internalised ageism for older people;
    - Shifting other stereotypical assumptions about older people, including their levels of conservatism, and
    - Shifting older people's stereotypical assumptions about younger people.
- Communities and services should therefore advocate, and support existing efforts, for systemic change in how older people are treated post-retirement, including their other opportunities to mentor and share their wisdom and knowledge with younger people.

Racism

- Forging connections between older Caucasian people and younger people of diverse cultural backgrounds proved educational and was experienced positively. This was an unforeseen benefit of the intergenerational program and is a theme worthy of further exploration. For while there is no current evidence about the capacity of prevention interventions to reduce both ageism and racism, careful consideration should be given to this nexus, including the use of measurement tools to capture change in racist attitudes and/or cultural stereotyping.

Recommendation

- Measure whether intergenerational programs are effective in shifting racism as a driver of abuse where they intersect with ageism and other forms of discrimination.

Discrimination based on gender identity and/or sexuality

- The one pairing that included two openly LGBTIQA+ people was perceived as extremely successful by both participants. It also bridged "generational" gaps in understanding about a range of issues relevant to queer lives and communities. This may be one way of combatting negative stereotypes about LGBTIQA+ people of different generations from within the LGBTIQA+ community (in turn, combatting a driver of abuse in homophobia and/or transphobia). It may also go some way to alleviating the currently unacceptable levels of psychological distress experienced by many queer people in Australia [67].
- Younger people in the intergenerational program were especially concerned (when being paired, and at the beginning of the program) that older people would be homophobic or transphobic. This was especially the case when the older person was religious. Nonetheless, two younger queer people forged strong bonds with older religious people who had progressive politics. In any future similar programs, younger LGBTIQA+ peoples' fears about religious-based discrimination should be taken into account as that fear may well be justified. However, there is potential to connect younger LGBTIQA+ people with older religious people to combat preconceived notions that older religious people are necessarily homophobic or transphobic. Nonetheless, to do this would be difficult, as ideally it first needs to be established that those older people were not in fact homophobic or transphobic.

Recommendations

- Support intergenerational programs for older LGBTIQA+ people with a particular focus on alleviating loneliness and psychological distress, as well as generating conversation and understanding across generations about issues pertinent to queer communities.
- Facilitate partnerships between organisations that work to prevent family violence in LGBTIQA+ communities and faith-based communities to promote inclusion, and safer, more diverse families and communities.

A positive experience

In general, I have had little experiences of sharing, talking and laughing with younger people.

I am only 67 years old, and not one hundred, but being a working-class lesbian of my generation there was much less thoughts of having children and hence have no adult kids or grandchildren in toe. My living babies are 'fur babies'. In fact, I thought in coming to terms with my sexuality in my mid/late twenties that if I had a child it may be taken off me by Child Protection due to my lesbianism. I know this did factor in some women losing their child as a baby boomer lesbian/mother.

I found the conversations with a 28-year-old lesbian interesting and fun. Maslow's hierarchy of needs springs to mind, that is, for people/animals' food and shelter top priorities and then psychological needs further down the pyramid. However psychological needs no less important in some aspects of living each day on our planet.

I do miss the ongoing positive connections but understand the limits of the research project.

Addressing the risk factors of abuse

Loneliness and social isolation

- Isolation and loneliness were mentioned in the rapid review, workshops, PAG meetings, and the intergenerational program. While this issue was predominantly spoken about in relation to older people, there is evidence to suggest that younger people experienced higher levels of loneliness [68], and were more impacted by the COVID-19 pandemic in terms of psychological distress and social connectedness [53]. This was also reflected in the quantitative findings of the pilot, notwithstanding the minor variations in scores just after the program ended and at follow-up. Provided the matching of the generations is done thoughtfully, intergenerational programs, such as this, are an effective way to reduce loneliness and social isolation across generations.

Recommendation

- Facilitate partnerships between organisations that service youth and older people in order to reduce loneliness and isolation experienced across generations.

Preparing for disasters and the impact on family violence

- Disasters (not just pandemics) are likely to be more frequent due to the effects of environmental and climate change [53]. Disasters change the dynamics of family violence, including the abuse of older people, and this needs to be taken into consideration when designing programs to prevent any type of family violence.
- Technology has a crucial role to play in disaster but is both a positive and negative for older people. For instance, greater numbers of older people using technology may increase the frequency of financial abuse, but it also enables them to stay connected socially, e.g. as they did in this intergenerational program. Online programs, such as this program, can also create new possibilities to build connections between people who may experience heightened isolation (e.g. people living in rural and remote areas and people living with disabilities), in turn increasing protective factors.

Recommendation

- Family violence prevention programs must build and/or enhance digital literacy in older people. This includes facilitating access to the appropriate technology, access to training on how to safely use it, and opportunities to connect with families, friends, and communities [69].

Care planning for later life

Many younger people in the study were concerned about their futures in later life. For example, some younger participants in the workshops and intergenerational program discussed having children who could “look after them” when they were older, and were resolved “not to go into aged care”. This is likely a significant source of distress for many people in the community, both old and young. For younger people, this program may have heightened their fears about ageing but also encouraged them to be proactive about planning for issues that may arise as they age.

Recommendations

- Advocate and/or develop programs that prepare younger people for challenges they will face as they age. Examples of such programs include financial planning, care planning, and palliative care, and require input from diverse sectors such as health and aged care, banking and finance, families and community services. Such programs may show promise in addressing the drivers and risk factors of abuse of older people.
- Invest in long-term research to investigate the impact of intergenerational programs on younger people’s care planning.

Idea for a book

'The Premise'

You have 1 year to live.
You have a huge bucket-list.
What else do you need to do before you say 'good-bye' to your life?

A special note on gender inequality and caring

In this project, there was no significant impact of gender inequality on the quantitative results. This is possibly because the majority of participants were women and therefore no analysis could be undertaken to discern differences in responses by gender.

Nevertheless, based on the team's wider knowledge and subtle cues in the interview data, there is a complex relationship between gender inequality and caregiving that needs further exploration. Therefore, this special note has been included to draw attention to these complex dynamics and recommend further work in this relatively under researched area.

- Two women who participated in the intergenerational program are likely to have been experiencing family violence, in the form of coercive control, by their male partners. Both women were carers for their partners. Caring for a male partner may put women at risk of intimate partner violence or other forms of abuse as they age, especially when traditional gender norms – such as men being in "control" of the relationship, or the "breadwinners" of the family – are challenged due to a man's poor health, disability or illness as he ages.
- Importantly, at least one participant expressed that the intervention provided a much-appreciated opportunity for her to take time away from caring, which also helped her gain independence and be assertive about her needs and boundaries. It is possible that older women who experience family violence in the context of being carers for their husbands need such opportunities to reassert their independence, and to redress harmful gender norms. Indeed, these opportunities may prove to be important 'protective factors' and should be investigated in the context of developing early intervention strategies for such violence moving forward [53].
- These findings add to available evidence, which to date, has largely framed carers as the likely perpetrators of abuse and the older person being cared for as the victim. This is logical because cognitive impairment,

dementia, poor physical health, frailty, functional dependency and disability are all risk factors for the experience of abuse. Similarly, caregiver stress is a known risk factor for perpetrating abuse.

- Thus at least three scenarios are likely when gender inequality and care intersect in later life:
    - Older women, who are carers, may experience abuse from their male partners related to the latter's health vulnerabilities.
    - Older women, who are carers, may perpetrate abuse on those they care for related to the latter's health vulnerabilities.
    - Older women who are in receipt of care, may experience abuse by their carers (irrespective of the latter's gender), related to their own health vulnerabilities and broader gender norms.
- These scenarios, and indeed other similar scenarios, deserve more attention in academic research to help develop evidence-based responses to these complex issues. Gender inequality in care dynamics may also be linked to the need to look at the influence of traditional gender norms on intergenerational abuse involving sons as perpetrators and mothers as victims, which has been mentioned in the literature [37]. However, much more research is required to make any definitive conclusions.

Recommendations

- Invest in research to investigate the relationship between gender inequality and care as both a driver and risk factor of abuse. Specifically, support research that examines:
    - The issue of intimate partner violence against older women (especially coercive control) in the context of caring: where the woman is either a caregiver or care recipient.
    - Gender norms and the expectations of women as mothers in the complex interdependent relationships that shape abusive intergenerational relations, especially the relationship between mothers and sons.
    - How to better integrate family violence and aged care services to ensure that older women experiencing abuse do not "fall through the cracks" between the two often "siloed" sectors.
- Invest and expand in carer support programs as an effective strategy to prevent the abuse of older people, especially older women.
- Provide opportunities for family carers, especially older women who care for men who are intimate partners, to independently access social networks and social support away from the person they care for as these are known 'protective factors' for experiencing abuse.

8. Elements and challenges to successful implementation

Key points

- An implementation toolkit should be developed so that other agencies who wish to pursue such initiatives can use evidence-based techniques methods to realise their program outcomes.
- Careful attention to pairing older and younger people, conversation guides, booster check-in calls, finite start and end dates to the program, and clear communication around 'closing off' the program enhance implementation.
- Onerous paperwork, including for police checks and survey measures, and asking participants for creative outputs can pose challenges to the program's success.
- Program staff must be skilled to deal with un/expected events such as disclosure of family violence, participant illness, and death.

In general, there is very limited evidence of the effectiveness of primary prevention interventions to mitigate the abuse of older people. Of a very small sample in the rapid review, intergenerational programs have been identified as the most effective. These programs are most effective when they involve social interactions (especially group-based, in person interventions). They are also most often multi-component, tailored (e.g. employing action research methodologies) and involve motivational interviewing, booster sessions, and a multi-professional team approach to program design and delivery [53].

This pilot intervention was therefore deliberately designed to contain such elements: including social interaction and "booster" calls delivered by a professional research team. A PAG was established that involved partnership across organisations, and co-designed the intervention with professional stakeholders, older people and family carers, as recommended by effective programming documented in the rapid review.

The section below outlines the elements and challenges to successful implementation of this program, which will be of help to professionals working in the family violence prevention and ageing sectors, as well as academics and policy makers. However, these insights are no substitute for an implementation toolkit, which would offer a systematic guide and more detailed instruction on how to design, implement, and evaluate intergenerational

programs to prevent the abuse of older people in real-world settings.

Recommendations

- Support the development of an implementation toolkit for other agencies to design, implement, and evaluate intergenerational programs to prevent the abuse of older people in real-world settings.
- To ensure consistency in primary prevention messaging, funders of the toolkit should ensure such messaging is embedded in the toolkit.

Elements for successful implementation

Pay careful attention to matching

Considerable time, thought and effort went into matching older people with younger ones. This is an important implementation activity because all interview participants saw shared interests and/or identity as essential to building rapport within their pair. They considered the matching process a vital component of the program's success:

"It worked well. And in part it worked well because you [project manager] did a terrific job of that first phone call to me, getting a bit of a sense who I am. And also checking out some of your thinking as to who you'll match me with. No, I think due to your skillset it's really led the way, in my opinion, to [the program] being a success".

Effective strategies

- As much as possible, match older and younger people by their hobbies, interests, and preferences for whom they would like to be matched with, giving consideration to relevant identities (e.g. sexuality and/or gender identity).

Provide an optional conversation guide

All participants were provided with a conversation guide, which had suggested topics for each week. This was designed with two things in mind: (1), the preferences of workshop participants for the kind of pilot we would test (originally face-to-face) and (2), the fact that participants were living in a pandemic. Indeed, the conversation guide was developed at the time of a very stringent lockdown in Victoria and assumed most participants would be staying home for the majority of the time, with very little interaction with others. While the conversation guide was later updated, it still reflected the circumstances of the period in which it was developed.

Participants used the conversation guide to varying degrees. Many of those interviewed did not use it at all, while others mentioned that they used it as a prompt at times but did not depend on it, or later ignored it. Some said it was necessary for

uncomfortable moments of ‘silence’ or pauses, while some followed it closely (usually at the instruction of one person in the pair) and explicitly asked questions that had been listed as “suggestions” under the weekly topics. Some participants identified questions that had been most interesting in eliciting conversation, which were usually more creative, such as “If you had your time over, what career would you have chosen?”

Overall, during weekly check-in calls, participants seemed to agree that the conversation guide was necessary. All participants interviewed suggested their conversations varied from 45 minutes to over one hour without struggle. From the notes taken by the research team during the program, there were some pairs who regularly spoke for much longer than one hour.

Effective strategies

- Always offer participants a conversation guide but do not make it mandatory for them to follow.
- As much as possible, co-design the conversation guide with program participants.

Booster ‘check-in’ calls

Participants gave very positive feedback on the booster “check-in” calls made by the NARI research team reporting that it helped them stay connected to the program and feel supported.

From the researchers’ point of view, this was difficult to navigate as many participants wanted to talk for much longer than their time realistically allowed, and this was especially the case with older participants who perhaps had more time to talk (i.e. were retired). In many instances, researchers felt they became a “pseudo” conversation partner for these participants and it was very difficult to find the balance between their need for social connection (particularly when many were physically and socially isolated from others) and the need to deliver the intervention on time. The researchers also often formed their own bonds with participants and many times enjoyed their check-in phone calls as much as the participants did. This does potentially pose a problem from a research point of view in that it may cross the boundary between a “research-based” interaction and a personal one (if such a dichotomy exists). However, literature about ethnographic research discusses this issue and does not necessarily find it to be a negative [70]. Rather, these are reciprocal social relations that develop between researchers and their interlocutors over time and are part of feminist-methodological pedagogy [71, 72], which recognises ‘friendship as a method’ [73].

It should also be acknowledged that the booster calls provided an important chance for the project manager to establish a trusting relationship with participants and monitor for signs of family violence. Indeed, it was through booster calls that the project manager identified two suspected cases of family violence, one which was later disclosed at interview. These calls appear to be essential in building rapport in the context of such personal and sensitive issues as the experience of family violence.

Effective strategies

- Program organisers should undertake regular 'check-in' calls with program participants to sustain adherence, and quickly identify and respond to any concerns. Fortnightly calls or other means of providing a 'booster' (e.g. text messages) may achieve the same result but this will need to be explored. Alternatively, considering how well check-in calls were received, more money could be built in to run such a project given how time and resource-intensive this proved.
- Staff making these calls should have strong interpersonal skills and be able to effectively communicate and work with diverse individuals and groups.
- Future pilot programs should be managed by an experienced researcher who is trained in recognising and responding to family violence, including violence against women and their children (as in the MARAM) and abuse of the older person. All project staff should also be trained in recognising and responding to family violence, with clear policies and processes in place for dealing with suspected and confirmed cases of family violence.

Length of the program

Participants overwhelmingly approved of the program length (six weeks), the duration of conversations (one hour) and the frequency of conversations (once per week). Many stated that too much longer would have been considered too much of a commitment, while any shorter would have hindered the development of rapport. Weekly interactions allowed conversations to flow well and helped build a stronger connection with their partner. Some participants did take breaks from the weekly schedule due to other commitments, which was not in the original program plan. This was particularly the case for those pairs whose six-week conversation period coincided with Christmas and the New Year break. For the majority of participants in this situation, this clash was difficult; however there were some people in the program who were happy to have someone to talk to over this period, as they were not in contact with or living near family or friends. In future, such a program would be best run at a time of year that does not coincide with major holidays.

Effective strategies

- The start date for pairs may be staggered but to enhance the success of intergenerational volunteer programs, the program needs a definite start and end date.
- Such programs should not be run over major holiday periods (e.g. Christmas, summer holidays) as this can compromise the length of the program.

Ending the program or 'closing off conversations'

The research team and participants discussed the difficulty of "officially" ending the intervention at six weeks and what this meant for the bond that had been forged between pairs. This issue was also raised and workshopped at PAG meetings, given it was discussed frequently in check-in calls with participants.

All those interviewed arranged to continue conversations with their program partners

after completion. These decisions were made independently of the research team. Examples of ongoing arrangements within pairs included: going for walks together to promote older people's physical activity, peer support and mentoring of younger people, arranging to meet for coffee, and exchanging articles of interest for discussion.

Several participants noted that it would have been challenging for them if they did want to end the relationship. The majority of participants felt that the research team handled this well by leaving it up to the participants to make the decision:

"I think [if you didn't want to stay in touch] that would be quite a difficulty actually, and maybe you [the research team] do, on second thoughts, given that possibility, need to have a strategy or guidelines. And maybe, as you [the project manager] suggested initially, perhaps it needs to be explicit that it can happen or not. But at the same time, you've got to be very careful that you don't set up an expectation that it will, leaving people who don't want to communicate after the program's over with a sense of they have in some way failed. I guess that's why my first thought, which I probably would stick to, is say nothing [about keeping in touch]. Tricky, isn't it? Tricky".

Photo of a table set for lunch

Meeting in person was a great idea and we had a lovely lunch [her] house, which allowed us to connect and I think feel more relaxed with each other.

Effective strategies

To facilitate the safe 'closing off' of the program, staff should remind participants:

- of the 'official end date' one week prior to the end date,
- that it is voluntary whether they opt to continue conversing in their pairs,
- that it is neither right nor wrong whether they opt to continue conversing in their pairs,
- that if they chose to continue conversing in their pair, the topics, frequency, and location of these conversations are at their discretion, and
- that the support infrastructure (e.g. booster calls) provided by the program will no longer be available.

Challenges to successful implementation

Requiring police checks for all participants

As per the ethics requirements, all participants who signed up to the program were initially required to obtain a police check (later revised to be a police check or working with children check). The police check was especially onerous for older people as it was best conducted online and many were not comfortable with technology and/or did not own computers. If participants needed to mail in the police check, it required lots of personal documentation to be copied and certified, before being mailed along with the cost of the check. NARI staff assisted as much as possible but during the lockdown this was difficult. Furthermore, police checks that were posted-in amplified older people's risk, as they had to venture into the community, which they had been advised by the government not to do. This requirement may also have skewed the sample towards those who were more computer literature and able to complete the check online.

Effective strategies

- Safety checks should not be onerous.
- Participants who have difficulty using technology will need support from program staff to complete and upload relevant checks.

Asking all participants for creative outputs

Participants provided very mixed feedback about the initial instruction to provide a creative output as a compulsory part of their participation in the program. Eventually the activity was changed from compulsory to optional.

Effective strategies

- Creative outputs should be optional for online intergenerational programs.
- Programs which are face-to-face may be able to facilitate the development of creative outputs as part of the program itself. Future research should explore this possibility.

Burdensome quantitative measures

Many participants felt the surveys were "blunt" instruments and several older people stated that they were "offended" by the Fraboni scale, which measures ageist attitudes towards older people. While it was necessary to measure ageism, perhaps more context could have been provided around the Fraboni scale in particular to avoid causing offence. In general, participants' scepticism about the quantitative measures played out in several ways:

- It was difficult to get people to return the surveys on time or complete them properly (e.g. some preferred to "answer" the question with words rather than circle a number) and many missed or left out questions.
- Many wanted to "talk" about the project instead of fill in the quantitative surveys. This may indicate a preference for qualitative interviews in such programs, or simply that mixed methods (rather than just quantitative research) must be pursued.

Effective strategies

- Evaluation outcome measure should be judiciously selected, especially if the evaluation is for programmatic rather than research purposes.
- Evaluation outcome measures should include a mix of quantitative and qualitative measures.

Planning for un/expected events

The health of older people involved in the program also presented a serious issue and needs to be considered and addressed moving forward. One older participant died during the program, which was distressing for the younger person they were paired with. The researchers regularly followed up with this younger participant to ensure her wellbeing had not been too adversely affected, and were satisfied that she was well. She also provided a creative reflection on the program including her conversation partner's death that indicated that she had found the experience positive and educational despite her sadness at his death.

Reflection

I am grateful that I was lucky enough to meet and spend some time with Mehmet thanks to NARI. He was wise, beautiful, considerate, and delightful. We met each other four times over the Zoom so far, and each time was filled with sharing our life experiences, smiles, enlightenments, thoughts, and our perspectives with each other. Our last meeting was very positive and bright as always.

Another older participant was very unwell during the program. As a result, the data pertaining to her pair was eventually excluded from analysis as she was unable to easily or regularly conduct phone calls. This was also of great concern to the research team given the potential impact on the younger person she had been paired with, should she become further

unwell or die. Moving forward, if younger people are the conversation partners for very unwell older people, this will need to be carefully managed by the research and/or support team involved.

As the program was intended to prevent the abuse of older people, it is essential to reiterate that at least one participant was discovered to be experiencing family violence and another suspected of experiencing it. In this pilot, the project manager was an experienced family violence specialist who was trained in risk assessment and had previously worked as a risk assessment trainer. This meant she was well equipped to both identify family violence and also knew how to address it (while the ethics application also dealt with the issue of what would be done to ensure participant safety during the program).

Effective strategies

- Research staff involved in the implementation of such programs should be trained in family violence risk assessment (including intimate partner violence). There must be a clear protocol to follow should family violence be identified.
- Research staff involved in the implementation of such programs should be trained in Mental Health First Aid. There must be a clear protocol to follow should there be an un/expected event (e.g. severe illness and/or bereavement). This will also be important if the Kessler Psychological Distress Scale (K6) is used again, given it measures psychological distress and has a 'cut-off' score for serious concern.

Suggestions for future research

As this study was a pilot, an appropriately small sample were recruited. Future studies should consider scaling up the sample to obtain meaningful quantitative data and establish the program's efficacy. In particular, study designers should consider the merits of an intergenerational primary prevention program within and outside the context of a disaster. Such an approach enables, on the one hand, face-to-face programs that could incorporate creative activities (including cooking, music or physical exercise, as was first suggested by co-design workshop participants), which may in turn facilitate the development of creative outputs as part of the program itself.

On the other hand, anticipating further lockdowns associated with pandemics and other disasters, researchers and ethics committees should collaborate to obtain pre-approval for projects that can be administered in such events to ensure the abuse of older people is prevented when the risk of family violence increases. This is especially the case for participants with lower levels of digital literacy, who arguably need greater social support than their digitally literate peers do, during a time of heightened vulnerability.

9. Conclusion

This research provides key learnings to guide policy and practice in the primary prevention of abuse of older people. Key to success was the oversight of a Project Advisory Group and co-design workshops including services, carers, and older people themselves, who designed and guided the pilot intervention, thereby helping us translate the evidence into practice.

From the small study sample, it was clear from both qualitative and quantitative data that both younger and older participants experienced a positive shift in their assumptions regarding the different generations, which is a key driver of elder abuse. The importance of intergenerational programs to LGBTQIA+ participants was evident as was the need to better explore the gender-caregiving nexus. Policy and practice must also consider intersections between ageism and other forms of discrimination and marginalisation, which may lead to different types of abuse for older people at the intersection of ageism and other forms of discrimination. The intergenerational program also showed promise in shifting some of the risk factors associated with experiencing and perpetrating abuse, including through amplifying social connection and tackling loneliness.

Our research is consistent with existing literature in confirming that intergenerational programs are effective as a primary prevention in addressing drivers of abuse of older people. Likewise, as identified in the rapid review, the success of the intervention is dependent on the approaches taken to implementation. Tailoring the intervention, incorporating motivational interviewing, booster checks, as well as having a multi-professional team approach all enhanced the success of the program. However, it is important that future iterations of such a program take into account the distress that can be experienced by both younger and older participants when the relationship “formally” ends.

Haiku

Unexpected charm
Conversations flowing free
I leave with a smile.

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Appendices

Appendix 1: Weekly suggested conversation structure

Week	Suggested topic/s	Instructions/example conversation points
1	Introduction and goal setting	Take some time to get to know each other. You might also want to think about how these six weeks of conversation can be beneficial for both of you. For example, you could write a list of what you would like to get out of the program, or achieve.
2	Personal history and culture	Get to know your conversation partner in more depth, with a focus on culture and life experiences. Examples topics include: Where is your communication partner from? (e.g. where were they born? What is their ancestry?) What language(s) can they speak? Where do they live, and how did they come to live in the place they are currently? Have they lived elsewhere? (e.g. interstate or overseas?) Are they working currently? Did they work previously? If so, what did they do? If they could have their time over, what career would they have chosen? Do they have close friends or family they are regularly in touch with?
3	Hobbies/interests	This is your chance to get to know each other's interests/hobbies in more depth. What do you like to do in your spare time? In the context of COVID-19, what hobbies are you able to do/continuing to do from home? Is there something you haven't tried before that you'd like to?
4	Cooking/food	What are your favourite foods or cuisines? Do you enjoy cooking? If so, what recipes are you best at cooking? Have you ever taken part in a cooking class? Do you have some sample recipes you can share with each other? (Given shopping has been more difficult in COVID-19: can you share some that only require a few ingredients?)

5	Exercise/physical activity	What types of exercise or physical activity do you most enjoy? In the context of COVID-19, what kinds of exercise are you able to continue doing from home, or a short distance from your house? Do you have some tips for types of exercise or physical activity your conversation partner may not have tried before?
6	Staying connected	What methods do you have for staying connected with friends and/or family while being required to physically distance? If you are comfortable using a computer or tablet: what online programs are available to allow you to connect with others during this time? If you are communicating via phone, what are some other means of communication during this time that you may have access to?