STAND UP SPEAK OUT
27-29 JULY 2026

2026 AUSTRALIAN ELDER ABUSE CONFERENCE

Results of the *No More Shame* cluster randomised control trial

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Disclosure of speaker's interests

- During the funding period BB declares receiving funding for distinct elder abuse research projects from the Attorney-General's Department and Allianz Australia.

- She also served on the advisory board for a Victorian legal service and now serves as a Board member for Council of the Ageing- Victora, which runs a legal service for elder abuse.

Scientific team

Bianca Brijnath – La Trobe University

Marina G. Cavuoto – National Ageing Research Institute (NARI)

Simona Markusevska – NARI; La Trobe University

Rachel Muoio - NARI

Cheryl Durston – consumer

Duncan Mortimer - Monash University

Joanne Enticott - Monash University

Catriona Turnbull - Edith Cowan University

Patricia Reyes - St Vincent's Health Sydney; University of New South Wales; Uniting War Memorial Hospital

Gianna Renshaw- Sir Charles Gairdner Osborne Park Health Care Group

Micah D. J. Peters - Rosemary Bryant AO Research Centre, University of South Australia

Briony Dow – NARI

Peter Feldman - NARI

Andrew Gilbert – NARI

Elizabeth Manias - Monash University

Claudia Cooper - Wolfson Institute of Population Health, Queen Mary University of London

Josefine Antoniades – La Trobe University

Sigrid Nakrem - Norwegian University of Science and Technology

Meghan O'Brien - Peninsula Health

Joan Ostaszkiewicz – NARI

Marion Eckert - Rosemary Bryant AO Research Centre, University of South Australia

Hospitals

HOSPITALS

- Sir Charles Gairdner Osborne Park Health Care Group
- Uniting War Memorial Hospital
- St Vincent's Health Sydney
- Western Health
- Barwon Health
- Rosebud Hospital, Peninsula Health
- Mornington Centre, Peninsula Health
- Hampstead Rehabilitation Centre, CALHN, Central Adelaide Local Health Network
- Queen Elizabeth II Hospital, Central Adelaide Local Health Network
- Bentley Health Service, The Royal Perth Group.

SITE PIs

- Patricia Reyes – War Memorial Hospital and St Vincent's Hospital
- Gianna Renshaw – Osborne Park Hospital
- Meghan O'Brien – Peninsula Health
- Sarah Booth – Western Health
- Karen Todd – Barwon Health
- Michelle Reid – Bentley Hospital
- Samara Osborne – The Queen Elizabeth Hospital and Hampstead Rehabilitation Centre

SITE CHAMPIONS

- Jane Jenkins – War Memorial Hospital
- Deanna Maunick – St Vincent's Hospital
- Anneliese McNeil– Osborne Park Hospital
- Sue Leake – Peninsula Health (TMC and Rosebud)
- Sarah Booth – Western Health
- Maggie Sapunar – Barwon Health
- Katherine Parke – Bentley Hospital
- Rachelle Grieve – The Queen Elizabeth Hospital
- Danielle Cowie – Hampstead Rehabilitation Centre

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Advisory group

- Zaineb Abdulhussein, Commonwealth Department of Health, Disability and Ageing
- Kristy Ryan, Commonwealth Attorney-General's Office
- Vicki Nash, Elder Abuse Action Australia
- Samantha Edmonds, Older People's Advocacy Network
- Sue Elderton, Carers Australia
- Megan Corlis, Australian Nursing and Midwifery Federation
- Kylie Cakau, Australian Nursing and Midwifery Federation
- Carolanne Barkla, Aged Rights Advocacy Service
- Susan Kurrle, University of Sydney & Northern Sydney Local Health District

Consumers

- Cheryl Durston
- Roger Bell
- Therese Findlay
- Helen Borland
- Lora Yeung

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Approvals

- Funder: the Medical Research Future Fund (MRFF), Australian Government Department of Health.
- Ethical approvals: Austin Health Human Research Ethics Committee (HREC/92279/Austin-2023) with governance from all 10 hospital sites.
- Trial registration: ACTRN12623000676617.

Background

- 1 in six older people experience elder abuse but underreporting is high
- Hospital-based subacute clinical staff (hereafter staff) are in a unique position to detect and respond to elder abuse
  - Trusted by older people
  - Spend time with them
  - ‘Window of opportunity’
- However, many staff do not recognise elder abuse, do not report suspected cases, often lack the time, confidence, and knowledge to respond, and may have ageist attitudes that discourage disclosure.
- The most effective interventions to stop and prevent further occurrence of elder abuse include educating staff and involving multidisciplinary services.
- However, there are few trials in this area and none in Australia

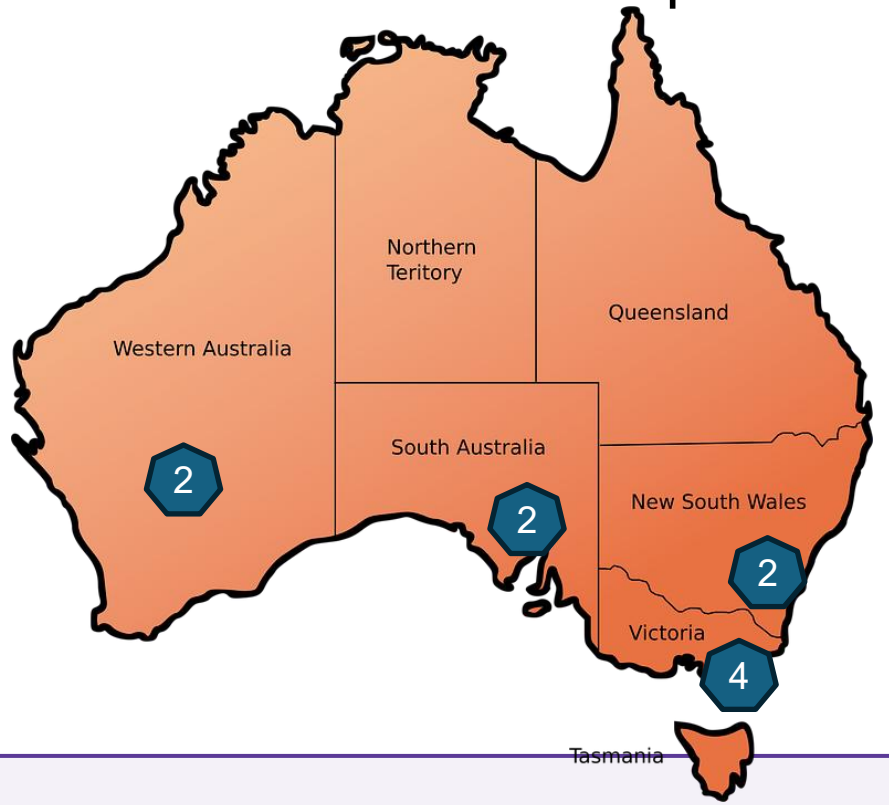
AIM

To test whether a multimodal intervention combining staff training, provision of a screening tool, and a site champion improves:

1. Staff knowledge and management of abuse and
2. Patients' sense of safety and quality of life

Design

- Pragmatic cluster randomised controlled clinical trial in 10 hospitals across four Australian states
- 7 February 2024 and 27 August 2025



Participants

Staff

- **Included:**
  - Inpatient subacute clinical staff providing direct care to older people, including medical, nursing, or allied health professionals.

- **Excluded:**
  - Staff who do not expect to be working at the site for at least 12 months post-baseline
  - Who participated in co-designing the training.

Patients

- **Included:**
  - All inpatients at participating sites
  - Aged 65 + (or aged 50 + if Aboriginal or Torres Strait Islander)
  - Willing to participate
  - Individually capable of providing informed consent.
- **Excluded:**
  - Patients receiving palliative care
  - Lacking decision-making capacity

Process

Recruitment

- A site champion - senior social worker – undertook recruitment.

Staff baseline

- A site champion - senior social worker reminded health providers about their assessments.

Intervention

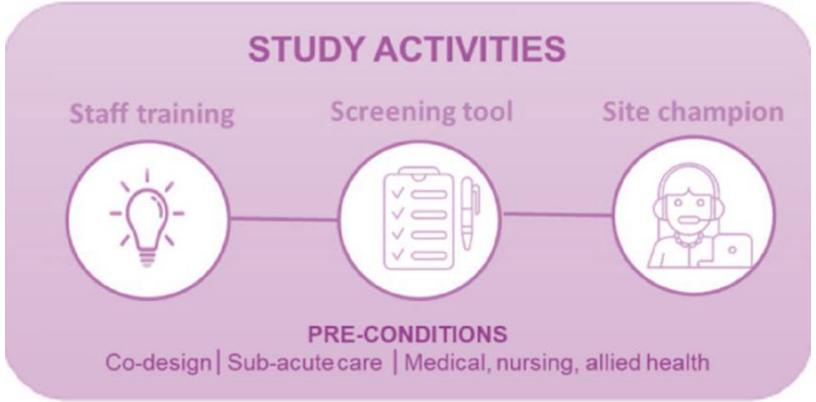
- Intervention sites (n=5) access the training throughout the intervention period (9m), use the AUSI, and are supported by the site champion (senior social worker)
- Control sites (n=5) are waitlisted.

Patient baseline

- A site champion - senior social worker – undertook data collection with older people.

Follow-up

- A site champion - senior social worker – undertook data collection with older people at 4 months and reminded health providers about their assessments at 4 and 9 months



Outcome measures

Staff

- Baseline, 4m, and 9m
- Collected in REDCap
- **Primary outcome:** Knowledge and Management of Abuse (KAMA)
- Secondary outcomes:
  - Caregiver Scenario Questionnaire (CSQ)
  - Carolina Opinions on Care of Older Adults (COCOA)

Patients

- Baseline and 4m (dropped the 9m FU due to recruitment difficulties)
- Collected in on paper (mostly) and entered into REDCap
- **Primary outcome:** Adult Social Care Outcomes Toolkit (ASCOT)
- Secondary outcomes:
  - Short Form Survey-12 (SF-12v2)
  - Adapted Resource Utilisation in Dementia lite (a-RUD-lite)

Randomisation

- Randomisation by minimisation procedure using state as a stratification factor
- Single-blinded study where the statistician and outcome assessors were blinded to allocation
- Randomisation occurred following baseline data collection for staff.
  - An independent biostatistician who is not a member of the research team generated the allocation sequence.

Sample size

- **Staff (KAMA outcome):**
  - n = 60 required
  - Detect medium effect (Cohen's d = 0.5)
  - Power = 80%; α = 0.01
  - Assumes SD = 4.8 (based on prior study)
- **Patients (ASCOT outcome)**
  - n= 10 clusters (5 intervention, 5 control) 40 participants per cluster
  - Detect medium effect
  - Power = 80%; α = 0.05
  - Cluster design assumptions: ICC = 0.1 (jurisdictional variation) SD = 0.2 (literature-based)

Sample size estimated using Shiny CRT calculator

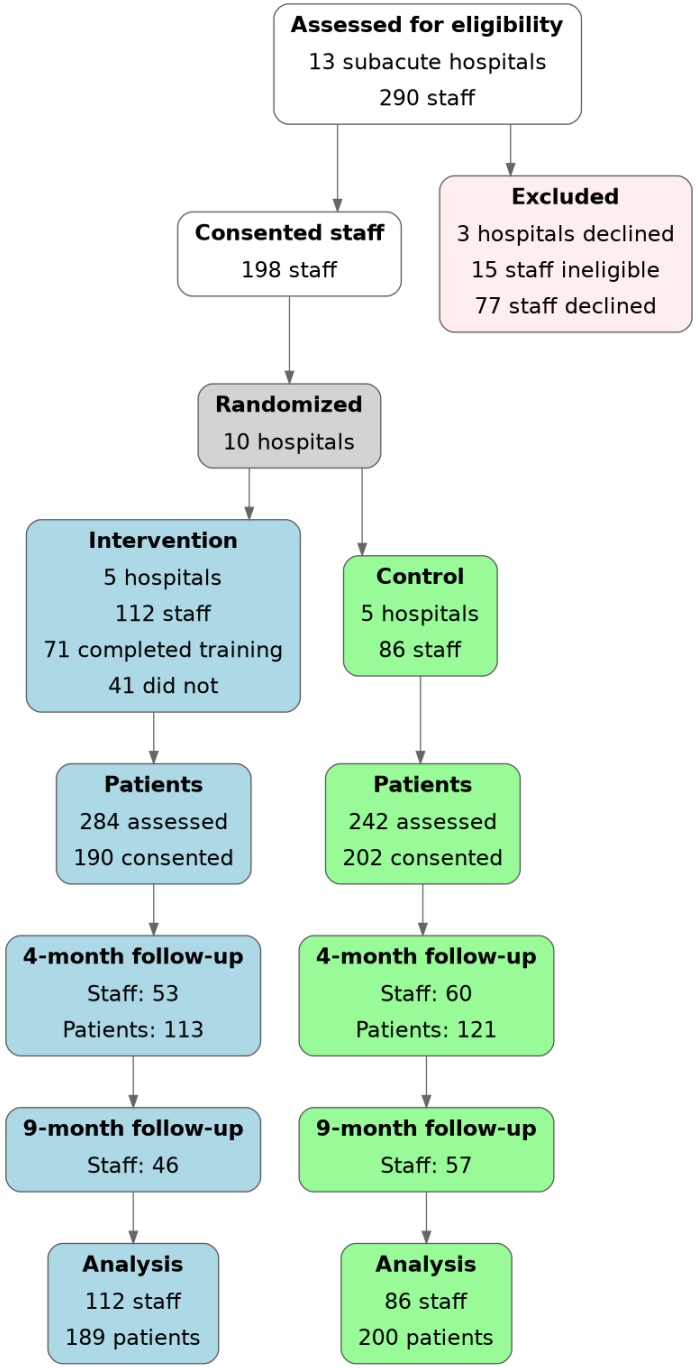
- Adjusted for recruitment realities: 53% refusal / unable to consent (based on prior UK work)

- **Final sample targets:**
  - **92 health providers**
  - **612 older people (~60 per site)**

Trial engagement

- Where hospital policy permitted: gift hamper provided to intervention and control sites at each follow-up
- Survey completion incentives:
  - Staff receive automatic survey links via REDCap
  - At each of three assessment points entry into a $250 gift card draw upon completion
- Baseline: most sites used the progress tracking thermometer we created to encourage staff recruitment
- Site champions sent reminders, especially at baseline

CONSORT FLOW DIAGRAM



Social media

Participant characteristics

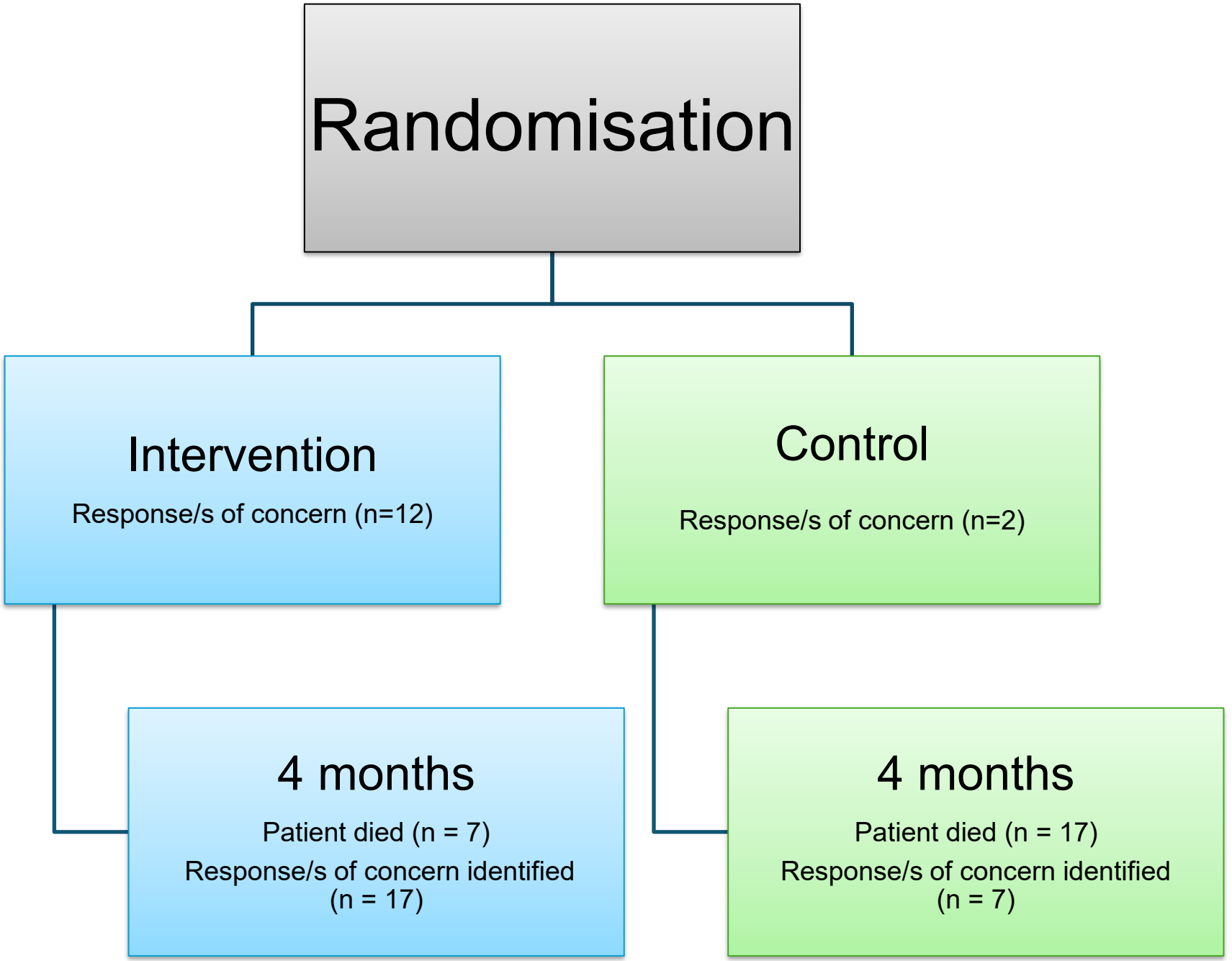
Staff

- Median age was 39 (IQR ~22)
- 173 (87.82%) women
- Social worker (62, 31.47%), allied health (70, 35.53%), nursing and medical (65, 32.99%)

Patients

- Mean age was 80.1 (SD 7.97)
- 220 (56.56%) women
- Economically well-off (209, 53.73%)
- Very good English (313, 80.46%)

ADVERSE EVENTS



Social media

Results - Staff

Overall score, mean (95% CI)			Overall difference between groups	
	Control	**Intervention**	**Mean (95% CI)**	**p-value**
Primary outcome				
KAMA knowledge_ITT[a]	23.08 (22.91, 23.26)	24.51 (23.99, 25.04)	-1.43 (-2.13, -0.73)	**<0.001***
KAMA knowledge per protocol[b]	23.12 (22.93, 23.30)	25.02 (24.42, 25.61)	-1.90 (-2.68, -1.12)	<0.001
KAMA knowledge multiple imputation[b]	24.23 (23.48, 24.98)	24.79 (24.08, 25.50)	-0.56 (-1.65, 0.53)	0.301
Secondary outcomes				
CSQ_ITT[c]	7.93 (7.90, 7.96)	7.92 (7.88, 7.96)	0.01 (-0.05, 0.08)	0.714
CSQ per protocol[d]	7.93 (7.91, 7.96)	7.98 (7.94, 8.03)	-0.05 (-0.12, 0.01)	0.125
CSQ multiple imputation[d]	7.87 (7.60, 8.13)	7.91 (7.60, 8.16)	-0.05 (-0.39, 0.30)	0.798
COCOA_ITT[c]	98.72 (98.57, 98.87)	100.63 (100.56, 100.72)	-1.92 (-2.15, -1.68)	**<0.001***
COCOA per protocol[d]	98.44 (98.38, 98.50)	100.07 (99.98, 100.17)	-1.63 (-1.67, -1.59)	<0.001 *
COCOA multiple imputation[d]	98.51 (97.56, 99.48)	99.59 (98.30, 100.96)	-1.07 (-2.42, 0.28)	0.120

a. Available case analysis_ITT: n= 108 participants and post-baseline data points=189.
b. Per protocol analysis: n= 106 participants and post-baseline data points=181.
c. Available case analysis_ITT: n= 107 participants and post-baseline data points=187.
d. Multiple imputation (MI) analysis_ITT: n=197 participants (as one participant had missing demographics).

Results – Patients

Overall score, mean (95% CI)				Overall difference between groups	
		Control	Intervention	Mean (95% CI)	p-value
Primary outcomes					
ASCOT/Scrqol	Available case[a]	0.81 (0.77, 0.85)	0.82 (0.79, 0.85)	-0.01 (-0.06, 0.05)	0.838
	Multiple imputation[b]	0.81 (0.79, 0.83)	0.82 (0.79, 0.84)	-0.01 (-0.04, 0.03)	0.843
Personal safety Item in ASCOT (ASCOT_13)	Available case[a]	0.72 (0.68, 0.76)	0.73 (0.71, 0.74)	-0.01 (-0.05, 0.03)	0.683
	Multiple imputation[b]	0.72 (0.68, 0.76)	0.72 (0.70, 0.75)	-0.01 (-0.05, 0.04)	0.799
Secondary outcomes					
SF-12_PCS	Available case[c]	35.29 (34.51, 36.07)	33.86 (32.23, 35.49)	1.43 (-0.79, 3.64)	0.206
	Multiple imputation[d]	35.40 (34.42, 36.38)	34.33 (33.22, 35.45)	1.07 (-0.49, 2.62)	0.178
SF-12_MCS	Available case[c]	50.34 (48.30, 52.38)	50.51 (49.49, 51.51)	-0.17 (-2.67, 2.33)	0.895
	Multiple imputation[d]	50.46 (48.99, 51.94)	50.43 (48.97, 51.89)	0.03 (-2.09, 2.16)	0.976

a. Available case analysis: n=201.
b. Multiple imputation (MI) analysis: n=373 participants (as some participants had missing demographics)
c. Available case analysis: n=216.
d. Multiple imputation (MI) analysis: n=373 participants (as some participant had missing demographics)

Conclusions

- Few trials have evaluated training interventions to achieve this; our trial adds to this sparse evidence and offers a feasible, effective, and implementable model for staff in busy hospital settings.
- The trial was associated with improved staff knowledge and management of elder abuse in busy hospital settings that was maintained for up to nine months, but not with change in older people's social outcomes.
- Analyses is ongoing …

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