MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

Elder Abuse in Aotearoa

The role and current state of MSD's Elder Abuse Response Services

December 2019

About this report

The purpose of this report is to provide insight into elder abuse in Aotearoa New Zealand, in particular the current state of the Ministry of Social Development's (MSD's) Elder Abuse Response Services (EARS).

Earlier this year, the Family Violence Team (the Team) visited 15 EARS providers across Aotearoa. The aim of this engagement was to gain an understanding from providers about what is affecting elder abuse in their communities, the strengths and weaknesses of EARS, and potential opportunities to improve future services.

This report focuses on the current state of elder abuse and EARS, with a future state report to follow, identifying next steps in strengthening services. This report provides a blended analysis of the themes from our discussions with providers alongside literature on older people and elder mistreatment, neglect and abuse.

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PART ONE:
WHAT IS ELDER ABUSE?

Older people across Aotearoa New Zealand are dealing with the harm caused by mistreatment, abuse and neglect. This abuse can happen to people from all ethnicities, religions, socio-economic groups, genders, cultures, sexual orientations, and marital statuses. The reality is that the attitudes and actions involved in the abuse of older people can often go undetected and are complex to define. Sometimes those who are harmed, or causing harm, do not realise it is occurring or are in denial that it is.

Elder abuse is an insidious issue; at least one in 10 people over the age of 65 in Aotearoa experience some form of elder abuse.[1] The World Health Organisation (WHO) estimates that this could be affect one in six people (over the age of 60) worldwide. However, with around 96 percent of cases going unreported, the rates are likely to be much higher.[2]

There are various definitions for elder abuse in Aotearoa. An international definition from the WHO and the United Nations is commonly adopted, which states that elder abuse is "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".[4] This does not include stranger scams that older people may also be victims of. The lack of a consistent definition has made it difficult to collect usable data for research and policy responses[1] and has contributed to variable education and response approaches.

Elder abuse is often complicated and unclear and there can be inconsistencies or ambiguity about what is defined as abuse. It is important to recognise that elder abuse is not perpetrated in a standardised manner and is highly dependent on an individual's circumstances. Consequently, responses need to be tailored to the needs of the older person and their environment.

Elder abuse and other types of family violence

The person most likely to commit elder abuse is a family member[15]; however, elder abuse lacks visibility in family violence discourse. It does not have the social and institutional visibility of the other family violence categories, such as child abuse and intimate partner violence (IPV), which have both experienced significant political and social investment over the last decade. As a result, elder abuse does not receive the same level of political awareness, resources and funding.

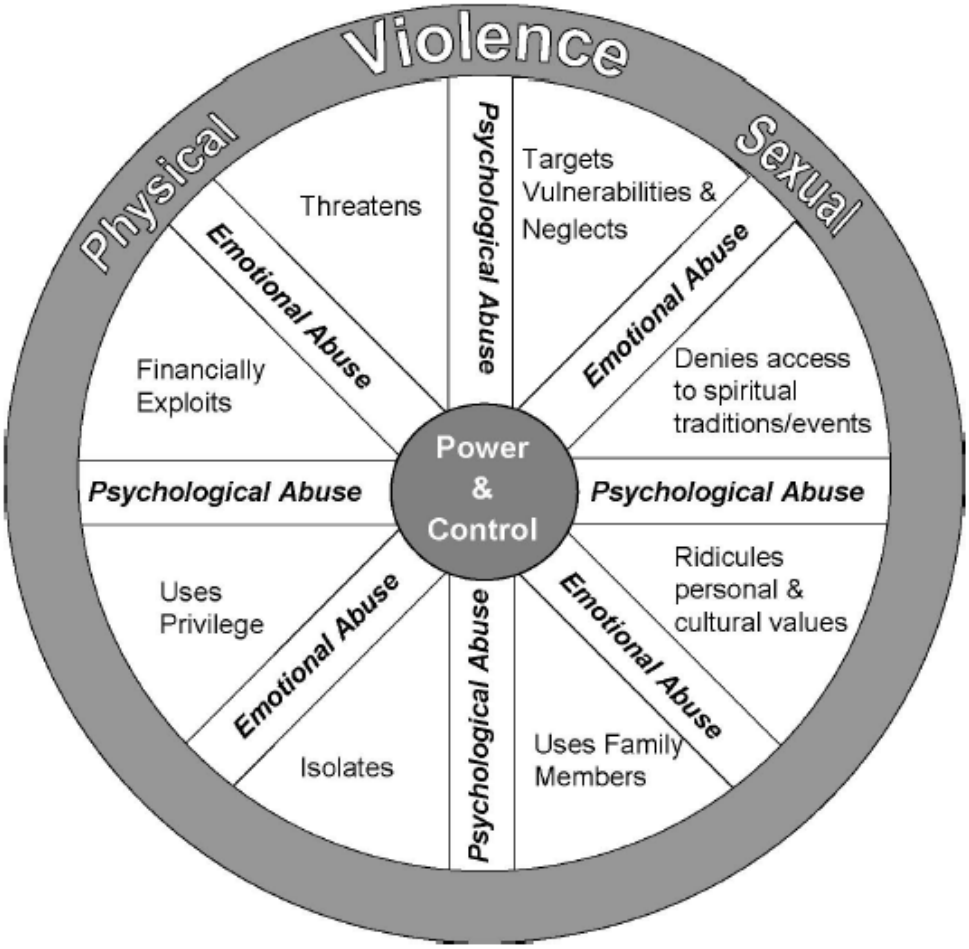
Traditionally, elder abuse has been treated as an older person issue, with little consideration given to how the abuse of older people affects family, whānau, and communities. Typically, more awareness is raised around the online scams that target older people, rather than the harm being caused within their homes by people they know.

The Forms of Elder Mistreatment, Neglect, and Abuse

Elder abuse can happen once or repeatedly. It comes in many forms, including psychological, financial, physical, sexual, institutional, and intentional or unintentional neglect. Each case is unique and often includes more than one type of abuse.

Abuse in Later Life Wheel

The Abuse in Later Life Wheel is a modified version, created by the National Clearinghouse on Abuse in Later Life, of the Duluth Power and Control and Equity wheels. The wheel identities examples of the abuse faced by older people and indicates the connected and often interdependent nature of abuse.[47]



Psychological abuse

Psychological and emotional abuse are the most common forms of elder abuse.[1,3,15] EARS providers reported that most, if not all, cases typically include elements of psychological abuse, which often erodes a person's dignity and makes them more vulnerable to other forms of abuse.

Psychological abuse inflicts mental pain or distress on an older person through verbal and non-verbal behaviours.[7] It typically includes name calling, bullying, threats, and harassment. Cases may entail someone telling an older person that they're worthless and stupid, telling them they have dementia (even when they don't), treating them like a child, threatening to withdraw affection or move them into aged care. Due to the importance many older people place on social connection, it can be common for people causing harm to threaten taking away the ability for them to interact with family and friends. [8]

Psychological abuse may take the form of isolating an older person from family members and friends, as well as limiting their interaction with the community. This may occur slowly over time, with the older person becoming more socially isolated and reliant on the abuser.

"mum can't come to the phone right now" & *"dad's too tired for visitors"* are common isolation techniques

Financial abuse

Financial abuse is a prevalent type of abuse and includes the illegal or improper use of funds or other resources.[7] National studies indicate that over 50 percent of elder abuse cases involve financial abuse[9.] and EARS providers noted that there is a financial element of abuse evident in many of their cases. This can include a person not helping to pay for bills when living with an older person, incurring expenses that the older person is then responsible for, stealing money or goods from the older person, forcing someone to sign a will/power of attorney document/ or contract. The level and nature of this type of abuse varies. Some behaviours can seem relatively harmless – taking a $20 note out of a parent's wallet or paying for personal groceries with their card without asking, highlighting the ambiguity of abusive behaviours. Others are more harmful – borrowing $40,000 for a house deposit and never paying it back, selling an older person's home and retaining the proceeds, or siphoning large amounts of money from their accounts.

EARS providers reflected that a major factor causing financial abuse is 'inheritance impatience', which comes from people's feelings that they are entitled to an inheritance from older family members. As the average life expectancy increases, so does the amount of time it can take for people to receive proceeds from family estates. This can lead to impatience and anger, which may prompt fraudulent appropriation.[10]

Physical abuse

Around 1 in 5 cases of reported elder abuse involve physical abuse.[15] Physical abuse is the infliction of pain, injury or use of force. It includes a range of behaviours, including hitting, punching, shoving, pushing, and rough handling. It can also include the inappropriate use of restraints or confinement, for example mishandled and improper restrictive practices in care facilities, and the use of medications that sedate or cause harm. Physical abuse of older people can often go unnoticed, for example bruises and abrasions may be written off as a result of a fall.[7,8]

Sexual abuse

Although sexual abuse does not appear to be as common as other forms of abuse, it does occur, with women 6 times more likely than men to be sexually abused.[18] It includes using sexually offensive language, inappropriate touching, unwanted sexual contact and rape. Some studies indicate that sexual abuse is more likely to happen in residential care facilities, rest homes, and retirement villages.

EARS providers highlighted that the level of sexual abuse against and amongst older people is probably higher than believed. However, abuse is rarely disclosed by a victim and/or reported by staff to authorities. Carers and staff are typically poorly trained to appropriately manage these problems[19] and there is a risk that sexual abuse may not be taken seriously due to ageism and the notion that older people are asexual [49].

Institutional abuse

Institutional abuse may occur in a place where older people are provided care, including: residential care facilities, rest homes, care and acute wards, day care, and emergency and outpatient departments.[45] It can occur when policies or practices cause harm to an older person or disregards their rights. This may include: strict routines e.g. inflexible meal times and diets; inappropriate rationing of continence products, and disrespecting culture and customs of older people. International evidence indicates that over 60 percent of staff in residential facilities admit to perpetrating elder abuse, with the risk of abuse increasing when the victim has cognitive impairment and disability, is over the age of 75, and is a female.[46]

Neglect

Neglect is the failure to provide for physical, emotional and social needs. It comes in two forms, self-neglect and neglect by other people.

Self-neglect is where an older person is not able to take care of themselves, either because they don't have the capacity, the inclination, or the resources. Some groups do not include self-neglect as a form of elder abuse as they respect the right of an older person to make decisions on matters affecting their own lives. However, the nature of self-neglect is important as it may not be a result of lifestyle decisions, but rather unintentional due to limited or restricted access to services, or physical and mental decline. [11]

Neglect by others includes intentional and unintentional neglect by someone who has assumed responsibility for the care and wellbeing of an older person and fails to provide appropriate care. Unintentional neglect typically occurs when the carer does not have the skills or knowledge to care for a dependent person; they may be unaware of how to identify and meet a person's needs, may not know where to access support, or may be ill and unable to provide care.[11]

Intentional neglect occurs when an older person is deliberately abandoned or not provided with proper medical care, food and water, shelter, hygiene, warmth, or clothing. Signs of neglect vary, but some cases involve: being left in clothing covered in faeces and urine for long periods of time, malnourished and dehydrated, dirty from the lack of baths or showers, or having bed or pressure sores developed by being left in one position for too long. [7,11]

People with the responsibility to care for older people may be family members, friends, and public or private health professionals. Neglect may also occur in a variety of settings, including in the home or in aged care facilities.[11]

Who experiences abuse and mistreatment?

As discussed, people from all backgrounds may be abused. There is a dearth of data and research on elder abuse and who is more likely to experience abuse. However, with what is available, coupled with EARS providers' feedback, the following has been captured:

- Elder abuse is not limited to people 65+; under 65s may also experience it. People age at different rates, with demographics, genetics, social and economic status, and work history being contributing factors. Arbitrary age cut offs ignore these factors and result in many people not being able to get the help they need.[16] This is significantly important for Māori and Pasifika people, who are more likely to have age-related issues younger and often face issues accessing relevant services.
- People over the age of 80 experience proportionally higher levels of abuse than other age groups in the older population.[12] EARS providers indicated that this age group is also less likely to know their rights, compared to those aged between 65-80. This reduces their likelihood of recognising abuse and seeking support.
- Women appear, overall, to experience slightly more abuse than men, particularly psychological and sexual abuse. However, men often experience more coercion and theft.[1, 17] Some older women may also be at risk of financial abuse due to their lack of familiarity with handling money due to cultural norms and expectations of women as they grew up which limited their use and control of money.[13]
- Currently married people typically experience the lowest levels of elder abuse, with divorced, separated, and widowed people more likely to experience theft and psychological mistreatment.[1]
- The risk of a person experiencing elder abuse also increases if they have dementia, mental health issues, physical disabilities or reduced cognitive capacity. [6,17]
- Although there are not many studies in Aotearoa comparing elder abuse among cultures and ethnicities, one study found that Māori are more than twice as likely to be coerced, be verbally and emotionally abused, and feel uncomfortable with a member of their family than non-Mäori.[1]

It is important to note that the understanding of elder abuse and who experiences it is limited by the availability of good data. It is also impacted by the level of engagement with services by people experiencing abuse. For example, Pākehā, heterosexual, and cis-gender older people are more likely to access services and take part in research, therefore, information about prevalence rates is often skewed to represent this proportion of the population, while other population are underrepresented.

Who abuses?

Elder mistreatment, abuse and neglect is committed by a variety of people for different reasons.

To indicate the heterogeneity of people who abuse and their motivations, table one highlights five primary personality types of abusers.

Table 1: Five Personality Types of Offenders [14,29]

Overwhelmed abuser	• well intentioned, qualified and fit caregivers • overwhelmed and under immense pressure • quality of care reduced - can cause verbal or physical abuse and neglect
Impaired abuser	• well-intentioned caregivers • have problems that affect ability to care for dependent old people (e.g. disabilities, frailty, mental illness)
Narcissistic abuser	• ill-intentioned, motivated by personal gain • use other people and their assests • older people are a means to an end • can include: inheriting assets, accessing welfare benefits or appropraiting valuables
Domineering or bullying abuser	• feel justified in abusing others • know how to get away with abuse • attack those who are vulnerable and with perceived less power
Sadistic abuser	• harming and humiliating others gives feelings of power and importance • take pleasure in fear • lack of guilt, shame or remorse

The variation of abusers, their personalities and their motivations can affect the level of abuse and the approaches needed to make and keep an older person safe.

Although people who perpetrate elder abuse come from a range of backgrounds, the following outlines the most likely groups:

- Family members are responsible for over 70 percent of elder abuse. [15] Approximately half of all abuse is committed by adult children and 43 percent of older people who are harmed also live under the same roof as their abuser. [15, 20]
- People who cause harm to older people come from all ages and genders. Evidence indicates that women and men are similarly responsible for abuse, with women more likely to cause harm through neglect and men through physical and sexual abuse. [14, 40]
- Carers are a commonly discussed perpetrator group in elder abuse discourse. Carers may be informal (e.g. spouses, adult children, relatives, and friends) or formal. Carer abuse can happen anywhere, including in the home and in rest homes and residential care facilities.
- Often elder abuse by carers is associated with stress and intense workload of looking after a dependent person. [14]Although this is accepted by many to be the norm for some cases, WHO stresses the risk of overidentifying with caregiver stress and the difficulties of caregiving when discussing elder abuse. [41]

- Other than family and carers, offenders can also be neighbours, friends, and other people in positions of trust such as lawyers, accountants and doctors. For example, an EARS provider noted a case where a landlord increased rent illegally and charged for incidentals significantly beyond their true cost.
- Offenders of mistreatment and abuse often have personal problems, including financial difficulties, substance abuse disorders, mental health issues, limited social supports, cognitive or physical impairments, police arrests and poor employment records.[14,42] EARS providers highlighted the significant impact of alcohol and drug abuse on elder abuse cases, with many offenders suffering from some form of substance dependency.

Factors impacting risk of abuse

There are various factors which increase an older person's risk of abuse. Table 2 lists common risk factors, categorised by victim, perpetrator and contextual characteristics.

Table 2: Risk factors of elder abuse [6, 16, 21]

Victims/Survivors	Perpetrator	Context
• Cognitive impairments and dementia • Developmental disabilities • Physical impairments and disabilities • Mental illness • Dependency (social, emotional, physical) • Ethnic minority • Isolation (social, geographic) • Past abuse and history of family violence	• Substance abuse • Financial difficulties and dependencies • Carer burden and stress • Mental illness and psychological problems • Past abuse and history of family violence	• Ageism • Enduring Power of Attorney • Poor family relationships • Housing pressures • Crowded and shared living situations • Institutional abuse in residential care facilities

Of these common risk factors, a few were highlighted during our visits with EARS providers and in elder abuse research. These factors, from the victim/survivor and context areas, are further discussed below.

Victim/Survivor

Social isolation

Risk factors for lower social connectedness outcomes include being an older person, people living with poor health or a disability, and people living alone .[6] An older person may fit into all three risk groups, compounding the effects of social isolation. When people feel disconnected, not valued, or have little support from others, they face greater risks of anxiety, depression, and vulnerability.

EARS providers noted that many of the people they work with suffer from social isolation and loneliness. OECD studies showed that only 40 percent of older people socialised with friends once a week, compared to those of working age (61 percent) and youth (92 percent). [43]

Living alone or without access to transport increases the risk of isolation. This may be a problem for older migrants who have few friends and family members in Aotearoa, or those not very familiar with the English language or the local culture.

> *"Nobody wants to feel isolated or alone. Feeling like we've lost our social circle can affect many aspects of our lives negatively, even our health"*
> Office for Seniors

EARS providers indicated that social isolation and lack of social support are key issues facing elderly people, with some elderly people going months without having a conversation with another person. Higher social support is seen to decrease an elderly person's risk of mistreatment.[26] Older people who are socially isolated often have fewer protective factors increasing their vulnerability to abuse. They may depend more on one person or are vulnerable to people striking up relationships and taking advantage of the situation. For example, EARS providers gave examples of women befriending older men and using their friendship to obtain gifts and funds, and then threatening to discontinue their companionship if the men do not comply.

People across Aotearoa New Zealand do not have equal access to services and support. People in rural areas experience a high level of isolation (geographical and social) compounding their risk of vulnerability and abuse. They are more likely to be dependent on a person living with them, particularly for transport and provision of basic goods, or if they live alone they can be isolated from people and services which could recognise and respond to the abuse and neglect. This may also be the case for Pasifika, Asian and people from other ethnic minorities, who are less likely to engage with services or take advantage of social community events and rely more on family members and friends.

Health

Having ill-health can increase the risk of elder abuse, mistreatment and neglect. Health issues often increase with age and can include physical and cognitive impairment, disabilities, chronic illnesses, and dementia. Around 60 percent of people in Aotearoa over 64 identify as disabled, with the percentage increasing for Māori and Pasifika, 74 percent and 78 percent respectively.[44] These chronic conditions and disabilities increase the level of ongoing care, support, and special equipment required by an older person, increasing their dependence on others.

Dementia is a major risk factor for elder abuse.[6,14] Approximately 10 percent of people over the age of 64 have dementia[25], with women 30 percent more likely than men to have dementia.[24] Studies indicate that up to 23 percent of older people with dementia are physically abused.[48] EARS providers note that people's misunderstanding of dementia can lead to frustration, bad decision making, and impatience when dealing with those who suffer from it. Having dementia can also make it more difficult for people to report abuse or to have their claims taken seriously. People may think changes in behaviour are a result of dementia rather than symptoms of abuse or people may discount claims of abuse made by a person with dementia. Patients may also not be aware of what is happening and/or have little ability to communicate what they are experiencing.

Health issues, such as cognitive and physical impairment, can add to the complexity of a case. It may affect the relationships within a family - emotions may be in flux and stress levels high. Having a loved

one go through these changes can affect a whānau's sense of structure, with roles often reversed between parents and children. People close to an older person affected by these health issues may not understand the reality of the situation, resulting in fear, confusion, denial, and anger. This can result in disagreements between whānau, which causes stress for the older person, and may put an older person at risk of harmful attitudes and behaviours.

Context

Ageism

Ageism is a socially-condoned and institutionalised form of prejudice, with limited research and awareness-raising about its effects. [23] The rhetoric around ageing often focuses on disability, illness, and reduced functionality. Particularly in developed nations, the overall idea is that getting old is negative and that as we get older we have less to contribute and become a burden to society. The majority of people in Aotearoa say that they respect older people[31] and believe they should be respected and protected [30]. However, this is not always reflected in practise, and around 11 percent of people agree that violence against an older person can be justified, as 'older people can be frustrating'.[30] Older people face various hurdles due to discriminatory and prejudicial attitudes and behaviours by individuals and institutions. The homogeneous treatment of older people also fails to recognise the diversity of people within this age group and the need to approach each person as an individual.

Older people are vital members of our whānau and communities, passing on traditions, stories, experience, and skills. Traditionally, age was a sign of wisdom, with elders respected for their knowledge and expertise. This is still the case in various cultures, for example the role of kaumātua in Māori communities; however, the changing nature of families and the spread of Western attitudes can affect these traditions.

The widespread infantilisation of older people can also lead to internalised-ageism where older people hold these negative beliefs about themselves due to societal conditioning.[13] This can reduce their feelings of usefulness and value and increase the likelihood that they become passive and dependent on others. Concerningly, it can also affect an older person's perception of mistreatment, seeing it to be a result of age and dependency.

People who work with older people, such as counsellors, health professionals, and educators are not exempt from the effects of ageism. [14, 21] Age-related illnesses are often treated as less important, and questionable symptoms and behaviours are often written off as age related, even if they are not.[23] It can also result in the downplaying of an older person's concerns and feelings, affecting their ability to obtain needed support and resources.[22] These institutionalised ageist attitudes and behaviours contribute to the mistreatment of older people in society, which can result in the neglect, exploitation or abuse of older people. [23]

Enduring Power of Attorney

Cognitive impairments and dementia can often affect a person's ability to make informed decisions, which may result in them having to be assessed for capacity by a medical professional. Most assessments are performed by general practitioners on request, due to concerns from a lawyer or family members.

Capacity can be difficult to assess and exists on a spectrum, with some people able to perform some types of decision making, in which case they may be considered partially competent. It is also not static, and a person may be re-evaluated and deemed to have regained capacity. Illnesses and medications can have short term effects on someone's cognition, which may revert to its original state over time.

Ideally, prior to losing capacity, a person will appoint an Enduring Power of Attorney (EPOA) to act on their behalf. The EPOA is enacted when the person is declared incompetent by a medical professional. Issues often occur where a person has not appointed an EPOA, requiring the family court to act on the person's behalf through the Protection of Personal and Property Rights Act 1998. [7]

Many elder abuse cases include issues around EPOAs. Those who are involved in an EPOA, including agencies such as health and banking organisations, are often inconsistently provided information about their responsibilities and the role and limitations of an EPOA. Some people who hold EPOA do not understand that it is linked to the older person's level of capacity, and that an EPOA can only be invoked when an appropriate medical professional deems that they do not have capacity.

People who hold EPOAs can access and use funds, and make decisions regarding housing and health treatment, often without having to justify these decisions or proving that they align with the interests and wellbeing of the older person. The lack of oversight of people who hold EPOAs and the decisions they make on behalf of the older person, and the lack of a register to help agencies identify the status of an EPOA, causes significant issues.

In many cases, the lack of awareness around the importance of an EPOA, coupled with the cost, mean that many older people have not set one up before they are deemed to not have capacity. This can leave them open to exploitation and mistreatment.

Housing

EARS providers highlighted that housing options for older people are changing. Fewer older people own their own home, and with the cost of home ownership increasing those who do often cannot maintain them. A lot of housing is also not accessible for older people, particularly those with disabilities or reduced physical capacity, and new housing initiatives are often aimed at first home buyers and the needs of young families.

The number of older people in multi-generational living situations is increasing. Across Aotearoa multi-generational living increased by 50 percent from 1996 to 2013, with this number rising to 98 percent in Auckland.[50] Although Pasifika and Asian older people are more likely to live in multi-generational households than pākehā and Māori [33], the increase is occurring across a variety of ethnic and cultural groups.[32] Living intergenerationally can provide valuable social interaction, familial support, and resource pooling. However, it can also be stressful and confining. Research indicates that older people from Asian and Pacific backgrounds feel more lonely living with their adult children than those that live alone, whereas the opposite is true for Pākehā, and Māori experience similar degrees of loneliness in both situations. This may be because some older Pasifika and Asian people, specifically those who have immigrated here, living with family may not involve much interaction with others outside of the home, which can be exacerbated by not being able to speak English. [33]

EARS providers stated that as the housing shortage in Aotearoa continues to put strain on whānau, they are recognising more housing-related factors of abuse. Many families are moving in with their older relatives and are not helping to cover the costs of living, others are experiencing mortgage or rent pressures and are seeking money from parents. Some are moving older relatives in with them to reduce costs or moving them into rest homes in order to sell the house or live in it, and others are lashing out at older relatives due to stress and helplessness. An EARS provider highlighted a growth in cases where children are dealing illicit substances from their parent's property, leaving the older person feeling unsafe and fearful in their home.

The instability of housing increases the risk of older people being put into, or choosing, unsafe living options. EARS providers highlighted that there is no emergency housing or safe houses for older people in volatile situations. Temporary housing is also in high demand, with significant waitlists in many areas. If temporary housing is obtained it is often not easily accessible, in bad condition, and in unknown or unsafe areas. The housing shortage has also led to more homeless older people, with providers identifying them as being more at risk of being taken advantage of or abused in their vulnerable situation. The lack of housing for older people and the ongoing effects of housing issues across Aotearoa are increasing opportunities for older people to be mistreated and abused.

Effects of abuse

Elder abuse can have devastating consequences for older people being abused. It also has wider impacts on whānau, communities and society. The following are examples of these effects:

- Older people who are abused experience physical effects such as pain, nutrition and hydration issues, sleep disturbances and insomnia, an impacted immune system, exacerbation of health issues, and broken bones and bruises.[35]
- Older people who are abused also experience mental and emotional effects such as feelings of guilt, shame, fear and embarrassment. It can take a toll on their self-esteem, cause emotional distress, and make them feel helpless, stupid, and insecure.
- Over half of the people who experience mistreatment and abuse suffer debilitating long-term health problems, including depression, anxiety, post-traumatic stress disorder, and exacerbation of health issues. It can also decrease a person's life expectancy.[1, 21, 27, 34]
- There are also the effects of tangible losses, such as money, cars, and homes. Financial losses have significant and everlasting impacts for an older person. They often do not have the means to make up for these losses and with less financial resources they might stop purchasing medication and food, going to doctors' appointments, turning on heating, or paying for maintenance on their homes.
- Older people who are abused often become less autonomous and more dependent on services - needing ongoing support from health or residential care sectors. [20]
- Older women who are sexually abused suffer from up to 70 percent more gynaecological, stress and central nervous system problems, they also pass away sooner than those that are not abused. [17]
- It can cause a breakdown of whānau relationships and rifts between family members. Discord and conflicting values, behaviours, and beliefs can put strain on a family, particularly the older person, creating a sense of loss, grief, helplessness, and sadness. It can destabilise a whānau and healthy mutual relationships between members. [20]

- Widespread mistreatment and abuse of older people may support ageist beliefs and behaviours, impacting society's ability to include older people as productive, valuable, contributing members of a community.

EARS providers highlighted the importance of focusing on the effects of elder abuse. They indicated that the dehumanising or infantilisation of older people often results in a lack of empathy towards older people who are experiencing mistreatment and harm. This puts them even more at risk, and feeds into the ongoing effects of ageism.

PART TWO:
The Role of MSD's Elder Abuse Response Services

Elder abuse is a widespread social issue across Aotearoa New Zealand. MSD's Elder Abuse Response Services (EARS) is the largest coordinated national programme responsible for delivering non-crisis response services to those experiencing, or at risk of experiencing, abuse. This discussion will outline the background of EARS, EARS providers and the services they deliver, and the issues faced by current service delivery.

Background

In July 2017, elder abuse services underwent significant changes. Services were reprioritised from their core focus on prevention to intervention, resulting in Elder Abuse and Neglect Prevention (EANP) services becoming EARS. EANP funding was approximately $1.3 million per annum. This was increased to approximately $2.9 million, as funding was acquired from the SAGES programme ($1.6 million), a community-based mentoring programme that aimed to reduce the social isolation of older people by connecting them to individuals and families that needed help and support.

Under EANP, providers were contracted to deliver prevention and education services, with the majority being Age Concern affiliated organisations. Age Concern New Zealand was contracted to support EANP providers' service delivery and reporting and provide national coordination (quality assurance and professional development) for all EANP providers.

The focus of EANP was to reduce the number of incidences of elder abuse and neglect by educating health professionals and community carers, raising public awareness and coordinating and monitoring the service response to suspected cases of abuse or neglect. Although in practice, providers delivered prevention and response services. Limitations of the services included: limited funding, few providers for cultural minorities and services did not provide full geographic coverage.

Contrastingly, the goal of EARS is to achieve more immediate and improved outcomes for people over the age of 65 experiencing or at risk of experiencing elder abuse. Changes included:

- a primary focus on intervention
- improved geographical coverage
- a focus on local needs
- culturally responsive providers
- discontinuing Age Concern New Zealand's position as sector support

The procurement process, and the shift of focus to intervention, created opportunities for new providers to enter the sector. Some of the providers previously delivering EANP received contracts for EARS. In total, there are 21 contracted EARS providers, two of which are consortia (totalling approximately 28 provider members). Fourteen of the contracted EARS providers are led by Age Concern members.

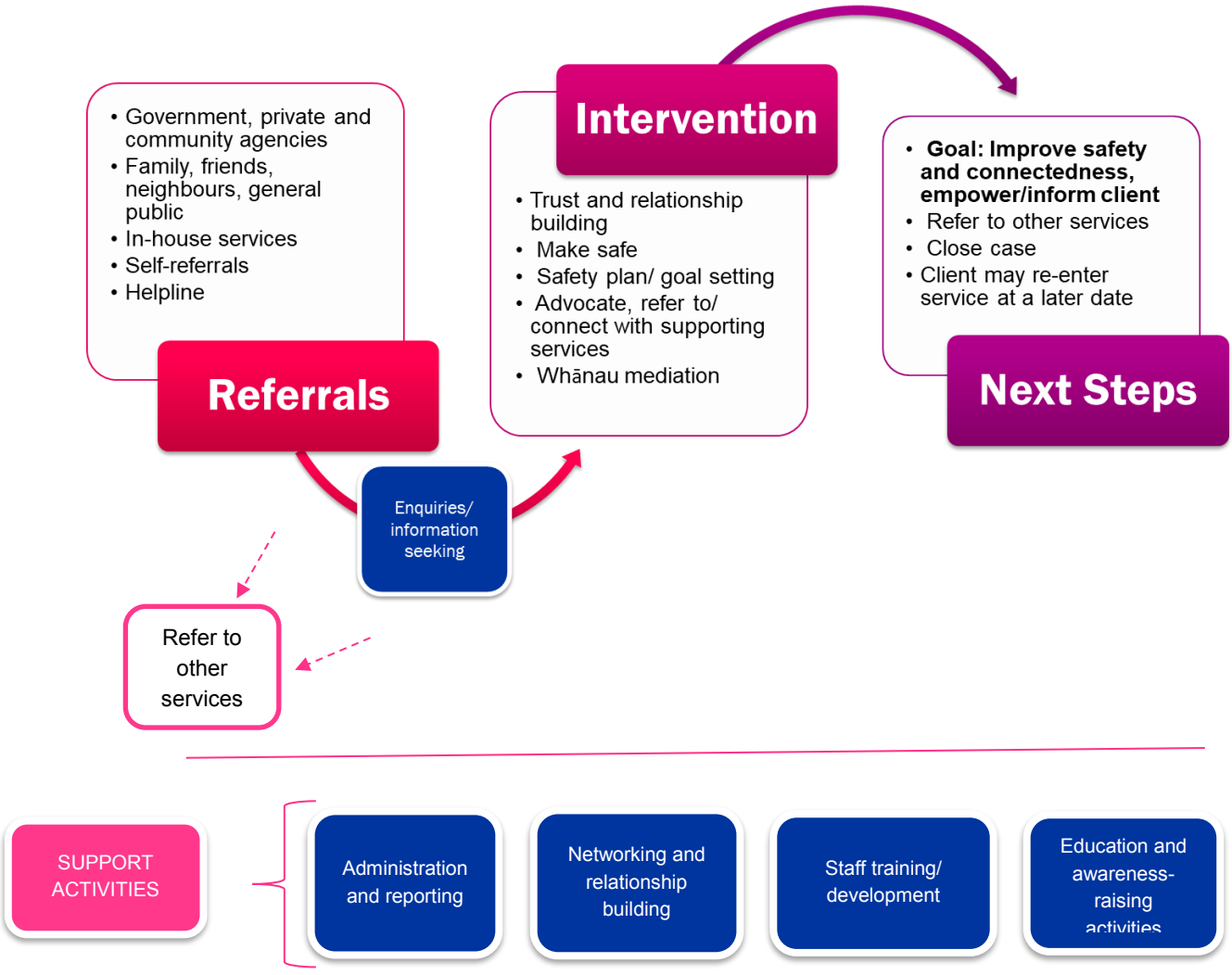
Under EARS, the Office for Seniors became responsible for prevention and managing activity to raise awareness and educate audiences on elder abuse. A 24/7 confidential national EARS helpline was also implemented to provide information and support for people who are either experiencing elder abuse or are concerned about abuse happening to others, referring people to their local EARS provider as appropriate.

Elder Abuse Response Services

Cases of abuse or potential abuse that are reported are referred to various organisations and undergo different levels of intervention.

Figure 2 provides an overview of EARS and the process of delivering the service, including the major response activities (referrals, intervention, and next steps) and the support activities (indicated in the blue boxes).

Figure 1: EARS Case management



Where do EARS referrals come from?

EARS are accessed through referrals from family, friends, neighbours, and agencies. Agencies are a major referral group and include: Police, DHB, health care professionals, Work and Income, Needs Assessment Care Services, banks, accountants, lawyers, and rest homes etc. Providers also receive self-referrals; however, most indicated that this was not as common and varies by provider.

Many providers noted that referrals also come through other services they deliver, for example kaumātua groups, community support services, and meal and recreational programmes. Some also

receive referrals through education and awareness raising activities, although EARS providers highlight that this pathway for referrals has reduced due to the limited education work they deliver.

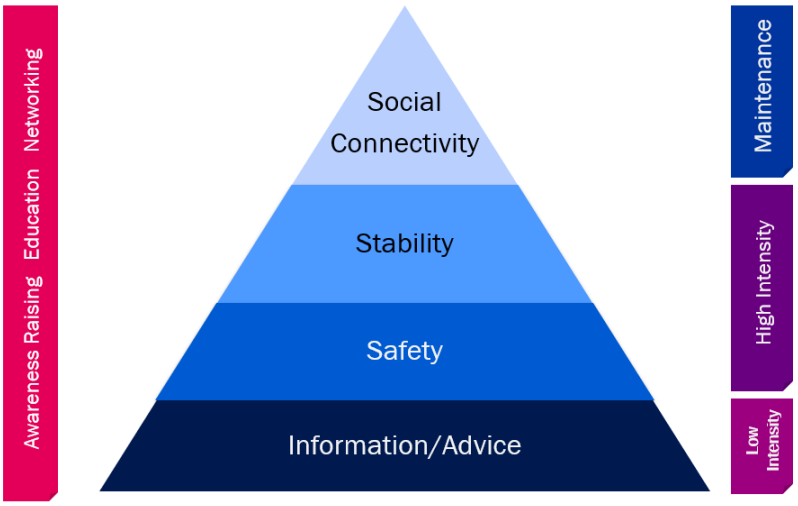
While referrals come from a range of sources, in many cases EARS providers need to determine if elder abuse is occurring or at risk of occurring.

The role of EARS intervention

EARS respond to older people experiencing or at risk of experiencing elder abuse. Intervention comes in various forms based on client needs. It also differs across providers and staff, depending on their preferences, resources, and capabilities. The following is a brief description of the types of activities included in most EARS providers' intervention:

- Once elder abuse is determined to be occurring or at risk of occurring and they have consent to work with a client, service delivery focuses on ensuring the older person's safety and ongoing protection while respecting their autonomy. This includes working with the client to create safety and goal plans. Staff invest a lot of time initially in building the relationship and trust with the client.
- EARS staff each have a different way of working with whānau. Some providers see the older person as their only priority, and wrap the services around them, with limited interaction with whānau. Other providers work with the older people and the whānau, seeing a healthy whānau and the safety of the older person as top priorities. This may include whānau mediation, goal setting with whānau members, and identifying what action plan is best suited to the needs of the whānau so that they are connected and safe.
- Sometimes family or whānau members may contact providers and work alongside them to improve safety of the older person being abused.
- EARS staff advocate on behalf of their client and help them understand their rights. They often spend time accompanying a client to health, legal, and bank appointments, and help them to access agency support and services in their communities. This may include services and activities such as home help, home nursing, meal support, in-home respite or day-centre respite care, social connection services, and visiting services. These services are integral to ensuring that an older person is connected and safe on an ongoing basis after they exit EARS.
- The length of time a client may stay in EARS differs between cases, although most are between three to six months. However, some cases can take years. It is also common for people to exit services and come back in again later; this cycle may occur multiple times.
- The level of client interaction and intensity of services provided varies by case depending on client need. Some clients need extensive advocacy, safety and social support put in place, others may only need basic information and safety support. Figure 2 indicates the levels of intervention and the flow from low intensity cases to maintenance stages. Most EARS providers focus on the low to high intensity activities due to their limited capacity to provide maintenance services.

Figure 2: Intervention levels and activities



Support activities

During our visits with EARS providers it was apparent that although elder abuse intervention is a major activity within EARS, it is not as effective or achievable without support activities. These support activities are often resource intensive yet commonly ignored during historical funding determinations. The following is an overview of these activities:

- Staff spend a lot of time on enquiries and advice activities. This includes discussing the situation, providing information and recommendations, and trying to determine if elder abuse is occurring. Enquiries are not always one-off interactions, and sometimes they may turn into a client or stop at the enquiry stage. At times the enquirer does not want to provide the name or contact details of the person who may be experiencing abuse, or they may explicitly ask that the person not be contacted. This can make a case very difficult for an EARS worker as they try to identify whether elder abuse is occurring and the best course of action.
- EARS staff may also refer clients to services which can serve their needs better. For example, an older woman experiencing IPV may be referred to the local Women's Refuge as they have the capability and experience of working with IPV cases.
- EARS providers vary in their level of resources. Some have administration staff to complete paperwork, reports, and funding applications. However, other providers rely on EARS staff or managers to complete these activities. In all cases, EARS staff spend a lot of time recording case notes and updating client information.
- Most EARS providers have built extensive relationships with local agencies, community groups, and professionals to support their operations. They rely heavily on these relationships to ensure that they can deliver responsive services to their clients, leveraging the knowledge, skills, and resources of their networks. Most Age Concern providers have Advisory Groups to help provide advice on cases and ways to respond. These Advisory Groups typically consist of local police, DHB workers, NASC workers, and lawyers. These networks help EARS providers

ensure that people experiencing harm in our communities have the right services to meet their needs.

- Although EARS focus on intervention and response, some EARS providers continue to provide some education and awareness raising activities. Often this is only by request from community groups, or for residential care facilities/rest homes. All EARS providers noted that they want to have the capacity to deliver these activities as it helps to build awareness of elder abuse in their communities and acts as a referral pathway for potential cases.
- Some EARS providers have Community Support workers who help to support the work of EARS. They serve as eyes and ears in the community and identify potential people at risk of elder abuse. They also help to improve the ongoing safety and wellbeing of the older person as they transition out of EARS, providing valuable support in the maintenance phase. Most of the Community Support workers are philanthropically funded, and most EARS providers do not have one. Many EARS providers highlighted the need for Community Support workers to support the work of EARS and keep people safe from abuse.
- Some providers also offer other services/support alongside EARS. Examples include accredited visiting services, meals on wheels or meal services, social activity sessions, or exercise classes. What is offered is usually affected by resources available, other contracts from agencies (e.g. Ministry of Health), and their organisation's wider purpose. Providers who have these additional services often use them to maintain the safety of their EARS clients. It enables them to wrap supportive services around them whilst also maintaining an ongoing relationship.

Issues with delivering EARS

During our visits with EARS providers, many highlighted various issues they face delivering EARS. These issues may arise from difficulties with cases, from the lack of capacity and capability of the provider, and from external system issues.

Issues arising within case management

- One of the main issues for providers is obtaining consent from the older person to provide intervention, as well as gaining access to them. Some older people may be wary of providing written consent, and only provide verbal consent. Other times they may not understand what consent entails. This is compounded by cognitive impairment and impaired mental capacity. Other times the abuser may act as a gatekeeper and make it difficult to talk to the client alone or become aggressive to the victim or EARS worker when seeking consent. Obtaining consent can require significant time investment and relationship building.
- The relationship between the older person experiencing abuse and the person causing it can create complications when dealing with a case. These relationships can stop an older person wanting to report or pursue a case. Some older people experiencing abuse and mistreatment choose to stay in these situations as it is preferable than losing contact with their family or friends. Others may not agree that what is occurring is abuse and refuse to take the issue any further. Even if the police are involved, the older person may be uncooperative and not support the laying of charges or any ongoing investigations. Services are limited in what resources, support and information they can provide; a lot of decision making must come from the older person, if they are able.

- Although cases of abuse are serious, they are not always criminal offences and may be difficult to resolve. For example, an older person who gives money to an adult child with the implication that the money will be paid back, but no contract, often has difficulties pursuing a judicial avenue due to the uncertain nature of the 'loan'. There are limited avenues to get back any funds, and EARS providers do not have any statutory power.
- The ability for support agencies to act can also be complicated by mental capacity and dementia, which affects an older person's understanding of a situation and/or their ability to provide consent. If part of the intervention required is around EPOAs, services may also have difficulty working with the person who holds EPOA, particularly if they are the one causing harm.
- Family member relationships can also cause issues during intervention. Providers note that in many cases sibling disagreements result in setbacks for intervention, with the older person caught in between the interests of their children and/or their spouse. Providers may have to spend time working with these family members to ensure that the older person's interests are presented, and that outcomes meet the needs of the older person with as much support from whānau as possible.

Issues arising from provider capability and capacity

- Most of the new providers had little to no previous experience offering elder abuse services prior to the EARS contract and it took significant time to find appropriate elder abuse staff once they attained the contract. Many highlight the lack of support they received from the Office for Seniors and MSD in helping them to appropriately deliver the service or provide consistent practice guidelines. Some have only acquired EARS staff in the last year.
- Some kaupapa Māori providers highlighted that it was perceived by the public that they only delivered services to Māori. It has taken a lot of time and networking to spread awareness that they cater to people of all ethnicity experiencing or at risk of elder abuse in their contracted region.
- Due to the limited number of providers, they each cover large service delivery areas and/or population base. Staff spend a lot of their time travelling to clients or case assessments – sometimes they are only able to visit one client a day. This results in a lack of choice for people experiencing elder abuse and can mean that people in rural areas are less likely to be able to access services.
- Some providers only have one or a few staff spread over a large region. Therefore, many staff perform their duties alone. The work can be dangerous, and most rely on support from Police (if available) when visiting potentially dangerous locations or situations. Working in isolation puts significant stress on staff and the lack of intra-service networking opportunities has reduced their ability to share ideas and develop supportive relationships.
- Currently, EARS staff are having to manage high caseloads, resulting in a risk of unsafe practice. There are approximately 32 FTE across New Zealand delivering EARS. In 2019, 4,204 people were referred to EARS, this is 30 percent above contracted volumes and has resulted in each FTE having to manage 131 referrals on average. Research indicates that elder abuse cases are becoming more complex, with housing pressures, substance abuse, familial relationships, and deteriorating health compounding the issues faced by older people and

their families. EARS staff indicate that the increase in complexity means that more time is required to ensure each client is safe and supported to remain safe.

- Providers stressed the importance of prevention and intervention in the sector and highlighted that in order to ensure a robust and effective service, both are required. Some EARS providers deliver education and response services, which requires a few to seek funding via other means. However, those with limited resources and lack of funding have been unable to continue education and awareness raising activities.
- The lack of training available to EARS workers was highlighted as an issue by various providers. They note that they were initially informed that training support and guidance would be provided to them by the Office for Seniors and MSD. However, they have not received any training and very limited support.

Issues arising from the external system

- The level and success of immediate intervention and long-term maintenance is not only impacted by the interests of the older person, but also the availability of other services. For example, housing, social connection programmes, in-home support, and home visiting services are not available in many areas of Aotearoa, particularly in rural areas. Therefore, EARS providers face difficulties ensuring their clients are connected and safe. It also may lead to EARS providers stepping in to provide these high need or crisis services, although they are not resourced to do so.
- Mental health services and counselling are also in high demand in every region. Long waitlists and strict criteria are barriers to older people accessing these services, and EARS providers state that youth are given preference. Some of the older people being abused present with past trauma which may increase their vulnerability to experience abuse as an older person. Many of these people have never accessed mental health services to work through this trauma. Only a few of the EARS providers have in-house counsellors who they are able to refer their clients to. There are limited alternatives available for the older person unless they have the means to access private and expensive practices.
- Although agencies (public, private and community) interact with older people regularly, providers state that many agencies do not appropriately understand the needs of older people. They also do not sufficiently know how to recognise risk factors or potential cases of abuse. Many providers highlighted the need for agencies to undergo more rigorous training on the effects of ageism, and how to recognise and appropriately respond to elder abuse. The lack of agency awareness is considered a high-risk factor - if groups who interact with older people daily and make policies that impact them are not properly trained on older people's rights and abuse, then reduction and response to elder abuse is likely to be weak and minimal.
- A common issue between and within government, private, and community agencies is the siloed nature of operations. The lack of communication and coordination often results in duplication of or gaps in services. EARS providers noted that their clients often have 'five cars parked in the driveway', with various agencies interacting with one client at one time about different issues. Many providers have created their own networks and work with local agencies to identify which party is best able to meet the needs of the older person, with support from the other agencies if needed.

- EARS providers highlighted the exploitation of older people by agencies (particularly government agencies) as part of their operations. Agencies may use older people as support systems without proper assessment or information and insufficient regard to the risk on the older person. Although this exploitation appears to be born from a lack of understanding about the affect these activities may have on older people, they can have significant consequences. Examples of exploitations are putting mokopuna and parolees in older relatives' care without undertaking appropriate assessments and providing resources to ensure all parties are safe and supported.

The need for more culturally diverse services

Elder abuse occurs across all cultures and ethnicities, however, there are differences between what is perceived as elder abuse and how people respond to prevention and intervention methods.[6,37,38] Typically, definitions and responses to elder mistreatment, neglect and abuse in Aotearoa are commonly based on a white, heterosexual, cisgender, middle class perspective. This is often replicated in the institutional practices, laws and policies. This results in the approach to elder abuse reflecting only a portion of older people and their lived experiences.

Currently, elder abuse services and support are mainly designed and delivered by pākehā services to pākehā. Although there are a handful of kaupapa Māori providers delivering EARS, they are only available in parts of the Central North Island and Bay of Plenty areas. Many of them also predominantly work with pākehā due to difficulties in engaging other ethnic and cultural groups, even Māori. Some EARS providers indicate that the levels of Māori engaging with their services are increasing, and that this is due to significant investment in building relationships with local iwi and whānau Māori outside of elder abuse services. However, practices may still be pākehā-derived, and most EARS providers recognised that there are significant gaps in services that reflect Pasifika, Asian, and migrant/refugee people's needs.

Providers noted that older people from minority cultures are often not aware that elder abuse services and/or support services for older people are available, and that this represents an important gap in current service delivery. This barrier to engagement is compounded when an older person does not speak English and the service only provides pākehā-based support and only English-speaking services. Therefore, they rely on their whānau and friends to interact with institutions and agencies.

There is a lot of shame associated with elder abuse, particularly abuse by children or mokopuna. Therefore, older people may not feel comfortable speaking to someone about the abuse they are experiencing or approaching elder abuse services. Some may not feel comfortable accessing elder abuse services which do not reflect their culture, whereas others may prefer to go to a service which does not. However, typically they do not have a choice of provider, as there is usually only one available in a region.

Funding and Contracting

Funding

Funding for EARS in 2019/20 is approximately $3.052m per annum. Of this, $2.664m funds approximately 28 providers (some of which hold a contract as part of a collective/consortium) to deliver EARS nationwide and $0.135m funds Homecare Medical to deliver the 24/7 helpline, 0800 EA NOT OK.

Although funding for elder abuse services increased in the shift from EANP to EARS, it was coupled with a larger cohort of providers being required to provide more in-depth services to more people. The change in services and funding provided did not reflect the actual cost of providing intensive intervention verses prevention, which has resulted in funding not being enough to cover the costs of delivering a best-practice intervention service nationwide. This has limited providers' ability to meet increasing demand and provide in-depth support to people experiencing elder abuse.

EARS providers receive contributory funding via a rate per client, with rates significantly varying from one provider to another.

The number of EARS workers around Aotearoa is limited, with some regions having less than one FTE to deliver EARS. It is difficult for providers to acquire and retain high quality staff due to their limited ability to give competitive remuneration. The recent increase to social worker remuneration within Oranga Tamariki, and subsequently DHBs, has put pressure on the NGO sector. They are unable to match this rate and are also not funded by agencies to provide a similar remuneration to their staff. Many providers can only afford EARS staff part time, impacting the number of clients they can serve and the level of support they can provide.

During our engagement, providers noted that funding is often insufficient to cover intervention services, and that there is typically no funding for support activities. They also highlighted that although they want an increase in awareness raising and education, they do not have the capacity to serve a resulting increase in EARS demand. Therefore, an increase in education and prevention would need to be coupled with an increase in response resources.

The minimal funding provided to deliver EARS also results in providers spending a significant amount of time seeking other sources of funding. However, providers noted that philanthropic funding is difficult to attain for two reasons. Firstly, philanthropic funds do not like 'topping-up' government-funded services, due to the perception that government should be fully funding them. Secondly, services for older people are not 'attractive, shiny, or sexy', with youth-centred services typically given priority.

The limited availability of funding affects providers' ability to innovate and deliver holistic wraparound services. Overall, EARS providers highlighted that they would prefer an FTE funding model, with FTE rates equitable to OT and DHB social worker rates and calculated based on actual workload, including overhead costs. More information on this funding type can be found within MSD's Family Violence Funding Approach report.[39]

In Budget 18, MSD received $76.157m over four years to stabilise and strengthen family violence services. The 2018/19 and 2019/20 funding allocation was prioritised to stabilise crisis, non-mandated perpetrator and family centred services. EARS did not receive any of this funding as future funding considerations need to be informed by this current state review.

Contracts and Reporting

Providers noted that they spend considerable time on reporting. Many of their data management systems do not easily provide the data required by MSD, with many hours spent extracting data from their database. They also note that many of the reporting measures MSD requires are irrelevant and do not capture the true nature of the service. Therefore, they rely on capturing qualitative findings in the notes section of the report. This is more time-intensive, but they feel it is necessary to give MSD a better understanding of the services they deliver and the impact on their clients.

Providers highlighted that reporting requirements change frequently and that they are given little warning about potential changes. The terminology and definitions of reporting measures also appear to be unclear, resulting in inconsistent application across providers. Contract managers also appear to be providing differing advice regarding reporting definitions and standards. This affects MSD's ability to evaluate services and their effectiveness, or to identify trends.

Most providers advised that they do not know what happens with the reports they send MSD, with limited feedback provided by MSD after they are submitted. Sometimes they hear back if their numbers are not meeting contract requirements, but they are not provided with positive feedback or any indication how they are doing compared to other providers.

The number of clients that EARS providers are contracted to serve appear to be inconsistent and not determined by need or demand in the region. A client is also counted when their case is closed or opened. Many providers highlighted that counting closed cases or new cases gives a distorted view of services. Some providers highlight that their most complex cases can take a long time to work with, and that not capturing these people distorts the numbers. Feedback also showed that providers with a high load of complex, long-term cases are more likely to look like they are not performing well. They state that it would be better to report on open cases than closed or new cases.

Due to the limitations of funding and contracting for EARS, providers are at risk of not being able to provide effective services to older people in their communities. It also limits their ability to meet any increase in demand or complexity of cases, as well as implement innovate practices.

Summary

Elder abuse is a pervasive issue affecting older people in Aotearoa. People are at risk of various forms of abuse by the people they know and trust.

Older people from all walks of life may experience elder abuse, with mental and physical impairments, dementia, advanced age, ethnicity and gender affecting risk and types of abuse. People who perpetrate abuse are also diverse, with motivations differing by abuser.

Various factors impact an older person's risk of abuse, including an older person's health and social connections and an abuser's substance abuse and mental health. Risk of abuse is also impacted by wider contextual issues within communities, including ageism, increasing housing pressures and the lack of oversight on enduring power of attorneys.

The effects of elder abuse can be significant for the victim, their family and whānau, and the community. Older people who are abused may face increased physical and mental health risks, financial and material losses, disempowerment and helplessness, and social isolation and loneliness. Abuse can also cause rifts within whānau and may support ageist and harmful stereotypes and behaviours in Aotearoa.

The complexity of elder abuse requires a specialist and dedicated approach and people experiencing abuse need intensive support to help them to become safe. EARS deliver response services across Aotearoa, providing intervention to older people who are affected by elder abuse. They work with and advocate for older people who have been abused, which often means working closely with a victim's whānau, other agencies, and community groups.

Although EARS providers are working hard to meet the need of their clients, they are managing an increasing number of challenges and issues when delivering services in their communities. The major issues faced by providers currently are the lack of resources and limited number of FTE to deliver services to large regions and populations, affecting their ability to provide robust and effective services to people experiencing abuse. Building relationships with older people and ensuring that they are safe and connected takes significant resources; however, limited funding for providers and increased demand for services is putting pressure on resources and reducing providers' capacity to ensure robust approaches.

To ensure that EARS are supported to meet challenges and provide effective services, MSD will explore future opportunities to strengthen services. The findings from this report will be used to inform a future state report, which will identify and discuss these opportunities in order to better meet the needs of older people experiencing, or at risk of experiencing, elder abuse in Aotearoa.

Bibliography

[1] Waldegrave, C. (2015). *Measuring elder abuse in New Zealand: Findings from the New Zealand Longitudinal Study of Ageing (NZLSA)*. Family Centre Social Policy Research Unit. Retrieved from http://superseniors.msd.govt.nz/documents/elder-abuse/elder-abuse-technical-report.pdf

[2] Yon, Y., Mikton, C. R., Gassoumis, Z. D., & Wilber, K. H. (2017). Elder abuse prevalence in community settings: a systematic review and meta-analysis. *The Lancet Global Health*, *5*(2), e147-e156.

[3] World Health Organization. (2018). *Elder abuse*. Retrieved from https://www.who.int/news-room/fact-sheets/detail/elder-abuse

[4] World Health Organization. (2002). *Missing voices: views of older persons on elder abuse* (No. WHO/NMH/VIP/02.1). World Health Organization.

[5] Wolf, R. S. (2000). The nature and scope of elder abuse. *Generations*, *24*(2), 6.

[6] Ministry of Health. (2007). *Family Violence Intervention Guidelines: Elder Abuse and Neglect*. Retrieved from https://www.ageconcern.org.nz/files/EANP/Family%20Violence%20Intervention%20guidelines-elder-abuse-neglect.pdf

[7] Health Navigator NZ. (2019). *Elder Abuse*. Retrieved from https://www.healthnavigator.org.nz/health-a-z/a/abuse-elder/

[8] Australian Law Reform Commission. (2017). *Elder Abuse: A National Legal Response.* Retrieved from https://www.alrc.gov.au/publication/elder-abuse-a-national-legal-response-alrc-report-131/1-executive-summary-4/what-is-elder-abuse-3/

[9] Davey, J. A., & McKendry, J. (2011). Financial abuse of older people in New Zealand. Retrieved fromhttps://www.ageconcern.org.nz/files/EANP/Financial%20Abuse%20of%20Older%20People%20in%20NZ,%20Judith%20Davey%20and%20Jayne%20McKendry%202011.pdf

[10] Baum, C. (12 September 2018). Inheritance impatience: 'Our family has been wrecked by this experience'. *The Guardian*. Retrieved from https://www.theguardian.com/lifeandstyle/2018/sep/12/inheritance-impatience-our-family-has-been-wrecked-by-this-experience

[11] Elder Abuse Prevention Unit. (2014). *Neglect*. Retrieved from https://www.eapu.com.au/elder-abuse/neglect

[12] Jeter, L. (2011). *Facts on Elder Abuse – Australia*. Retrieved from https://www.ohchr.org/documents/issues/olderpersons/submissions/elderabusepreventionassociation.pdf

[13] Peri, K., Fanslow, J., Hand, J., & Parsons, J. (2009). *Keeping older people safe by preventing elder abuse and neglect*. Retrieved from https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/journals-and-magazines/social-policy-journal/spj35/35-keeping-older-people-safe.html

[14] Fallon, P. (2006). *Elder abuse and/or neglect: Literature review*. Ministry of Social Development.

[15] Age Concern New Zealand (n.d.). *Elder* Abuse and Neglect. Retrieved from https://www.ageconcern.org.nz/ACNZPublic/Services/EANP/ACNZ_Public/Elder_Abuse_and_Neglect.aspx

[16] Moir, E., Blundell, B., Clare, J., & Clare, M. (2017). Best Practice for Estimating Elder Abuse Prevalence in Australia: Moving towards the Dynamic Concept of 'Adults at Risk' and away from Arbitrary Age Cut-Offs. *Current Issues in Criminal Justice*, *29*(2), 181-190.

[17] Smith D, Bugeja L, Cunningham N, et al. A systematic review of sexual assaults in nursing homes.The Gerontologist. 2017; 1-15. Retrieved from https://www.mcmasteroptimalaging.org/blog/detail/blog/2019/01/15/sexual-assaults-against-older-adults-in-nursing-homes-recognizing-the-signs-and-asking-for-help

[18] The Meyer Law Firm. *Elder Sexual Abuse*. Retrieved from http://www.nursinghomeabuseguide.org/sexual-abuse/

[19] Bandera S. Counting sexual assaults in Ontario nursing homes. CTV W5. 9 April 2016.

[20] Williams, E. (5 June 2018). The Effects of Elder Abuse. *Eldernet Gazette*. Retrieved from https://www.eldernet.co.nz/gazette/the-effects-of-elder-abuse/

[21] Perel-Levin, S., & World Health Organization. (2008). Discussing screening for elder abuse at primary health care level by Silvia Perel-Levin.

[22] Grainger, K., Atkinson, K., & Coupland, N. (1990). Responding to the elderly: Troubles-talk in the caring context. *Communication health and the elderly*, 192-212.

[23] Nelson, T. D. (2005). Ageism: Prejudice against our feared future self. *Journal of social issues*, *61*(2), 207-221.

[24] Kiely, A. (20 Sep 2018). *Why is dementia different for women?* Retrieved from https://www.alzheimers.org.uk/blog/why-dementia-different-women

[25] National Research Council. (2003). *Elder mistreatment: Abuse, neglect, and exploitation in an aging America*. National Academies Press.

[26] Dong, XQ. & Simon, M. (2008). Is greater social support a protective factor against elder mistreatment? Gerontology, 54, 381–388. DOI: 10.1159/000143228

[27] Jeter, L. (2011). *Facts on Elder Abuse – Australia*. Retrieved from https://www.ohchr.org/documents/issues/olderpersons/submissions/elderabusepreventionassociation.pdf

[28] Smith D, Bugeja L, Cunningham N, et al. A systematic review of sexual assaults in nursing homes.The Gerontologist. 2017; 1 -from https://www.mcmasteroptimalaging.org/blog/detail/blog/2019/01/15/sexual-assaults-against-older-adults-in-nursing-homes-recognizing-the-signs-and-asking-for-help

[29] Ramsey-Klawsnik H (2000) "Elder-Abuse Offenders: A Typology", *Generations*, 24(2):17–22.

[30] McLaren, F. (2010). Attitudes, Values and Beliefs about Violence within Families. *New Zealand: Center for Social Research and Evaluation*.

[31] Nielson. (2016). *Attitudes towards ageing: Technical Report 2016*. Commissioned by Office for Seniors.

[32] Atkinson, K. (6 March 2017). *Growing demand for multi-generational living*. Retrieved from https://www.generation.co.nz/whats-happening/growing-demand-for-multi-generational-living

[33] Jamieson, H. A., Gibson, H. M., Abey-Nesbit, R., Ahuriri-Driscoll, A., Keeling, S., & Schluter, P. J. (2018). Profile of ethnicity, living arrangements and loneliness amongst older adults in Aotearoa New Zealand: A national cross-sectional study. *Australasian journal on ageing*, *37*(1), 68-73.

[34] Lachs, M. S., Williams, C. S., O'brien, S., Pillemer, K. A., & Charlson, M. E. (1998). The mortality of elder mistreatment. *Jama*, *280*(5), 428-432.

[35] Centres for Disease Control and Prevention. (2019). *Elder Abuse: Consequences*. Retrieved from https://www.cdc.gov/violenceprevention/elderabuse/consequences.html

[36] Kozak J and Lukawiecki T (2001) *When Home is Not a Home: Abuse and Neglect in Long-Term Care, A Resident's Perspective*, National Clearinghouse on Family Violence, Ottawa, Canada.

[37] Moon A (2000) "Perceptions of Elder Abuse among Various Cultural Groups: Similarities and Differences", *Generations*, 24(2):75–81.

[38] Barnes, H. M. (2000). Kaupapa maori: explaining the ordinary. *Pacific Health Dialog*, *7*(1), 13-16.

[39] Ministry of Social Development. (2019). *Family Violence Funding Approach*. Retrieved from https://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/initiatives/family-and-sexual-violence/family-violence-funding-approach.pdf

[40] Cyphers, G. (1999). Out of the Shadows: Elder Abuse & Neglect. *Policy and Practice*, September: 25–30.

[41] World Health Organization. (2002). *Missing voices: views of older persons on elder abuse* (No. WHO/NMH/VIP/02.1). World Health Organization.

[42] Swanson, S. (1998). *Abuse and Neglect of Older Adults*. National Clearinghouse on Family Violence, Ottawa, Canada.

[43] OECD. (2011). *How's Life? Measuring well-being*. Paris: OECD Publishing.

[44] Statistics New Zealand (2014). *Disability Survey: 2013*. Retrieved from https://www.stats.govt.nz/information-releases/disability-survey-2013

[45] Williams, Eve. (2018). *Institutional Abuse*. Retrieved from https://www.eldernet.co.nz/gazette/institutional-abuse/

[46] Yon, Y., Ramiro-Gonzalez, M., Mikton, C. R., Huber, M., & Sethi, D. (2018). The prevalence of elder abuse in institutional settings: a systematic review and meta-analysis. *European journal of public health*, *29*(1), 58-67.

[47] National Clearinghouse on Abuse in Later Life. *Abuse in Later Life Wheel*. Retrieved from http://www.uwosh.edu/ccdet/caregiver/Documents/Blue/Handouts/barbabuse.pdf

[48] Dong, X., Chen, R., & Simon, M. A. (2014). Elder abuse and dementia: a review of the research and health policy. *Health Affairs*, *33*(4), 642-649.

[49] Malmedal, W., Iversen, M. H., & Kilvik, A. (2015). Sexual abuse of older nursing home residents: A literature review. *Nursing Research and Practice*, *2015*.

[50] Atkinson, K. (2017). *Growing demand for multi-generational living*. Retrieved from https://www.generation.co.nz/whats-happening/growing-demand-for-multi-generational-living