Literature Scan

Prevention of Abuse of Older People (AOP) within Aotearoa: A scan of the literature.

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Social Change & Innovation

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Executive summary

Ihi Research undertook an initial scan of available literature for the Ministry of Social Development (MSD) to better understand the abuse of older people (AOP) within Aotearoa New Zealand, as well as factors associated with it. The following questions guided the scan:

- **What is the current state of evidence in relation to the abuse of older people (elder abuse) within Aotearoa New Zealand?**
    - What is known? What does literature cover, include, focus on, privilege, prioritise?
    - What isn't known? What is not covered, left out, silent, marginalised, underprivileged?
- **In the context of Aotearoa New Zealand, what is known about:**
    - the drivers of harm for abuse and their relationship with prevention?
    - universal protections against the abuse of older people?
- **What areas or fields of research beyond literature focussing on AOP/elder abuse could provide further insights for the prevention of AOP?**
- **What recommendations emerge for further research?**

Evidence was sought from a variety of published sources (peer reviewed journal articles, book chapters, published reports, websites, media reports etc). A total of 24 sources were included in the scan that focussed specifically on AOP within Aotearoa. Another 24 evidence sources were also included from other fields of research to provide further insights on risk and protection factors and for the prevention of AOP. There are specific limitations in relation to the analysis, as it was conducted in a short period of time and should not be taken as a full literature review. However, analysis highlighted opportunities for further research.

In relation to what is known about AOP within the context of Aotearoa, several themes emerged from analysis that emphasised the complexity of the phenomenon, and the challenges associated with studying it. These include:

- There are various competing theories and methodologies that underpin research into AOP
- There are challenges and limitations associated with key definitions

- AOP is difficult to detect, and underreporting is a significant issue
- There are common risk and protective factors identified in the literature.

Trust (and the breaking of that trust) is often emphasised in definitions of AOP. However, definitions of AOP have changed over time and commonly accepted definitions have been criticised as not accounting for cultural differences, particularly the absence of spiritual abuse.

Results emphasise the considerable gaps within the available evidence related to AOP within Aotearoa. There are also acknowledged ethnic and gendered biases within the literature. There is a dearth of research on older people who identify as takatāpui, lesbian, gay, bisexual, transgender or intersex. Māori, Pacific, Asian, diverse migrant communities and disabled peoples located across urban and rural settings are also under-represented within the current evidence-base. In particular, there is a lack of research on older people within our prison system. Cultural diversity needs to be recognised and addressed, which is more than ethnicity as it relates to the values, beliefs and practices of particular groups. Whilst ageism was identified as a risk factor, there was not enough attention given to racism. Literature scan analysis also suggests that the framing of literature/research is largely deficit in nature. Older people are largely portrayed as vulnerable victims and there is a lack of a strengths-based focus.

The context in which people live influence the risk and protective factors related to AOP. A lack of acknowledgement of government social and economic policies that place some groups of older people at risk of AOP is evident in the literature.

Findings highlighted the interrelated nature of risk and protective/preventative factors and how these emerged across wider environments. Risk factors emerged in the absence of protective factors. Analysis highlighted the emphasis on risk factors, but there was little evidence on how to prevent and/or address AOP, particularly given most abusers are identified as family/whānau members. Whilst family mediation and restorative justice were identified in one study, there was concern expressed about the cultural competence of staff who may be involved in such processes.

A summary of common findings emerging from literature scan analysis are presented in the following figure. Four key domains surfaced: aged adults, caregivers, context and system drivers interact to increase the risk of AOP. Preventive factors associated with each of these domains have been shown to decrease the risk of exposure to AOP.

Findings from Literature Scan

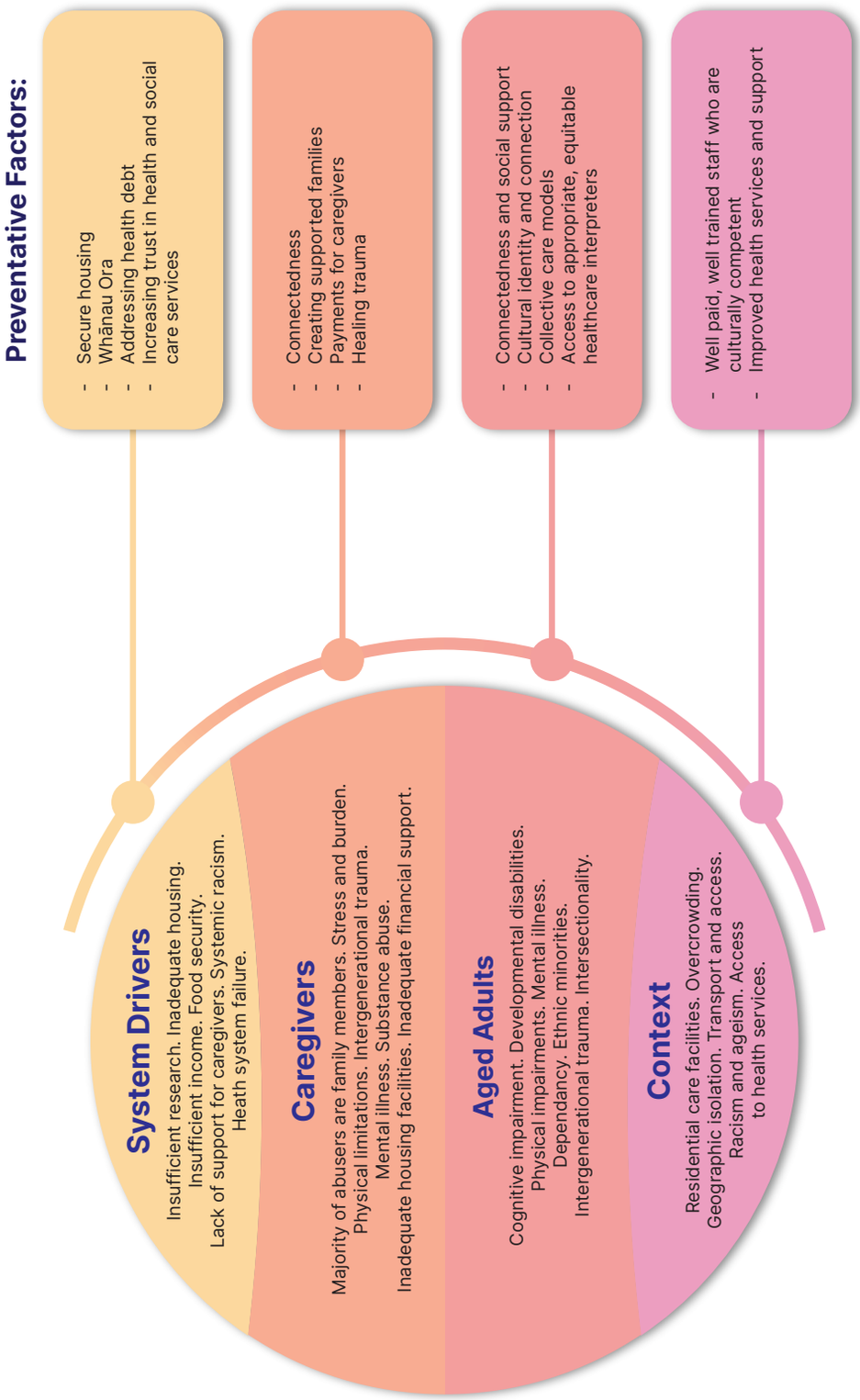

Figure 1. Key findings from the review

Recommendations for further research emerged from analysis:

- Undertake further research into the four domains (aged adults, caregivers/whānau/family wellbeing, context and systems drivers) that emerged from this literature scan to better understand how they interact to increase and/or reduce the risk of AOP.

- Address the lack of research that addresses the intersectionality of older people prioritising their voices and advocacy groups in an investigation into risk and protective factors associated with AOP within Aotearoa.

- Fund research and development into culturally embedded, collective care initiatives (such as Whānau Ora) and with community champions and influencers (such as Matt and Sarah Brown) to better understand the impact on such approaches to address/prevent AOP within specific communities.

- Understand the influence of wairua – spiritual health and wellbeing, and its relationship to AOP as a protective and/or risk factor within culturally diverse communities within Aotearoa.

- Undertake partnership research and development with whānau, hapū and iwi to better understand the impact of papakāinga and kaumātua-centric housing initiatives and its relationship to AOP.

- Fund longitudinal research to better understand how wider contextual issues and systems drivers of harm and protection influence the prevalence of AOP within specific communities.

Introduction

The Abuse of Older People (AOP), also known as elder abuse, is receiving more attention within Aotearoa (Woodhead, 2018) and internationally (World Health Organization, 2022a). Understanding and preventing this type of abuse must be a priority for governments and society, as it is a human rights issue and social justice concern (Bagshaw, Adams, Zannettino & Wendt, 2015). Research undertaken overseas (Lachs et al, 1998 cited in Storey, 2020) found victims of elder abuse are three times more likely to die within nine years following abuse than non-victims. According to research conducted in the United States, estimated costs of elder abuse "contribute more than $5.3 billion of the nation's annual health expenditures." (Weissberger, Goodman, Mosqueda, Schoen et al, 2020, p. 2).

Within Aotearoa New Zealand, the Ministry of Social Development (MSD) is working with diverse communities to develop and implement evidence-based family and sexual violence prevention initiatives. A change in legislation recognised AOP as a form of family violence through the passing of the Family Violence Act, 2018. In addition, AOP can be perpetuated in aged care settings, and by governments through inequitable social and economic policies that inhibit the health and wellbeing of older citizens (World Health Organization, 2022a; Woodhead, 2018). There is increasing interest in evidence-based programmes focussed on the prevention of AOP. However, there has been limited research previously commissioned in relation to AOP which specifically focusses on prevention.

Ihi Research undertook a brief literature scan to assist MSD in framing further inquiry in this area.

The following questions guided this review:

- **What is the current state of evidence in relation to the abuse of older people (elder abuse) within Aotearoa New Zealand?**
    - What is known? What does the literature cover, include, focus on, privilege, prioritise?
    - What isn't known? What is not covered, left out, silent, marginalised, underprivileged?
- **In the context of Aotearoa New Zealand, what is known about:**
    - the drivers of harm for abuse and their relationship with prevention?
    - universal protections against the abuse of older people?

- **What areas or fields of research beyond literature focussing on AOP/ elder abuse could provide further insights for the prevention of AOP?**

- **What recommendations emerge for further research?**

Search process

Ihi researchers collaborated with key staff from the Ministry of Social Development to locate initial relevant documents and published research. To widen the document search, the following search terms were used:

Elder, older people/adults, neglect, abuse, violence, health, caregiving, childminding, culture, grandparents, Pacific, Pasifika, Māori, Asian, residential settings, nursing staff, aged care, risk/protective factors, New Zealand, Aotearoa, rainbow, Indigenous.

These terms were used to locate literature and were coupled with other terms such as measure(s), definition(s), screening tool(s), intervention(s), strengths-based, impact and innovation. Further information on the methodology can be found in Appendix 1.

In total, 24 documents/sources that specifically focussed on AOP within Aotearoa were included in this scan. A further 24 documents which related to other fields that were linked to risk/protective factors within Aotearoa were also reviewed and included in the literature scan. The following table provides a summary description of the types of documents/publications reviewed.

Included sources related to the study of AOP within Aotearoa New Zealand		Included sources related to other fields of research (that are linked to risk/ protective factors identified with AOP) conducted within Aotearoa		Total Number
Type of document	**Number**	**Type of document**	**Number**	
Peer reviewed journal articles	9	Peer reviewed journal articles	9	18
Thesis	1	Thesis	1	2
Reports	9	Reports	13	22
Media/websites	5	Media/websites	1	6
Totals	**24**		**24**	**48**

Table 1. Summary description of scanned documents

Considerations

This literature scan was completed within a short time frame so is constrained in terms of its depth and scope and should not be considered a literature review. All reviewed material was written in English and does not include studies or publications written in te reo Māori and/or other Pacific languages. Search terms used in this literature scan, such as Māori, Pacific and Asian older people are also limiting as they do not recognise the “cultural and historical diversity” of peoples within these ethnic groups (Anae, Anderson, Benseman & Coxon, 2002, p. 2).

Results

The current state of evidence

The following section addresses the first set of inquiry questions: 'What is the current state of evidence in relation to the abuse of older people (elder abuse) within Aotearoa New Zealand? What is known and given prominence? What does the literature cover?'

Several key themes emerged from analysis.

- Various competing theories and methodologies underpin research into AOP
- There are challenges associated with key definitions
- AOP is difficult to detect, and under-reporting is a significant issue
- There are common risk and protective factors identified in the literature

Findings from the literature scan highlight the complexity of the phenomenon, and the challenges associated with studying it.

Section 1: What is known?

Various theories and methodologies used to study AOP

The literature scan identified various theories and methodologies (qualitative, quantitative, mixed methods) that underpin research into AOP within Aotearoa. Frequently used theories were noted by Woodhead (2018, p. 32) to underpin research into AOP. These include:

- The 'Stressed caregiver' theory (the burden of caring for an older person, particularly if they have complex needs).
- 'Psychopathology' theory (where caregivers have limited abilities to care for an older person due to alcoholism, mental issues, etc).
- 'Dependency' theory whereby the older person is dependent on the caregiver and the caregiver is dependent on the older person.
- 'Life Course' perspective and 'learned violence' concept are identified as common theories used in the study of AOP (as described by Woodhead, 2018). Woodhead notes these theories include the role of family violence and the interplay of social relationships and bonds (both positive and negative), across a person's lifespan. Intergenerational violence is relevant

in the study of AOP. For example, when a child who was abused by a family member, is now older and is tasked with looking after the older person who had previously abused them.

- 'Ecological' theory highlighting various interacting levels (individual, family, community, society) that influence both risk and protective factors related to AOP.

It is widely acknowledged that there are different forms of AOP, including physical, psychological/emotional, financial, neglect and sexual abuse (Ministry of Social Development, 2019; Woodhead, 2018; Păroşanu, 2017; Peri, Fanslow, Hand & Parsons, 2008). Institutional forms of AOP include policies and practices that do not uphold an older person's rights and can include bullying and disrespectful behaviour (Peri et al, 2008). There is also discriminatory abuse, which includes "racism, ageism, discrimination based on disability, and other forms of harassment, slur or similar treatment." (Păroşanu, 2017, p. 4).

The following list provides some examples of the way AOP has been studied within Aotearoa:

- Waldegrave (2015) gathered data in 2012 through the New Zealand Longitudinal Study of Ageing (NZLSA). The Vulnerability to Abuse Screening Scale (VASS) developed for the Australian Longitudinal Study of Women's Health as a self-report screening scale for elder abuse was applied. This study was considered significant as it was the first to provide an "evidence-base of the prevalence of elder abuse, some of the populations most affected and the observed impacts of it." (p. 1). Several other studies/ reports identified in this scan referenced this evidence (for example Woodhead, 2018).

- Peri, Fanslow, Hand and Parsons (2008, p. 18) used an Ecological Framework (citing the work of Krug et al, 2002) to identify various levels of risk and protective factors as experienced by older people in Aotearoa (individual, family, institutional, community, societal and cultural).

- Woodhead (2018) analysed data through the 2010 and 2012 waves of the New Zealand Longitudinal Study of Ageing (NZLSA) which focussed on health and ageing indicators. This was the same data used by Waldegrave (2015). Multiple regression, moderation and mediation analyses and longitudinal analyses were applied by Woodhead (2018), following up in two years to identify specific risk factors for AOP.

- Nanai, Thaggard and Tautolo (2021) explored the thoughts and experiences of 12 Samoan tagata matutua (older people) related to abuse of older people, using talanoa methods.

- Weatherall (2001) used a mixed methods approach (questionnaire and interview process) to investigate managers' experiences of elder abuse occurring within residential care facilities. Twenty-seven residential care facilities in Wellington were identified, participants included 26 managers, with one person being responsible for two facilities.

- Park (2014) investigated the psycho-social impacts of elder mistreatment on the health and wellbeing of 10 older Korean people living in New Zealand.

- Păroşanu (2017) undertook a comprehensive literature review on elder harm and restorative practices examining research from Aotearoa and internationally.

- Păroşanu and Marshall (2020) evaluated a pilot project that employed restorative, family mediation approaches for addressing harms experienced by older persons within whānau/families.

There are government reports/websites detailing data on AOP including:

- Ministry of Social Development reports (2019, 2020) that have examined elder abuse in Aotearoa and the current state of MSD's Elder Abuse Response Services. The later report "provides a high-level overview of the proposed future strategy" for these services.

- Te Tari Kaumātua Office for Seniors (2022a&b) reports on elder abuse. The Office recently announced that 11 "successful organisations" will share $250,000 to fund projects to help prevent elder abuse (2022a, p. 1). These projects have received funding but have not yet been evaluated.

- The New Zealand Government (2021) has initiated a campaign to create awareness on elder abuse and its harms.

A number of organisations have published data on AOP within Aotearoa including:

- New Zealand Nurses' Organisation (2017). This publication details results from an elder abuse helpline. Calls were answered by experienced registered nurses who were trained to deal with elder abuse.

- Age Care Concern (2023a&b) provides information on the rights of older people and publishes data related to AOP.

There are a few studies on family violence that highlight the age of victims and identify AOP as a family violence issue:

- Dissanayake and Bracewell (2022) investigated front page (media) articles

related to specific characteristics (gender, age, ethnicity) of people who were victims of family violence.

- Te Aorerekura (2022) published results from a series of hui, written submissions and conversations with older people and kaumātua. The report describes "the experience for older people and kaumātua with the family violence and sexual violence systems and the opportunities for improving how Aotearoa New Zealand work to prevent, respond, heal and recover from these forms of violence" (p. 1).

- Fanslow, Gulliver, Hashemi, Malihi and McIntosh (2021) examined the methods for data collection through the 2019 NZ Family Violence Survey. Specific questions were included that related to those older than 65 years (women and men).

Although not specifically investigating AOP, there are other studies that touch on aspects known to contribute to AOP. For example, Muru-Lanning, Lapsley and Dawes (2021) used kaupapa Māori research methods to better understand the perspectives of kaumātua (older Māori men and women) in relation to ageing well. Burholt, Balmer, Frey, Meha, et al., (2022) investigated caregiver stress amongst older people's caregivers during COVID-19. Other reports have published the views of Māori service providers to create an 'Elder Abuse Management Policy' (see Violence Intervention Programme Taranaki DHB, 2019). Hikaka and Kerse's (2021) study on older Māori and Aged Residential Care makes the point there is limited ethnicity-based analyses, which hampers the identification of inequities. There is a need to explore the quality of care for kaumātua in aged residential care facilities.

Some published material is related to the development of appropriate screening tools and the detection of AOP. For example, Hall, Smith, Turner, et al. (2022) have used New Zealand data to identify opportunities to improve detection of older adult abuse.

Common recommendations call for further research into AOP within Aotearoa as robust evidence is needed to inform policy and practice. There is also widespread concern that AOP will increase as the population of older people grows within Aotearoa. Păroşanu and Marshall (2020) highlight estimations that "the number of people aged 65 or above" will likely double "to 1.2 million by 2035, and there will be an even greater relative increase in the over 80 decile" (p. 4).

Challenges associated with key definitions

A common problem or issue relates to definitions, particularly associated with defining 'old age' and 'abuse'. According to the Ministry of Social Development (2019) most definitions and services reflect, "Pākehā, middle-class, heterosexual, cisgender, perspectives" (p. 24) and this significantly inhibits progress. Within

Aotearoa, old age is tied to 65 years and older. This is typically viewed as the retirement age, partly because at 65 people can receive benefits from the New Zealand superannuation scheme (Woodhead, 2018). However, there is no compulsory retirement age in Aotearoa and many older people choose to work beyond 65 (full or part-time) and still receive superannuation payments (Age Concern, 2023a). Citing the work of Cannon (2015), Woodhead notes three classifications of older people that are recognised within the literature: "the young-old (65-74 years old), the old-old (75-84 years old) and the oldest-old (85+ years old)" (2018, p. 4). Woodhead warns that old age is a social idea, significantly influenced by socio-cultural and political factors (ibid).

Defining abuse is also challenging, partly because there are different dimensions of abuse, and these have changed over time. A WHO report (2002) stated that older people experience abuse under three distinct areas:

- Neglect — isolation, abandonment and social exclusion
- Violation — of human, legal and medical rights
- Deprivation — of choices, decisions, status, finances and respect (p. v)

A more recent WHO definition states; *"The abuse of older people, also known as elder abuse, is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person*[1]*. This type of violence constitutes a violation of human rights and includes physical, sexual, psychological and emotional abuse; financial and material abuse; abandonment; neglect; and serious loss of dignity and respect."* (World Health Organisation, 2022a, p. 1).

Findings from the literature scan indicate that many authors reference the first sentence of the definition above. For example, Woodhead (2018)[2] cites both Age Concern New Zealand (2007) and the Ministry of Health (Glasgow, & Fanslow, 2006) publications and their use of this. Woodhead herself uses this definition (2018). This definition is also utilised in Te Aorerekura (2022) and the 'Violence Intervention Programme Taranaki DHB' (2019) as it is encompassed within definitions of family violence (Dissanayake & Bracewell, 2022; Te Aorerekura, 2022; Violence Intervention Programme Taranaki DHB, 2019). While neglect is included in the definition it is important to note that self-neglect is not, nor is harm committed by strangers (Păroşanu, 2017).

Trust (and the breaking of that trust) is often emphasised in definitions (Păroşanu, 2017; Waldegrave, 2015). The abuse of trust and subsequent harm on the older person was commonly identified at an individual level (committed by someone known to the older person, where there should be an expectation of trust). For example, Health Navigator New Zealand (2020) emphasised that, "Elder abuse is any behaviour causing harm or distress to an older person by someone they should be able to trust" (p. 1). It is frequently accepted that AOP occurs across diverse

communities and research within Aotearoa has involved Pākehā, Māori, Pacific, and Asian communities. Research undertaken by Peri et al (2008) concludes that "abuse is a human thing, not an ethnic thing" (p. 9).

However, commonly accepted definitions of elder abuse have been heavily criticised both within Aotearoa and overseas, as they do not account for spiritual abuse or harm (Peri et al, 2008) as experienced by Pacific elders within Aotearoa (Nanai, Thaggard, & Tautolo, 2021) nor Indigenous elders in the United States (Gray, LaBore, & Carter, 2021). Spiritual abuse harms the older person's spiritual integrity and general wellbeing, through a lack of access to spiritual resources and/or practices that prevents them from pursuing spiritual expression (Gray et al, 2021; Nanai et al, 2021; Peri et al, 2008). Within Aotearoa taha wairua (spiritual dimensions) is an essential Pou of Professor Mason Durie's Te Whare Tapa Whā that underpins a unified model of Māori health. It is linked to taha tinana (highlighting physical dimensions), taha hinengaro (highlighting emotional dimensions), taha whānau (highlighting social dimensions) and the interwoven connections to whenua (Rochford, 2004).

A study included in this literature scan (Muru-Lanning, Lapsley & Dawes, 2021) involved kaumātua (older Māori men and women) talking about their own wellbeing as they aged. Findings emphasised the importance of 'ageing well' as a holistic process, connecting hinengaro (mental health), wairua (the spirit and spiritual health), tinana (physical health) and te taiao (natural environments) (Muru-Lanning, Lapsley & Dawes, 2021). Although this study was not focussed on abuse of kaumātua, findings highlight the importance of spiritual health connected to other dimensions of hauora (health). Such results have implications for defining abuse as experienced by culturally diverse communities, as well as the development and implementation of appropriate screening tools, prevention approaches to AOP and early intervention programmes.

AOP is difficult to detect, and under-reporting is a significant issue

Abuse of older people is difficult to detect, and older people can experience more than one form at once (Ministry of Social Development, 2020; Păroşanu, 2017). It is significantly under-reported and largely hidden, yet it is viewed as increasing within Aotearoa (Te Aorerekura, 2022; Ministry of Social Development, 2020; 2019; Păroşanu, 2017) and internationally (WHO, 2022a). Under-reporting is linked to a general lack of awareness of 'what counts' as abuse within families and communities (Woodhead, 2018). Older people often do not report abuse due

[1] This definition was first used in 1995 by the UK's Action on Elder Abuse and adopted by WHO (cited by Păroşanu, 2017, p. 2)

[2] In addition, Woodhead (2018) argues that "Specific to New Zealand is an additional sixth form of abuse called abuse of enduring power of attorney. This occurs when a person who has been appointed as an enduring power of attorney abuses their entrusted powers and fails to operate in the best interests of the older person" (p. 8). However, this is likely to be seen as a form of financial or material abuse.

to feelings of shame and fear (Păroşanu, 2017), particularly if the abuser is a whānau/family member or intimate partner (Nanai, Thaggard & Tautolo, 2021). In addition, older people may put up with abuse from whānau/family members due to feelings of loyalty (Thaggard, Boon-Nanai, Tautolo & Montayre, 2000). Dementia and cognitive and physical decline also impact people's abilities to be aware that abuse is occurring (Păroşanu, 2017). Even if older people report abuse, their complaints may not be taken seriously (Woodhead, 2018). Ageism and ageist attitudes contribute to the problem of under-reporting (Woodhead, 2018). Ageism is a serious form of discrimination within Aotearoa, that violates the rights of older people (Ministry of Social Development, 2019; Woodhead, 2018).

Whilst it is difficult to ascertain exact statistics of abuse of older people within Aotearoa, due to chronic under-reporting (Woodhead, 2018), it has been described as "New Zealand's greatest hidden secret" (Stuff, 2019, p. 1). Results from a longitudinal study of ageing within Aotearoa (Waldegrave, 2015) suggest one in 10 people over the age of 65 experience some form of abuse. It is recognised as a serious and growing problem (Office for Seniors, 2022a&b; Ministry of Social Development, 2020; 2019), with some agencies stating it is "rampant" within Aotearoa (New Zealand Nurses' Organisation, 2017, p. 1). Dissanayake and Bracewell (2022) cite statistics from the NZ Police (2018) that suggest as many as three in four cases of elder abuse go unreported. In addition, many more people are reaching retirement age, therefore the number of older people who experience abuse is expected to grow (Ministry of Social Development, 2020; Păroşanu & Marshall, 2020).

To ascertain the prevalence of abuse amongst older people, screening tools, questionnaires and surveys have been developed, but response rates can be limited if participants do not have access to the internet and/or if they do not have proficient English language skills (Feltner, Wallace, Berkman, Kistler et al, 2018). In English-dominated countries such as Aotearoa, screening tools, surveys and call centres are typically conducted in English, which limits the ability to connect with older people who are not fluent English speakers (Woodhead, 2018). The lack of trained language interpreters who are easily accessible by older people compounds the problem of AOP (Peri et al, 2008).

Commonly identified risk and protective factors

There are varying studies that have identified frequent risk and/or protective factors associated with the abuse of older people within Aotearoa. These are located across a wider eco-system that impacts the health and wellbeing of diverse communities as they age.

Risk factors

Literature findings highlight that risk factors are most obvious through the absence of protective factors. For example, ill-health, loneliness, and low social support are identified as key risk factors of elder abuse (Te Aorerekura, 2022; Ministry of Social Development, 2019; Woodhead, 2018; Waldegrave, 2015; Peri et al, 2008). Risk factors increase with advanced age and are associated with deteriorating mental and physical health. Dementia and cognitive decline make it difficult for an older person to understand what is happening for them as well as their ability to report abuse (Păroşanu, 2017). Vulnerability when relying on people for daily care and support is a risk factor (New Zealand Government, 2021). "A vulnerable adult is someone who because of their age, sickness or mental impairment, or because they are in detention, is completely unable to remove themselves from the care or charge of another person" (Community Law, 2023, p. 1). The issues of vulnerability and neglect of older people has implications for research into AOP within the prison system, since older people are unable to remove themselves from the care they receive. There was a dearth of research that examined this within the AOP literature.

However, others suggest that more research is needed in this area (Ara Poutama Aotearoa Department of Corrections, 2021; Office of the Inspectorate, Department of Corrections, 2020; Waitangi Tribunal, 2017). For example, a study undertaken by the Office of the Inspectorate on the lived experience of older people within the prison system emphasised that the prison system is designed for younger prisoners and that "prisoners 65 years and older have not been managed by Corrections as a distinct group" (p. 9). Despite the fact the numbers of older people within our prison system are expected to grow, this study found there was not enough attention being given to the needs of older prisoners to ensure their imprisonment was humane and safe.

For older prisoners, whose physical or cognitive abilities are declining, the prison environment can be extremely challenging. Double bunked cells, limited disability cells, limited accommodation adaptations (e.g. grab rails, ramps, emergency alarm buttons and shower seats) and long walking distances to various facilities, including health centres and programme rooms, are some of the issues older prisoners face when in prison. Some researchers have described this experience as a 'double punishment', as older prisoners are naturally exposed to a harsher prison environment than younger prisoners (Office of the Inspectorate, Department of Corrections, 2020, p. 13).

This report also noted some examples of "unreasonable use of restraints" being used on older people when travelling to health appointments (Office of the Inspectorate, Department of Corrections, 2020, p. 20). In addition, it was noted that prison standards highlighting the need for prisoners to travel in safe and decent conditions were not being followed.

Many older prisoners we spoke with talked about their distress when travelling long distances between prisons in the prisoner escort vehicles. Prisoners said they were placed in steel cages, had no or limited access to toileting facilities and drinking water, had little opportunity for comfort breaks, were required to travel long distances and often did not understand why they were being transferred. Many also described the physical condition of the drive as being particularly hard on their bodies. Prisoner escort vehicles are not fitted with seat belts (Office of the Inspectorate, Department of Corrections, 2020, p. 21).

There are expressed concerns the Department of Corrections has failed to meet its obligations under Te Tiriti o Waitangi, as "the difference between Māori and non-Māori reoffending rates is substantial, undisputed and contributes to the disproportionate number of Māori in prison" (Waitangi Tribunal, 2017, p. x). This implies that Māori are more likely to be overrepresented in the older age group of prisoners and maybe more vunerable to abuse and neglect. Further research is needed to ascertain risk and protective factors for AOP for diverse populations within our prison system.

Risk factors are often related to the personal circumstances of older people (Woodhead, 2018). Although there are many different types of abuse, psychological/emotional abuse, neglect and financial abuse are most commonly reported, both within Aotearoa (Boon-Nanai, Thaggard & Montayre, 2022; Te Aorerekura, 2022; Ministry of Social Development, 2019; New Zealand Nurses; Organisation, 2017; Waldegrave, 2015; Park, 2014; Weatherall, 2001) and overseas (Fraga Dominguez, Storey & Glorney, 2021; Weissberger, Goodman, Mosqueda, Schoen, Nguyen, Wilber, Gassoumis, Nguyen & Han, 2020; Bagshaw, Adams, Zannettino, & Wendt, 2015). Women are reported as experiencing more abuse as they age than men, with Māori experiencing significantly more AOP when compared with non-Māori (Waldegrave, 2015). In addition, sexual abuse is reported less often and seen to impact older women more than men (Ministry of Social Development, 2019).

It has been reported that over 50% of elder abuse cases involve financial abuse (Ministry of Social Development). Poverty and financial hardship of older people and/or their family members (particularly those who are the main carers of older people) are key risk factors (Boon-Nanai, Thaggard & Montayre, 2022; Gray, LaBore, & Carter, 2021). Inheritance impatience has been associated with financial abuse by family members. Physical abuse has been identified in one in five cases of reported elder abuse (Ministry of Social Development, 2019).

Family and institutional risk factors include 'caregiver'[3] stress and burden. Caregiver burden is associated with the high demands placed on carers who are tasked with looking after older people with complex health needs (Ministry of Social Development, 2019; Woodhead, 2018). Currently carers of older people are undervalued and are low-paid or unpaid. Caregivers often lack training and receive little or no professional support (Tough, Brinkhof & Fekete, 2022).

Citing research by Decalmer and Glendenning (1993), Peri et al (2008) note that institutional abuse and neglect can include "medication errors, high use of psychotropic drugs, poor management of challenging behaviours particularly of residents with dementia and poorer functional outcomes" (p. 16). Neglect may not be intentional and may be more to do with a lack of appropriate training and supervision (Tough, Brinkhof & Fekete, 2022).

Research within Aotearoa indicates the majority of abusers are family members (Age Care Concern, 2023b; Te Aorerekura, 2022; Boon-Nanai, Thaggard & Montayre, 2022; Scoop News; 2021; Parosanu & Marshall, 2020; Woodhead, 2018; New Zealand Nurses' Organisation, 2017; Park, 2014; Weatherall, 2001). Current statistics suggest that 70% of abusers are family/whānau members (Te Aorerekura, 2022) with more than half of alleged abusers being either adult children or grandchildren (New Zealand Nurses' Organisation, 2017). The quality of the relationship between the older person and the carer is important (if the relationship is positive – this is a protective factor and if it is negative – this is a risk factor). Past experience of abuse and a history of family violence is also identified as a risk factor (Ministry of Social Development, 2019).

One study by Park (2014) found that older Korean migrants to Aotearoa, may be more susceptible to family abuse and neglect. Park (2014) interviewed older Korean people (aged between 71 and 88) who had migrated with their families and who had self-identified as being neglected and mistreated in family settings. Findings highlighted 'Hwa-byung', described by participants as an anger disease. Participants grew angry and frustrated as they struggled with feelings of abandonment and increased isolation, whilst experiencing emotional and financial abuse by family members. Multiple negative impacts included "emotional distress, physical pain, low self-esteem, demoralisation and depression, isolation and unhappiness" that impacted on the health and wellbeing of participants (p. 126). Park (2014) found that older migrants were more "likely to experience the stress of adjustment, emotional distress with language barriers, cultural alienation and social isolation" as they struggled with cross-cultural adaptation (p. 127).

Ecological risk factors are also highlighted in the literature emphasising various interdependent layers of risk operating at an individual level, family level, institutional level and community and society level (Ministry of Social Development, 2019; Peri et al, 2008). To highlight interacting factors the Ministry of Social Development published the following table on risk factors for victims/survivors, as well as for the perpetrator of abuse and the wider influencing context (2019, p. 10).

[3] Caregiver stress and burden is covered in more detail in the following section 'Systems drivers of caregiver stress and burden'

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

Table 1 Risk Factors for elder abuse taken from Ministry of Social Development (2019, p.10).

Wider environmental factors include the COVID-19 and Omicron virus outbreaks and subsequent lockdowns introduced to combat rising infections rates. In some areas COVID-19 has been identified as increasing the risk of AOP (Mckew, 2020).

Ageism is evident as a common environmental risk factor and systems driver of harm within the literature. However, other environmental risk factors related to 'discriminatory abuse' are not given enough attention, despite the significant harms these produce. For example, racism, negative stereotypes and discrimination are clearly evident in social service and health provision for older Māori and Pacific people (Savage et al, 2020; Waitangi Tribunal, 2019; Ryan, Grey & Mischiewski, 2019). Research has highlighted the significant distrust that many Māori and Pacific people have towards government agencies, that prevent them from gaining the help they need (Cram et al, 2022; Savage et al, 2021; Savage et al, 2020; Waitangi Tribunal, 2019). A lack of interpreters within our health system and agencies working to protect older people from abuse who are not fluent in English, is discriminatory and a considerable risk factor (Peri et al, 2008).

Protective factors

Protective factors are seen to eliminate many risks of AOP, but these appear considerably under-researched in studies when compared to risk factors. Protective factors operate across the wider ecosystem of connectedness and inclusiveness (individual, family, institution, community and wider society). A key protective factor is the valuing of older people and their contribution to family, community and societal wellbeing within Aotearoa (Age Concern New Zealand 2023a; Te Aorerekura, 2022; Fanslow et al, 2021; Office for Seniors, 2019).

Social support for older people has been identified as a protective factor, including regular face-to-face contact with others in the community (Woodhead, 2018). Positive cultural identification is also recognised as a protective factor, alongside community connectedness (Peri et al, 2008). Supportive families are protective against all forms of elder neglect and abuse (Peri et al, 2008). High numbers of well-paid, well-trained staff who are culturally competent within residential care facilities are also identified as protective (Te Aorerekura, 2022).

Age friendly communities are important for preventing elder abuse, as they foster social connectedness (Peri et al, 2008). These communities value older people and their contributions to community life. Such communities have accessible public transport, accessible social and primary health services as well as community facilities and affordable, safe and secure housing. Doctors, banks, police, churches and faith communities all play a part in identifying AOP and intervening to protect older people (Peri et al, 2008).

Increased community and societal awareness and visibility of what constitutes AOP is identified as a protective factor (Te Aorerekura), alongside appropriate legal protections and understanding of measures such as Enduring Power of Attorney. Liveable incomes for the older person and their carers have also been identified as protective factors (ibid). Some reports included in this literature scan, were not focussed on AOP but identified key government strategies – such as the 'Better Later Life Strategy' (Office for Seniors, 2019). The vision of this strategy is that "Older New Zealanders lead valued, connected and fulfilling lives - Kia noho ora tonu ngā kaumātua" (p. 2). Key actions to underpin the 'Better Later Life Strategy/ include:

- Achieving financial security and economic participation for older people
- Promoting healthy ageing and improving access to services
- Creating diverse housing choices and options
- Enhancing opportunities for participation and social connection
- Making environments accessible.

These actions are aligned to protective factors within the AOP literature, such as healthy ageing and increased social connection (Woodhead, 2018).

Section 2: What isn't known?

Limitations and gaps within the available evidence-base

Results from the literature scan demonstrate considerable gaps and also emphasise limitations within the available evidence related to the abuse of older people. This has been reported within Aotearoa (Te Aorerekura, 2022; Hikaka & Kerse, 2021; Nanai, Thaggard, & Tautolo, 2021; Ministry of Social Development, 2020; 2019; Woodhead, 2018) as well as internationally (Gray, LaBore & Carter, 2021; World Health Organisation, 2022a; Bagshaw, Adams, Zannettino & Wendt, 2015). Empirical studies on the abuse of older people are limited and the views of older people are often not sought (Fraga Dominguez, Storey & Glorney, 2021). The lack of reliable and valid data on both the prevalence of abuse of older people from diverse communities, and the risk and protective factors associated with it is a systems driver of harm (WHO, 2022a; Feltner, Wallace, Berkman, Kistler et al, 2018). Whilst research into AOP has identified ecological influences such as individual, family, institutional, community and society (Peri et al, 2008), there is far less attention given to government social and economic policies that influence risk and protective factors. Literature scan analysis also suggests that the framing of literature/research is largely deficit in nature. Older people are portrayed as vulnerable victims and there is a lack of a strengths-based focus.

There are considerable ethnic biases within the evidence. The majority of participants involved in research are identified as Pākehā/European (Te Aorerekura, 2022; Păroşanu & Marshall, 2020; Woodhead, 2018; Păroşanu, 2017; Bagshaw, Adams, Zannettino & Wendt, 2015). This is partly due to ageing statistics (they live longer), and they are more likely to be included in studies (Păroşanu, 2017). Within Aotearoa, statistics highlight that Pākehā Europeans make up around 88% of the 65+ population, Māori 6%, Asian 5% and Pacific peoples 2% - although the percentage of Māori and Pacific older populations are expected to grow rapidly in the next 50 years (Te Aorerekura, 2022).

Some studies show greater ethnic diversity. For example, whilst Woodhead's (2018) study indicated the majority (62.4%) were non-Māori, 37.6% identified "as Māori" (p. 68). The number of Māori participants was well above demographic proportions (meaning this was a significant sample). However, data from Māori participants were analysed with the wider sample and not analysed separately as a sub-group. Therefore, it is difficult to know if their responses were comparatively different to their non-Māori peers. Within Aotearoa, there is a lack of ethnicity data on older people who live in aged care facilities and there are concerns about the quality of care for kaumātua Māori (Hikaka & Kerse, 2021).

Woodhead (2018) does note cultural biases within screening processes to identify abuse of older people both within Aotearoa and overseas. Citing other authors (Lachs & Pillemer, 2004; Mukherjee, 2013) she argues that in some Asian cultures older people are expected to be cared for by younger family members in ways that relieve the older person of decision-making burdens, including their

input into financial and health matters. Family members may act on behalf of an older family member, as this is seen as a sign of respect, and may do so without the older person's informed consent or input. This same act in Western European cultures can be considered as financially and psychologically abusive and overcontrolling (Woodhead, 2018).

Research conducted with Samoan elders within Aotearoa highlights the different cultural expectations and collective, cultural obligations that exist in contrast to individualistic, Pākehā norms (Nanai, Thaggard & Tautolo, 2021). In a qualitative study conducted by Nanai et al (2021) tagata matutua (Samoan elders) talked about how they perceived elder abuse, such as family members being placed in care homes dominated by palagi practices. One elder explained it like this.

"It's like sinning. If we put our elders in a rest home; that's emotional abuse. I'm sure no elder wants to go and stay there. They want to be looked after by their children." (Nanai, Thaggard & Tautolo, 2021, p. 411)

There are significant gaps in the available evidence-base and this constrains policy and practice designed to prevent abuse from occurring. For example, there is a dearth of research into the experiences of AOP from older people located in rural areas across Aotearoa. Given that isolation is a significant risk factor, older people living in isolated communities may be more at risk. There is also a lack of research into the perspectives of older people with disabilities. According to statistics from the Ministry of Social Development (2019), "60 percent of people in Aotearoa over 64 identify as disabled, with the percentage increasing for Māori and Pasifika, 74 percent and 78 percent respectively" (p. 11).

There is a dearth of research on older people who identify as takatāpui, lesbian, gay, bisexual, transgender or intersex. Diverse migrant communities also appear to be under-represented within the current evidence-base. Government funding[4] for preventing elder abuse within Aotearoa, has a strategic focus to include older people (65+) from Māori, Pacific, ethnic, rainbow, and disabled communities, however these initiatives have not yet been evaluated (Office for Seniors (2022a). Research and development initiatives must be more inclusive to understand the prevalence of abuse of older people and how to prevent and address it.

There is also a lack of research on culturally embedded, collective care models to prevent and/or address AOP. The Ministry of Social Development (2020) admit "there are a limited number of Elder Abuse Response Service providers specialising in delivering services to Māori, Pacific, Asian, and ethnic minority communities" (p. 17). One study included in this literature scan, evaluated a restorative justice pilot project in situations of elder abuse, harm, and neglect (Păroşanu & Marshall, 2020). Facilitators involved in the pilot had previous training "in restorative justice and/or mediation" and had some prior knowledge of family systems and family violence dynamics (Păroşanu & Marshall, 2020, p. 15). Although the pilot was

[4] The Elder Abuse Prevention Fund (Office of Seniors, 2022a).

largely evaluated as bringing about positive change, acknowledged limitations included the very small number of older people who participated in the study, with the majority being Pākehā/European. The cultural competence (or lack of such competence) of restorative justice facilitators was also highlighted.

To state the obvious, older people within Aotearoa are not homogeneous. Understanding the intersections of difference is essential in any project aimed at understanding AOP within Aotearoa, and the risk and protective factors associated with it. Intersectionality was developed by Professor Crenshaw to highlight the burden of compounding disadvantages unique to African American women. Intersectionality holds that the traditional models of oppression impacting people, such as those based on race/ethnicity, gender, religion, socio-economic status, dis/ability, sexual orientation and age, do not act independently of one another. Rather these forms of oppression interact creating a system underpinned by multiple forms of discrimination (Crenshaw, 1991). In relation to understanding protective factors and interventions designed to address AOP, this must lead to more nuanced analysis – moving past simplistic notions of 'what works?' to focus on 'what works – for whom? And under what set of conditions?'

Section 3: In the context of Aotearoa New Zealand what are the drivers of harm and their relationship with prevention?

The following section highlights findings from the literature scan regarding wider systems drivers of harm and their relationship with prevention approaches. Analysis indicates the abuse of older people is largely viewed as an individual, family/aged residential care issue and community-society level issue (Burholt, Balmer, Frey, Parsons et al, 2022; Dissanayake & Bracewell 2022; Păroşanu & Marshall, 2020; Fanslow, Gulliver, Hashemi, Malihi et al, 2021; New Zealand Government, 2021; Ministry of Social Development, 2020; 2019; New Zealand Nurses' Organisation, 2017). However, such findings ignore multiple drivers of harm that compound deprivation and marginalisation, placing older members of some communities more exposed to risk factors of abuse as they age. Findings presented in this section identify drivers of harm that negatively influence healthy ageing for these communities and what this means for prevention approaches within Aotearoa.

Colonisation, assimilation and racism

Racism, in all its forms, appears as a significant systemic driver of harm and this is most evident in research that accounts for the marginalisation of older Māori communities within Aotearoa (Hikaka & Kerse, 2021). Ageism for whānau Māori is a by-product of colonisation and racism. Prior to the arrival of the colonisers,

kaumātua (older people) were highly valued for their expertise and wisdom necessary for the health and wellbeing of whānau (Reid et al., 2017; Hokowai et al, 2020). The loss of status and disconnection to whenua and whakapapa, has placed older Māori at risk of abuse and neglect.

Whānau are the primary social unit and cornerstone of Māori society contributing to the expansion, health and wellbeing of hapū and iwi (Watene et al., 2017; Reid et al., 2017); a social unit that has been destabilised and disenfranchised as a direct result of deliberate successive government policies (Savage et al, 2021). Colonisation, assimilation, and systemic structural racism has resulted in whānau Māori experiencing deprivation, marginalisation and psychosocial harms (Savage et al., 2021; Watene et al., 2017; Waitangi Tribunal Report, 2019; Pihama et al., 2019; Reid et al., 2017; Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988). These harms have impacted whānau Māori in ways that have transmitted trauma across generations (Savage et al, 2021). Māori now suffer ill-health at greater rates than their Pākehā peers, and ill-health (mental and physical decline) is a risk factor for AOP (Woodhead, 2018).

Despite the signing of Te Tiriti o Waitangi in 1840, Māori collective strength (underpinned by whānau, hapū and iwi relationships) was menacing to 'Pākehā power-brokers' (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988, p. 58). This was evident in public announcements made by Sir Francis Dillon-Bell (a notable 19th century politician). "The first plank of public policy must be to stamp out the beastly communism of the Māori!" (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988, p. 58). Therefore, the undermining of Māori connectedness and supportive relationships that contributed to whānau wellbeing was not just a result of colonisation, but an important component of the colonial process (Reid et al., 2017). Cultural alienation, ill-health, isolation and loss of connection to whakapapa and whenua place older Māori at risk of elder abuse and neglect.

As early as 1863, legislation was used by the State to commit atrocities and human rights violations against tangata whenua. One example was the Suppression of Rebellion Act suspending the right to a fair trial and ensuring the imprisonment of whānau who opposed land confiscations (Bull, 2004). An indemnity Bill was also passed which ensured that crimes against a person or property were no longer deemed a criminal offence if committed by State volunteers or constabulary, provided the victim was Māori (Bull, 2004).

Successive governments developed and implemented enduring racist policies that stripped whānau of their ancestral lands and access to resources, as well as their language and culture (Reid et al, 2017). The increased labour demands, coupled with State policies of urbanisation and assimilation, saw waves of whānau moving into unfamiliar urban areas. The detrimental effects of urbanisation on whānau Māori have been identified as contributing to AOP within Māori communities (Peri

et al, 2008). This is evidence of cultural abuse, removing older Māori people's autonomy and ability to carry on valued cultural practices important for their health and wellbeing.

Savage, Moyle, Kus-Harbord, Ahuriri-Driscoll at al (2021) recently produced a comprehensive research report for the Royal Commission of Inquiry into State Care Abuse within Aotearoa (1950-1999). The study examined over 482 documents, including published research articles, advocacy group inquiries, government reports and institutional records. Their research focus was the cause of over-representation of Māori tamariki and vulnerable adults in State Care. Their findings demonstrated that successive governments were complicit in the removal of generations of tamariki Māori from their whānau, placing them in abusive environments that had devastating, negative impacts over decades. Whakapapa trauma has enduring consequences altering the DNA of colonised, Indigenous communities (Savage et al, 2021). Indicators of whakapapa trauma are evident within Māori communities who suffer from deteriorating health, higher rates of incarceration, domestic abuse, homelessness, isolation, mental illness, drug and alcohol addiction, unemployment and underemployment and reduced educational opportunities (Savage et al, 2021). These are all identified as risk factors for elder abuse (Ministry of Social Development, 2019).

There is plenty of evidence that trauma, if not resolved within one generation, can be passed from one generation to the next (Savage et al, 2021; Chief-Moon-Riley, Copeland, Metz & Currie, 2019, Ussher, 2021; Walters, Mohammad,Evans-Campbell, Beltrain, Chae & Duran, 2011). The loss of age-honouring values within Māori and Pacific communities within Aotearoa, has been particularly devastating for older people from these communities (Nanai, Thaggard, & Tautolo, 2021; Woodhead, 2018; Reid et al., 2017). Hokowai, Oetzel, Simpson et al (2020) emphasise the devastating intergenerational harms that have negatively affected kaumātua[5] hauora and status that have occurred through government policies of assimilation.

"Many of today's kaumātua, for example, were punished for speaking te reo Māori (the Māori language) through the colonial education system including in Native Schools. Moreover, during the time that this generation of kaumātua were going through State education, Māori children were generally defined as 'retarded' based on Western models of developmental psychology, with the blame being squarely located on 'traditional' Māori culture. That is, State policy was hegemonic in that it purposefully discouraged Māori children from practicing and valuing their Indigenous language and culture, whilst actively promoting the dominant non-Indigenous culture as superior." (Hokowai et al, 2020, p. 3). The result is that many kaumātua experience 'cultural dissonance' that isolates them from their

[5] Hokowai et al (2020) emphasise that the term kaumātua has different meanings in te ao Māori, however, is increasingly used as an identifier for an older Māori person. Kaumātua traditionally was a term used to identify someone with status and valid knowledge. However, these authors note, due to colonisation, many older Māori people today may lack cultural expertise and connection to te ao Māori and whānau, hapū and iwi.

culture (Hokowai et al, 2020, p. 3). Cultural connection has been identified as a protective factor for preventing AOP.

Pacific peoples within Aotearoa have also endured State endorsed racism and discriminatory practices (Asafo, 2021). The most noticeable of these was the Dawn Raids in the 1970s. These raids on Pacific households were part of a "full on political and legal strategy" implemented by both Labour and National governments (Asafo, 2021, p. 1). Despite the State initially facilitating the migration of Pacific peoples as a cheap labour force, the economic downturn of the 1970s meant that Pacific families were strategically blamed for rising unemployment and a rising cost of living (ibid). Negative stereotypes related to Pacific peoples as 'lazy' and 'greedy' 'dole-bludgers' have persisted despite the Crown's recent apology for the Dawn Raids (Asafo, 2021, p. 1). State endorsed racism has had devastating, detrimental impacts on Māori and Pacific communities and this has led to intergenerational harms directly impacting the health and wellbeing of whānau/families (Asafo, 2021; Savage et al, 2021). Structural and institutional racism is evident within our health system, and many Māori and Pacific people mistrust health professionals and their advice. Health professionals have been identified as people who can detect and report elder abuse (Woodhead, 2018). This presents a significant issue in the detection of AOP by health professionals.

Many previous studies have emphasised the distrust and anxiousness that Māori and Pacific people feel when interacting with mainstream health providers due to institutional racism, which influences the quality of health care they receive (Savage et al, 2020; Waitangi Tribunal, 2019; Ryan, Grey & Mischiewski, 2019; Davis et al., 2005). A lack of sustainable government funding for whānau-centred health and social services is also linked to structural racism (Savage et al, 2020; Waitangi Tribunal, 2019). For example, findings from an investigation into MSD's Elder Abuse Response Services found some kaupapa Māori providers were frustrated over a lack of government agency awareness that they cater for all ethnicities, resulting in lower referral rates of older people for services that are protective in nature (Ministry of Social Development, 2019).

Traditionally, kaumātua were viewed as taonga (treasure) and had a vital role in preserving and passing on valued cultural knowledge (Barnes & McCreanor, 2019). Despite their value and importance in te ao Māori, kaumātua have been largely neglected from research into healthy ageing from mainstream government agencies (Dawes, Lapsley, & Muru-Lanning, 2022). The loss of cultural status, undermined by colonisation and assimilation, continues today. It can be seen in the neglect to involve kaumātua in designing solutions for healthy ageing that directly impacts them (Hokowhitu, Oetzel, Simpson et al, 2020).

The loss of age-honouring values has also impacted the status of Pacific elders. Nanai, Thaggard and Tautolo (2021) researched the views of older Samoan adults within Aotearoa to ascertain their views and experiences of abuse as older people. Talanoa methods were used as the study involved 12 Samoan

tagata matutua (older people) who had all been born in Samoa but were now living in Aotearoa. Study findings emphasised the traditional and important cultural role that tagata matutua held in relation to "maintaining harmony within communities as well as preserving and passing on cultural traditions and values to the younger generations" (Nanai, Thaggard & Tautolo, 2021, p. 408). Vā is the relational space within Samoan communities that is imbued with respect, reciprocity and honour. Serving and valuing the elderly is customary in Samoan culture. However, intergenerational differences were identified as contributing to abuse, in particular the loss of respect and status for tagata matutua (Nanai, Thaggard & Tautolo, 2021).

What this means for prevention?

Prevention approaches must recognise the enduring, devastating impacts of colonisation, assimilationist policies and structural racism which has negatively impacted Māori and Pacific communities. There has been a long history of deficit thinking and pathologising practices within Aotearoa that have tried to 'fix' the perceived deficiencies within Māori and Pacific communities (Bishop & Glynn, 1999). "Fixing people" leads to a focus on narrowly defined "problems" and limits the range of legitimate solutions" (Productivity Commission, 2015, p. 4). Kaumātua and whānau have long experienced the 'done to' intervention logic, that outside agencies (and their representative providers) know best how to 'fix' them (McMeeking, 2020). This assumption does not consider how services may contribute to harm experienced by whānau, or the contribution to the ongoing destabilisation of social and cultural constructs related to the status of kaumātua/older people. Standardised mainstream social services and health-care systems that rely on a 'one size fits all' approach perform poorly for those in society with complex needs (Heatley, 2016, p. 59). The same could be said of 'standardised' initiatives that aim to prevent abuse of older people from occurring.

Te Tiriti o Waitangi and partnership approaches should underpin prevention work aimed at addressing these harms to prevent AOP within whānau, hapū and iwi. As stated by MSD, there is a need "to pay attention to the interests of Māori and be guided by Te Tiriti o Waitangi as a founding document of our country. Our intent is to work closer with iwi, hapū and whānau as guides to understanding our responsibility to better serve communities" (Ministry of Social Development, 2020, p. 9).

Structural racism, assimilation policies and ageist practices have harmed Pacific communities within Aotearoa, resulting in intergenerational family violence (Leonard, Te Hēmi & Donovan, 2020). According to MSD, in the area of AOP there is a need to develop "authentic relationships with Pacific peoples, families and communities to drive greater impact on positive outcomes. Ensure there are key stakeholders in the decisions, design, development and delivery of matters that impact on Pacific and provide safe spaces for them to have their voice heard" (Ministry of Social Development, 2020, p. 8).

Research emphasises the importance of kaumātua-centric initiatives, as well as whānau-centred services to strengthen kaumātua and whānau competencies or capabilities to address any harms they experience and lead the types of lives they value (Dalziel et al., 2019). This is a key feature of Sen's approach to wellbeing analysis and human development (1993, 2015). However, enabling kaumātua to live the lives they value also requires a focus on wider systemic processes that enable and/or constrain their freedom to pursue their actions, and the actual opportunities whānau have, given their personal and social circumstances. There is plenty of evidence highlighted in the following sections of compounding systems drivers that place Māori and Pacific older people at risk of abuse.

Systems driver: Caregiver stress and burden

As identified earlier, caregiver stress, burden and financial hardship are known risk factors of elder abuse within Aotearoa (Burholt, et al., 2022; Tough, Brinkhof & Fekete, 2022; Storey, 2020; Păroşanu & Marshall, 2020; Ministry of Social Development, 2019; Woodhead, 2018).

Caregivers may intend to provide care for older adults but lack the necessary knowledge, skills, and practical ability to do so (Burholt, et al., 2022; Tough, Brinkhof & Fekete, 2022; Storey, 2020; Păroşanu & Marshall, 2020; Ministry of Social Development, 2019; Woodhead, 2018; DeLiema et al, 2018). Citing research conducted in Aotearoa (Alpass, Szabo Allen & Stephens, 2017), older kaumātua receive significantly more hours of informal (unpaid) care e.g., from whānau, than non-Māori, and whānau carers are more likely to live in the same house or on the same property (Lapsley, Hayman, Muru-Lanning, Moyes et al, 2020). Holdaway et al (2021) notes that "living in multigenerational family settings" means less ability to "qualify for formal home support (e.g., help with shopping, travel for medical attention, or household cleaning)" (p. 2). Research demonstrates that both Māori and Pacific families are more likely to live in intergenerational living arrangements

(Te Aorerekura, 2022) and are less likely to move into long-term residential care[6] when compared with their Pākehā peers (Holdaway, Wiles, Kerse et al, 2022). Burholt et al (2022, p. 6) cited research undertaken by Alpass, Szabo Allen and Stephens (2017) that found female caregivers and Māori caregivers of the elderly have the poorest mental health and suggest this is linked to broader "social, economic, cultural and political inequities".

Inability to qualify for formal home support through extended family arrangements places more pressure on whānau Māori and Pacific families who care for older family members at home. Gott et al (2015) studied the experiences of whānau Māori caregivers, who were caring for someone with a life-limiting illness. Results highlighted financial constraints that limited the caregiving abilities of whānau and that costs were both direct and indirect. For example, whānau had parking and transport costs, admissions to hospital, cost of food, clothing, and bed linen etc. Gott et al. noted that whānau with life limiting illnesses, may need new clothes because of weight loss and/or new bed linen due to laundry demands. Indirect costs were those incurred by whānau members because of their caregiving role. These costs were typically incurred due to the need to change or reduce employment obligations and/or related to lost employment opportunities. Whānau who were in paid work were often forced to fit in caring tasks around work. This could mean using annual leave and sick leave entitlements and/ or taking unpaid leave. Some whānau in Gott et al.'s study had to give up paid work altogether to care for whānau members. Others were unable to look for work because of their caring responsibilities and faced the consequences of having their benefits cut. Some whānau reported that caring had negatively affected their own health and wellbeing. Physical harm could be caused by lifting whānau members. They noted considerable serious impacts for whānau, including developing significant debt and the need to move to a smaller house or less expensive accommodation. In extreme cases, whānau reported going without food because they could not afford to buy enough for everyone in their care (Gott et al., 2015). Anxiety, depression, and insomnia associated with caregiving could also incur financial costs. This could be related to additional doctor visits and prescriptions for medication, both when caregiving whānau are looking after a whānau member and after their passing. The grief of losing a loved one could compound anxiety for caregiving whānau (Gott et al., 2015).

The results from Gott et al's (2015) highlight the burden, stress and financial constraints caregivers face when caring for an older relative with life-limiting illnesses. Inability to qualify for formal home support through extended family arrangements places extra pressure on whānau who care for older family members at home.

[6] Long-term residential care is defined as "low, high, dementia and psychogeriatric care residential facilities, for both short and long-term care" (Holdaway, Wiles, Kerse et al, 2022, p. 2).

What this means for prevention?

Restorative justice practices have been promoted within Aotearoa as a way to address harms perpetrated by family members (Păroşanu & Marshall, 2020). However, the quality of this type of intervention work is dependent on the cultural and language competence of family mediators, restorative justice facilitators and counsellors, particularly as they work with culturally diverse older people and their families (Woodhead, 2018). In addition, Macfarlane (2012) emphasises that evidence-based practice within professional spheres, typically privileges Western knowledge in the ways it is "gathered, recorded, published and disseminated" (p. 207). Macfarlane argues the evidence-base that professionals use to inform their practice often does not adhere to, or include, mātauranga Māori and/or Māori preferred ways of working, despite many professionals working with whānau.

Caring for older people needs to be highly valued and promoted within Aotearoa and there needs to be more acknowledgement and prevention focus on caregiver burden. There needs to be more financial assistance for carers; for those who care for kaumātua/ older relatives at home, as well as higher pay and work conditions for those who provide care within residential care settings. Ongoing support and training should be available for all carers of older people.

Systems driver: the housing crisis

There is a housing crisis within Aotearoa. The Human Rights Commission is currently conducting a housing inquiry examining the conditions which negatively impact some communities. Interim findings highlight the problems of unaffordability, overcrowding, dampness, cold and mould and that housing conditions are significantly worse for Pacific and Māori communities. Senior Human Rights Advisor Vee Blackwood was recently interviewed by Pacific News Media (2022). She stated that other inquiries undertaken by the Human Rights Commission, such as the Pacific Pay Gap, highlighted that "Pacific peoples are undervalued for the work that they do, and this leads inevitably to being less able to afford decent housing" (Pacific New Media, 2022, p. 1).

Overcrowded housing is typically attributed to Pacific and Māori families wanting to live in large family groups (Pacific News Media, 2022). However, initial inquiries by the Human Rights Commission emphasise the current housing system is failing to deliver affordable, safe and secure houses that meet the diverse cultural needs of Māori and Pacific families and enable them to thrive in multi-generational living arrangements.

Research has emphasised the financial stress faced by many Pacific families and its connection to elder abuse (Boon-Nanai, Thaggard & Montayre, 2022). Using talanoa approaches, the researchers worked with 13 Pacific Island grandparents and great grandparents to identify themes of grandparent childminding. Traditionally the grandparent – grandchild relationship is treasured within Pacific cultures (Boon-Nanai, Thaggard & Montayre, 2022). However, prolonged child-minding undertaken by Pacific elders without the necessary housing arrangements and financial and social resourcing was considered a form of elder abuse by research participants. These Pacific elders often found themselves in challenging situations, as they opened their houses up for intergenerational living due to their adult children facing financial hardship. Whilst the study emphasised the many positive outcomes of looking after grandchildren, prolonged child-minding had negative impacts. These included higher levels of stress (both psychological and physical) resulting in poorer health outcomes and increased financial demands. Pacific grandparents and great-grandparents, particularly in urban areas like Auckland, are now pressured to house and look after adult children and grandchildren without access to adequate housing, wider community/social support and resources that traditionally supported intergenerational living within the Pacific Islands (Boon-Nanai, Thaggard & Montayre, 2022). This lack of adequate housing and wider social support to support intergenerational living places older Māori and Pacific peoples at risk of abuse and neglect, particularly from family members who are facing financial hardship (Boon-Nanai, Thaggard & Montayre, 2022).

What this means for prevention?

There needs to be considerable investment in safe, secure and affordable housing within Aotearoa. There also needs to be investment in intergenerational housing options for kaumātua and older Pacific people, who wish to reside with their families. There needs to be more investment in early childhood options that are affordable and accessible for families.

Systems driver: inequitable health outcomes

Poor physical health, physical disabilities and cognitive decline as experienced by older people can be key risk factors for elder abuse (Te Aorerekura, 2022; New Zealand Government. 2021; Ministry of Social Development, 2019; Woodhead, 2018). Increasing older people's health span[7] is key to healthy ageing (Office for

[7] Health span is related to the length of time that an individual is healthy and not just alive (Jayasena et al, 2020).

Seniors, 2019). However, successive governments have failed to honour Te Tiriti o Waitangi obligations, and this has resulted in the inequitable health status of Māori, who have "the poorest health status of any ethnic group in New Zealand" (Waitangi Tribunal, 2019, p. xii). Increased intergenerational exposure to health compromising conditions, created through decades of persistent and marked inequities, negatively impacts Māori and Pacific peoples' health (Dawes, Lapsley, & Muru-Lanning, 2022; Savage et al, 2020; Baker & Pipi, 2014; O'Sullivan, 2019). Older people who experience ill-health, whether its physical and/or cognitive decline can be more vulnerable to abuse, particularly if they are isolated and lack positive social connection with others (Woodhead, 2018).

Health inequities negatively impact Māori and Pacific communities' health as they age (Burholt, et al., 2022). Disadvantage is particularly amplified for Māori with disabilities (Waitangi Tribunal, 2019) and those living in rural areas who do not have significant access to effective primary health care (Health and Disability Review, 2021). In addition, there is "insufficient focus on and investment in primary and community care which helps keep people well and out of hospital" (Health and Disability Review, 2021, p. 5).

Current research demonstrates that Māori and Pacific communities disproportionately are affected by high rates of food insecurity and subsequent adverse health outcomes (Hynds et al, 2022; Shelling, 2019). Food insecurity has been defined as "a lack of consistent access to enough food to live an active, healthy life" (Hynds et al, 2022, p. 7). Studies demonstrate that low household income and poverty are a significant barrier for whānau to exercise healthy food choices (Glover, Wong, Taylor, Derraik, Fa'alili-Fidow, Morton & Cutfield, 2019). Research has shown that low-income neighbourhoods attract more fast-food outlets and smaller, more expensive convenience stores, as opposed to larger supermarkets with fresh produce available (Drewnowski, 2009). By contrast, more affluent areas generally have access to a wider range of fresher groceries, better food outlets and more opportunities for physical activity.

The current cost of living crisis within Aotearoa is disproportionately affecting low-income families, particularly Māori and Pacific families and people with disabilities (Macaulay, Simpson, Parnell & Duncanson, 2022). Results from this study emphasised that food insecurity was related to low income relative to essential household outgoings. Coping strategies invariably involved reducing the quality of nutritious food consumed in favour of high calorie, low cost but low nutrition meals (Macaulay, Simpson, Parnell & Duncanson, 2022). As income declines, energy dense but nutrient poor foods become the most accessible, affordable and available way to provide daily calories. The Poverty-Obesity Paradox "exists when those in poverty may consume enough calories to meet or exceed their energy requirements, but those calories do not necessarily contain enough macro or micro-nutrients needed to promote optimal health and prevent chronic disease" (Hynds et al, 2022, p. 16). Currently, individual choice of foods is emphasised as the problem and the solution, that if only low-income families

made 'better/healthier food choices' then they wouldn't be overrepresented in non-communicable diseases (NCDs) statistics (ibid).

Racial discourses in health literature are based on a narrow, shallow understanding of the processes that create health inequities. This creates a stigma that those amongst the lowest socio-economic groups are lazy, or not educated enough to make informed food decisions. It also ignores the destruction of healthy kai practices and environments caused by colonisation (Hynds et al, 2022). Previous research involving Māori and Pacific communities in food-and nutrition-related interventions related to changing food habits has revealed their distrust in mainstream health professionals (Littlewood, Canfell & Walker, 2020; Wild, Rawiri, Willing, Hofman & Anderson, 2021). Empirical studies have demonstrated that previous stigmatising or discriminatory experiences can affect whānau engagement with other "unrelated" health and social services (Wild et al., 2021, p. 675). This links back to a lack of trust in the system, that can prevent older Māori and Pacific peoples from disclosing abuse to mainstream health professionals.

Whānau Māori and Pacific peoples are now more vulnerable to being obese and having a chronic health condition (cancer, diabetes, or heart-related conditions) and this is more noticeable if their family has a history of such conditions (Wild et al, 2021; Kidd et al., 2013). Concerningly, child obesity rates are 1.6 times higher for Māori (aged 2–14) than the overall population (Wild et al, 2021). The prevalence of NCDs amongst adults, including type II diabetes, obesity and heart disease, are linked to poorer cognitive health and dementia as people age (Radio New Zealand, 2023; Littlewood., Canfell & Walker, 2020; Wild et al, 2021). Cognitive decline and dementia are known risk factors for AOP (Woodhead, 2018).

Research conducted within Aotearoa has demonstrated that financial hardship constrains Pacific peoples from accessing adequate primary health care. For example, a report by the Ministry of Health (2008) noted that Pacific peoples were significantly more likely (33.4%) to report that the cost of primary care was the main reason they did not regularly visit their GP (Ministry of Health, 2008). Other research (Jatrana, Crampton & Norris, 2011) indicated that Pacific people often did not collect prescribed medications from pharmacies due to the cost. Despite subsequent government increases in subsidies for health care and prescriptions, evidence indicates that poverty and financial hardship constrains Pacific people's ability to access health services (Jatrana, Crampton & Norris, 2011).

Other studies have shown how financial hardship exasperates health inequities for culturally diverse communities (Rush, Puniani, Snowling. & Paterson, 2007; Littlewood, Canfell & Walker, 2020; Wild, Rawiri, Willing, Hofman & Anderson, 2021). Within Aotearoa, lower income levels are most evident amongst Māori and Pacific communities, and this is a direct result of structural and institutional racism (Cram, 2011; Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988).

Studies within Aotearoa have linked poor physical and cognitive health as considerable risk factors for elder abuse (Ministry of Social Development, 2019; Woodhead, 2018).

What this means for prevention?

Prevention work needs to address health inequities and recognise the health debt owed to Māori and Pacific communities. There needs to be an immediate and long-term approach to improving the health span (as well as the age span) of these communities within Aotearoa. Improved physical and mental health, coupled with positive social connection as people age have been identified as key protective factors preventing AOP.

Culturally appropriate services for victims of whānau/family violence

Studies have shown that the deliberate dismantling of whānau relationships has resulted in intergenerational harms such as family violence (Pihama et al.,2019; Reid et al., 2017). Elder abuse can also be a form of family violence (Dissanayake & Bracewell, 2022).

Nikora (2007) argues that much of the literature on family violence, trauma, social work, psychology and healing has been dominated by Western perspectives, ignoring Indigenous knowledge, connections and approaches. The Eurocentric prevention focus in Aotearoa has entrenched colonial and racist mentalities that constrain the development of culturally appropriate and sustaining approaches to addressing family violence for Māori and Pacific communities (Savage et al, 2021; Leonard et al., 2020). For example, the importance of alofa and service to others, expressed through faith, peace, harmony and worship are important to Pasifika community wellbeing and collectivistic values (Leonard et al., 2022; Siataga, 2011). Leonard et al., (2022) highlight that Pasifika collectivistic and faith-based values are not recognised in dominant individualistic and clinical approaches to family violence interventions. Such findings resonant with research into AOP (Peri et al, 2008). A lack of pastoral and spiritual care within residential care settings was identified as “neglectful and emotionally abusive” from older people from “non-Pākehā ethnic backgrounds” (p. 42).

The absence of culturally sustaining and healing interventions places older Māori and Pacific peoples at risk of elder abuse (Woodhead, 2018). In 2017, the Family Violence Death Review Committee reported the disproportionate rate of

Māori dying from family violence and that this needed dire attention. More recent research shows slow progress. It has been reported wāhine Māori are more likely to be impacted by Intimate Partner Violence (IPV) than any other ethnicity within Aotearoa. Wāhine Māori who have disabilities and/or are transgender, experience much "higher levels of sexual violence and intimate partner violence (including repeat victimisation)" than other genders and those who are able bodied (New Zealand Government, 2021, p. 12). A known risk factor of elder abuse is a history of IPV abuse/family violence, as experienced by the perpetrator and/or victim (Ministry of Social Development, 2019).

The lack of culturally sustaining and appropriate interventions has also been emphasised recently by the Family Violence Death Review Committee (Cram, Short, Atwool, Cooze, Roguski, Waapu, Walker & Henaghan, 2022). The seventh report draws on findings and recommendations from in-depth reviews across 2019 and 2021, as well as previous committee reports, and highlights a lack of progress from government agencies, to work towards culturally sustaining and healing approaches within the context of family violence. The seventh report, 'A duty to care. Me manaaki te tangata' explores factors that inhibit caring for whānau who experience family violence. The authors note whānau, "often shoulder the burden of poor service delivery or the divide between Crown and community services." (p.12). These burdens reinforce whānau perceptions that no one is available to support them, creating situations of harm, isolation, and vulnerability.

What this means for prevention?

There needs to be immediate and long-term investment in culturally sustaining and healing approaches to address AOP within the context of whānau/family violence. Research has emphasised the majority of abusers of older people are family members (Age Care Concern, 2023b; Te Aorerekura, 2022; Boon-Nanai, Thaggard & Montayre, 2022; Scoop News; 2021; Păroşanu & Marshall, 2020; Woodhead, 2018; New Zealand Nurses' Organization, 2017; Park, 2014; Weatherall, 2001).

Protections

Although there are universal legal protections within Aotearoa, such as Human Rights legislation that protects the rights of our older citizens, there was less reporting or acknowledgement on this within the scan of literature. Woodhead (2018) notes that universal superannuation is available to citizens of Aotearoa

and New Zealand residents from the age of 65. However, the current cost of living crisis compounds inequities for older people, particularly if they do not own their own home by the time of retirement.

Aotearoa New Zealand has ambitious goals when it comes to promoting healthy ageing for all of our older citizens. The Healthy Ageing Strategy 'Better Later Life - He Oranga Kaumātua 2019 to 2034' sets the strategic direction for the delivery of services to people into and throughout their later years. The vision is that: "Older New Zealanders live valued, connected and fulfilling lives" (Office for Seniors, 2022, p. 1).

The strategy identifies five key areas for action:

- Te whai taituarā ahumoni me te whai wāhi ki te ōhanga/Achieving financial security and economic participation
- Te hāpai i te toiora kaumātautanga te whai wāhi hoki ki ngā ratonga hauora/ Promoting healthy ageing and improving access to services
- Te whakarite kōwhiringa kāinga rerekē/Creating diverse housing choices and options
- Kia maha ngā ara tūhonohono/Enhancing opportunities for social connection
- Te whakarite taiao e māmā ai te whai wāhi atu/Making environments accessible (ibid)

Age friendly environments are now needed that optimise people's abilities to live the lives they value as they age (Simpson, Oetzel, Wilson, Nock et al, 2022). Such environments support healthy ageing by offering affordable, safe and secure housing, accessible health and social services, transportation, walkable and inviting social areas, and communities that sustain social capital. These environments are sustained through physical, economic, cultural and social elements (Simpson et al, 2022). Healthy ageing as evidenced through physical and mental health and cultural/social connection are all identified as protective factors to prevent AOP from occurring (Woodhead, 2018).

The vision of our 'Healthy Ageing Strategy' is yet to be realised, and results from this literature scan emphasise that much more needs to be done to ensure age friendly environments for all. In 2022, Carolyn Cooper was appointed into the newly established role of Aged Care Commissioner (Health and Disability Commissioner, 2022). This was seen as an "important watchdog role to protect older New Zealanders" (New Zealand Government, 2022, p. 1). Te Tiriti o Waitangi also protects the rights of kaumātua, however there appeared a dearth of

research about how Te Tiriti could be used to underpin interventions to address AOP within Aotearoa. The most commonly reported legal protection for older people was enduring power of attorney (EPA) but cost is an issue (Ministry of Social Development, 2019; Woodhead, 2018). There are now more urgent calls for a collective and intersectoral approach (health, housing, transport, financial assistance, employment) to enable "older New Zealanders to lead valued, connected and fulfilling lives" (Office for Seniors, 2019, p. 2). However, these government agencies have consistently failed in their duty of care towards Māori and Pacific communities, and studies suggest a considerable lack of community trust in mainstream services (Savage et al, 2021).

To address the intergenerational and enduring harms of family violence and sexual violence the New Zealand Government launched 'Te Aorerekura', the national strategy to eliminate family violence and sexual violence within Aotearoa (New Zealand Government, 2021). The strategy is underpinned by Te Tiriti o Waitangi and is inclusive of tangata whenua and tau iwi. It outlines a whānau-centred model 'Tokotoru' to enable and enhance wellbeing in ways that eliminate family violence. Tokotoru – means the 'unbreakable three' – and outlines three intersecting dimensions to enable and enhance whānau wellbeing. These are:

- "Strengthening – a strength-based approach to enhancing the factors that support wellbeing and prevent harm
- Responding – holistic, safe, accessible, and integrated responses tailored to individuals, families, whānau and communities
- Healing – a focus on supporting recovery, redress, and restoration." (New Zealand Government, 2021, p. 35).

In addition, MSD (2020, p. 5) acknowledges the need for long-term investment, developing "new ways of working across government, and with iwi and communities" to reduce AOP. This next section examines what is known from other fields of research beyond literature associated with AOP that could provide further insights for its prevention within Aotearoa.

Section 4: What areas or fields of research beyond literature focussing on AOP/elder abuse could provide further insights for the prevention of AOP?

The importance and impact of culturally and socially connected communities

Social connectedness has been identified as enabling older people to age well (Te Aorerekura, 2022; Office for Seniors, 2019) and for Māori, Pacific and Asian older people this includes cultural connectedness (Dawes, Lapsley & Muru-Lanning 2022; Morgan, Wiles, Park, Maxwell et al, 2019). Research within Aotearoa explored what matters to older people when discussing social connectedness (Morgan, Wiles, Park, Maxwell et al, 2019). This qualitative study involved older Māori, Pacific, Asian and NZ European (NZE) participants talking about their perceptions regarding the value of social connectedness, as well as the factors that enabled or prevented it. Results emphasised that participants preferred to socialise with people from similar cultural backgrounds where they shared "taken-for granted social customs and knowledges" (Morgan et al, 2019, p. 1). Fundamental to social connectedness was the participant's yearning to be seen as agentic, able to foster relationships based on mutual respect and not being seen as a burden to family or their community. In this sense, social connectedness was linked to interpersonal relationships as well as the degree to which older people were valued for their contributions within whānau/families, communities and wider society..

Investigating results from the Life and Living in Advanced Age, a Cohort Study in New Zealand (LiLACS NZ) Dawes, Lapsley & Muru-Lanning (2022) highlight the importance of cultural connection for the health and wellbeing of older Māori people. This cohort study examined the health status of Māori and non-Māori in advanced age (80 years or more). Results showed that "physical health-related quality of life was associated with cultural practices, including frequency of marae attendance" (Dawes, Lapsley & Muru-Lanning, 2022, p. 434). Although Māori participants in the cohort study varied in their health status and experience of disability, they themselves defined "positive ageing" through "their capacity to participate in and contribute to the communities around them" (ibid). Findings also emphasised the importance of 'ageing well' as a holistic process, connecting hinengaro (mental health), wairua (the spirit and spiritual health), tinana (physical health) and te taiao (natural environments). Spiritual health and wellbeing have also been noted by tagata matutua (Samoan elders) as an important component of ageing well within research conducted within Aotearoa (Nanai, Thaggard & Tautolo, 2021).

[8] Whānau Ora is a major government funded health initiative in New Zealand, driven by Māori cultural values. As other authors have done, capital letters will be used when referring to the Whānau Ora policy approach (Whānau Ora) and lower-case letters when referring to the concept whānau ora (generally understood to mean family wellbeing) (Boulton et al, 2018, p. 45).

Such findings align with other research studies into the impact of socially connected communities (Wilkerson, 2022). These communities exist in localised sites where people know and trust each other. Social capital is evident in these communities, as people feel welcomed and see themselves represented. They are motivated and engaged in their own wellbeing and that of their community (Wilkerson, 2022).

Previous research within the context of Whānau Ora[8] and whānau-centred approaches has emphasised the importance of interventions being tied to their knowledge of, and relationships with, the communities they serve (Dawes, Lapsley & Muru-Lanning, 2022). Whānau Ora and whānau-centred approaches seek to support the whole whānau; a holistic approach that invests in whānau strengths and aspirations to achieve outcomes they themselves value. The term 'whānau' has been defined as "… a group bonded together" (Te Puni Kōkiri, 2018, p. 19). Bonding can be through shared interests and a common purpose, as well as through kinship and whānau, and can include several generations.

Whānau Ora is a culturally constructed intervention, inclusive of all ethnicities and communities (Te Puni Kōkiri, 2018). It is grounded in distinctly Māori principles and practices that have made demonstrable contributions to the wellbeing of all New Zealanders, irrespective of age, gender, ethnicity, culture, sexual orientation or religion (Te Puni Kōkiri, 2018). It represents a movement of resistance and reclamation by Māori and Pacific communities to facilitate healing and positive development within communities excluded from positive cultural, social, health and economic participation within Aotearoa New Zealand.

Central to the concept of Whānau Ora is 'mana motuhake' (autonomy, independence, and self-determination) (Te Puni Kōkiri, 2018). This approach is a radical departure from system-centred health care whereby power is solely in the hands of professionals (Matheson & Neuwelt, 2012). Placing whānau at the forefront of decision-making enables whānau-centred services and initiatives to strengthen whānau capacities and capabilities to lead the types of lives they value resulting in a holistic wellbeing focus (Dalziel et al., 2019; Te Puni Kōkiri, 2018). For example, the Mana Tū (Stand with Authority) is a whānau-centred programme, led by Associate Professor Matire Harwood[9] (Faculty of Medical and Health Sciences, General Practice and Primary Healthcare, The University of Auckland New Zealand). It is empowering whānau to take control of their health and wellbeing (Waatea News, 2020; Harwood et al., 2018; Selak et al., 2018) and is achieving recognition for the improvements achieved. Whānau feel more empowered, and better able to take control of their health and engage with the health system. The support of Navigators and community workers has helped reduce the level of racism and judgement whānau experienced as they engaged with the health system. Whānau have reported changing many aspects of their

[9] In 2019, Dr Harwood received Te Tohu Rapuora, for leadership and contribution to Māori health research, Health Research Council and Royal Society. More information on Dr Harwood and her whānau-centered approach can be viewed on: https://profiles.auckland.ac.nz/m-harwood

lives, such as eating and preparing healthier food, losing weight, improved diabetes control and quitting smoking (Tane et al., 2021; Waatea News, 2020).

Whānau Ora is an example of the transformative impact that occurs when whānau themselves are driving their own change (Durie, 2020; McMeeking, 2020; McMeeking et al., 2020; Workman, 2019; Smith et al., 2019; Te Puni Kokiri, 2018; Watene et al., 2017; Boulton & Gifford, 2014; Matheson & Neuwelt, 2012). Impacts include 'avoided outcomes' (McMeeking 2020, p. 37). This is where participants could have experienced negative health and social outcomes but did not due to the effectiveness of Whānau Ora and whānau-centred programmes (McMeeking 2020; Durie, 2020). In this sense, avoided outcomes have relevance for prevention initiatives that aim to increase older people's health span as they age, therefore protecting them from factors known to increase their risk of elder abuse.

Two case studies of Whānau Ora initiatives in the South Island emphasise the importance of kaumātua-centric, strengths-based social enterprise initiatives aimed at improving older people's health and wellbeing (Savage, Goldsmith, Hēmi & Dallas-Katoa, 2020). Although these initiatives were not directly focussing on preventing abuse of kaumātua, findings are consistent with research that highlights the importance of early interventions. In particular, the need to connect older people with the right health services, as well ensuring their access to social opportunities that prevent loneliness and social isolation[10].

One case study described the impact of the Kaumātua Specialist Kaimahi employed through Te Hauora o Ngāti Rārua Limited (in the Nelson/Marlborough region). The aim was to connect kaumātua and their whānau to services and provide navigation that were whānau-centric and met kaumātua aspirations and needs. Wānanga and hui were held with kaumātua to develop and appoint a specialist kaimahi role and to identify services and activities that kaumātua themselves wanted. Activities involved regular wānanga at Waikawa Marae, with transport being provided for those who needed it. Kaumātua engaged in walking groups, swimming groups, kapa haka, waiata and craft activities. Twenty kaumātua regularly attended and 140 registered to receive their newsletter. Impacts included that kaumātua identified themselves as empowered leaders and they were confidently participating in te ao Māori (the Māori world). Strengthened relationships and improved social connections that reduced kaumātua isolation, were also identified as positive impacts. Other desired hui identified by kaumātua included safe banking and finances, medication, elder abuse, power of attorney and writing a will and civil defence preparation (Savage et al, 2020). Kaumātua provided feedback on the effectiveness of activities through regular surveys and evaluations.

The other Whānau Ora case study evaluated by Savage, Goldsmith, Hēmi and

[10] Previous research into elder abuse within Aotearoa have highlighted these as protective factors (see Woodhead, 2018; Ministry of Social Development, 2019).

Dallas-Katoa (2020) was Kaumātua Roopu and Whakamana initiated by Te Roopu Tautoko ki te Tonga within Ōtepoti (Dunedin). Seventy-eight kaumātua enrolled in the programme and 45-50 attended whakawhanaungatanga days regularly. Kaumātua Roopu has led to positive changes in the lives of kaumātua, including reduced feelings of social isolation and isolation. Kaumātua have reconnected to local marae and engaged in waiata, kapa haka and karakia. Kaumātua contributed to the design of roopu activities, that included presenting cultural performances at various Dunedin rest homes. There was increased kaumātua attendance at Te Kaika health clinics, increased enrolment for fall prevention programmes and increased engagement with the National Bowel Screening programme. Kaumātua also asked for and attended sessions on improving personal safety and security. Kaumātua Roopu is underpinned by the values of Te Roopu Tautoko ki te Tonga which included: restoring culture, connection and identity as a foundation for successful participation in te ao Māori and society; reconnecting whānau with places, communities, history and traditions; re-igniting a passion for learning and empowering strong leadership (Savage et al, 2020).

These Whānau Ora programmes emphasise the importance of social enterprise with a focus on kaumātua empowerment and a culturally embedded, co-designed, strengths-based approach that improves the health and wellbeing of those involved.

Finally, a separate study identified essential co-design principles in the creation of an "age friendly" urban housing development for kaumātua within Aotearoa (Simpson, Oetzel, Wilson et al., 2022). In this study, Kaupapa Māori and participatory research methods were used to guide the construction of the housing complex. Te Rūnanga o Kirikiriroa developed the kaumātua community in partnership with the Rauawaawa Kaumātua Charitable Trust. They worked collaboratively with kaumātua, builders, government agencies and various funders to develop a papakāinga (traditional Māori housing/community complex), as well as provide wrap-around services to meet kaumātua needs. Results emphasised three essential co-design principles:

(1) Kaumātua-centred vision.

(2) Working to achieve the vision

(3) Living the shared vision

A kaumātua-centred vision ensured the project was "more than just housing; it was a pathway to building a culture-centred age-friendly housing community with, and for, kaumātua" (Simpson et al, 2022, p. 2268). Cultural and relational connectedness underpinned the vision that ensured intergenerational living. In particular, it was necessary that the housing and wider environment fostered and supported whanaungatanga (relationships) and manaakitanga (caring).

Working to achieve the vision entailed a partnership approach, not just with kaumātua, but with outside partners. Simpson et al (2022) note that banks were "reluctant to lend to Te Rūnanga because of revenue uncertainty" so partnership funding was critical to achieving the vision (p. 2269). This emphasised the importance of a shared vision, with other partners (government agencies, local councils etc) coming on board to ensure the vision could be achieved. External partnership expertise and assistance ensured the initiative was able to access funding and finance, develop effective applications for resource consents, and ensured construction was completed.

Finally, 'living the shared vision' was how the built environment helped create an environmental age-friendly setting that facilitated cultural and social connections between kaumātua, in ways that enhanced their hauora and wellbeing needs. Partnerships between government agencies and the Māori organisations involved, meant that wraparound health and social services were provided to kaumātua with the highest needs (Simpson et al, 2022). Such partnerships are essential if appropriate initiatives are to be developed to ensure all older people within Aotearoa 'age well' in ways that prevent abuse from occurring.

There are calls for further research and development funding for whānau-centred innovations within the context of healthy ageing for Māori and Pacific communities. For example, Hikaka and Kerse (2021) state there is an urgent need to resource the development of kaumātua-led and Māori-led Aged Residential Care and other Kaupapa Māori care models to appropriately address kaumātua aspirations and needs as they age.

The importance of culturally embedded, collective care and healing approaches

Other highly successful approaches that demonstrate positive change within communities affected by whānau/family violence, provide insight into the impact and significance of culturally embedded, collective care models that foster vulnerability and healing (Leonard, Te Hēmi & Donovan, 2020). Programmes supported by MSD such as 'My Father's Barber' and 'She is not your rehab' show how such initiatives can grow connections within communities and create safe spaces for people to be vulnerable and openly discuss any trauma and harm affecting them and their lives. Matt and Sarah Brown are influencers and champions for change within their communities. They demonstrate vulnerability by sharing their own experience of living with family violence and of healing approaches that have brought change to their lives. Their approach provides a safe space for others to share, to be vulnerable, to be open about the pain they are experiencing, and to take deliberate steps to keep self and others safe.

The counselling support provided within 'She is not your rehab' was successful because it was, "by design and intent, 'by Pacific for Pacific' (Leonard, Siataga, Savage, Standring et al, 2022). In addition, the counsellors had lived experience

of the challenges impacting their clients. They were also trained in Western therapeutic and Pacific approaches to healing. A key enabler of change was "their innate ability to create a safe space, giving care to the vā (the respect of the sacred space, dignity and harmony within relationships) within families and how this contributed to healing (Leonard et al, 2022, p. 2). As Leonard et al concluded the importance and impact of this could not be overemphasised.

Both 'My Father's Barber' and 'She is not your rehab' highlight the importance of 'Influencers' and 'Champions' within the context of whānau/family violence. Underpinning both approaches is the need to acknowledge racism and discrimination as creating an additional layer of trauma, increasing risks of family harm occurring. These programmes weave traditional Pacific healing and collective care approaches, with Western therapeutic models. Through healing and collective care, mana is restored, not only to the individual, but also to the community.

Summary

There are considerable lessons to be learned from innovations highlighted in the earlier section. In particular, the importance of social and cultural connectedness as key enablers of hauora (health, wellbeing and connection) for whānau Māori and Pacific families (Leonard, et al, 2022).

Case studies of Whānau Ora programmes emphasise the importance of social enterprise with a focus on kaumātua empowerment and a culturally embedded, co-designed, strengths-based approach that improves their health and wellbeing through enhanced social connections. These are known protective factors for the prevention of AOP. These holistic and culturally embedded programmes restored the status of older people and addressed isolation and loneliness. In other words, kaumātua-centred approaches recognised and drew on the strengths and abilities of older people, in ways that saw them contributing to their own wellbeing and to others within their communities. Partnerships between iwi and outside agencies and government funding were critical to the success of the kaumātua housing initiative.

Programmes already supported by MSD such as 'My Father's Barber' and 'She is not your rehab' provide insight into culturally embedded, healing initiatives. Approaches such as these were able to provide safe spaces for people to be vulnerable and openly discuss trauma and harm affecting them and their lives. Research within Aotearoa highlights the considerable problem of under-reporting and the reluctance of older people to talk about the harm they are experiencing. Overcoming shame and talking about AOP occurring within whānau/families is essential to healing. Lessons from these programmes highlight the importance of community 'influencers' and 'champions' who can front public campaigns to raise awareness of AOP and emphasise that it is ok to reach out for help.

Recommendations for future research

The following recommendations emerged from analysis:

- Undertake further research into the four domains (aged adults, caregivers/whānau/family wellbeing, context and systems drivers) that emerged from this literature scan to better understand how they interact to increase and/or reduce the risk of AOP.

- Address the lack of research that addresses the intersectionality of older people prioritising their voices and advocacy groups in an investigation into risk and protective factors associated with AOP within Aotearoa.

- Fund research and development into culturally embedded, collective care initiatives (such as Whānau Ora) and with community champions and influencers (such as Matt and Sarah Brown) to better understand the impact on such approaches to address/prevent AOP within specific communities.

- Understand the influence of wairua – spiritual health and wellbeing and its relationship to AOP as a protective and/or risk factor within culturally diverse communities within Aotearoa.

- Undertake partnership research and development with whānau, hapū and iwi to better understand the impact of papakāinga and kaumātua-centric housing initiatives and its relationship to AOP.

- Fund longitudinal research to better understand how systems drivers of harm and protection influence the prevalence of AOP within specific communities.

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Appendix 1.
Literature scan methods

The following questions guided this literature scan:

- **What is the current state of evidence in relation to the abuse of older people (elder abuse) within Aotearoa New Zealand?**
    - What is known? What does the literature cover, include, focus on, privilege, prioritise?
    - What isn't known? What is not covered, left out, silent, marginalised, underprivileged?
- **In the context of Aotearoa New Zealand, what is known about:**
    - the drivers of harm for abuse and their relationship with prevention?
    - universal protections against the abuse of older people?
- **What areas or fields of research beyond literature focussing on AOP/elder abuse could provide further insights for the prevention of AOP?**
    - What recommendations emerge for further research?

Search process

Ihi Researchers collaborated with key staff from the Ministry of Social Development to locate initial relevant documents and published research. To widen the document search, the following search terms were used: Elder, older people/adults, neglect, abuse, violence, health, caregiving, childminding, culture, grandparents, Pacific, Pasifika, Māori, Asian, residential settings, nursing staff, aged care, risk/protective factors, New Zealand, Aotearoa, rainbow.

These terms were used to locate literature and were coupled with other terms such as measure(s), definition(s), screening tool(s), intervention(s), strengths-based, impact and innovation. In total, 24 documents/sources that specifically focussed on AOP within Aotearoa were included in this scan. A further 24 documents related to other fields that were linked to risk/protective factors within Aotearoa and were also reviewed and included in literature scan. The following table provides a summary description of the types of documents/publications reviewed.

Included sources related to the study of AOP within Aotearoa New Zealand		Included sources related to other fields of research (that are linked to risk/ protective factors identified with AOP) conducted within Aotearoa		Total Number
Type of document	**Number**	**Type of document**	**Number**	
Peer reviewed journal articles	9	Peer reviewed journal articles	9	18
Thesis	1	Thesis	1	2
Reports	9	Reports	13	22
Media/websites	5	Media/websites	1	6
Totals	**24**		**24**	**48**

Table 2. Summary description of scanned documents

Analysis methods followed integrative literature review protocols. This, "is a form of research that reviews, critiques, and synthesises representative literature on a topic in an integrated way such that new frameworks and perspectives on the topic are generated." (Torraco, 2005, p. 356). It is a method that permits the presence of diverse sources and methodologies (including experimental and non-experimental research) and has the potential to contribute significantly to policy design and evidence-based practices.

Thematic analysis was employed with all included literature sources. Critical analysis involved deconstructing the topic into its basic elements (for example the characteristics of participants involved in research, definitions used related to AOP, the type of methodologies used, specific findings and recommendations, as well as significant gaps and biases in the evidence-base).

It is important to note that additional literature has been included in this final report, that were not included in the initial literature scan. This was done to further consider and reflect on overall research findings.

Considerations

This literature scan was completed within a short time frame so is constrained in terms of its depth and scope and should not be considered a literature review. All reviewed material was written in English and does not include studies or publications written in reo Māori and/or other Pacific languages. Search terms used in this literature scan, such as Māori, Pacific and Asian older people are also limiting as they do not recognise the "cultural and historical diversity" of peoples within these ethnic groups (Anae, Anderson, Benseman & Coxon, 2002, p. 2).


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