



families commission
kōmihana ā **whānau**

➤ Giving New Zealand families a voice *Te reo o te whānau*

RESEARCH REPORT NO 1/08
JANUARY 2008

elder abuse and neglect

EXPLORATION OF RISK AND PROTECTIVE FACTORS

A REPORT FOR THE FAMILIES COMMISSION

The Families Commission was established under the Families Commission Act 2003 and commenced operations on 1 July 2004. Under the Crown Entities Act 2004, the Commission is designated as an autonomous Crown entity.

Our main role is to act as an advocate for the interests of families generally (rather than individual families).

Our specific functions under the Families Commission Act 2003 are to:

- > encourage and facilitate informed debate about families
- > increase public awareness and promote better understanding of matters affecting families
- > encourage and facilitate the development and provision of government policies that promote and serve the interests of families
- > consider any matter relating to the interests of families referred to us by any Minister of the Crown
- > stimulate and promote research into families, for example by funding and undertaking research
- > consult with, or refer matters to, other official bodies or statutory agencies.

DISCLAIMERS

The views expressed in this report are those of the authors and should not be taken to represent the views or policy of the Families Commission or the Government. Although all reasonable steps have been taken to ensure the accuracy of the information, no responsibility is accepted for the reliance by any person on any information contained in this report.

COMPETING INTERESTS

The authors of this work are not aware of any competing interests that may impact on any aspect of work.

FUNDING

This study was funded by the Families Commission.

ACKNOWLEDGEMENTS

First we would like to thank the Families Commission for the financial support that gave us the opportunity to explore the risk and protective factors in older people.

We especially want to thank Age Concern New Zealand and Elder Abuse and Neglect Prevention Co-ordinators across New Zealand who gave their time and help in supporting the research and assisting the research team in so many ways. A special thanks to Ellice Rains who assisted in the research project.

Finally we wish to acknowledge the older people who so willingly shared their stories and experiences, and the service providers and NGO staff who shared their insights. You did this with dignity and determination in the belief that by telling your story it would raise public awareness and protect older people in the future from the perils of abuse and neglect. Thanks to all of you.

Families Commission
Public Trust Building
Level 6, 117-125 Lambton Quay
PO Box 2839
Wellington 6140

Telephone: 04 917 7040
Email: enquiries@nzfamilies.org.nz
www.nzfamilies.org.nz

Giving New Zealand families a voice *Te reo o te whānau*

ISSN 1177-3545 (Print)
ISSN 1178-1289 (Online)
ISBN 978-0-478-32804-2 (Print)
ISBN 978-0-478-32805-9 (Online)

elder abuse and neglect

EXPLORATION OF RISK AND PROTECTIVE FACTORS

A REPORT FOR THE FAMILIES COMMISSION

KATHRYN PERI, DR JANET FANSLow, DR JENNIFER HAND
JOHN PARSONS, SCHOOL OF NURSING, UNIVERSITY OF AUCKLAND
AUCKLAND UNISERVICES LIMITED, A WHOLLY OWNED COMPANY OF
THE UNIVERSITY OF AUCKLAND

CONTENTS

Preface 5

Executive summary 7

Aims and objectives 7

Methods 7

Results 8

1. Introduction 11

1.1 Project aims 12

1.2 Policy context 12

1.3 Defining elder abuse and neglect 13

1.4 Risk factors for elder abuse and neglect 13

1.5 Cultural context of elder abuse and neglect 15

1.6 Protective factors 15

1.7 Family context of elder abuse and neglect 15

1.8 Institutional abuse and neglect 16

1.9 Influencing societal factors 16

2. Methods 17

2.1 Research aims and objectives 18

2.2 Study design 18

2.3 Data collection 22

2.4 Data analysis 23

2.5 Ethics 24

3. Results 25

3.1 Introduction 26

3.2 Characteristics of informants who had been abused or neglected 26

3.3 Results from interviews and focus groups 30

3.4 Cultural contexts of elder abuse and neglect 53

3.5 ASPIRE database 57

4. Discussion 61

4.1 Introduction 62

4.2 Ecological levels for risk and protective factors for elder abuse and neglect 64

4.3 Limitations 66

4.4 Concluding comments 66

4.5 Recommendations 67

5. References 69

LIST OF TABLES

- Table 1:** Data collection from multiple sources by type and number 22
- Table 2:** Older people informants: Victims of elder abuse and neglect by type, relationship to victim and circumstances 27
- Table 3:** Risk and protective factors for elder abuse and neglect at an individual level 30
- Table 4:** Risk and protective factors for elder abuse and neglect at a family level 35
- Table 5:** Risk and protective factors for elder abuse and neglect at an institutional level 39
- Table 6:** Risk and protective factors for elder abuse and neglect at a community level 46
- Table 7:** Risk and protective factors for elder abuse and neglect at a society level 49
- Table 8:** Characteristics of the older people who triggered elder abuse clinical assessment protocols in ASPIRE study 58
- Table 9:** Characteristics of informal caregivers in a sample of older people who triggered elder abuse clinical assessment protocols in ASPIRE study 60

LIST OF FIGURES

- Figure 1:** Risk factors for elder abuse and neglect (Krug et al, 2002) 14
- Figure 2:** Ecological framework for violence prevention (Krug et al, 2002) 18
- Figure 3:** Sampling framework for risk and protective factors 19
- Figure 4:** Risk factors for elder abuse and neglect categorised in an ecological framework 64
- Figure 5:** Protective factors for elder abuse and neglect categorised in an ecological framework 65

PREFACE

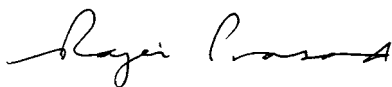
New Zealanders are increasingly concerned by the levels of violence in our society and in our families. The Commission is committed to reducing this violence and is a leader in the national, long term campaign to change the way New Zealanders think and act about family violence.

Our conversations with families and those who work with them have highlighted concerns about elder abuse and neglect. There has been limited research on this issue in New Zealand and the Commission is taking a systematic approach to finding out more about the experiences of older people.

This report is the first study to gather the views of a wide range of different organisations, individuals and experts on how and why elder abuse and neglect occurs and what can be done to prevent it.

In many cases, the abuse is carried out by someone the older person has loved and trusted, and cared for all their lives. As with other family violence the behaviour includes psychological, physical, sexual and emotional abuse as well as financial betrayal. This study reports on the risk and protective factors for elder abuse and neglect. Figures 4 and 5 (pages 64 and 65) provide a summary of these factors which could be useful to individuals, organisations and institutions who are providing services and support to older people.

I am grateful for the honesty and openness of the older people spoken to during this study. They have helped arm those who are designing or providing services and support for the elderly, with a better understanding of how to prevent elder abuse and neglect. The findings will also help the Commission and others to raise awareness of the value of older people and the need for information and resources that empower people to speak out and seek help and support. The report also draws attention to the need for better funding for services that respond to elder abuse and neglect.



Rajen Prasad
Chief Commissioner



Aucklander Betty Messent is one of more than a dozen people who have lent their faces to the Campaign for Action on Family Violence. Her appearance in the television advertisement draws attention to the issue of elder abuse.

EXECUTIVE SUMMARY

“All families and whānau should have healthy, respected, stable relationships, free from violence.” (The Taskforce for Action on Violence within Families, 2006).

The first report of the Taskforce for Action on Violence within Families (The Taskforce for Action on Violence within Families, 2006) endorsed the Families Commission’s three-year research work programme to improve our understanding of family violence and strategies for preventing it, which included work on elder abuse. The results of this project will provide the Families Commission with information towards the development of prevention initiatives. A highlight of this work is first-hand accounts from older people who have been abused or neglected.

Improving our understanding of the risk and protective factors for elder abuse and neglect will help predict situations where abuse or neglect is likely to occur in New Zealand. It will also increase our understanding of factors that build resilience or ameliorate situations that may otherwise result in abuse or neglect.

AIMS AND OBJECTIVES

The objectives of this project were to ascertain what factors may increase the risk of abuse or neglect and protective factors that may prevent abuse or neglect from occurring or recurring.

METHODS

Qualitative methods were used to capture data about elder abuse and neglect from a range of stakeholders. The sampling frame was designed to ensure that a wide range of expertise and knowledge was accessed. The sample consisted of:

- > older people, some of whom had experienced elder abuse, health professionals and representatives of non-governmental organisations and other providers of services for older people
- > representatives from various ethnic groups
- > representatives from multiple regions.

Data were collected through face-to-face, focus group and telephone interviews. Interview guides were developed after consultation and reviewing the literature. The interview guide was designed to collect data from all ecological levels, from the individual to the societal. Data analysis took a generally inductive approach.

RESULTS

The results are based on the perspectives of the informants in the study, and they identified the risk and protective factors discussed.

Individual level

Isolation and the increasing physical (and sometimes mental) challenges associated with ageing emerged as individual-level risk factors for elder abuse and neglect. They were compounded in people who had experienced other adverse events such as other forms of abuse and poverty.

Family level

Supportive families were recognised as protective against all types of elder abuse and neglect. Threats to families' ability to be supportive were varied, from longstanding abuse within families, to overburdened or greedy family members. Each of these strands is likely to require different prevention strategies, some of which are already being used (such as initiatives addressing child abuse, partner violence or caregivers' stress).

Institutional level

Risk factors in residential care settings concerned staffing issues, which were closely linked with training, funding, staff-to-resident ratios and organisational culture. Informants suggested that high numbers of well trained and well paid staff was a protective factor ensuring high-quality care.

It was also noted that various institutions other than care facilities play important roles in protecting older people from abuse and neglect. Some of the suggested prevention strategies involved banks, lawyers, churches and faith communities and police.



Community level

Many of the factors identified by informants at this level indicated the necessity of social connectedness, which was regarded as a protective factor. Multiple factors were seen as contributing to it, including accessible public transport, community facilities and housing policy. The availability of services was a particular issue in rural communities.

Societal level

Strong themes emerged about the undervaluing of older people in society as a whole. This was linked to the perceived 'lack of productivity' associated with people who are no longer in paid employment. Informants in this study overwhelmingly endorsed the need to promote more positive images of older people, and develop a culture of respect that valued the unique contribution of older people.

High-level societal issues such as the cost of living and unavailability of care were seen to contribute to pressures on families, creating environments where elder abuse and neglect are more likely to occur. In particular, pressures on adult family members to take paid employment limit the opportunities for families to provide care for their older members.

Beliefs about love and respect within families are challenged by other ideologies about families and individuals. For example, ideas about the intergenerational transfer of wealth may contribute to elder abuse and neglect into the form of financial abuse; and ideologies about family loyalty and personal independence contribute to the silence about abuse.

Cultural level

Māori perspectives on elder abuse in New Zealand were described in terms of the stresses and pressures of life on the whānau. The problem was most likely to be framed as being unloved, or lack of aroha, which was seen as putting the whole whānau at risk. Urbanisation was also considered to have played a role in the fragmentation of Māori values, by disrupting links to tribal lands and cultural norms. This was also thought to contribute to isolation.

Cultural diversity notwithstanding, common factors contributing to abuse and similar solutions emerged across Pacific, Indian, Chinese and mainstream communities. Someone from a Pacific community remarked, "abuse is a human thing, not an ethnic thing. When we are kind and loving we are all the same. The abuse issue is the negative aspect of being human."



1. INTRODUCTION

1.1 PROJECT AIMS

This report has been produced in response to a Request for Proposal from the Families Commission. Its overall goal is to help determine the risk and protective factors for elder abuse and neglect in New Zealand.

This project sought to improve our understanding of these risk and protective factors in New Zealand. It also sought to increase our understanding of factors that build resilience or ameliorate stressful situations that might otherwise result in abuse and neglect. With these aims in mind, the project explored elder abuse and neglect from the perspectives of the older person, service providers and co-ordinators of governmental and non-governmental organisations.

A certain amount is known about risk factors for elder abuse and neglect in other countries. This study contributes to this international pool of knowledge, and allows the findings of these international studies to be applied to the New Zealand context. The multifaceted approach of the study involved a comprehensive exploration of the contemporary issues regarding elder abuse and neglect in New Zealand.

Improving our understanding of the risk and protective factors for elder abuse and neglect will allow better prediction of situations where abuse or neglect are likely. If the factors identified in this study are supported by quantitative data, it is expected that the research findings could contribute to both prevention initiatives and intervention services, such as education and information for the public to reduce ageism, and for older people about their rights and sources of support; and the development of screening tools for services involved in addressing elder abuse and neglect.

1.2 POLICY CONTEXT

The Families Commission was established on 1 June 2004 by the Families Commission Act 2003, as an independent advocate for the interests of families generally (as distinct from the interests of individual families, or of individuals who are also family members). One of the Commission's strategic goals for 2006/07 to 2008/09 is to ensure that "Significant progress has been made towards preventing family violence". An objective towards this goal is that in 2006/07 the Commission will improve the understanding of the nature of elder abuse and neglect and of appropriate and effective prevention strategies.

The taskforce for action on violence within families

The Taskforce's first report (July 2006) (The Taskforce for Action on Violence¹ within Families, 2006) endorsed the Families Commission's work programme to improve understanding of family violence and its prevention. From July 2006 to June 2007 this included work on elder abuse prevention. The outcomes from this research will provide the Families Commission with a platform to initiate steps towards changing attitudes and behaviours towards elder abuse and neglect in New Zealand at the community and societal levels.

¹ The Taskforce for Action on Violence was established in June 2005 to advise the Family Violence Ministerial team on how to make improvements to the way family violence is addressed, and how to eliminate family violence in New Zealand. The taskforce is a significant commitment by government and non-government sectors, independent Crown entities and the judiciary, to work together and provide leadership to end family violence and promote stable, healthy families.

1.3 DEFINING ELDER ABUSE AND NEGLECT

The literature reveals that defining elder abuse and neglect is problematic and definitions vary internationally. The variation reflects differences in theories about the nature and causes of abuse of older people (Lachs & Pillmer, 2004).

For the purposes of this research project the definition used by New Zealand Age Concern Elder Abuse and Prevention Services was adopted. Age Concern New Zealand (Age Concern New Zealand Inc, 2005) says that elder abuse and neglect is usually committed by a person known to the victim and with whom they have a relationship implying trust. A person who abuses an older person usually has some sort of control or influence over him/her. Family members, friends, staff in residential facilities or anyone the older person relies on for basic needs, may be abusers. According to Age Concern New Zealand, four main types of elder abuse occur:

- > Physical abuse: the abuser may inflict physical pain or injury or use force on a victim.
- > Psychological/emotional abuse: behaviours by the abuser which cause the victim anguish, stress or fear.
- > Financial abuse: such as the illegal or improper exploitation and use of funds or other resources.
- > Sexual abuse: such as threats, forced engagement in sexual activity or exploitation of the inability to consent to sexual activity.

This definition is widely accepted and used in New Zealand. It was ratified at the National Strategic Research Planning day in 2006 as the agreed definition of elder abuse and neglect (Age Concern New Zealand Inc, 2006).

The interpretation of neglect is as problematic as that of abuse. Neglect has been shown to be the most common form of mistreatment of older people. In New Zealand, neglect is generally defined as a result of another person failing to meet the physical and emotional needs of an older person. Neglect is often further classified as passive or active. Passive neglect is the result of the carers' inadequate knowledge, illness or lack of trust in prescribed services. Active neglect is the conscious and intentional deprivation of an older person of care (Age Concern New Zealand Inc, 2005).

1.4 RISK FACTORS FOR ELDER ABUSE AND NEGLECT

In the last decade a few epidemiological studies have been done on risk factors for elder abuse and neglect, using case-control studies or longitudinal designs. However, Fanslow (2005) comments that the etiological data in these studies is "scant", and they are limited by their small scale, application to limited settings and the limited scope (p. 61). Caution is also advised because research in this area is at an early stage.

Some empirical studies indicate that a shared living situation is a major risk factor for elder abuse, and that people living alone are at lowest risk. An exception appears to be financial abuse, where the risk appears to increase for older people who live alone. The evidence from a Canadian survey clearly showed this kind of abuse as a discrete category (Choi, Kulick et al, 1999). Several studies have indicated higher rates of physical abuse of older people who have a diagnosis of dementia (Lachs, Williams et al, 1997; Paveza, Cohen et al, 1992). The prolonged disruptive and aggressive behaviour of a demented older person appears to be the catalyst for carers becoming increasingly stressed and distressed, which can contribute to abusive reactions.

Social isolation from family and friends (apart from the person they may be living with) heightens the potential for abuse, particularly when family stress is present. Such isolation renders the older person extremely vulnerable and can serve to conceal the abuse (Compton, Flanagan, et al, 1997; Pillemer & Suitor, 1992).

The most common factors associated with perpetration of abuse are the presence of mental illness and the misuse of alcohol (Homer & Gilleard, 1990). Depression also appears to be frequent among abusers, as is dependency by the perpetrator on the victim (Dyer, Pavlik et al, 2002).

There is conflicting evidence on the importance of the victim's health and functional status as a risk factor. Case comparison studies have generally failed to find functional impairment to be a risk factor for abuse by carers (Cooney & Mortimer, 1995; Wolf & Pillmer, 1989). From the literature, Fanslow (2005) identified a number of risk factors associated with elder abuse and noted that they represent some of the possible associations, but further exploration is needed into the relative strength of these factors, the presence of other factors and the ways in which they interact. To date, little empirical research has been carried out in New Zealand or elsewhere to determine social-level risk factors.

FIGURE 1: RISK FACTORS FOR ELDER ABUSE AND NEGLECT (KRUG ET AL, 2002)



1.5 CULTURAL CONTEXT OF ELDER ABUSE AND NEGLECT

To date, in New Zealand and internationally, there has not been sufficient epidemiological data collected on the topic to determine whether there are cultural or ethnic differences in the prevalence of elder abuse and neglect.

1.6 PROTECTIVE FACTORS

The idea of protection or resilience conjures up images of extraordinary feats in overcoming adversity. Traits such as hardiness, competence and ego resilience have been associated with people who have this capacity to withstand stress without permanent damage (Glantz & Johnson, 1999).

The protective factors described in the literature are diverse, but Garmezy (1985) distinguishes three core variables for people in stressful situations. The first is a combination of temperament and personality attributes such as activity level when confronted with new situations. The second factor is families who are caring, cohesive and warm. The third factor is the availability of social support. A recent study by Brozowski and Hall (2003) using data from the 1999 Canadian General Social Survey found that older people who had regular contact with their own adult children significantly reduced the risk of being abused.

1.7 FAMILY CONTEXT OF ELDER ABUSE AND NEGLECT

Data from Age Concern New Zealand, which provides services for preventing elder abuse and neglect in New Zealand, reported that of their clients who were abused in the context of family care, 38 percent of the abusers were living with the client, 24 percent in the role of primary caregiver (Age Concern New Zealand Inc, 2005).

There is concern that elder abuse in family units may be increasing. This concern is being raised because of the increasingly ageing population, and the increasing proportion of older people with chronic disabling conditions. Certain societal and policy trends such as 'ageing in place' initiatives will require more involvement by families in providing care. Changing demographics regarding life-span have both positive and negative effects on intergenerational relationships.

In this category of family violence, financial abuse may be a key component or motivating factor associated with the abuse (Hand, Elizabeth et al, 2002). While financial abuse is part of the spectrum of violence associated with intimate partner violence in broader conceptual models (such as The Power and Control Wheel) it is usually included in the definition of elder abuse and neglect.

Pillemer and Finkelhor note that the dynamics between spouses are different from those that involve adult children (Pillemer & Finkelhor, 1989). They therefore argue that "it is reasonable to assume that the factors precipitating marital violence among the elderly will differ, at least in part, from those precipitating adult children's abuse of their elderly parents" (p. 182).

1.8 INSTITUTIONAL ABUSE AND NEGLECT

Definitions of elder abuse can also encompass abuse by caregivers who do not have family relationships with the victim (eg, abuse in residential care settings).

It is virtually impossible to estimate neglect in residential care in the absence of National Standards of Care. Studies that explore quality of care may go some way to determining the scale of the problem. Such neglect can include medication errors, high use psychotropic drugs, poor management of challenging behaviours, of residents with dementia and poorer functional outcomes (Decalmer & Glendenning, 1993).

1.9 INFLUENCING SOCIETAL FACTORS

Societal influences that increase the risk of abuse are primarily embedded in what is commonly termed *ageism*. The term was coined in 1969 by Robert Butler, the first director of the National Institute on Aging, University of California, Berkeley. He likened it to other forms of prejudice such as racism and sexism, defining it as a process of systematic stereotyping and discrimination against people because they are old (Palmore, 1990). He noted that stereotypes are made up, seldom with any real basis in fact. Stereotypes allow little room for individual variation, and negative stereotypes receive more publicity than the more favourable characteristics associated with the same groups of people. Societal expectations of older adults suggest that they are 'lesser beings', asexual, intellectually inflexible and at the same time forgetful and unproductive.

Ageist attitudes are perpetuated in many ways: for example, in the media, images of older people are often negative, and colloquialisms referring to older people unfavourably are common. Ageism has consequences, including inadequate services for older people, the violation of their legal and financial rights and negative effects on their mental health.



2. METHODS

2.1 RESEARCH AIMS AND OBJECTIVES

This exploratory qualitative study addressed the following:

- > Factors that may increase the risk of abuse or neglect occurring.
- > Protective factors that may have prevented abuse or neglect from occurring or recurring.

2.2 STUDY DESIGN

The study was designed to enable identification of a wide range of potential risk and protective factors associated with elder abuse and neglect in New Zealand. The applied Ecological Framework (Krug et al, 2002) (Figure 2) was used as a guide. It is a commonly used framework for conceptualising, identifying and addressing issues of violence. The framework allows the relationship between individual and contextual factors to be represented and explored, and treats violence as the product of multiple influences. It is a useful framework for examining elder abuse and neglect and for organising policy discussions (Fanslow, 2005).

FIGURE 2: ECOLOGICAL FRAMEWORK FOR VIOLENCE PREVENTION (KRUG ET AL, 2002)

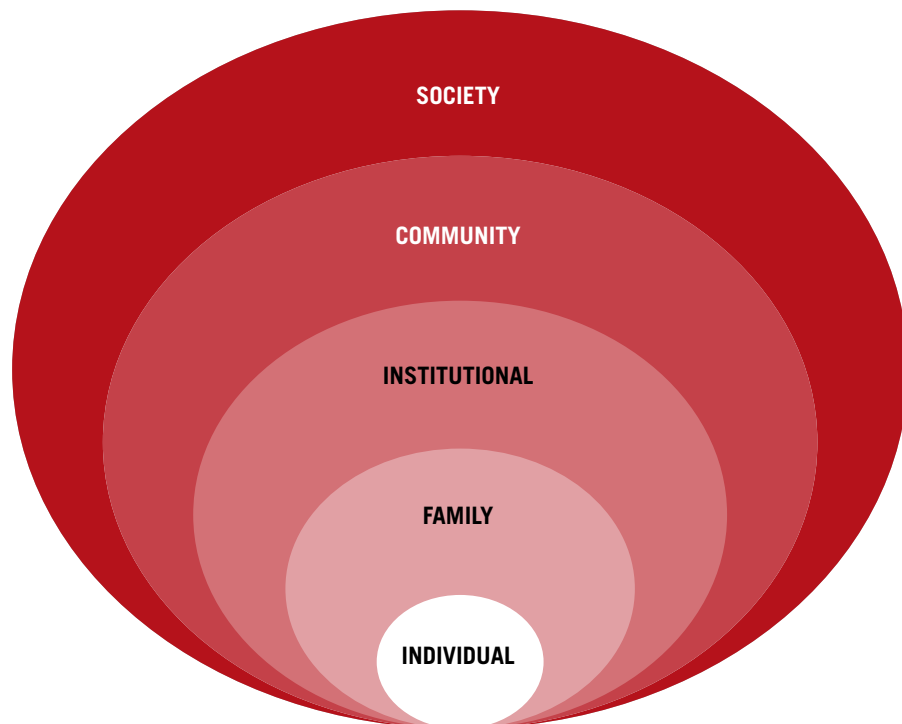
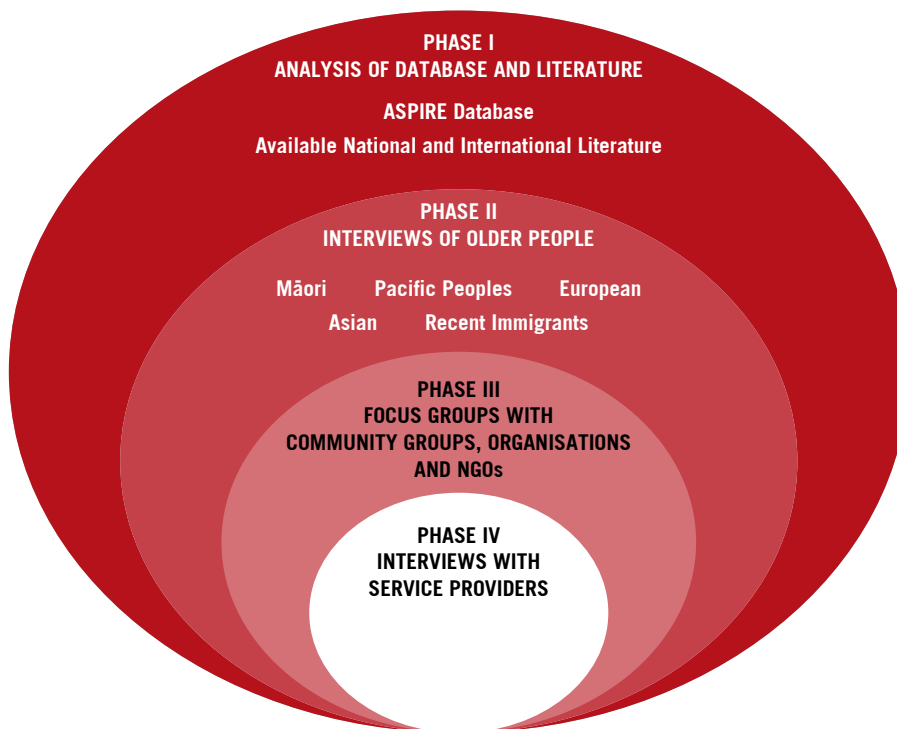


FIGURE 3: SAMPLING FRAMEWORK FOR RISK AND PROTECTIVE FACTORS



A broad sampling framework was developed in order to gather input from diverse individuals and groups. In particular, we sought to ensure that our sample included representatives of a wide range of ethnic groups, from different geographic regions and diverse perspectives (for example, those of older people who had experienced abuse, and of service providers). Each component of the sampling frame is described in detail below.

Participants were sought who were over the age of 65, included Māori, Pacific, Asian and European ethnicities and resided in different locations (rural areas, provincial towns and large centres).

The following groups were sampled:

- > Older people who had been abused and/or neglected, some living in the community, others in residential care.
- > Older people who had not been abused or neglected. All of them lived in the community.
- > Non-Government Organisation (NGO) and government service providers. This group comprised representatives from the Mental Health Foundation, the Stroke Foundation, Victim Support, the Auckland City Mission, the Alzheimer's Society, the Police and Home Support services.
- > District Health Board (DHB) service providers. This group included health professionals from the following groups: needs assessment service co-ordinators, social workers, gerontology nurse specialists, registered nurses and nurse managers residential care.
- > Representatives from ethnic-specific NGO service providers such as Asian Services of the Problem Gambling Foundation of New Zealand, TOA Pacific Inc, Shanti Niwas Charitable Trust and Te Oranga Kaumatua Kuia Disability Support Services.
- > Three individual Māori informants, one Pacific Indian and one Chinese.

Phase I: Analysis of database and literature

The literature search examined most up-to-date understandings of risk and protective factors associated with elder abuse and neglect, internationally and nationally. This information helped in developing the interview schedules.

Databases searched

Ageline, Australian Domestic and Family Violence Clearinghouse, Embase, IPLit (IPRC), Medline, New Zealand Family Violence Clearinghouse (and the Agenda for Family Violence Research bibliography), Psychinfo and SafetyLit.

Search strategy

Search strategy terms for Embase, Medline and Psychinfo included: elder abuse, neglect, aged, elderly, older people, elder care risk factor, protective factor.

Inclusion criteria

The references were selected for their relevance to the topic on the basis of the abstract provided. Original research and a limited number of review articles were included.

Ethnic and other minority groups

A number of articles considered factors associated with elder abuse in specific ethnic communities and, in at least one case, in relation to migrant status. One paper about Native Americans was included. The literature search confirmed the paucity of research on this issue among the Māori and Pacific communities in New Zealand.



ASPIRE database

ASPIRE (Assessment of Services Promoting Independence and Recovery in Elders) is a prospective meta-analysis of randomised controlled-trial evaluations of three ageing-in-place initiatives: Coordination of Services for Elderly (COSE) in Christchurch; the Promoting Independence Programme (PIP) in Lower Hutt; and Community FIRST (Flexible Integrated Restorative Support Team) in Hamilton. The study was undertaken by the University of Auckland under contract to the Ministry of Health. In 2004 and 2005 across the three sites, 569 older people living at home who were assessed as having high or very high needs (or as candidates for residential home placement) were recruited to the study, and followed up for two years. Most of them indicated that they had an informal caregiver, of whom 50 percent were their spouses.

The ASPIRE study utilised the MDS–HC, a comprehensive assessment tool for older people, and a number of other scales to assess the quality of life and sense of burden felt by the caregiver. The MDS–HC comprises two elements. The first is an assessment component where multiple domains of function, health, social support and service use are measured. Selected subsets of MDS–HC items provide a standardised mechanism to identify individuals who could benefit from further evaluation of specific problems or for risk of functional decline. These ‘trigger’ items led to the second component of the RAI–HC, the Clinical Assessment Protocols (CAPs), which provide general guidelines for further assessment and individual care planning. One of the CAPs in the tool is for elder abuse and neglect. The triggers that might suggest abuse or neglect or a significant risk of abuse requiring further investigation are fear of a family member or carer; unexplained injuries, broken bones, burns, neglect, abuse or mistreatment; and being physically restrained.

For the purposes of this study, the ASPIRE provides valuable information, but is limited to the older people themselves and their nominated informal caregivers. Most but not all elder abuse is instigated by an informal caregiver, but this exclusive focus is nevertheless a limitation of the ASPIRE study. However, the ASPIRE study randomly recruited 569 of the most ‘at-risk’ older people and therefore the simple descriptive work around the reported incidence is particularly valuable.

2.3 DATA COLLECTION

Qualitative methods and multiple data sources were used to glean data about the risk and protective factors for elder abuse and neglect.

Table 1 shows the categories of participants and types of data collection strategies used and numbers of semi-structured and telephone interviews and focus groups. The next sections in the report outline the recruitment and data collection techniques employed for each category of informant.

TABLE 1: DATA COLLECTION FROM MULTIPLE SOURCES BY TYPE AND NUMBER			
	SEMI-STRUCTURED INTERVIEW	FOCUS GROUPS	TELEPHONE INTERVIEWS
Older person abused	15		
Older person non-abused		2 (n=22)	
NGO		4	2
DHB		2	
Ethnic groups Māori, Pacific Indian and Chinese	3	1 (n=5)	

Phase II: Interviews with older people

Hearing from older people who had experienced abuse and/or neglect was a central purpose of the study, and has been attempted in few other studies. A two-stage recruitment procedure was used to contact and interview these people in a way that minimised the risk of re-traumatising them. Elder Abuse and Neglect Prevention Services (EANP) was invited to participate, and asked to make the first invitation to potential participants who were now in safe situations.

Twenty-two EANP Services from around New Zealand were invited to participate in the study. Eight declined, citing a lack of suitable clients as their main reason. From the remaining 14 services, eight EANP service co-ordinators agreed to help recruit older people who had experienced abuse or neglect.

Potential older informants were chosen and initially approached by the elder abuse co-ordinator to ascertain their interest in participating in the study. Of 25 older people approached across New Zealand, 15 agreed to be interviewed by a member of the research team.

People over the age of 65, who were known to have been victims of abuse or neglect and were living in community dwellings or residential care facilities, were included in the study.

People were excluded if they were unable to give informed consent, or acutely unwell. Abused older people were also excluded if they were in vulnerable positions, or still considered active cases by elder abuse care co-ordinators.

Older informants were offered face-to-face interviews in their homes at times convenient to them. The informants were put at ease, the interview process was explained and written informed consent obtained. Interviews included discussions about their experiences as victims of abuse and/or neglect, and were largely directed by the informants. Interviews explored the abusive situation, the relationship with the abuser

and the physical and emotional impact of the abusive situation. The informants' view on strengths and coping strategies was also assessed, as was the effectiveness of service agencies who had worked with the older person and perpetrator. Prevailing attitudes in communities in general were also discussed. Prompts were used to expand on important areas, and cues were followed so that underlying issues could be explored. Interviews lasted between 60 and 90 minutes. They were audiotaped, and notes were taken during the conversations.

Phase III: Focus groups with older people who had not experienced abuse

Informants who attended social activity groups run by Age Concern in Wellington and by TOA Pacific (a service provided for older Pacific People) in South Auckland were invited to participate in a focus group. These were older people who had not experienced abuse. A total of 22 people participated in the focus groups.

Informants gathered at a site in their community. Informed consent was obtained before the interviews commenced. A facilitated discussion, based on the discussion guide, was led by experienced facilitators, assisted by note-takers. Focus groups were audiotaped and notes were taken.

Phase IV: Interviews with service providers, community groups and NGOs

Focus groups were conducted with DHB staff members in the North Island and South Island. The DHB focus group informants were from a range of health professions and roles and included gerontology nurse specialists, social workers, registered nurses, needs assessment service co-ordinators (NASC), Māori NASC and mental health professionals.

Four focus groups were held with NGO groups and service agencies, two in the North Island and two in the South Island. The informants were from a range of organisations and held a range of roles including: Mental Health Foundation, Stroke Foundation, Victim Support, Auckland City Mission, Alzheimer's Society, Police, and Home Support services. There were also representatives from other organisations that provide care and support services to older people.

2.4 DATA ANALYSIS

Qualitative research works in a natural setting to understand specific behaviours and their subtle variations, and uses categories to describe and analyse social phenomena (Creswell, 2003). The qualitative data were prepared in a standard Word/rtf format for importing into Excel. A generally inductive approach was employed to analyse the qualitative data to identify dominant and significant categories and themes in the text data (Thomas, 2006). The trustworthiness and reliability of the analysis was assessed by an independent researcher, who re-coded sections of the text to ensure consistency. The emergent themes were checked by cultural key informants to ensure the themes were understood and were consistent with the reported perspectives and experiences of those interviewed.

ASPIRE data analysis

Procedures of the statistical analysis system SAS (SAS Institute Inc, Cary NC) were used for the subgroup analysis. The ASPIRE data analysis was undertaken by the Clinical Trials Research Unit, School of Population Health, University of Auckland.

The demographic characteristics of participant-triggered MDS–HC abuse items were summarised and descriptive summary statistics were reported. Frequency tables, percentages and the summary statistics (mean, median, standard deviation, minimum and maximum) were provided for discrete and continuous variables respectively.

2.5 ETHICS

Ethics approval was sought and received from the University of Auckland Ethics Committee in March 2007 (Ref 2007/042) to conduct interviews and focus groups with NGOs and personnel.

Ethics approval was sought and received from the Multi-Region Ethics Committee in May 2007 (Ref MEC/07/04/056) to conduct interviews and focus groups with older informants and DHB service providers.

All the older people and health and service agency staff who agreed to take part in the study gave written informed consent.

All the interviewers were experienced in qualitative interviewing and received a comprehensive briefing about elder abuse and neglect. This was essential to ensure that if any adverse effects became apparent during the interview, victims were provided with appropriate support. The method of recruitment also allowed close monitoring and any necessary support to be delivered by the elder abuse co-ordinator.



3. RESULTS

3.1 INTRODUCTION

This chapter explores the results obtained from the various data sources. The first section illustrates the results obtained from interviews with older people who had experienced abuse. It also covers data from focus groups conducted with older people who had not been abused, NGOs and DHB staff and key informant interviews. This is followed by an exploration of risk and protective factors for elder abuse from different cultural perspectives. Finally, data obtained from 'at-risk' older people and their informal caregivers obtained from the ASPIRE database are examined.

3.2 CHARACTERISTICS OF INFORMANTS WHO HAD BEEN ABUSED OR NEGLECTED

Table 2 provides information about the 15 older people interviewed who had experienced abuse. All the 12 females and three males identified as being of European descent. Their ages ranged between 76 and 95; the mean age was 83 years. Four of them were psychologically abused, three claimed to be financially abused, three claimed to be both financially and psychologically abused and two said they were both psychologically and physically abused. It is not uncommon for several types of abuse to be present simultaneously. Data from Age Concern New Zealand found this commonality with its sample of 2,000 reported cases of elder abuse and neglect over a five-year period.

Two participants residing in residential care were identified as being institutionally neglected, and neglect was identified by one community-dwelling participant and another suffered neglect and psychological abuse. The majority of the victims experienced some adverse effects to their mental or physical wellbeing, the most common complaints being insomnia and depression. Table 2 illustrates characteristics of the abused older people who were interviewed for this study in detail. In the sample, the perpetrators were predominantly immediate family members (n=11) and included sons, daughters and extended family members including a niece and a son-in-law. Four of the perpetrators were not related to the victim: two landlords, one boarder and one tradesman.

These results should be interpreted with caution as our access to the victims of abuse and neglect was highly selected, in that the elder abuse co-ordinators chose the potential clients from closed cases. This raises the issue of selection bias. Co-ordinators of EANP services selected potential victims and approached them initially. However, the types of abuse reported by the victims interviewed and their relationships with the perpetrators were consistent with the types of abuse reported nationally and internationally.

TABLE 2: OLDER PEOPLE INFORMANTS: VICTIMS OF ELDER ABUSE AND NEGLECT BY TYPE, RELATIONSHIP TO VICTIM AND CIRCUMSTANCES

GENDER	AGE	TYPE OF ABUSE	RELATIONSHIP OF PERPETRATOR	CIRCUMSTANCES
Female	80	Financial	Non-family	Preying tradesman
Female	83	Psychological	Non-family	Landlord attempted to evict victim
Female	80	Psychological/physical	Son	Unemployed son using drugs and alcohol living with victim
Male	85	Financial/psychological	1 son and 1 daughter	Property ownership dispute. Activated EPOA against victim's wishes following an illness
Female	76	Psychological	Non-family	Boarder with drugs and alcohol abuse refused to leave premises
Female	81	Financial	Niece	Niece disposed of victim's personal possessions and property, activated EPOA, stole money from victim's bank account
Female	86	Institutional neglect	Staff	Staff neglecting to attend to victim's needs
Male	95	Financial/psychological/physical	Son	Living with victim, unemployed alcohol and drug abuse. Activated EPOA, sold house. Physically abused victim
Female	86	Psychological	Non-family	Landlord attempted to evict victim
Female	80	Institutional neglect	Staff	Staff neglected to attend to victim's needs
Female	82	Psychological/neglect	Son	Son verbally abused victim as a consequence of caregiver burnout
Male	78	Financial/psychological	Daughter and son-in-law	Victim took in daughter and son-in-law, eventually victim evicted out of his own house
Female	79	Psychological/physical	Son	Victim periodically housed son who abused alcohol and drug use. The victim's tenancy was revoked regularly due to son's behaviour requiring re-housing
Female	84	Financial	Daughter-in-law	Undertook regular grocery shopping, banking for victim but also used victim's money to buy own groceries and stole money from victim's account
Female	90	Neglect	Daughter	Refused to let victim go to local daycare centre

To provide a voice for the older people in this study, three vignettes have been created. They represent an amalgam of the characteristics of the participants who experienced abuse or neglect. The intention is to protect the confidentiality of the cases.

Vignette one

Mr R, an 80-year-old widower living on his own, a victim of financial and psychological abuse having been stripped of his assets and most of his income by appointed trustees with an enduring power of attorney.

Mr R had been a hard-working person, leaving school at an early age to work in the family business. The business became extremely successful and over the years Mr R accumulated considerable wealth and property. On the advice of his lawyer several years ago he set up an enduring power of attorney, appointing his eldest son and youngest daughter as trustees.

After his retirement Mr R maintained an active interest in business and family affairs. He often helped his adult children with DIY projects, minded the grandchildren, and in general felt part of a loving family who enjoyed getting together for family occasions such as special birthdays and weddings.

Last year, as a result of a stroke, Mr R was admitted to hospital for a period of rehabilitation. The stroke affected his speech and swallowing, making it difficult for him to talk and necessitating his being tube fed for several weeks. While he was in hospital his eldest son and youngest daughter visited Mr R, demanding that he sign several documents stating that financially he was on the verge of bankruptcy. At the time he felt powerless and had little energy to dispute the claim, and felt compelled to sign the documents. He made a full recovery and returned home.

About three weeks following his return home he began to question family members about the apparent 'risk' of bankruptcy, but they paid little regard to his questions. He eventually sought legal advice and discovered that his properties (which subsequently have been sold) and a considerable amount of income had been signed over to his two appointed trustees with no apparent evidence of pending bankruptcy. On discovering this fraudulent behaviour, Mr R sought advice from the local Elder Abuse Prevention Service, changed lawyers and took legal action to revoke the power of attorney from his daughter and son. Attempts by Mr R to contact his family to discuss the situation have been met with hurtful comments such as "You silly old coot, you have lost your marbles, you don't know what you are talking about any more." His family has little or no contact with Mr R and he is no longer invited to family gatherings and received no birthday cards despite recently celebrating his 80th birthday.

The impact of the financial and psychological abuse at the hands of his family has affected his physical and mental wellbeing. He no longer sleeps or eats well, spends a considerable amount of time trying to figure out how the family gained control of his assets, and how he can punish his family for the harm they have caused him. Mr R describes feeling sad, lonely, angry and confused about the way his family has treated him.

Vignette two

Mrs H is a 76-year-old woman, a victim of physical and psychological abuse. She lived for 20 years in a domestic violence situation perpetrated by her husband. Her daughter was also the victim of verbal and physical abuse at the hands of the father. The husband died suddenly, and while Mrs H and other family members went away on holiday, the son sold the family home, claiming that the father had left the property in his name. Mrs H had had little experience in legal and financial matters during her marriage and was encouraged by her lawyer to sign papers to give up her home.

During this time her son began abusing Mrs H by removing her personal possessions from the home, deliberately running over her garden and getting rid of her gardening tools, and preventing her from using the common driveway and insisting that she park her car on the road, despite her being in severe hip pain awaiting hip surgery. The son constantly niggled at her and refused to allow her to eat with the family until eventually she was kicked out of her house.

She initially resorted to going to the Salvation Army for help as she was ashamed of her son's behaviour and blamed herself for the situation she had found herself in. Extended family members became aware of the situation and sought advice from the Elder Abuse and Neglect Prevention Services. Mrs H has agreed to legal intervention to prosecute her son for dishonesty and deceit.

Vignette three

Mrs M is a 70-year-old woman, a victim of psychological abuse. She has lived alone in her two-bedroom unit for a number of years. She describes herself as fiercely independent, and has volunteered to work for community organisations, which has given her much pleasure. Her son, in his early forties, returned from living overseas a year ago and moved in with his mother. He has a past history of alcohol and drug abuse of which Mrs M was unaware at the time. Over a period of months the son, under the influence of drugs and alcohol, verbally abused and threatened his mother, causing her psychological suffering and fear. She seldom goes out now and no longer volunteers to work in the community agencies.

The case came to light when Mrs M called the police one night requesting assistance, fearful for her life as her son had punched her and broken up furniture. A trespass order was served on the son, but three days later she allowed the son to return to live with her because she felt sorry for him and he had no place to stay. This pattern was repeated on several occasions. Initially the local community constable and victim support officer offered counselling and advice and notified the Elder Abuse and Neglect Service. A group conference involving a social worker, police, victim support and an elder abuse co-ordinator was held and arrangements made for regular monitoring by the elder abuse co-ordinator. Mrs M has been provided with advice on alternative housing options but at present wishes to remain in her own home despite the risk.

3.3 RESULTS FROM INTERVIEWS AND FOCUS GROUPS

This study was designed to explore the experiences of older people who had been abused or neglected and those who had not. Perspectives on elder abuse and neglect from service providers, NGOs and key informants also contributed. In the majority of cases an arbitrary classification of elder abuse by physical, sexual, emotional/psychological and financial and neglect labels was problematic, as many victims experienced more than one type of abuse.

Direct quotes are included where appropriate to contextualise important issues arising from the data. The people quoted are classified into three categories, allowing confidentiality to be maintained while integrating the different data sources into a cohesive representation of the views of the participants. The first category is the informants (including those older people who had experienced abuse and those who did not identify themselves as being victims of abuse). The second category is focus group participants, and comprises informants from NGOs and DHB staff. Finally, quotes from key informants are included.

Categories were identified as representing risk and protective factors, and placed on the five levels of the ecological framework (Krug et al, 2002). This allowed an exploration of the relationship between individual and contextual factors, recognising that elder abuse and neglect is the product of multiple levels of influence on behaviour.

Table 3 shows the risk and protective factors that became apparent from analysis of the data.

TABLE 3: RISK AND PROTECTIVE FACTORS FOR ELDER ABUSE AND NEGLECT AT AN INDIVIDUAL LEVEL	
RISK FACTOR	PROTECTIVE FACTOR
Isolation	Assertive personality
Poor physical health	Educated about rights
Mental competency	Having supportive family/friends/peer networks
Housing/living arrangements	Development of coping strategies
Ongoing partner violence	
Personal characteristics	
Personal shame or guilt	

INDIVIDUAL-LEVEL RISK FACTORS

Isolation

Isolation had different meanings for different informants. For example, older people living with family members can feel isolated by being excused from normal family activities such as sharing meals together, or by being asked by family members to keep to their own rooms. Older people living in rural communities have particular social isolation issues that related to factors such as distance from neighbours and local amenities, and limited or no access to public transport. Living alone was a potential factor in increasing older informants' risk of abuse and neglect:

Living alone made me feel uncomfortable and isolated at times. You are always wondering and worrying about what the day is going to be like and then you worried about what tomorrow might bring. You had no one to talk to, no one to share your fear. Sometimes I felt so alone. (Abused, female, age group 70–75)

Older people who are lonely, isolated or dependent are more at risk ... may also have low energy to resist. (Christchurch, NGO focus group)

Poor physical health

A number of older people identified poor physical health as a risk factor for being abused or neglected. Older informants who had recently experienced a significant health event such as suffering a stroke reported that this had been a significant factor in their abuse. In addition, chronic health issues such as visual and hearing impairments, or being dependent on another for assistance with the activities of daily living was considered to have contributed to the abuse or neglect. All abused older people informants described insomnia as an issue, and a lowered mood state and depression was cited by 10 of the victims of abuse. While this may also have been an effect of the abuse, it also left them feeling more vulnerable and at risk of the abuse recurring:

People are lonely and desperate to talk to anyone ... so are prey to physical and financial abuse. (Wellington, NGO focus group)

The older informants who identified themselves as victims of institutional abuse commented that dependency as a consequence of poor physical health put them at risk for abuse and neglect. This was more likely to be noted by victims in hospital-level care than those in the lower-level care provided in rest homes. One older informant who had been admitted to hospital following a stroke (a victim of institutional neglect) cited an example of physical abuse:

I couldn't talk at that stage because of the type of stroke I had. I had only been sitting up at the hospital for about half an hour at a time. I was absolutely exhausted when they finally came to me. They never even apologised for leaving me in that chair all that time. (Abused, female, age group 70–85)

Another older informant describes his experience of financial abuse perpetrated by his family following a stroke:

They targeted me when they knew I was most vulnerable with my stroke condition and I was a complete pushover with those people I loved but in fact it was nothing more than outrageous theft and greedy hijacking by using my power of attorney to get their hands on my property. (Abused, male, age group 70–85)

Mental competency

The exclusion of older people with competency issues from this study meant that they were not approached or interviewed. However, the issue of mental competency was identified by older informants, service provider and NGO informants as a risk factor for elder abuse and neglect. Dementia and other conditions that reduce cognitive abilities (such as stroke) were specifically mentioned:

... particularly at the early stages of dementia it is a big factor (risk factor), can have problems understanding financial situation. This makes it easy for door-to-door salespeople to take advantage. (Wellington, NGO focus group)

According to service provider and NGO informants, poor understanding of dementia in general by older people and their families, and lack of knowledge of caring for demented older people heightens the risk of abuse and neglect. One NGO informant talked about examples of locking people in their rooms for their safety:

Families will say they do it for safety reasons. Even when the family have the best of intentions they don't really know what else to do. (Wellington, NGO focus group)

One older informant who had been a victim of psychological abuse claimed that the informant was no longer able to make decisions because she was losing memory, perpetrated by her son:

My son came and said, 'Mum I want you to have your memory tested by a special doctor.' I thought this was strange but I went along with it just to please him. When I saw the doctor he said my memory was 10 out of 10. (Abused, female, age group 70–85)

Housing/living arrangements

Housing/living arrangements emerged as a risk factor for abuse and neglect. In the majority of cases, the older person in question lived with other members of the extended family, including children and grandchildren.

Older informants of financial abuse indicated that they considered themselves at increased risk of abuse because of the nature of their living arrangements, for example if they lived with a family member with mental illness or drugs or alcohol addiction.

Owning property appeared to place the older people at risk, and this risk appeared to increase substantially if family members had some nominal investment in the property.

One older informant recounted how he was targeted at home by several family members:

You invaded my own space, from that moment on you stole away my home, completely destroyed my peace of mind, and disregarded my state of health with your ill willed dominance and your evil advantages. (Abused, male, age group 70–85)

Another older informant described the relationship with their son after he moved into their home:

He came over from Australia to care for me and even got the carer's benefit but he didn't have the ability to look after himself let alone me as he was an alcoholic. He didn't get enough from the benefit so he started stealing from me. When I got wind of it I started asking questions about the bank statements. He wouldn't read them to me and I couldn't see. Anyway if he was in a bad mood he will come and put his hands around my neck and squeeze tight to frighten me. (Male, age group 75–95)

Ongoing partner violence

Partner violence appeared to be a consistent theme over time. The marriages were described by the older informants in question as brutal and violent, fuelled by alcohol and drugs in a number of cases. The informants commented how they often noticed that their sons behaved in the same way as their abusive husbands.

Trusting

Trusting people, trusting family members, and having a trusting nature were all considered by victims to have contributed to their becoming victims of abuse or neglect. Both men and women held this view.

The 'trusting nature' of the older generation was also noted by NGO focus groups.

Poor life skills

Older informants felt that having poor life skills increased their risk of being abused or neglected. They attributed their abuse to lacking some of the practical skills required to function on a practical day-to-day basis. A good example was an inability to keep up to date with modern technologies. A common theme with the older informants was inability to manage a cheque account and technologies such as ATMs and EFTPOS. This increased the risk of being financially abused, especially for people with limited access to transport or a disability that prevented them from travelling to do their own banking. Being poorly educated (like, for example, the informant who was taken out of school to help run the family farm at the age of 12), being raised in an orphanage, and living in a violent abusive home as a child were the reasons to which the older informants attributed their poor life skills. Being treated badly seemed to thread through into their adult lives. One informant stated:

I have been ill treated all my life, walked over most of my life, first by my parents, then by my husband and now with my adult sons... They are just like their father. (Abused, female, age group 70–85)

They don't know how to use the ATM machine so they give PIN number to caregiver. (Wellington, NGO focus group)

One older male informant felt his abusive situation was due to poor parenting, which had left him vulnerable. He saw this as contributing to his being abused and neglected as an older person.

Being stoical

Stoical traits, although often considered a protective factor for abuse and neglect, may also serve to increase their risk. Older informants described strategies to handle adversities which had hampered the reporting of abuse and neglect to outside agencies. As a consequence of this stoical behaviour the older person may remain at risk for considerably longer. One older informant explained her reason for remaining in an abusive situation:

When you get old you look for your comfort zone ... when you find this zone you don't want to move, don't want to look for change or challenges, and therefore will just accept your lot. (Abused, female, age group 70–85)

Personal shame or guilt

Often a perception of trust left older informants feeling ashamed of the actions of family members who were abusive or neglectful. "The silence of abuse" is how one older informant termed this situation. Another who was both physically and psychologically abused felt that at the time she had to endure the abuse because "after all he is my flesh and blood". (Abused, female, age group 70–85)

Culture was shown to have an influence on the sense of shame experienced by older people when they are abused by a family member:

For Chinese, respect to older people and support is important. When the children do not respect the parents feel very shamed. This makes it harder to disclose. (Chinese key informant)

INDIVIDUAL-LEVEL PROTECTIVE FACTORS

Assertive personality

When older informants were asked what they thought might have protected them from being abused, a number of them wished they had been more assertive: “I have been a door mat all my life.” (Abused, female, age group 65–75)

Those who had been assertive learnt that this trait might well have added a protective layer:

In the end being stubborn and single-minded has helped me cope with the abusive situation. I wish I had learnt this much earlier. (Abused, female, age group 70–85)

Educated about rights

It was evident that being well informed about rights and the ways they can be utilised when one becomes disabled or dependent, not only empowers the older person but also provides protection. This is so for all older people and may be particularly important for older immigrants:

Older people don't understand the New Zealand system; they don't know how to go about understanding what is normal. They need education – workshops to help them protect their own rights. (Chinese key informant)

Having supportive family/friends/peer networks

Having a loving and caring family protected the older informants from being abused. In addition, friends can contribute to protective factors as confidantes and as part of the social network of the older person. Friends often have the closest relationships with the older person.

Friends provide a level of protection not afforded by family members. Older informants who had been abused or neglected felt that they could have protected themselves more if they had disclosed the abusive situation sooner. Telephoning friends was a way of securing emotional support. An older informant put it this way:

Sharing the information with someone I trusted was a big load off my mind. I was able to sleep better and in some ways it made me stronger and made me stand up for myself. (Abused, female, age group 70–85)

A Wellington focus group of non-abused older people spoke of the importance of older people “having their own social life” and “reducing their dependence on the children”.

Development of coping strategies

The majority of the data obtained from an individual level arose from interviews with older informants retrospectively discussing their experiences of abuse. Although this is considered a real strength of this study it did mean that in some cases the ‘protective’ factors identified were in fact strategies that minimised the effects of the abusive situation or that helped the older person to cope, rather than preventing its occurrence. It is important to keep this in mind when considering the individual-level protective factors. Strategies identified included volunteering as a means of minimising social isolation, and pacifying the abuser.

An older informant described two coping strategies he used to reduce the risk of abuse from his daughter:

I coped initially by being tolerant and never bad-mouthing my daughter who had moved in. When it got real bad I just moved out – it seemed to be the only way. (Abused, male, age group 60–75)

FAMILY-LEVEL RISK FACTORS

TABLE 4: RISK AND PROTECTIVE FACTORS FOR ELDER ABUSE AND NEGLECT AT A FAMILY LEVEL

RISK FACTOR	PROTECTIVE FACTOR
Family member with mental health issues and/or substance abuse	Children and other relatives who care
Dysfunctional families	
<i>Ongoing intimate partner violence</i>	
<i>Children abusing parents</i>	
Overburdened families	
<i>Time constraints</i>	
<i>Lack of money</i>	
<i>Lack of capacity to cope with caring needs</i>	
Overbearing families/take total control	
Family greed	
Families that are geographically separated	
Suspected sexual abuse by husband, with wife not mentally competent	

Family member with mental health issues and/or substance abuse

This risk factor was mentioned across all types of abuse, including sexual violence. It was mentioned by service providers, and older informants who had experienced abuse, and in connection with institutional abuse. It was strongly related to the living situation of the older person, who might be particularly vulnerable to abuse by an adult child with mental health problems and/or substance abuse problems who was living with the older person. Where adult children were dealing in drugs this also increased the risk of neglect and financial abuse. Sons and husbands were most frequently mentioned as perpetrators. The situation may be particularly compounded when the perpetrator is a child, as a mother’s attachment to her own child can inhibit her from invoking protective strategies such as seeking a trespass order or asking him or her to find other accommodation. The following statements from older abused informants bear this out:

My son has a short fuse and gets angry but it's unpredictable and I live in fear and being frightened because of his anger. It always gets worst when he has money and goes out and gets drunk and gambles. (Abused, female, age group 70–80)

He doesn't go out any more and talks to no one. Anybody who comes to the house, he hides away in his room. When they have gone I worry what he might do. Sometimes he might start drying the dishes and next slam them down breaking them. I tell him to stop doing it but he doesn't want to listen. (Abused, female, age group 70–80)

Families with a history of violence

Having a family with a history of violence was identified as a risk factor for physical violence, psychological or emotional abuse, neglect and financial abuse. This history took various forms, such as intimate partner violence for the duration of a marriage may continue into older age; or older persons who had neglected their young children might now be abused by those children as adults as they became increasingly vulnerable:

My parents never looked after us, they went where they wanted, spent their money where they wanted, never cared about us. (Pacific, non-abused focus group)

The children think it's pay-back time; they will often say what goes around comes around when I ask them why they are threatening their elderly parent... (South Island, key informant)

In families where there is a culture of silence about abuse of all kinds, disclosure of elder abuse is further inhibited. These situations were described as being exacerbated when perpetrators also had other problems, such as substance abuse, gambling or a criminal history.

Overburdened families

This risk factor was mentioned in relation to physical abuse, neglect and financial abuse. Families could be overburdened in various ways: lack of time, lack of money, juggling young children, jobs and other commitments. Caregiving for the older person can itself create stress within families, particularly when combined with a lack of caring or nursing skills, and lack of awareness of or access to support. Families may have the expectation and the desire to provide care for the older person, but the emotional, financial and physical strain can lead to their not coping and resenting the older person. Being overburdened can manifest itself in a number of ways. Some examples were described by focus group informants:

A wife who ordinarily takes exemplary care of an ageing husband with Alzheimer's gets him ready to go out of the house – when she turns away briefly he undresses himself, and she hits him in frustration. (Auckland, service provider focus group)

In a family who is financially stretched, the adults go out to work and leave an 11-year-old granddaughter to look after her grandfather who has a catheter. (Auckland, service provider focus group)

Providing care for the older person can also increase the burden for families, particularly if they do not feel they have the skills or personal attributes necessary to undertake this role. In some cases the caregiving responsibilities are unequally shared between family members, and one person (often an unmarried adult daughter) shoulders most of the caregiving responsibilities, and feels increasingly resentful and eventually becomes neglectful towards the older person. (Auckland, service provider focus group)

Overbearing families/take total control

This was identified as a risk factor for financial abuse and neglect. In some situations, particularly common in Pākehā families, an adult son may prematurely take control of a parent's (mother's) financial resources. In other situations, identified most often by Pacific respondents, children or grandchildren move into the older person's home, and take over the space (for example, children move into the bedrooms, and the older person is moved to sleep in the lounge), and break or mistreat the older person's belongings. Grandparents of all cultures reported looking after grandchildren; however, some felt overburdened by this task and some, notably in Pacific families, felt over-utilised as a source of childcare.

Family members may also deny an older person decision-making rights; for example, children may say that, as the older person is not earning money any more, they no longer have such rights. Family members may also assume that an older person is not mentally competent to make decisions once they move into a residential care facility. Alternatively, they may deny an older person the option of going into residential care.

Examples from older informants highlight this issue:

...own precious things, little items, are thrown about and abused by the kids because they are not valued by the kids and the older person can't do anything. (Pacific, O/P non-abused focus group)

In NZ the older people have only a benefit and the younger ones have bigger money they seem to think they have a bigger say. (Pacific, non-abused focus group)



Family greed

Family may not want to spend the older person's resources to ensure that the older person gets the quality of care needed, including good residential care. Family members may also take advantage of the situation for their personal financial gain when an older person goes into residential care. Respondents also reported situations where family members who held enduring powers of attorney misused them for personal gain. Some informants reported that grandchildren were used as means of blackmail for extorting money or property (for example, grandchildren were coached to ask the older person for money, or older people were threatened with not seeing their grandchildren if they did not provide money or property). The Chinese key informant suggested that in the Chinese community, addiction to gambling leads to stealing, shouting and psychological abuse.

An older informant describes the actions of their daughter following her move to a rest home:

It was just greed. I had been giving her \$50 each week for a lot of years and then when I came in here [residential care] she took everything. She robbed me of my money and sold all my possessions. (Abused, female, age group 75–85)

Families that are geographically separated

This was primarily identified as a risk factor for emotional abuse and neglect. Family members can be in different cities and countries from the older person, who may be living in the community or in residential care. In either case, geographical distance can restrict contact between the older person and their family, which can lead to limited awareness of the older person's changing needs and limited monitoring of the quality of the home help or residential care the older person is receiving:

Supportive family is key to keeping the older person safe but this has all changed now as many live overseas. (Wellington, NGO focus group)

Suspected sexual abuse by husband, with wife not mentally competent

For sexual violence, only two family-level risk factors were identified by the service providers. These related to cases where it was suspected that sexual assault was being committed by husbands, who were removing their wives with dementia (who were therefore not mentally competent to consent to sexual intercourse) out of residential care settings and home for a while, with the wife later returning distressed. A second scenario that concerned service providers was the potential for sexual violence in cases where an adult son with substance abuse problems insisted on himself performing all the assistance with daily living (such as toileting and showering) for an increasingly disabled mother.

That these were the only scenarios in which sexual assault was mentioned reflects the general lack of discussion of the whole issue of sexual violence by all the informants. Its absence from the discussions may reflect the taboo and silence that surround sexual violence, compounded by generational approaches to the subject of sex, and societal beliefs that older people are asexual.

FAMILY-LEVEL PROTECTIVE FACTORS

Children and other relatives who care

Having a close, supportive family was universally endorsed as a protective factor against all kinds of abuse. Older informants said, for example:

Coming from a loving caring family that respects and values older people, the grandchildren learn from their parents about this respect. (Wellington, O/P non-abused focus group)

Some look after their parents at home because they remember the parent looking after them when they were kids. (Auckland, Pacific NGO focus group)

INSTITUTIONAL-LEVEL RISK FACTORS

TABLE 5: RISK AND PROTECTIVE FACTORS FOR ELDER ABUSE AND NEGLECT AT AN INSTITUTIONAL LEVEL

RESIDENTIAL CARE	
RISK FACTOR	PROTECTIVE FACTOR
Quality of facilities	Improve quality of care with efficient and effective regulatory monitoring systems
<i>Staffing levels</i>	Well trained and well paid residential care staff
<i>Unsafe environment</i>	Improved systematic and institutional policies and procedures
<i>Bullying by staff</i>	Appropriate use of EPOA and safeguarding residents' allowances
<i>Funding</i>	
<i>Bullying by residents</i>	
<i>No external advocates or monitoring services</i>	Regular external monitoring services
OTHER INSTITUTIONS	
RISK FACTOR	PROTECTIVE FACTOR
Lack of pastoral care	Staff education in spiritual care The development of pastoral and spiritual care services
Employers who are not 'family friendly'	Service agencies' staff training
Services agencies' responses to older people	

A number of risk and protective factors emerged specifically for residential care settings.

Quality of residential care facilities

In residential care, quality of care equates with quality of life. Residential care facilities are often overly controlling, with the result that residents become objects of care rather than partners in choice and decisions about their daily routine. This was highlighted by service providers, NGOs and both the older informants who were residents:

The elderly won't complain as they are reliant on the organisation for their care. (Wellington, NGO focus group)

You call this care – you are just told what to do, when to do it and you have no say. I am fighting all the way to do what I want. (Abused, female, age group 75–85)

Staffing

Inadequate staffing levels are a reality in residential care. When insufficient staff were available the provided care was more likely to be inadequate. This took the form of responses to residents' immediate needs, such as lack of or delayed response to call bells, food being served cold, inadequate or no assistance with eating and inadequate monitoring of the residents in general.

Because the staff have no time I know now that I have to ring the bell at least half an hour before I want something as I know that is how long it takes them to answer the bell. Then they will put me on the toilet and leave me there sometimes for 45 minutes. (Neglected, female, age group 75–85)

The employment of agency staff has become common practice in residential care in order to maintain mandatory staff ratios. The service providers and NGOs indicated that the job performance of agency staff was frequently inadequate or insufficient, and at best inferior to the job performance of some regular staff. Informants from residential care explained that the use of agency staff put a heavy strain on the budget and often meant they worked one staff member short rather than blow the budget.

Informants reported that residential care staff members often worked double and extra shifts in many facilities. Informants and other staff often chose to work extra shifts for financial reasons. At other times, they worked additional hours to help out “as someone needs to provide the care”. Informants who worked extra shifts said they were often physically and emotionally tired, which reduced morale and contributed to poor job performance. A key informant from residential care said that the consequence of poor staffing levels was unacceptably high staff turnover in residential care facilities at all levels:

Sometimes there is understaffing so I cannot give really proper caring. There is one nurse for 20 residents. We cannot handle them as we would like. We just give them the pills. It is just functional but not communicating. It's not how it is supposed to be. (South Island, service provider focus group)

Staff training

Nursing skills, knowledge and expertise were indicated by informants as important factors in the provision of adequate resident care. Poorly trained staff provided substandard care and eroded the residents' safety and quality of life. Staff training at all levels was reported as being provided on an ad hoc basis by facilities. Service providers and NGOs thought that training was adequate at best, but on the whole a lot more was needed to improve the quality of continuing education. Mandatory training on residents' rights, fire and safety procedures, lifting techniques and skin-care were provided at least monthly. Informants felt there was little or no time spent on teaching health care assistants how to communicate with dementia patients, although an estimated 70 percent of residents have long- or short-term memory problems.

One nurse came in to talk to me on the way home one night. She had been working in the dementia unit by herself and the patients were being very difficult. Anyway she said that at one stage she just stood in the corridor and burst into tears – it had got too much for her. After a good cry she felt better and continued to put all the residents to bed. (Neglected, female, age group 75–85)

Bullying by staff

Because of ineffectual orientation or supervision, newly appointed health care assistants are often left to flounder with only the help of a loosely appointed preceptor. Informants from residential care facilities said that orientation usually consisted of simply working alongside other health care assistants, who were not prepared or inclined to train new staff. The staff charged with orienting new staff often resented the time required of them, and took that resentment out on the new worker. One key informant, a nurse manager, discovered this after six newly appointed health care assistants resigned after two or three weeks on the job. Staff harassment can be subtle in residential care and is often demonstrated by poor staff cohesion and general dissatisfaction. Informants also felt that cultural differences can cause tensions in a facility's staff relationships, and a subculture of discrimination can develop.

It came to my notice by a whistleblower why a number of the new staff were leaving. The staff who had been working in the place for a long time were picking on new staff to the point that they up and left. We lost six new staff members before it came to our attention. (South Island, service provider focus group)

Some informants had also experienced bullying by staff, the most frequent form being psychological abuse. Yelling at residents often seemed to happen after a staff member had made a concerted effort to keep their temper under control. Another common form of mistreatment is ignoring residents' calls for help. Indifference and apathetic behaviour, disregard for residents' privacy and staff having little energy or not speaking to residents when providing care, were all distressing for older informants.

Funding

Informants from the NGO and older people's focus groups, and informants in residential care felt that inadequate funding in residential care facilities creates environments in which care practices are of poor quality and often below standard:

The meals are disgusting, we are always hungry. Sometimes they forget to even bring a meal in and when they go and look for a meal the cook says there is nothing left. (Neglected, female, age group 70–80)

Frail older people were considered to be at greater risk, particularly in facilities without continuing-care beds or dementia units. Older people who were not transferred to higher levels of care when this was appropriate were considered to be at heightened risk of neglect. Informants felt that the reason for this is likely to be purely financial. Service provider informants explained that, if a person is relocated, the rest home owners may have beds unoccupied and thus be unfunded. Informants also thought that residential care operators may have financial incentives not to rehabilitate older people, as more funding is received for providing hospital bed care, even when this level of care is no longer required by the particular person.

Bullying by residents

Bullying and other less obvious problem behaviours committed by residents against other residents can have long-term damaging effects. Informants said that bullying appears to occur in the more communal places such as dining rooms or lounges. Claims to a favourite chair or always being in charge of the TV remote were considered to be forms of bullying by older informants:

I refuse to go down for meals in the dining room. It's awful – the residents are picky with the ones who can't feed themselves properly. I would rather stay in my room and have my meals. Anyway I don't eat the meals much, they are so awful. This little dog next door usually waits and I give him the meat, it's so tough. (Neglected, female, age group 70–80)

Lack of external monitoring and advocates

Poor family monitoring of the quality of care and quality of life for residents was mentioned by older informants and service providers. Residential care services are fragmented and lack consistency of delivery across the nation. Many at-risk residents are frail, have communication difficulties, suffer from severe dementia and are likely to have few or no visitors. This group of people is more vulnerable to external or internal physical, emotional and financial abuse, and neglectful situations:

Families are no longer coming in to visit the older person. They are busy and don't make it a priority to visit the rest home. (Auckland, Indian key informant)

Lack of pastoral or spiritual care

Informants from the focus groups as well as older informants, particularly those from non-Pākehā ethnic backgrounds, felt that less than adequate recognition was given to spiritual wellbeing and pastoral care in residential care settings. The older people related such care to the need to acknowledge a person's sense of meaning and purpose in life, which may or may not be expressed through formal religious beliefs and practices. Not acknowledging these needs reduced the quality of life and social context for these older people. From their viewpoint, lack of recognition of spiritual needs such as food requirements or private prayer facilities, and language difficulties, were neglectful and emotionally abusive. The conventional structures and care practices that predominate in residential care settings were considered to disregard spiritual wellbeing.

Service providers, ethnic NGOs, key informants and older informants affirmed that spiritual caring in the context of the caring relationships was less than adequate:

It is about the quality of the relationship between the staff and the residents. I know when it's right as I can see and feel the compassion and expression of love from them. (South Island, key informant telephone interview)

I think it is pretty important for Chinese older people to have interpreters available to provide spiritual care in a culturally appropriate way. (Auckland, NGO focus group)

The practices of institutions other than residential care facilities were sometimes seen as contributing to situations of abuse or neglect. For example, employers can be reluctant to provide workers with time out for caring for older people. In particular, service providers felt that informal caregivers were often refused time off work to provide care when family members such as older parents were unwell or needed help to keep appointments with lawyers, bank managers or doctors. This placed increased financial and time pressure on families who need or want to provide additional care for older people in their family:

Employers are not often good at giving people time off for helping elderly parents. (Christchurch, service provider focus group)

Service agencies' response

According to older informants, NGOs and service providers, some agencies do not respond quickly and appropriately to signs of elder abuse and neglect. Key informants perceived that because they were older their needs were minimised and given a low priority. Older informants were also confused about the role that agencies such as police can play, and why police at times were not able to act as the older informants felt they should. Older informants and NGO providers both felt that banks and other financial institutions did not sufficiently monitor older people's accounts to detect and query unfamiliar patterns of money use. This was considered to contribute to the risk of financial abuse:

Banks take things at face value. (Christchurch, service provider focus group).

I couldn't read my bank statements due to my bad eyesight. The bank should have noticed that my money was being withdrawn in large sums. When I did go and see them they told me it wasn't their job to monitor everyone's account. (Abused, male, age group 85–95)

INSTITUTIONAL-LEVEL PROTECTIVE FACTORS

Well trained and well paid residential care staff

Well trained, highly capable staff were regarded by service provider and NGO focus group informants as essential for supporting residents' independence and their ability to exercise free choice:

They have the chance to be the eyes and ears if they are up-skilled. (South Island, service provider focus group)

Regulatory monitoring systems

Service provider and NGO focus group informants felt that residential care facilities should move towards the development and implementation of uniform, universally required, data collection systems as a basis for measures of performance quality. Informants suggested various ways performance could be monitored; for example, by establishing minimal standards of acceptable performance for facilities, based on explicit sets of criteria to allow benchmarking against similar organisations. Informants felt that this process would eventually establish quality indicators, which could be used to identify instances of problematic care, or to rank facilities' performance.

Institutional policies and procedures

Institutional processes that compel residents to adhere to rigid time-constrained schedules replaced by care models that respect individual wishes, and enhance respect for and the exercise of individuality within a facility. Informants from all categories reported that this was seen as a potential protective factor.

Informants from residential care settings felt that ensuring that agency or casual staff don't routinely work in specialist dementia units was a potential way of protecting residents from the frustrations and resentment of casual staff. These frustrations were seen to result from time constraints that inhibit effective communication with these high-need residents.

Appropriate use of EPOA and safeguarding residents' allowances

Reducing or preventing financial abuse in residential care was mentioned by older informants and service providers. All agreed that education and clear guidelines about enduring powers of attorney (EPOA) and the execution of the EPOA are needed:

Be sure about who you are appointing. Drop the word 'complaint'... too stressful. In rest homes talk to peers. (Wellington, NGO focus group)

Hospital/residential care staff need to be vigilant about lawyers or family requesting signature from older adult. (Christchurch, service provider focus group)

With respect to financial abuse, service providers also mentioned potential protective strategies, including education for individuals and professionals (health care staff, lawyers), and also suggested considering community and societal attitudes towards money and the intergenerational transmission of wealth. More structural protective strategies (such as a national register of enduring powers of attorney) were also suggested.

Service providers suggested that clearer procedures were needed to protect subsidised residents' weekly allowances from Work and Income. For example, service providers suggested that setting up trust accounts in residential care facilities would solve the problem of the theft of such money by family members. One suggested that a managed fund would provide protection for residents' money:

I don't know how many times I ask families to buy the resident a new nightie, for instance. I will keep asking them and then they come in with a summer nightie for the resident to wear in the winter. We know the families receive the \$28 allowance. Some families just can't be bothered, or use the resident's funds for their own personal use. This is a very common occurrence in this facility. (South Island, service provider focus group)

The family was using the personal allowance and not giving the money for haircuts, doctors' appointments and clothing. (Pacific, NGO focus group)

Regular external visitation

Enhancing life within residential care settings by engaging families and volunteer co-ordinators, with an emphasis on working in partnership with residential care staff, was suggested by service provider and NGO informants as a way to improve the overall quality of life for older people. It was also seen as a way of providing an extra 'surveillance' mechanism.

Older informants suggested that there was scope for social workers and NASC workers involved in case management of older people in residential care facilities to inform their clients of their rights. Furthermore, it was suggested that the complaints procedures available should be routinely advised to residents and their families, so they know what to do if they have concerns about the quality of services provided, or more direct allegations of abuse. Protection for staff who wish to raise questions about practices in their own establishments (whistleblowers) and penalties for non-reporting of suspected abuse and neglect were also considered necessary:

Social workers used to be attached to rest homes but not anymore. That used to protect people against abuse. (Wellington, O/P non-abused focus group)

Health and safety people in rest homes can help but have a limited role. We need to expand the advocacy role and local and national networks and organisation to support them. (Wellington, O/P non-abused focus group)

Advocates may be made up of a group of residents. This works well in some institutions. (Wellington, O/P non-abused focus group)

GPs have ready access to people in rest homes, but unless GPs are supported and guided in this area they will not look for cases of elder abuse. In order to improve communication, NGO and older informants supported the idea of regular multidisciplinary meetings as a protective mechanism. These meetings might involve all levels of staff, with a focus on problem-solving for difficult or at-risk older residents.

Pastoral and spiritual care

Māori key informants said that there were intrinsic benefits in being Māori when working with Māori in a spiritual way. One key informant said:

Our whakapapa and our Māori taonga are fundamentally used as a protective tool. Particularly with our older Māori people they have true recognition of our history and where we are from, and if I identify with my maunga (mountain), my iwi, this gives them an automatic connection somehow through me. So certainly the concept and the ability of being Māori when working with Māori people is a real asset. The protective factor is enhanced by the concept of historical knowing (whakapapa) and being able to integrate the knowing of whakapapa into the delivery of daily care. (Auckland, Māori key informant)

Meeting spiritual needs is perhaps easier if family members, who know the beliefs and practices of the older person, can ensure they were adhered to as part of daily life. As one NGO informant said, it is easier to maintain these spiritual connections when they were part of earlier family life.

Service provider, NGO and older informants suggested that education and training of staff on spiritual issues might give them the skills to approach and integrate spiritual needs into care and assessment. It was suggested that the establishment of formal pastoral and spiritual care services might also help to address the perceived imbalance.

Service agencies' staff training

Establishing regular staff training on elder abuse and neglect for service agencies in general would raise awareness of the issue. Informants from non-Pākehā ethnic backgrounds and older informants considered that such training of staff would make them more aware of scenarios in which older people are at risk of abuse. This was suggested as a preventive measure for financial abuse, to be provided in settings such as banks and financial institutions.

COMMUNITY-LEVEL RISK FACTORS

TABLE 6: RISK AND PROTECTIVE FACTORS FOR ELDER ABUSE AND NEGLECT AT A COMMUNITY LEVEL

RISK FACTOR	PROTECTIVE FACTOR
Council policies allowing 'mixed' housing	Small close-knit communities can look out for each other
Lack of public transport, or other physical barriers contributing to isolation	Prompt accessible geriatric services able to respond to urgent situations
Limited availability of respite care and other services in some communities	Communities that have regular interagency meetings to facilitate sharing of information with regards to at-risk older people
Lack of volunteers	
Limited availability of interpreters	
Community ideas about the (un)acceptability of residential care for older people	
Monitoring by agencies with a rapid response (police, health services, EAN services) is inadequate	

Housing policy

Concern was expressed by NGOs, service providers and older informants that changes in the housing policy of some local councils have placed some older people at risk of intimidation and abuse. Specifically, policy changes that have allowed more 'mixed' use of residential housing areas, rather than housing specifically for older people, has led to concerns that older people are at risk of intimidation and abuse by other residents. In addition, some city councils have sold housing stock into private ownership, which has resulted in increased rents for older people, and in some cases eviction. This was noted by informants from Wellington and Auckland:

Removing specialised housing for older people has placed some older people at risk of intimidation/abuse by others in the housing area. (Wellington, NGO focus group)

City council's housing policy can place older people in risk situations, for example with inappropriate mixtures of tenants. (Auckland, service provider focus group)

The council has let us down and it has been hanging over our heads whether we will be evicted or not. (Abused, female, age group 85–95)

Lack of public transport

Lack of public transport and other physical barriers can contribute to isolation, which was identified as a risk factor for elder abuse and neglect at the individual level. Informants also noted that factors such as the availability of public transport and the accessibility of venues for people with wheelchairs and walkers were important in making community facilities accessible to older people:

Using walking frames is very difficult in some shopping centres and on footpaths. (Abused, female, age group 70–85)

Respite care and other services

In some communities, the lack of respite care services and of services such as daycare centres for older persons was seen as a risk factor for abuse. Without these services caregivers have limited options for breaks from caregiving responsibilities, which

increases their stress. It was noted by service providers from the South Island that rural communities are particularly likely to have limited resources of these types:

Accessible community daycare can provide a safe haven. (South Island, service provider, telephone interview)

Rural communities may keep older people at home because services are not available, as well as because of financial cost. (South Island, service provider, telephone interview)

Rural community services can be fragmented, under-resourced or non-existent. (South Island, NGO focus group)

In rural locations, GP coverage can be very poor. (South Island, key informant)

Lack of volunteers

Lack of available volunteers in the community was thought to increase risks associated with elder abuse and neglect, as it can contribute to social isolation. The pool of people available to participate in schemes for actively befriending older people may be limited, and inhibit the ability of other institutions (such as churches) to provide meeting opportunities for older people.

Lack of interpreters

The limited availability of interpreters means that health needs, including those associated with elder abuse and neglect, may be missed in non-English speaking communities. This was raised by an ethnic key informant and NGO informant:

Chinese migrants do not know the language (English), or where to get help. (Auckland, NGO focus group)

We should use independent interpreters and not family members when interpreting for at-risk older people but often it is hard to find one quickly. (Christchurch, service provider focus group)

Community ideas about residential care for older people

Some communities have a strong belief that residential care for the elderly is unacceptable. For example, in Indian communities, a son is likely to be expected to care for his mother. Some church communities reject families that put their elders into residential care. This can put older people at risk of abuse, if the family is unable or unwilling to provide the requisite care at home, yet feel that they will be ostracised by their community if they put the older person into a residential care facility. If the community is a “closed community” (Christchurch, service provider focus group) families are fearful of either exposing their need for help from their own community or accessing other support services:

Culturally it is not the done thing. There is a social stigma when you can't look after them [the old person]. (Auckland, service provider focus group)

COMMUNITY-LEVEL PROTECTIVE FACTORS

Small close-knit communities

According to informants from service provider and NGO focus groups, the social links between community members, such as friendship and common membership of groups, can serve as an important protective factor against elder abuse and neglect:

The community as a whole has a responsibility to watch over neighbours. (Auckland, NGO focus group)

The idea of having a community support 'street' to support anyone who is sick, in the local neighbourhood. (Christchurch, service provider focus group)

Community, to some extent, knows what is going on. They need permission to act as the 'eyes and ears' and the knowledge to know how to help and support. (Wellington, NGO focus group)

Prompt accessible geriatric services

Places that had specialist geriatric health services were seen as having advantages for older people. Service provider and NGO informants felt that the timely availability of these services allowed specialised assessment, and facilitated the provision of support for caregivers or of home support services, or placement in immediate safe houses or residential care:

In rural locations, GP and specialist geriatric services cover can be poor and often unable to complete competency assessments within reasonable timeframes. (South Island, NGO focus group)

Having a personal GP can be protective, versus one who places priority on treatment for younger people. (Auckland, service provider focus group)

Regular interagency meetings on the provision of services to elder abuse cases or people thought to be at high risk have been established in many centres for some time. When these are working well, informants thought they afford protection to older people, because better decision-making and support can be achieved by pooling information and resources. Such meetings typically involve health professionals, police, social workers, NASC and others:

Network meetings between care providers on a regular basis can provide a forum to share information, alerts, etc. (South Island, NGO focus group)

Vigilant monitoring by a lead agency would protect the older person in a more structured way and information could be shared with others involved. (South Island, NGO focus group)

Communities that have regular interagency meetings are able to share information on a regular basis, and can share information on individuals who may be at high risk. (Auckland, NGO focus group)

SOCIETY-LEVEL RISK FACTORS

All informants identified financial abuse as an important problem. Most information regarding physical abuse and neglect at the social level comes from the DHB and NGO focus groups and informants from the Indian and Chinese communities. The people who were interviewed who had been abused expressed strong emotion about the ageism, abuse and lack of respect they experienced.

TABLE 7: RISK AND PROTECTIVE FACTORS FOR ELDER ABUSE AND NEGLECT AT A SOCIETY LEVEL

RISK FACTOR	PROTECTIVE FACTOR
Ageism and social marginalisation	Treating older people with respect
Role of women/gender roles	Public understanding of the ageing process
Pressures on families created by 'pace' of life	Education of financial needs of older people and EPOA
Financial pressures on families	
Societal ideas about families	
Societal ideas about individuals	

Ageism and social marginalisation

Informants from all groups expressed the feeling that older people are fundamentally undervalued and not respected. For some this is linked to the fact that older people are no longer in paid employment, which is a reflection of social and cultural norms about 'productivity'. Other informants reported that older people are so commonly linked with images of loss of health, income, physical and mental competence, that older people themselves almost expect that this is how their lives will be:

There are these ageist views which keep people down ... older people, once retired, are often not respected. (Wellington, NGO focus group)

They think we have lost our marbles and don't want to attend to older people. (Abused, female, age group 70–80)

There is a general feeling of ambivalence towards older people in the town I live in. (Wellington, non-abused focus group)

Gender roles

Older informants noted that cultural expectations about the role of women created risks for particular types of elder abuse. They highlighted the risk of financial abuse that has been created by cultural stereotypes prohibiting women from handling or making decisions about money. Lack of familiarity with handling money leaves them at risk of financial abuse such as the misuse of EPOA, and approaches by con-artists in the community. Women in the 'old' age cohort, and women from some ethnic communities, were considered to be at higher risk of this type of abuse:

My husband controlled all the finances. I didn't know how do things like sign a cheque so when he died I was reliant on my daughter-in-law to help ... she went on and helped herself to my money. (Abused, female, age group 70–80)

Time pressures on families

There are shifts in the ability of families to engage older members socially and to care for those in need. Family solidarity may be valued as an ideal but is under pressure from economic stress on families and changing cultural perspectives on reciprocity among generations and on collective responsibility. Older people in residential care may not be visited because the adults in the family are already overburdened with making a living and raising children. This view was expressed by both ethnic and non-ethnic informants:

Society is very selfish. The young and the middle-aged are too busy for older people. (Christchurch, service provider focus group)

Carers are in a sandwich situation. (Wellington, NGO focus group)

Sometimes we have no choice. We have to take our older person where they can be looked after 24/7 while we go and do our own things ... something we never used to do but this is New Zealand and we have to look at our own lives as well. (Pacific, O/P non-abused focus group)

Financial pressures on families

There was recognition that financial pressures on families were great, and that societal factors, such as high interest rates, contributed to this burden. Informants felt this pressure often increased when blended families, trust funds or land ownership were involved:

People are becoming more self-centred because of the economic situation, with both parents working and little time left over for the older generation. (Auckland, Indian focus group)

Rural families with potentially large inheritances work with legal systems to remove legal titles from one side of the family. (South Island, NGO focus group)

Societal ideas about families

Some societal ideas about families and roles within them were also thought to contribute to elder abuse. For example, beliefs about the intergenerational transfer of money and property can lead to financial abuse. Ideas about loyalty to family members can get translated into silence about abuse:

My other son wouldn't believe me when I eventually told him what he [abusive son] was doing to me. (Abused, male, age group 85–95)

Some [family members] have the idea that 'my parents' money is 'my own'. (Christchurch, service provider focus group)

Societal ideas about individuals

Cultural norms about the importance of independence and not asking for help can contribute both to the occurrence and repetitive nature of elder abuse. Older informants described their strategies for handling adversities which actually hampered early reporting of abuse and neglect to outside agencies. Stoicism can cause the older person to remain at risk for a considerably longer period:

I didn't tell anyone about the situation as I didn't know what would happen to me. I have always had to stand on my own two feet. (Abused, female, age group 65–75)

I didn't want to make a fuss. (Abused, female, age group 70–80)

SOCIETY-LEVEL PROTECTIVE FACTORS

Treating older people with respect

Fundamental respect for older people as valuable individuals in their own right was regarded as an essential protective factor by all individuals and focus group informants. They voiced a strong message that positive images of older people needed to be actively sought out, and actively disseminated through the community:

Focus on changing societal attitudes to value the person, from all members of society. (Auckland, service provider focus group)

We need publicity about older person's rights on radio and TV. (O/P, non-abused focus group)

Treat old people with respect. (Abused, female, age group 75–85)

Public understanding of the ageing process

Informants of service provider and NGO focus groups felt that there was a need for widespread education about the ageing process and about preparation for positive ageing. This included consideration of financial and pragmatic needs (such as enduring powers of attorney and housing), as well as physical and emotional needs:

Being well informed about rights and different ways these rights can be used when one becomes disabled or dependent on others for support and care will not only empower the older people but also be a way of providing protection at all levels. (Auckland, service provider focus group)

Education of financial needs of older people and EPOA

Service providers and NGOs all strongly endorsed the importance of fostering more widespread understanding of EPOA and its correct use, and of fostering skills for financial planning for retirement. These were seen as critical to preventing financial abuse:

Educate public on issues associated with preparing financially and otherwise for ageing. (Auckland, service provider focus group)

Need to understand the boundaries of the EPOA. (Christchurch, service provider focus group)

Keep talking about abuse; give it wide publicity making sure that the information is out there so everyone knows what neighbours, family and friends should be aware of. Some people cannot believe that our old people get treated like they do sometimes. (Auckland, Pacific non-abused focus group)

Set up a Helpline that is confidential where older people can call and talk about the abusive situation. (Non-abused focus group)

SUMMARY

In summary, this chapter has reported the risk and protective factors and categorised them into the five ecological levels: individual, family, institutional, community and society. The categories are not mutually exclusive, with overlaps apparent in the results. The dynamic interactions between the levels are played out in the framework and these interactions represent risk and protective factors from the perspectives of informants in this study. The main risk and protective factor categories identified by the informants are presented in Figures 4 and 5. These will be discussed in detail in the discussion chapter.

The cultural context of elder abuse and neglect are discussed in the following section.



3.4 CULTURAL CONTEXTS OF ELDER ABUSE AND NEGLECT

Māori perspective

Māori perspectives on elder abuse in New Zealand for this report were provided by key informants from several Māori service providers. Māori providers acknowledged that kaumātua and kuia are valuable and respected members of Māori society. They are the treasures of their communities, iwi and hapū because of their whakapapa, age, wisdom, knowledge and te reo Māori.

Māori perspectives on elder abuse in New Zealand are defined by the stresses and pressures of life that surround the whānau. Abuse and neglect of kuia and kaumātua has been, and to some extent remains, a hidden problem. The problem was more likely to be thought of as being unloved or of aroha being missing between the whānau. This puts the whole whānau at risk.

It was suggested that urbanisation has played a role in the fragmentation of Māori values, and has contributed to disruption of links to tribal lands and cultural norms. Urban Māori were seen as more likely to be living outside their traditional tribal areas, and those living away from their families were seen to be at more risk of isolation.

Common problems of neglect and emotional abuse in older community-dwelling Māori were recognised by the informants. Māori service providers spoke most frequently about whānau caregivers. Whānau caregivers were chosen from the extended whānau; such a caregiver was often a younger member of the whānau, usually unemployed, with little knowledge or the skills required to provide care, or even the life skills to take care of themselves. The risk of neglect and abuse was seen to increase as the whānau caregiver became overburdened and stressed in the caregiving role.

Informants also noted that whānau were more likely to refuse formal support services which might buffer the burden of caregiving. Working with families/whānau on suspected abuse and neglect was seen as an opportunity to provide a framework for whānau to accept formal support services.

Māori service providers reported that older Māori dementia sufferers with behavioural problems are at increased risk of abuse and neglect from family/whānau members. This abuse can take many forms, from yelling and shouting to inappropriately activating an EPOA in order to gain access to land and money.

Informants also noted that control over older people's access to mokopuna/grandchildren was common, and that mokopuna were used as a form of coercion:

If you don't look after them (the grandchildren) then we won't bring them to see you. (Auckland, Māori key informant)

Kaumātua and kuia loved the reciprocity of mokopuna visits but had no control over when they saw the children. It was reported that they do not always have a say as to when and how this should be arranged. Controlled access was perceived as a way of denying older Māori the right to develop relationships with their grandchildren. In contrast, affirmation of cultural values reinforces positive attitudes towards whānau, which in turn was seen as a potential protective strategy to shield Māori elders from abuse and neglect.

A high level of cultural identification was reported by participants to be a protective factor. It was defined as functioning in a cultural context where its members are meeting cultural demands and needs successfully. In a family environment that is safe and

secure, members learn competencies, develop strengths and incorporate norms that provide a basis for personal resilience:

Resilience taught by my parents to stand up and be proud. Staunch is a word that comes to mind. (Auckland, Māori key informant)

Families like this were considered to be more likely to provide a protective and secure base, so that when a crisis occurred the family could provide support and assistance.

Informants noted that social connectedness might be enhanced for Māori elders by providing social networks to protect and support them spiritually. Daycare centres designed for and by Māori elders were recommended to provide the opportunity to socialise with peers, gain companionship and develop their own activities and networks. Such centres were seen as a place that might also rekindle traditional Māori health practices such as medicinal herbal gardening and miri miri (Māori massage).

Other cultural perspectives

Pacific peoples, Chinese and Indian perspectives on elder abuse in New Zealand were defined largely but not wholly by the experience of migration and the cultural shifts they had to make to live in a country with different lifestyles and demands and without the personal networks and the community and social resources of the original country.

Pacific service providers and community workers focused in discussion on beliefs and values essential to the happiness of older people, and on the loss of language and with it “some of the culture and some of the values and beliefs”.

While factors such as housing stress on families was recognised, there was no sympathy for ‘young people’ who neglected or abused elders – who “did not love and pamper” their older people.

Chinese people in New Zealand are also largely recent migrants and the breakdown of the reciprocal roles of older people and the younger generations was also reported. Common problems identified were financial abuse, neglect, abusive and neglectful role modelling by adults and the social and linguistic isolation of the older people.

Informants from the Indian community preferred the term ‘neglect’ rather than ‘abuse’, and identified the common problems of exclusion of older people, disrespect and isolation, which they attributed to financial family stress, and lack of time. All groups noted that this “would not happen” in their countries of origin, although cultural changes there including the problem of abuse transferred from generation to generation within families, was acknowledged.

A common theme was the exploitation of older people to help with domestic duties and the care of children, financial abuse and abuse associated with inappropriate living arrangements. Pacific informants noted the problems of overcrowded housing where the older person has no quiet space or privacy, instances of families moving into an older person’s home so that “the old lady ends up sleeping in the lounge”. They also identified as abuse “young parents dropping off two or three children with the grandparents; no food, no nothing and the grandparents’ benefits all goes to feeding the little ones”. Other instances of financial abuse were where the family uses the older person’s personal allowance, “not giving money for the haircut, for the doctor’s appointment and not even for the clothing of the old person”.

Adults from India also live in extended family households, and neglect and disrespect were seen as resulting from stress associated with lack of time for family interaction, or

where living arrangements violate cultural norms. Similarly, Pacific concepts of respect are challenged by shortages of housing and appropriate caregivers. For example, brothers and sisters should not live in close proximity, and a daughter in a caregiving role should not bathe or dress her father. Problems occur when two sets of parents (of adult children) live under the same roof, or the older person lives with the daughter rather than the son.

Older Chinese people were said to have a dream of following and supporting their child, of selling everything in China and coming to New Zealand to look after the grandchildren. But having done so they often have no-one to talk to and no control over finances. Adult children feel that money is family money, and the son in particular may feel that it is his right to use the mother's money. She may end up living alone in poor housing, or in residential care if businesses fail and houses are lost.

The economic stresses and ambition of Chinese adult children were also considered to be factors in the financial and psychological abuse and social isolation of older people. The costs of family members' addiction to gambling and smoking were specifically mentioned, with older people pressured to fund these activities; for example, by threats of loss of family contact if they do not comply. Expectations that reciprocal obligations will be fulfilled are often disappointed, and the older person may complain, lose their temper and shout. Grandchildren follow this example and shout at the older person.

Pacific informants also noted the increasing isolation and erosion of respect for older people, saying that "children are so active and the older person gets stressed and yells at the kids or the kids become very rude to the old person". They noted that "the old person runs out of energy, can't get on with their own life, and uses up all their money. The older people have no time to go to groups or even free time to visit." This lack of consideration for the older person's emotional, physical and social needs causes loneliness and feelings of helplessness, and can lead to depression and suicide.

The stigma attached to abuse and the reluctance of older people to expose their family to community disapproval leads to lack of disclosure of needs for care and support, and contributes to ongoing hidden abuse. This situation is exacerbated for those increasing numbers who have no opportunities to speak in their own language with their age peers, who do not understand the New Zealand system and who have only the immediate family to care for them.

Abuse, isolation and lack of power in family settings may be replicated in residential care. There is a stigma attached to placing an older person in residential care but nevertheless older Pacific, Chinese and Indian people are living in these facilities. Pacific people observed a connection between the way the family treated the old person and their treatment in care. If a person is neglected by the family and not visited, they may be abused or neglected by the staff – "they are not looked after the same way as others because there doesn't seem to be others loving them so they are not caring for them the same way as they do those who have a visitor all the time". They reported instances of nurses being unkind and smacking older people. Pacific, Indian and Chinese people in residential care are also at risk of physical abuse and neglect because of the perceived disinterest of families. They are also subjected to extreme linguistic and cultural isolation.

The lack of social and community networks make older people more vulnerable and is a factor in continuing abuse, as under these circumstances abuse is more easily hidden and the old person does not have the knowledge, language or means to seek support. A Chinese informant remarked that "the Chinese in China are changing and becoming more individualistic ... and this is happening even faster in New Zealand

where people want more independence. This makes the elderly more vulnerable to neglect and abuse. They need support to build up their own group of friends.” An Indian informant described a day centre as an ideal support, “a place to go where they can talk with others, share past experiences as well as provide a place to talk freely about the family situation”.

Pacific people also recognised the importance of community engagement by older people in informal groups, in community centres and in churches, and focused on “going back to culture and language to ensure that older people are consulted in decision-making in families”. Equally important for Pacific people was giving a good example as a community, “making sure we pamper our children and be respectful of older people around us. Bring love and respect of older people into everyday life.”

There is diversity within the Pacific, Indian and Chinese communities but common factors contributing to abuse and similar solutions were identified across these and mainstream groups. As someone from a Pacific community remarked, “abuse is a human thing, not an ethnic thing. When we are kind and loving we are all the same. The abuse issue is the negative aspects of being human.”

Affirmation of traditional cultural values of loving and caring and respect for elders and reciprocity was seen by all as essential to preventing elder abuse. These values were seen to be missing in community life in New Zealand society now. This was vividly expressed in this way: “You are trying to canoe up instead of down sometimes with these young people” by a Pacific informant. Cultural strengths of family solidarity, obligation of parents to children and children to parents and community support were highlighted.

However, the strong cultural norms requiring family members to support and protect each other actually appeared to increase abuse when it did occur, because of the fear of community disapproval and the reluctance of older people to disclose abuse and seek help, thus stigmatising the family. The importance of supports outside the family and community to balance the dependence of older people on their immediate families was acknowledged. Suggestions for ways to break down the isolation and build up the spiritual strength and social networks of older people included extending services such



as Time Out day sessions at community centres, training active older people to visit the home-bound, developing telephone networks and providing transport to enable people to access services and religious organisations and to connect with each other. It was noted that some key service organisations for older people do not work with Asian people.

Other services specifically and repeatedly identified as contributing to the protection of older people from abuse were educational and informational services designed to break down the marginalisation and increase the independence of older people. They include providing information for the public, families and older people themselves about the rights of older people, the caring benefits available to families, government policies about positive ageing and, for those new to the country, information about the way the New Zealand legal, financial and health systems work and what is and is not acceptable in the community.

Workshops specifically to educate people on how to identify and stop abuse were wanted. Another key area of need was showing people how to set up and access their own bank accounts. Such groups will have diverse learning and informational styles, and the effectiveness of these initiatives depends on appreciating and catering to these differences.

Finally, informants stressed that one voice does not speak for all. For example, the cultural realities do not match current funding criteria. The delivery of informational and other services must take cultural diversity into account. All who contributed their views to this study want a more ethnically and culturally informed approach and suggested stronger links between culturally based NGOs and government.

3.5 ASPIRE DATABASE

Of the 569 older people who were recruited to the ASPIRE study over 18 months, 21 triggered at least one Elder Abuse CAP (EAC) during the first 12 months of the trial period (Parsons et al, 2006).

The four Elder Abuse trigger items in the MDS–HC assessment, which may signal (potential) abuse include: fear of a family member or carer; unexplained injuries; broken bones, burns, that are neglected, abused or mistreated; and being physically restrained (for example, limbs restrained, the use of bed rails, being confined to a chair). Of the four trigger types, 13 of the 21 (62 percent) older people reported fear of a carer or family member. One older person (4.8 percent) had an unexplained injury, while two (9.5 percent) reported neglect, abuse or mistreatment. A total of seven (33.3 percent) indicated that some form of physical restraint had been used. As some individuals reported more than one trigger, percentages add up to more than 100 percent. Since the total number of cases of suspected elder abuse and neglect identified from this database was small, the characteristics and outcomes are presented as total numbers rather than by groups.

The mean age of the sample identified as at risk of elder abuse was slightly lower (78 years) than the baseline mean age of ASPIRE participants (84 years). The at-risk group was also a highly dependent group, all of them reliant on others to assist with all everyday activities. Less than half of the at-risk sample of older people (n=10) lived in their own home. Nine of the older people had informal care-givers living permanently with the older person; the other older person lived alone and was visited daily by an informal care-giver. Living arrangements for the other 10 older people included five who lived with adult children, two in retirement villages and two who resided in private hospitals.

Just over half of the group reported an admission to a hospital in the past year, suggesting that these participants may be at high risk, not only for abuse and neglect, but also of severe health problems.

TABLE 8: CHARACTERISTICS OF THE OLDER PEOPLE WHO TRIGGERED ELDER ABUSE CLINICAL ASSESSMENT PROTOCOLS IN ASPIRE STUDY (N=21)

Female	14	(68%)
Mean (range) age (n=21)	78	
Married	21	(100%)
Ethnicity European	18	(86%)
Health and disability needs		
High	15	(71.4%)
Very high	6	(28.5%)
Living arrangements		
Own home	10	(48%)
Family member's home	5	(24%)
Retirement village/unit	2	(9.5%)
Community residential home	2	(9.5%)
Private hospital	2	(9.5%)
Memory problems (self-reported)		
Yes	15	(71%)
Communication problems		
Yes	11	(52%)
Hospital admission in past year		
Yes	11	(52%)
Home alone		
Yes	7	(33%)
Has a caregiver		
Yes	14	(66%)
Requires help for everyday activities		
Yes	21	(100%)
Social activities		
Not having visitors or visiting people	15	(71.4%)
No decline in social activities in last three months	13	(61.6%)
Not seeing/speaking to relatives	1	(4.7%)
No interaction with friends	7	(33.3%)
No interaction with neighbours	9	(42.8%)
Not attending religious meetings	2	(9.5%)
Not attending meetings of community/social group	5	(23%)
Feel lonely when alone	11	(52.4%)

Consistent with 90 percent of older people enrolled in the ASPIRE study as a whole, the older people 'at risk' of elder abuse and neglect were also found to have reduced social networks. Participation in preferred activities by eight of the participants had reduced over the previous three months. Just over half of the at-risk group reported feelings of loneliness, which reinforces the finding related to reduced social networks.

Informal caregiver demographics

The informal caregiver baseline demographics were collected at the same time as the older person's baseline assessment was completed. In total, 13 informal caregivers were identified as providing a caregiving role for the 21 older people who triggered a potential at-risk elder abuse and neglect CAP. The average informal caregiver's age was 60 years. A high proportion of caregivers lived with the older person (69 percent). The caregiver tended to be an adult child, and only six of the caregivers were in paid employment. The caregivers reported a high level of dissatisfaction, as recorded on the Caregiver Reaction Assessment (median: 77, based on the 24-item CRA; possible range: 24 to 120, with the higher score representing greater dissatisfaction with the caregiving role).



TABLE 9: CHARACTERISTICS OF INFORMAL CAREGIVERS IN A SAMPLE OF OLDER PEOPLE WHO TRIGGERED ELDER ABUSE CLINICAL ASSESSMENT PROTOCOLS IN ASPIRE STUDY (N=13)

Age mean (n=13)	59.55	
Gender		
Female	8	(61%)
Male	5	(38%)
Lives with older person		
Yes	9	(69%)
No	4	(30%)
Relationship with older person		
Child or child-in-law	7	(53%)
Spouse	5	(38%)
Other relative	1	(7.6%)
Employed		
Yes	6	(54%)
No	7	(46%)
Caregiver Reaction Assessment		
Median	77	SD 8.14

4. DISCUSSION

4.1 INTRODUCTION

This research project is the first in New Zealand to seek to identify risk and protective factors associated with elder abuse and neglect from data that were not drawn from service-based statistics. By seeking input from a wide range of data sources, including older people themselves, service providers and NGOs that provide support services to older people and their families and individuals from diverse ethnic groups and geographic regions, the study tapped into an extraordinarily wide range of expertise. The qualitative methods employed also contributed to the richness of the data gathered.

An additional strength of the project was the use of the ecological model as a framework. It increases the potential for unpicking the complex interaction between individuals and their environment (Glantz & Johnson, 1999), and identifies factors that can be modified at the social and group level, as well as the individual level.

The richness of the data collected also covers the wide variety of circumstances that can be counted as elder abuse and neglect. This variety needs to be acknowledged, as some of the risk and protective factors identified are likely to be most relevant to a single category of abuse (such as abuse perpetrated by staff within residential care settings), while other such factors may be relevant to all categories of elder abuse and neglect (for example, societal views on the role and value of older people).

Certain categories stand out from the results.

Individual level

Isolation and the increasing physical (and sometimes mental) challenges associated with ageing emerged as among the primary individual-level risk factors associated for elder abuse and neglect. They were compounded when they occurred in a life context that included other adverse events such as other forms of violence, and poverty. Perpetrators were generally family members or close relatives, adding a further complexity to the risk and protective factors.

Family level

Supportive families were universally recognised as protective against all types of elder abuse and neglect. Threats to the ability of families to be supportive were varied, ranging from longstanding issues of violence within families, to pressure on family members who were overburdened, and greed. Each of these strands is likely to require different prevention strategies, some of which are already being developed (for example, child abuse prevention initiatives, strategies to increase the responsiveness to victims of intimate partner violence; and strategies designed to reduce stress on caregiver and improve work-life balance).

Institutional level

Key risk factors associated with elder abuse and neglect in residential care settings related to issues of staffing, which were linked with training, funding, staff-to-resident ratios and organisational culture. Informants in the study clearly linked optimal numbers of well trained and well paid residential care staff with the provision of quality care.

It was also noted that other 'institutions' have important roles to play in protection from elder abuse and neglect. Some of the suggested strategies involved banks, lawyers, churches and faith communities and police.

Community level

Many of the risk and protective factors identified at this level spoke of the value and necessity of community connectedness. Older people need social networks in their own generation and across generations. Multiple factors were seen to contribute to social connectedness, including accessible public transport and community facilities and housing policy. The availability of services (or lack thereof) was raised as a particular issue in rural communities. The social connectedness found in close-knit communities was regarded as a protective factor.

Society level

Strong themes emerged about the undervaluing of older people in society as a whole. This was linked with the perceived lack of productivity of people who are no longer in paid employment. Participants in this study overwhelmingly endorsed the need to promote more positive images of older people, and develop a culture of respect and valuing the unique contribution of older people.

Current high-level societal issues such as the cost of living and the unavailability of caregiving were seen to contribute to the pressures on families that create environments where elder abuse and neglect are more likely to occur. In particular, pressures on adult family members to be in paid employment limit opportunities for even close, supportive families to provide care for older people.

Ideologies about love and respect within families are challenged by others' ideologies about the ways families and individuals are supposed to behave. For example, ideas about the intergenerational transfer of wealth may contribute to the occurrence of elder abuse and neglect, in relation to financial abuse. Ideologies about family loyalty and personal independence contribute to the silence about abuse.



4.2 ECOLOGICAL LEVELS FOR RISK AND PROTECTIVE FACTORS FOR ELDER ABUSE AND NEGLECT

FIGURE 4: RISK FACTORS FOR ELDER ABUSE AND NEGLECT CATEGORISED IN AN ECOLOGICAL FRAMEWORK

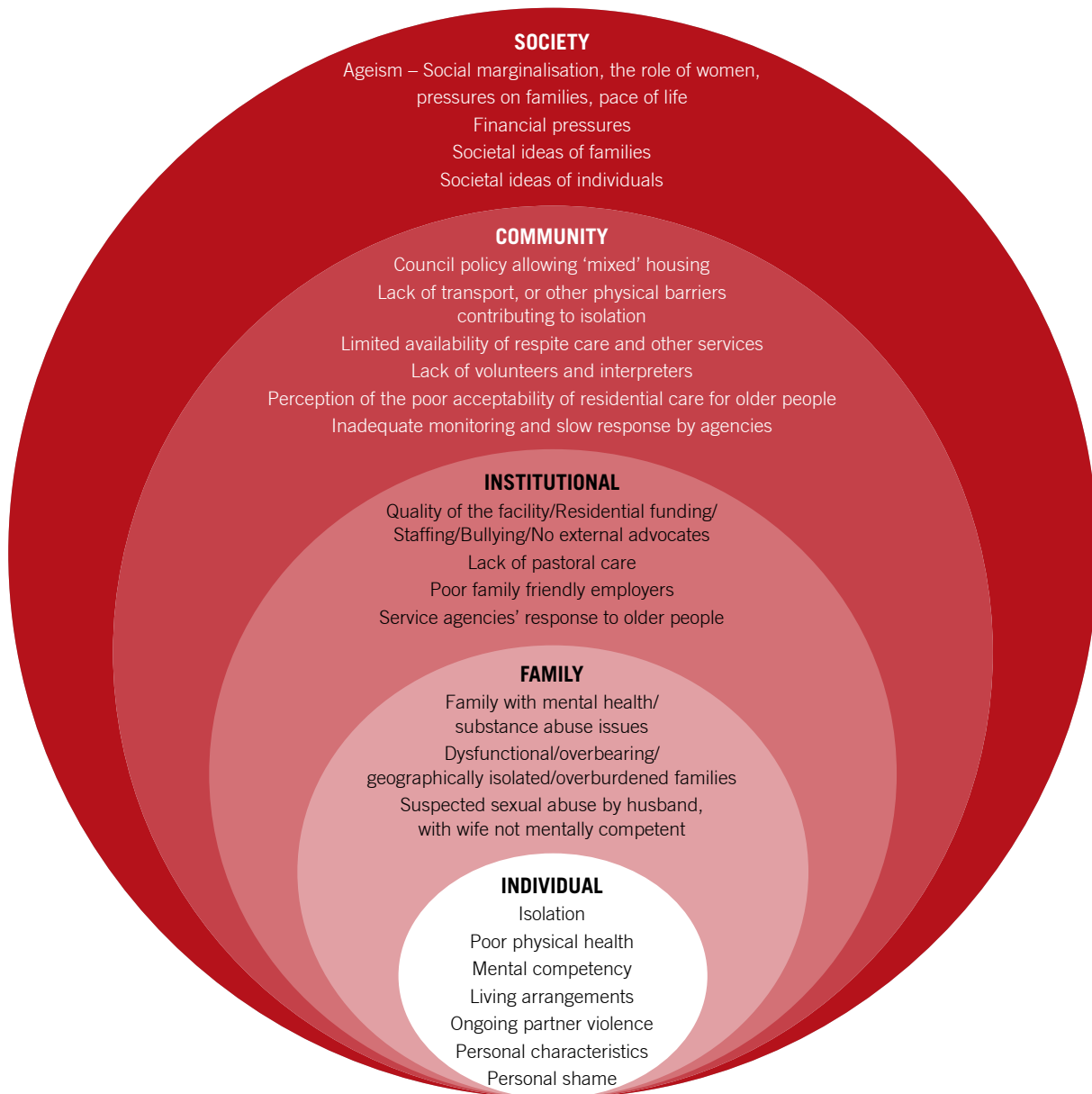
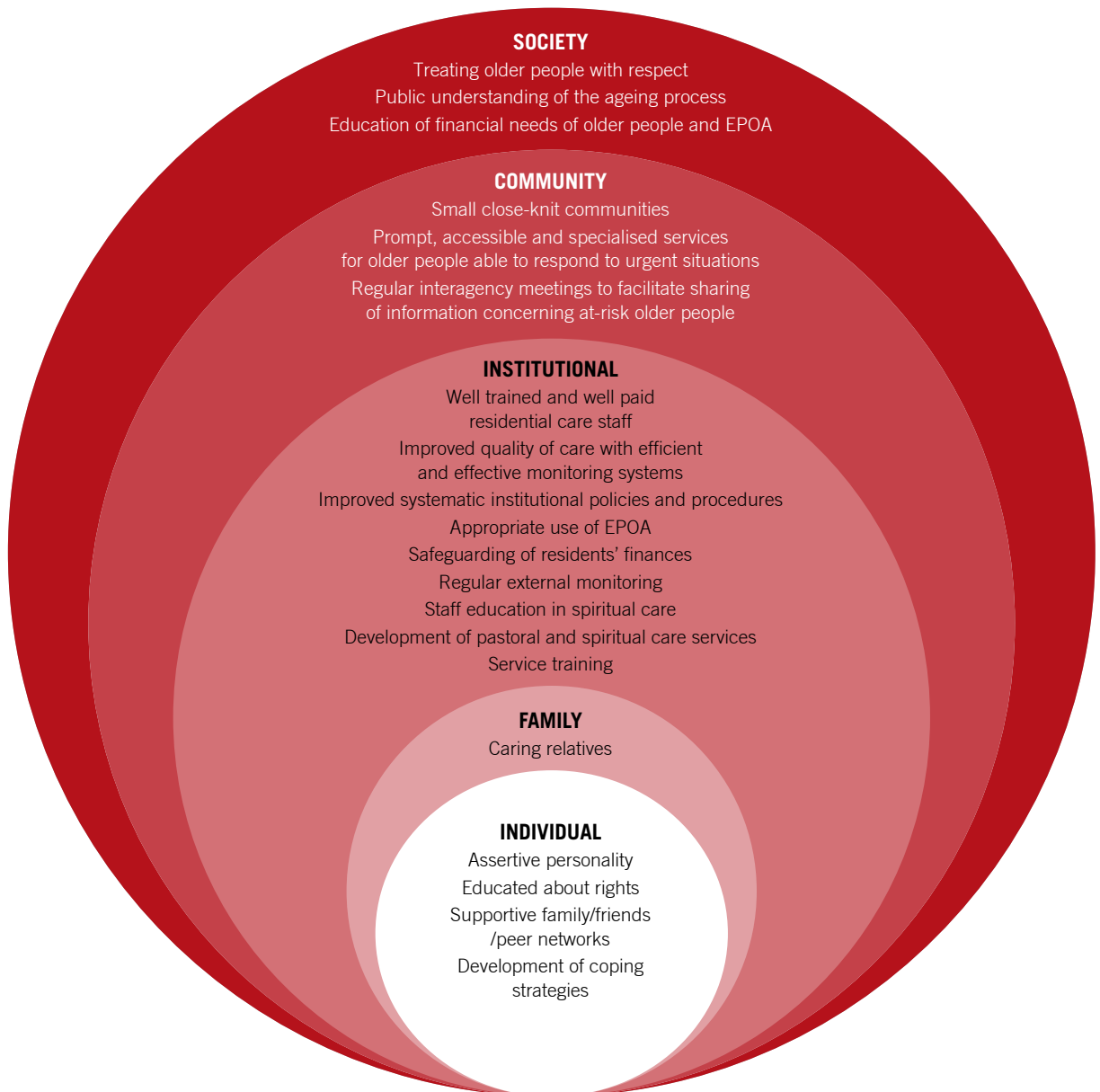


FIGURE 5: PROTECTIVE FACTORS FOR ELDER ABUSE AND NEGLECT CATEGORISED IN AN ECOLOGICAL FRAMEWORK



ASPIRE

These findings are highly relevant for planning interventions to strengthen older people's social networks and participation in social activities. Elder abuse research asserts that enforced isolation is common amongst abusers and the abused, and that isolation allows them to maintain a blanket of secrecy. This secrecy is often linked to shame on the part of the abused, which is conducive to ongoing abusive behaviour by the perpetrator. Studies have shown that social isolation is one of the key risk factors for older people (Schiamberg & Gans, 2000).

The at-risk older people reported a high level of dependency and high cognitive impairment. Interestingly, however, 13 of the 21 ranked their self-reported health and rated their quality of life as very good. This finding indicates that, despite being at risk of abuse and neglect, these individuals still experienced some degree of subjective wellbeing. Living in the community rather than residential care may act as a buffer to some extent.

4.3 LIMITATIONS

A limitation of qualitative research is that it cannot provide an indication of the scale of a problem in the community, nor can it determine the relative weight of different risk or protective factors. The findings from the present study, therefore, cannot provide us with insight as to which types of elder abuse and neglect are most common, or what factors most urgently need to be addressed. What the findings can provide us with is a list of factors that might productively be tested in a quantitative sample, to determine their relative contribution to the overall problem of elder abuse and neglect.

Finally, while we sought to canvass the views and understandings of a wide range of informants, we did not interview any perpetrators of elder abuse. Nor did we interview caregivers of older people who are examples of ageing positively.

Our recommendations will concentrate on how the findings of this research can be used to support policy and practice, and inform a programme of research to further our understanding of elder abuse and neglect in New Zealand.

4.4 CONCLUDING COMMENTS

Older people, families and communities will benefit from the positive perspectives the informants and researchers observed. Strong themes that emerged from the data were valuing and respecting older people, developing strong and healthy families and preparing for positive ageing.

Valuing and respecting older people

All informants recognised the need to promote more positive images of older people, and to develop a culture of respecting them and valuing the unique contributions that older people can make. Contributions to society other than participation in the paid workforce need to be recognised, and caregiving and human connection in various contexts (to an older person, or by an older person caring for others such as grandchildren) need to be valued more highly. Valuing of and respect for older people is most likely in a society in which the old and the young are well integrated.

Developing strong and healthy families

Valuing and respecting others is most effectively learnt in family contexts. The findings of this study highlighted the strong links between a family history of abuse and later risk of elder abuse and neglect. Effective prevention strategies for child abuse and intimate partner violence may also contribute to reducing abuse throughout the life-span.

Adequate support for the family members of older people and particular care for those family caregivers with mental health and addiction problems is important.

Preparing for positive ageing

The study's findings highlighted a need for more concerted efforts to help individuals and families to prepare for positive ageing. Many strands were noted in this area of need. Understanding of age-related changes is needed, to prepare for physical, psychological, emotional and social changes, and to be prepared financially. Housing options are also crucial, not only as regards quality residential care, but also access to safe and supportive rental and other housing. Older people are also protected when they are well informed about their rights.

This report illustrates the complexity of elder abuse and neglect, and the multiple factors that can contribute to its occurrence. Any prevention or intervention strategy will need to recognise this complexity. While not definitive, the findings suggest important implications for people preparing for old age, for the support of families, for the planning of communities and for societal attitudes and public policy.

4.5 RECOMMENDATIONS

Policy

The informants and the research team all acknowledged that there is already a substantial policy base for many of the suggestions generated by this study for action to respond to elder abuse and neglect. In particular, the Positive Aging Strategy, the Health of Older People Strategy and the Ministry of Health's Family Violence Intervention Guidelines: Elder abuse and neglect were mentioned. These high-level policy documents were considered to provide important frameworks for action. A number of participants said that they considered some of the most important prevention strategies for elder abuse and neglect to be the widespread implementation and appropriate resourcing of these existing strategies. In particular, strategies to promote positive interaction among the generations and positive images of older people were identified as important for affirming the value of older people.

Practice

As in the policy environment, the research team also acknowledges that there are good examples of the practical implementation of the frameworks in some local and regional settings (such as the Auckland City Council Positive Aging Strategy). However, the geographic variation in implementation of strategies and services (rural locations have more limited resources) remains a challenge. Funding for direct services related to elder abuse and neglect is limited, which limits what can be accomplished. Residential care facilities also report being under-resourced, and having difficulty attracting and retaining well trained staff at all levels.

Research

1. Further research is necessary to determine the prevalence of elder abuse and neglect in New Zealand.

This could be accomplished in several ways. One option would be to piggy-back direct questions about abuse onto an existing study of older people in New Zealand. A second would be a national or regional study for the specific purpose of assessing the prevalence of elder abuse and neglect.

In either case, findings from the present study suggest that the questions in such a prevalence study would need to elicit information as to who were the perpetrators of the abuse, and the types of abuse that occurred. Further documentation of this information from a population-based sample would be necessary to identify the largest groups of abusers, and the most frequent types of abuse, so that priorities for action could be established.

Findings from the present study suggest that the following categories of perpetrators need to be considered: family members; caregivers (in-home, or in residential facilities); professionals (such as lawyers, health care professionals); and tradespeople. Information should also be sought on the frequency and co-occurrence of different types of abuse, including physical, sexual, psychological and emotional abuse, neglect and financial abuse. In particular, given the paucity of information on sexual violence, specific questions will be needed to gain an understanding of the scale of this problem.

2. Quantitative assessment will be needed of the frequency and relative strength of risk and protective factors.

The risk and protective factors identified in this study need further exploration, to determine their distribution in the population, and the strength of their contributions to the risk or the amelioration of the risk of specific types of elder abuse.

These factors will need to be operationalised; with standardised questions to establish their reliability and validity. These standardised questions would then have to be administered to a large enough sample of people with knowledge about the abuse status of the subjects, to determine which factors actually increased the risk, and which conferred some protection from abuse. This information is necessary to guide the development of effective and appropriately targeted intervention and prevention strategies.

3. Further in-depth investigation is needed of older people and families that are doing well, particularly under adverse circumstances.

The paucity of protective factors found in the present study may partly be a reflection of the 'squeaky wheel' phenomenon, where the situations that cause concern attract the most attention. The effective steps that individuals, families and services take, even where the older people are suffering increasing disability, or the families are under financial or other strain, may go unnoticed. Further structured exploration of individuals and families that are doing well, using case studies or other investigative techniques, could be a fruitful way of discovering and documenting more protective strategies.

4. In-depth investigation is needed of the views of younger generations about ageing and the value of old people.

Another priority is understanding the perspectives of young people and taking into account their diversity on how they regard the older generation. This information is important not only for educating the young and adult members of society, but also to support projects targeting negative images of older people.

5. REFERENCES

- Age Concern New Zealand Inc. (2005). *Age Concern Elder Abuse and Neglect Prevention Services: An analysis of referrals for the period: 1 July 2002 to 30 June 2004*. Author, Wellington.
- Age Concern New Zealand Inc. (2006). *National Action Plan and National Reference Group Report*. Author, Wellington
- Brozowski, K., & Hall, D. (2003). 'Elder Abuse in a Risk Society'. *Geriatrics Today*, 6: 167–172.
- Choi, N., Kulick, D., Mayer, J. (1999). 'Financial Exploitation of Elders: Analysis of risk factors based on county adult protective services data'. *Journal of Elder Abuse Neglect*, 10: 362–369.
- Compton, S.A., Flanagan P., Gregg, W. (1997). 'Elder Abuse in People with Dementia in Northern Ireland: Prevalence and predictors in cases referred to a psychiatry of old age service'. *International Journal of Geriatric Psychiatry* 12: 632–635.
- Cooney, C., & Mortimer, A. (1995). 'Elder abuse and dementia: a pilot study.' *International Journal of Social Psychiatry*, 41: 276–283.
- Creswell, J. (2003). *Research Design Qualitative, Quantitative and Mixed Methods Approaches*. Sage Publications, London.
- Decalmer, P., & Glendenning, F. (1993). *The Mistreatment of Elderly People*. Sage Publications, London.
- Dyer, C., Pavlik, D.B., Murphy, K., Hyman, D.J. (2002). 'The High Prevalence of Depression and Dementia in Elder Abuse and Neglect'. *Journal of the American Geriatrics Society*, 48: 205–258.
- Fanslow, J. (2005). *Beyond Zero Tolerance: Key issues and future direction for family violence work in New Zealand*. Families Commission, Wellington.
- Garmezy, N. (1985). 'Stress-resistant Children: The search for protective factors'. *Recent Research in Developmental Psychopathology*: 213–233.
- Glantz, M.D., & Johnson, J.L. (1999). *Resilience and Development: positive life adaptations*. Kluwer Academic/Plenum Publishers, New York.
- Hand, J., Elizabeth, V., Martin, B., Rauwhero, H., Burton, M., Selby, S., Falanitule, L. (2002). *Free from Abuse: What women say and what can be done*. Public Health Promotion, Auckland District Health Board, Auckland.
- Krug E.D., Mercy, L.L., Zwi, J.A., & Lozano, R. (2002). *World Report on Violence and Health*. World Health Organisation, Geneva.
- Lachs, M.S., & Pillmer, K. (2004). 'Elder abuse'. *The Lancet*, 64: 1263–1272.
- Lachs, M.S., Williams, C., O'Brien, S., Hurst, L., Horwitz, R. (1997). 'Risk Factors for Reported Elder Abuse and Neglect: A nine year observational cohort study'. *Gerontologist* 37: 469–474.
- Palmore, E.B. (1990). 'Predictors of Outcome in Nursing Homes'. *Journal of Applied Gerontology*, 9(2): 172.
- Parsons, M., Anderson, C., Senior, H., Chen, X., Kerse, N., Brown, P., Jacobs, S., Jorgensen, D., & Kilpatrick, J. (2006). *ASPIRE (Assessment of Services Promoting Independence and Recovery in Elders)*. The University of Auckland, Auckland.
- Paveza, G. J., Cohen, D., Eisdorfer C., Freels, S., Semla, T., Ashford, J.W., Gorelick, P., Hirschman, R., Luchins, D., Levy, P. (1992). 'Severe Family Violence and Alzheimer's disease: prevalence and risk factors'. *Gerontologist*, 32: 493–497.
- Pillemer, K., & Sutor, J.J. (1992). 'Violence and Violent Feelings: What causes them among family care givers?' *Journal of Gerontology*, 47: 469–474.
- Pillemer, K., & Findelhor, D. (1989). 'Causes of Elder Abuse: Care-giver stress versus problem relatives'. *American Journal of Orthopsychiatry*, 59: 179–187.
- Schiemberg, L., & Gans, D. (2000). 'Elder Abuse by Adult Children: An applied ecological framework for understanding contextual risk factors and the intergenerational character of quality of life'. *International Journal of Aging and Human Development*, 50(4): 329–359.
- The Taskforce for Action on Violence within Families. (2006). *The Taskforce for Action on Violence within Families: The first report*. Ministry of Social Development, Wellington.
- Thomas, D.R. (2006). 'A General Inductive Approach for Analyzing Qualitative Evaluation Data'. *American Journal of Evaluation*, 27(1): 1–10.
- Wolf, R.S. & Pillemer, K. (1989). *Helping Elderly Victims: The reality of elder abuse*. Columbia University Press, New York.

Families Commission research reports

- 1/05 *Review of New Zealand Longitudinal Studies*, Michelle Poland and Jaimie Legge, May 2005.
- 2/05 *Review of Parenting Programmes*, Anne Kerslake Hendricks and Radha Balakrishnan, June 2005.
- 3/05 *Beyond Zero Tolerance: Key issues and future directions for family violence work in New Zealand*, Janet Fanslow, August 2005.
- 4/05 *Focus on Families: Reinforcing the importance of family*. Families with dependent children – Successful Outcomes Project. Report on literature review and focus groups, Katie Stevens, Marny Dickson and Michelle Poland with Rajen Prasad, October 2005.
- 5/05 *Methodologies for Analysing the Impact of Public Policy on Families: A conceptual review*, Jacqui True, October 2005.
- 1/06 *What Makes Your Family Tick?* Families with dependent children – Successful Outcomes Project. Report on public consultation, Robyn Seth-Purdie, Andrew Cameron and Francis Luketina, March 2006.
- 2/06 *Review of the Empirical Literature Assessing the Impacts of Government Policies on Family Form: A report for the Families Commission*, Jeremy Robertson, Vanessa Rogers and Jan Pryor, April 2006.
- 1/07 *When School's Out: Conversations with parents, carers and children about out of school services*. A Families Commission report, Donella Bellett and Marny Dickson, February 2007.
- 2/07 *Moving On: Changes in a year in family living arrangements*. A Families Commission report, Michelle Poland, Andrew Cameron, Karen Wong and Michael Fletcher, February 2007.
- 3/07 *It's About Time: Towards a parental leave policy that gives New Zealand families real choice*. A Families Commission report, Marny Dickson, Helen Moore, Karen Wong and Susie Johnston, August 2007.

Reports are available on the Commission's website www.nzfamilies.org.nz or contact the Commission to request copies:

Families Commission
PO Box 2839
Wellington 6140
New Zealand
Telephone: 04 917 7040
Email: enquiries@nzfamilies.org.nz

Wellington office

Public Trust Building, Level 6
117–125 Lambton Quay
PO Box 2839, Wellington 6140
Phone 04 917 7040
Fax 04 917 7059

Auckland office

AMI House, Level 5
63 Albert Street, Auckland 1010
Phone 09 970 1700

Email

enquiries@nzfamilies.org.nz

Commission website

www.nzfamilies.org.nz

***The Couch* website**

www.thecouch.org.nz