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# National Study of Abuse of Older People

## Disability Synthesis Report

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

TE KĀHUI RANGAHAU MANA TAURITE
NEW ZEALAND POLICY RESEARCH INSTITUTE

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The views expressed in this report are those of the authors and do not necessarily reflect those of the MSD or any other government agency.

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## Disclaimer

The following disclaimer applies to findings based on analysis of data from the Integrated Data Infrastructure.

These results are not official statistics. They have been created for research purposes from the Integrated Data Infrastructure (IDI), which is carefully managed by Stats NZ. For more information about the IDI please visit: https://www.stats.govt.nz/integrated-data/

Access to the data used in this study was provided by Stats NZ under conditions designed to give effect to the security and confidentiality provisions of the Data and Statistics Act 2022. The results presented in this study are the work of the authors, not Stats NZ or individual data suppliers.



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# EXECUTIVE SUMMARY

This report synthesises findings on the abuse of older people (AOP) among disabled older New Zealanders, drawing on three strands of the *National Study of Abuse of Older People*: the 2024–25 *Prevalence Survey*, qualitative interviews, and analysis of administrative data from the Integrated Data Infrastructure (IDI). Together, these sources provide the most comprehensive picture to date of the AOP experiences of disabled older people and the inequities they face.

## Disabled older people are more likely to experience harm

Key findings are:

- Disproportionate prevalence: Disabled older people experience abuse at far higher rates than their non-disabled peers. In the *Prevalence Survey*, 27.7% of those with high functional limitations reported abuse in the past year, compared to 14.9% of those with no/low limitations. Neurodivergent older people reported even higher rates, with one in three experiencing abuse.
- Multiple forms of harm: Abuse was not confined to a single type. Disabled older people often faced intersecting forms of abuse – neglect, financial exploitation, psychological manipulation, and coercive control – reflecting both their reliance on others and broader societal marginalisation.
- Hidden but systemic: Administrative data confirm disabled older people are two to three times more likely than non-disabled older people to appear in police, Accident Compensation Corporation (ACC), hospital, or interRAI records for abuse-related incidents. Yet these datasets capture only a fraction of actual experiences, meaning much abuse remains hidden.
- Impacts: The consequences extend beyond immediate harm. Victim-survivors reported powerlessness, loss of identity, compromised health, financial instability, and social isolation. Experiences of ageism and ableism often undermined confidence in seeking help and diminished trust in services.
- Protective and risk factors: Supportive partners, meaningful employment/work, and cultural & spiritual resilience could buffer against abuse. Risk was heightened by dependence on others for daily needs, family loyalty norms, intergenerational caregiving stress, histories of trauma, and systemic failures in health, justice, and social support.

## Current AOP prevention and response systems are inadequate

Available support is limited and not responsive to the needs of disabled people, with most only seeking help after abuse escalated to concerns for their physical safety. Disability-related reliance on others, including the person harming them, further limits opportunities for support. When help or intervention was sought from formal services (such as police), participants reported negative or unsatisfactory responses. Disabled older people spoke of alienation and collusion between the person perpetrating abuse and professionals, with (false) cognitive decline narratives undermining help-seeking attempts.

Ensuring access to safe, well-supported carers, in addition to effective AOP responses, is crucial. About one in six older people with high functional limitations reported having a professional carer at home. This suggests that many rely on family and other informal sources of care, increasing risk factors while limiting help-seeking. Legal safeguards are inadequate, excluding older people from decision-making, and leaving them exploited by those responsible for abuse. More broadly, disability-responsive, culturally safe, and trauma-informed services are required across the health, justice, and social sectors.

## Improving prevention and support requires coordinated action

Priorities include:

- Embedding monitoring that identifies disabled people within AOP data collections.
- Strengthening carer support systems, with safeguards against abuse.
- Reviewing legislative and policy frameworks for adequacy in protecting disabled older people, especially the Protection of Personal and Property Rights (PPPR) Act 1988 and Property (Relationships) Act 1976.
- Partnering with Disabled People's Organisations (DPOs), Māori and Pacific leadership, and neurodivergent communities to co-design prevention and support strategies.
- Supporting further research, especially in aged residential care and on long-term AOP impacts.

This synthesis report highlights that preventing and responding to the abuse of disabled older people is not only a matter of safety and wellbeing, but a fundamental moral question of equity and social justice.

# 1. INTRODUCTION

This report is part of the *National Study of Abuse of Older People in Aotearoa New Zealand* (NZ), commissioned by the Ministry of Social Development (MSD) as part of its Prevention of Abuse of Older People (AOP) work programme. The *National Study* was undertaken in 2024 and 2025, with the wider project including five main components:

1. Prevalence Survey – A nationally representative survey capturing older people's self-reported experiences of abuse.
2. Integrated Data Infrastructure (IDI) analysis – Examination of AOP through linked administrative datasets, including police, ACC, hospital admissions, InterRAI, and the NZ Crime & Victims Survey (NZCVS).
3. Qualitative interviews – In-depth interviews with older victim-survivors of abuse to explore the contexts in which AOP occurs, and the barriers and enablers to seeking help across four groups: Māori, Pacific, NZ European, and disabled people.
4. Contextual analysis of financial abuse – Mixed methods study exploring how financial abuse is identified, addressed, and prevented within financial institutions, supplemented with insights from the legal sector.
5. Analysis of economic and social costs – Estimates the economic impact of AOP on individuals, whānau, communities, and government systems, and outlines broader social consequences such as reduced wellbeing and lost productivity.

This study includes 10 key reports:

1. Overall synthesis report, summarising the key findings from all parts of the project.
2. Disability synthesis report, summarising key findings about AOP among disabled older people (this report).
3. Survey findings report, presenting results from the *Prevalence survey on the abuse of older people in Aotearoa New Zealand*.
4. *Prevalence survey of abuse of older people: Methodology report.*
5. *Defining thresholds for measuring prevalence of abuse of older people in Aotearoa New Zealand*, a supplementary report to the main *Prevalence Survey Report* that presents research into the application of AOP thresholds to the survey data.

6. The main *Evidence from the Integrated Data Infrastructure (IDI)* report, detailing analysis of AOP among those living in the community using administrative and NZCVS data from the IDI.
7. Supplementary IDI report on AOP among those in aged residential care.
8. *Findings from qualitative interviews with NZ European, Māori, Pacific, and disabled older people who have experienced abuse*, which presents findings from qualitative interviews of victim-survivors undertaken across four groups: Māori, Pacific, NZ European, and disabled older people.
9. *Financial and legal perspectives on financial abuse of older people in Aotearoa New Zealand* report, presenting system-level insights on financial AOP from qualitative interviews with finance industry and legal professionals, and supplemented with other information gathered from financial institutions.
10. Economic and social costs report, presenting research into the economic and social costs of AOP in NZ.

## 1.1 Structure of the report

In this report, we summarise analyses to focus on the experiences of disabled people, drawing from our *Qualitative Interviews Report* (see Section 2), *Prevalence Survey Report* (see Section 3), and main *IDI Report* (see Section 4). Section 5 provides concluding remarks.

## 1.2 Study aims and definition of AOP

The main aims of the *National Study* were to:

- Establish a baseline prevalence of AOP in NZ, for multiple forms of abuse and population groups.
- Explore the uses and limitations of administrative data for measuring and monitoring AOP.
- Identify impacts of AOP on a range of health and economic outcomes.
- Estimate the cost of AOP to the NZ economy.
- Understand ways the financial system responds to AOP and identify systemic actions that could protect those experiencing it.

Although there is some variation in the exact definition used across international research, the working conceptual definition of AOP is similar across the existing surveys examined. The study uses the following working definition of AOP, which is consistent with the most recent survey of AOP prevalence carried out in Australia:

> *A single or repeated act or failure to act, including threats, that results in harm or distress to an older person. These occur where there is an expectation of trust and/or where there is a power imbalance between the party responsible and the older person. (Qu et al., 2021)*

This study aims to capture different forms of physical, sexual, financial, psychological, cultural & spiritual harm, and neglect. The Australian survey (Qu et al., 2021) was the first to include harm relating to language and culture. Our study extends this previous work by asking a more detailed set of questions on cultural (including language) harm, as well as spiritual harm. We also asked these questions of all participants, whereas the Australian survey only asked these questions of culturally and linguistically diverse (CALD) participants.

Like most international prevalence surveys, our survey only asked about harm that was committed by someone known to the respondent (e.g. family members, friends, neighbours, acquaintances, or professionals such as medical professionals, care workers, or finance professionals). In practice, this may not always align with the working definition of "an expectation of trust and/or where there is a power imbalance" between the party responsible and the older person.

For example, a neighbour or casual acquaintance might be known to the older person, but may not hold a position of trust or power. Conversely, a stranger acting in an official capacity (e.g. a government agent) might hold significant power or trust, yet be excluded from the survey's scope because they are not personally known to the respondent. This highlights a potential grey area in how abuse is defined versus how it is measured in prevalence studies.

The definition of AOP used in this study does not require intent to harm. Harm is considered harm regardless of whether it was caused deliberately or unintentionally, through action or inaction. This reflects the reality that abuse can occur in a range of situations, including those where the behaviour is not recognised as harmful by the person responsible, or where it has become normalised over time. By focusing on the impact on the older person, rather than intent, the study aims to capture the full range of experiences that may cause harm or distress, particularly where there is an expectation of trust or a power imbalance.

A note on terminology: We use the terms *abuse of older people (AOP)* and *harm* interchangeably. Abuse refers to the actions or failures to act that cause harm or distress to an older person. Harm describes the consequences or outcomes of those actions. Together, these terms capture both the behaviours and their impact on older people.

## 1.3 Defining disability in the National Study

There is minor variation in how each of the three underlying *National Study* components define a disabled older person. We summarise each approach here, for convenience:

- Qualitative Interviews Report: Participants were able to self-identify as a disabled older person.
- Prevalence Survey Report: Disability status is determined using the Washington Group Short Set on Functioning[1] (WGSS), with the Social Investment Agency's classification into no/low/high functional limitation; neurodivergent status is assessed separately.
- Main IDI Report: A range of administrative data sources are used to determine disability status (disabled or not disabled). For example, self-reported WGSS information in the 2018 and 2023 Censuses, supplemented with administrative indicators in needs assessment data.

1 The WGSS is based on the International Classification of Functioning, Disability and Health (ICF); see https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health

# 2. QUALITATIVE INTERVIEWS

This section presents a summary of findings relevant to the disabled older people cohort from the *Qualitative Interviews Report* (for a detailed discussion see Section 8 of the full report; Wilson et al., 2026).

## 2.1 Methods

The qualitative component of the *National Study* focused on understanding the context and impact of AOP across four specific cohorts: Māori, Pacific peoples, NZ European, and disabled people aged 55+ years.

Participants were recruited through community networks, snowballing, and culturally grounded approaches (e.g. wānanga for Māori, talanoa for Pacific peoples). Interviews took place between July 2024 and June 2025. Most were conducted one-on-one, although some Māori participants chose to take part in a group wānanga. Interviewers asked about experiences of harm, its effects on health and wellbeing, and how people sought safety and support. Transcripts were thematically analysed for each cohort.

We interviewed 71 participants aged 55+, and living in the community, across four groups: NZ European (n=18), Māori (n=15), Pacific (n=21), and disabled older people (n=17). Most were women (75%), although men were also represented. Many carried lifetime histories of trauma and abuse that shaped their vulnerability to harm in later years.

The disabled older people cohort were aged between 65–89, with the majority falling within the 65–79-year age range. They were predominantly women (82%), with men comprising 18% of the disabled people interviewed. Three-quarters (76.5%) identified ethnically as NZ European, while 11.8% identified ethnically as Māori, with the remaining participants identifying with the 'Other' category.

Those participating identified in which group they would participate. Nevertheless, we recognised that some participants could belong to one or two other cohort groups (i.e. identify as Māori with Pacific ancestry and being disabled). We managed this by respecting the person's wish to self-select into a cohort group.

In line with the *Prevalence Survey*, we did not include people unable to provide informed consent, those at increased risk of harm by participating, or those in aged residential care. This study required the participants to provide informed consent freely based on their understanding of the information provided (Sacco et al., 2021). Therefore, participants needed to be able to communicate coherently and possess the capacity to comprehend the study and what was expected of them, so some

types of impairments are inherently absent from the data.

## 2.2 What we heard

The older people participating in this study commonly expressed feelings of invisibility, silence, marginalisation, and isolation. Disabled older people's narratives tended to be outcome-centred; it was more common for them to explain how the abuse made them feel or describe its impact.

### How abuse manifested

AOP across all population groups led participants to feel isolated, powerless, and ashamed. It influenced their social, cultural, and financial environments. For the disabled people interviewed, abuse was multi-layered and could involve people outside of their families, such as caregivers. Those we spoke to experienced multiple forms of harm rather than discrete manifestations of one or two types of abuse.

Systemic factors, ageist, and ableist beliefs contributed to abuse within this group. Disabled older people dependent on others to care for them are at heightened risk of abuse, especially emotional and financial abuse. Isolation, infantilisation (treating a competent adult like a child), and a lack of emotional and financial resources were often used as tactics by those causing them harm.

Some disabled people's reliance on others for support, together with drivers for abuse (like ageism, financial insecurity, coercive control, and alienation), enabled the continuation of abuse. This is aided by mental health issues, substance use, and perpetrators' collusion with professionals. In this study, disabled people's sense of shame, inner strength, and family loyalty also contributed to having limited support.

Those causing harm also questioned the older person's sanity and decision-making capacity, raising concerns about their memory loss, dementia, and erratic moods. Seeking help was framed as the disabled older person's paranoia and compromised mental capacity – this created a space for health or legal professionals to unwittingly collude with the person responsible for the abuse. Disabled older people often framed limited opportunities for, and poor experiences of, help-seeking as a consequence of being dependent on the person perpetrating the abuse.

### The impacts of abuse

The disabled older people interviewed reported powerlessness, loss of identity, compromised financial wellbeing, compromised mental and physical health, and

social isolation. Likely due to disabled older people's experiencing complex, multi-layered abuse, its impact left participants with an array of feelings, including financial loss, denigration, subservience, and helplessness.

A disabled older person's substance use negatively impacts their confidence and motivation, leaving them feeling like they are unable to confront the person responsible for harming them. Those with substance abuse disorders described it being weaponised by the person harming them, which resulted in their alienation and continued infantilisation. Examples included loss of agency following the disabled older person's disclosure of a substance abuse disorder, following a fall or after their hospitalisation. In all situations, infantilisation resulted in perpetrators either controlling their finances, putting pressure on the disabled people to provide the perpetrator with an Enduring Power of Attorney (EPOA), or feeling goaded into moving to a retirement home.

Reluctance to seek help is also driven by an unwillingness to be a burden, feelings of shame, a desire for stoicism, and a commitment to upholding family loyalty. Consequently, disabled older people can have inadequate support, such as legal protection and police intervention.[2] When accessed, these supports often resulted in ageism, not being believed, and having their cognitive capacity questioned, all of which, in turn, diminished their confidence.

## Protective and risk factors

Disabled older people identified protective factors that buffered them from the impacts of being abused. These included:

- Supportive partners boosted their sense of resilience.
- Employment, which provided disabled older people with a place to escape their abusive environments and boosted their confidence and identity.
- Using protective knowledge systems and strategic denial of harmful narratives (cognitive negation) as strategies to fortify their resilience and to resist the confusion, mental exhaustion, fear, and learned helplessness that the person responsible for the abuse instils in them.

Despite these protective factors, disabled older people identified several risk factors. They included:

2 Of the seven participants who discussed reporting their abuse to police, only one described a positive interaction. In this case, they reported their adult child assaulting them. For this disabled older person, the police were described as efficient in their crisis response, as well as ensuring they received ongoing support through a local non-government organisation (NGO).

- Older people's beliefs that privileged the importance of the family, the sanctity of the family, and protecting those responsible for the abuse to avoid potential consequences such as a criminal record or imprisonment.
- A change in marital status that results in the loss of a person who protected an older person from abuse.
- Natural disasters cause significant disruptions for disabled older people, both socially and financially, especially when they need to change houses, which results in the loss of essential support systems.
- A less visible form of harm occurs when older people experience harm from children or grandchildren for whom they also provide care. Some participants described caring for children or grandchildren with foetal alcohol spectrum disorder (FASD) or other conditions who sometimes displayed aggressive or challenging behaviour. They reported receiving little or no support from the police or other agencies in managing these situations[3].

For disabled older people many factors, sometimes co-occurring, were identified as enabling the continuation of abuse. When disabled older people rely on others for support, ageist attitudes and assumptions about disability or mental illness can make it easier for those causing harm to gain sympathy from others, while the older person's wellbeing can be overlooked. A further deterrent to leaving or not disclosing the abuse is the older person's need for financial security. The intersection of age with prolonged abuse impeded help-seeking and leaving an abusive relationship. The lack of emotional resources was especially discussed in relation to intimate partner violence (IPV), as were financial costs and poor employment prospects.

Disabled older people's sense of duty also enables the person harming them to exercise coercive control and entrap them. Those perpetrating abuse used threats (potential and real) and manipulation involving restricting access to their grandchildren, and demands to hand over money, purchasing assets like cars, or forcing the older person to engage in activities against their wishes (such as child-minding) that impact their wellbeing. The strategies the person causing harm utilises make the older person more dependent and/or compliant.

Contributing factors included early childhood and adulthood trauma. For those disabled participants who had experienced this, they consistently asserted that past exposure to abuse eroded their self-confidence. Decreased self-confidence was especially discussed in relation to having the confidence to identify and address negative behaviours and demand appropriate treatment and respect.

Therefore, these disabled older people were reluctant to seek legal protection or

3 Those we interviewed spoke of the requirement for co-morbid conditions (e.g. autism and FASD) to access disability-related support for their child/grandchild, and of the punitive rather than whānau-centred or health-based response formal intervention typically entailed.

police intervention to avoid family members having a criminal record or being imprisoned, describing these outcomes as detrimental to their grandchildren. Some older people blamed themselves for their children's behaviour, believing that their own childhood trauma had affected their parenting. This further discouraged them from disclosing the harm they experienced or seeking support.

Alienation of disabled older people leaves them with limited support options and opportunities to seek help and to disclose their abuse. Coupled with gaslighting (the subtle psychological manipulation that distorts the reality of victims so they question their sanity and judgement), it eroded disabled older people's confidence. It also compromised their sense of self, making it difficult to remove themselves from the abuse. These insidious tactics used by a person causing harm serve to isolate disabled older people from their social networks and professionals, such as doctors and lawyers.

A significant risk factor for the abuse of disabled older people is the intersection of ageism[4] and the onset of a disability, impairment, or mental illness, compounded by isolation, infantilisation, and substance use. Factors that enable the continuation of abuse include histories of early childhood and adulthood trauma, a reluctance to access support from social networks, and negative help-seeking experiences.

4 Ageism refers to how stereotypes and assumptions about older people shape the way they are treated. The ***National Study*** identified ageism as a key driver of AOP and a barrier to effective prevention and responses. See the ***Qualitative Interviews Report*** and the ***Perspectives on Financial AOP Report*** for further discussion.

# 3. PREVALENCE SURVEY

This section presents a summary of findings relevant to the disabled older people cohort from the main *Prevalence Survey Report* (Meehan et al., 2026).

## 3.1 Method and questionnaire design

The *Prevalence Survey* was carried out in the second half of 2024 under the neutral title *Health and Wellbeing of Older New Zealanders Survey*, to create a safe and respectful context for participants.

The survey used computer-assisted telephone interviews with 5,613 people aged 55 and over who were living in the community. A blended sample was drawn from the NZCVS panel and the Electoral Roll. Māori, Pacific peoples, and Asian respondents were oversampled to allow robust subgroup analysis, and survey weights were applied to ensure the data was nationally representative. For the full methodology, refer to the *Survey Methodology Report* (Tee et al., 2025).

The questionnaire covered six forms of harm: neglect, financial, psychological, physical, sexual, and cultural & spiritual (see Section 3.2 below). Respondents were asked about specific behaviours from people they knew, such as family, friends, neighbours, or professionals.

Based on weighted data, the full sample reflected NZ's community-dwelling population aged 55+. About 41% were aged 55–64, 33% aged 65–74, and 26% aged 75+. Just over half were women, and 73% identified as European, 10% as Māori, 9% as Asian, and 4% as Pacific peoples.

### Identifying disabled people

Disability status is based on the WGSS; neurodivergent status is assessed separately and is also included here. We use the Social Investment Agency's classification into: 1. Those with no functional limitations (i.e. no difficulty seeing, hearing, walking or climbing steps, remembering or concentrating, washing all over or dressing, communicating using your usual language); 2. Those with low functional limitations (i.e. some difficulty with at least one of these activities); and 3. Those with high functional limitations (i.e. a lot of difficulty, or cannot do at all, for at least one of these activities) (Social Investment Agency, n.d.).

## 3.2 Abuse measures

### Harm subtypes

The survey measured six forms of harm through behaviour-specific questions about things done by someone the respondent knew in the last 12 months.

- Neglect (10 questions). Respondents were first asked if they needed help with daily activities such as meals, transport, or personal care. If they did, they were then asked who provided the help and whether they always received the help they needed. For example, *"In the last 12 months, did you need help doing routine housework, and if so, did you always receive it?"*
- Financial harm (8 questions). Covered misuse of money, property, or financial authority. For example, *"In the last 12 months, has someone taken your money or possessions without your permission?"*
- Psychological harm (10 questions). Asked about insults, belittling, exclusion, manipulation and threats. For example, *"Has anyone repeatedly ignored you or excluded you?"*
- Physical harm (9 questions). Asked about violent or coercive acts. For example, *"Has someone grabbed, pushed or shoved you?"*
- Sexual harm (5 questions). Focused on unwanted sexual behaviours. For example, *"Has someone touched you in a sexual way against your will?"*
- Cultural & spiritual harm (11 questions). Covered disrespect or exclusion linked to culture, language, and spiritual beliefs. For example, *"Has someone prevented you from speaking your preferred language?"*

Any single incident of financial, physical, or sexual harm was considered abuse. For neglect, psychological, and cultural & spiritual harm, thresholds were applied to focus on repeated or serious patterns (referred to as the Cumulative Harm Index (CHI) – Very Serious threshold). See the supplementary *Thresholds Report* (Scott et al., 2026) for a detailed discussion of thresholds used.

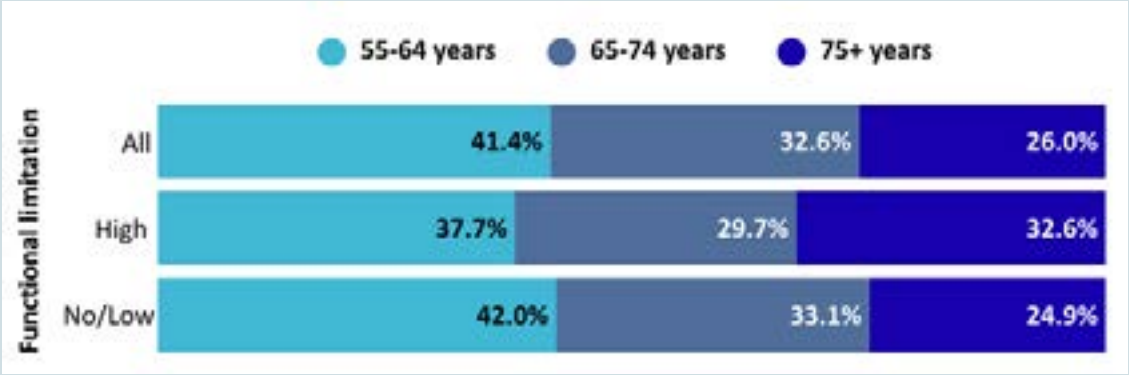
## 3.3 About the sample

We explored whether people in the sample with high functional limitations were different from those with no/low functional limitations across a range of characteristics, including age, ethnicity, gender, professional care, and experiences of past harm.

Figure 1 shows the age distributions. There was a statistically significant difference

in the age distribution between people with no/low functional limitations and those with high functional limitations, with a larger proportion of people with high functional limitations being aged 75 years or older (33% versus 25%).

Figure 1: Age distribution, by disability status




Note: Unweighted/weighted counts are 4,760/1,315,354 for no/low functional limitations; 853/215,380 for high functional limitations.

Figure 2 shows the distribution of ethnicity, which was statistically significantly different between the two groups. This appears to be driven by people with high functional limitation being more likely to be Māori (15% versus 9%), reflecting the higher rates of functional limitation among the Māori population overall.

Figure 2: Ethnicity distribution, by disability status




Note: Unweighted/weighted counts are 4,760/1,315,354 for no/low functional limitations; 853/215,380 for high functional limitations.

Figure 3 shows the gender distribution. There is no statistically significant difference by disability status.

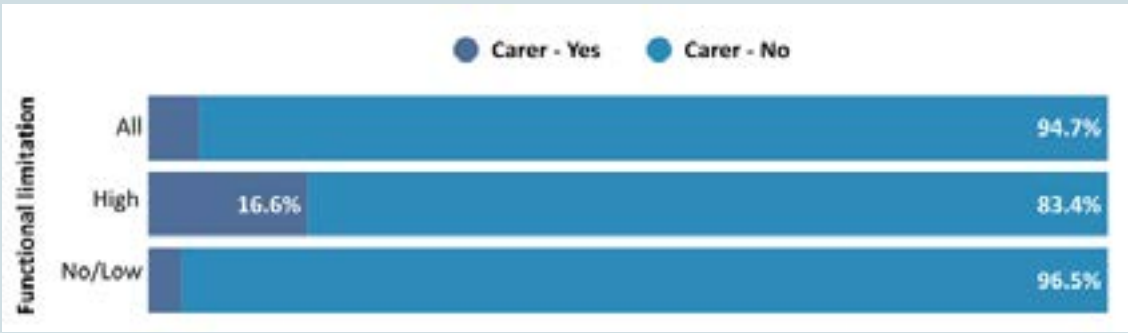
Figure 3: Gender distribution, by disability status




Note: Responses of another gender/don't know/refused suppressed due to small sample size; Unweighted/weighted counts are 4,760/1,315,354 for no/low functional limitations; 853/215,380 for high functional limitations.

In Figure 4, we show the probability of having a professional (paid) carer at home for each group. There is a statistically significant difference, with those with high functional limitation being more likely to have a carer at home. However, most respondents with high functional limitations did not have a professional carer (83%).

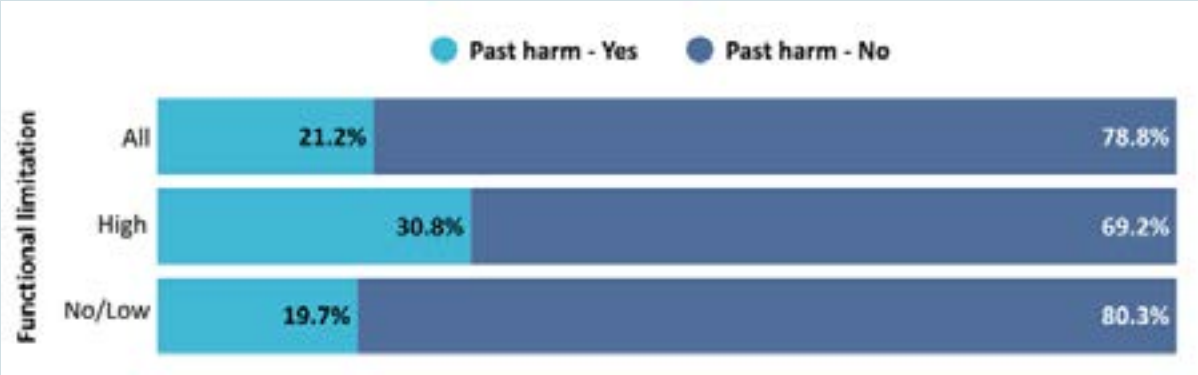
Figure 4: Professional carer at home, by disability status




Note: Responses of don't know/refused suppressed due to small numbers; Unweighted/weighted counts are 4,760/1,315,354 for no/low functional limitations; 853/215,380 for high functional limitations.

Previous experience of harm by a known person is shown in Figure 5. Older people with high functional limitation were statistically significantly more likely to have experienced past harm by someone they knew (30% versus 19%).

Figure 5: Experience of past harm by known person, by disability status




Note: Unweighted/weighted counts are 4,760/1,315,354 for no/low functional limitations; 853/215,380 for high functional limitations.

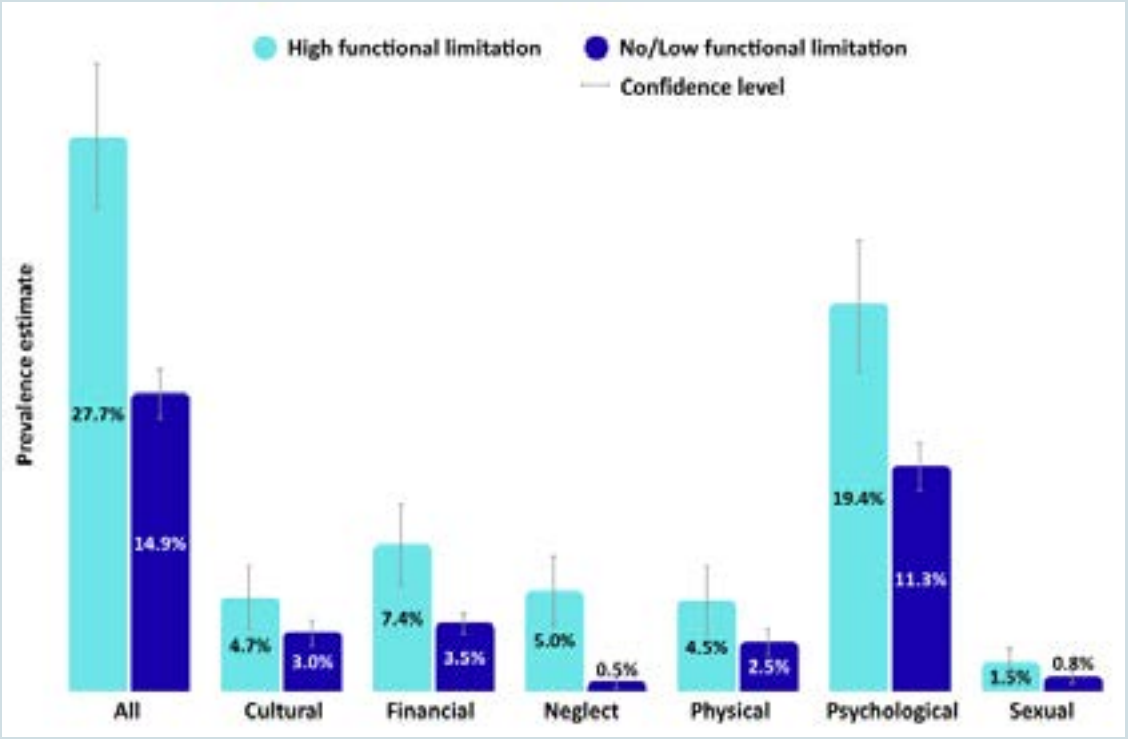
## 3.4 Survey prevalence estimates

Prevalence rates are much higher for those with high functional limitations than those with no or low functional limitations (Figure 6). The overall prevalence rate is over one in four for those with high functional limitations (27.7%, equating to 59,700 disabled older people); prevalence almost halves for those with no or low functional limitations (14.9%). The patterns are similar for all harm subtypes, and statistically significant for neglect, financial, and psychological harm.

Neglect for those respondents with high functional limitations (5%, or 10,800 disabled older people) is about 10 times higher than that among respondents with no or low functional limitations (0.5%). Those with functional limitations are more reliant on others to assist them with their day-to-day activities and are therefore more vulnerable to neglect. While about one-quarter (25.9%) of those with no or low functional limitations need some sort of help with day-to-day activities, almost two-thirds (66%) of those with high functional limitations need help with them.

Financial abuse is also more prevalent among those with high functional limitations (7.4% versus 3.5%; equating to 15,900 disabled older people), as is psychological abuse (19.4% versus 11.3%; or 41,400), physical abuse (4.5% versus 2.5%; or 9,800), sexual harm (1.5% versus 0.8%; or 3,100), and cultural & spiritual harm (4.7% versus 3.0%; or 10,100).

Figure 6: Survey prevalence, by disability status



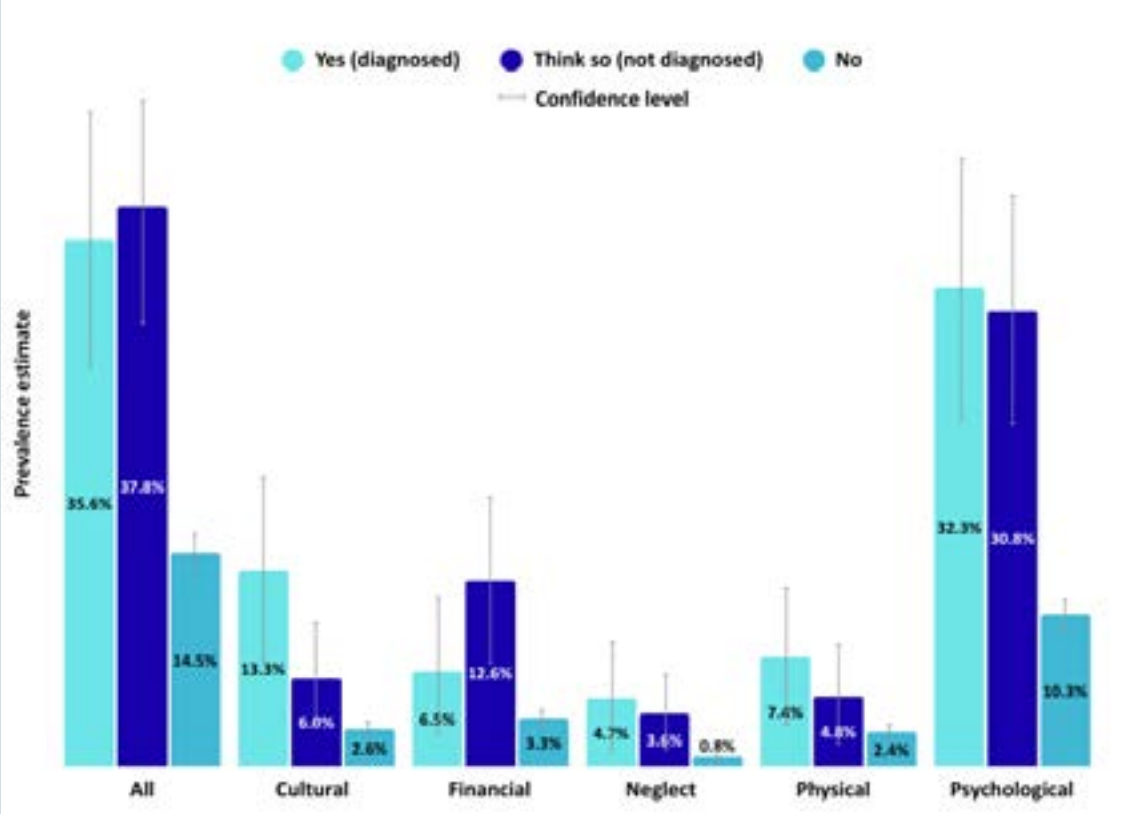

Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on CHI–Very Serious threshold where relevant. Underlying unweighted/weighted counts for each subtype varied from 831/212,000 to 853/215,400 (high functional limitation) and 4,636/1,282,600 to 4,760/1,315,400 (no/low functional limitation).

There are also clear differences by neurodivergent status (Figure 7). The overall AOP rates among those with a diagnosed neurodivergent condition (such as autism or ADHD), or a suspected but undiagnosed one, are similar at slightly over one-third (35.6% and 37.8%, respectively; equivalent to 52,800 older people). This is more than twice that of those who do not have a neurodivergent condition (14.5%).

While differences by harm subtype were generally not statistically significant, psychological harm stood out. Rates were roughly three times higher among those with a diagnosed (32.3%, or 20,900 older people) or suspected (30.8%, or 24,000 older people[5]) condition than among those without (10.3%). Statistically significant differences were also observed for financial harm (12.6% for suspected versus 3.3% for non-neurodivergent; or 9,900 older people) and for cultural & spiritual harm (13.2% for diagnosed versus 2.6% for non-neurodivergent; or 8,600 older people). These findings point to a heightened risk of harm for neurodivergent older people, particularly in areas where power, trust, and communication play a strong role.

5 Note the weighted count is higher than for the diagnosed group, due to the larger number of respondents reporting they suspect neurodiversity versus those who have been diagnosed (78,400 versus 65,200).

Figure 7: Survey prevalence, by neurodivergent status




Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on CHI–Very Serious threshold where relevant. Underlying unweighted/weighted counts for each subtype varied from 216/64,500 to 221/65,200 (diagnosed) and 257/78,000 to 259/78,400 (think so – not diagnosed). Sexual harm omitted due to small underlying counts.

# 4. INTEGRATED DATA INFRASTRUCTURE (IDI)

The *Prevalence Survey* results were supplemented with analysis of administrative data to investigate AOP from another perspective. While the survey provides the most reliable national prevalence estimates, administrative data help show how harm comes to the attention of services such as police, hospitals, and ACC. Using both approaches gives a fuller picture: survey data capture experiences that often remain hidden, while administrative data capture cases where harm is visible in service systems.

This section presents a summary of findings relevant to the disabled older people cohort from the main *IDI Report* (Chen et al., 2026).

All data are sourced from Stats NZ's IDI, and analysis is restricted to those aged 55 years and older living in private dwellings between 2015 and 2022.

We identified cases of AOP using the following data:

- Police victimisation records – offences where the offender was identified and known to the victim.
- ACC claims – injuries coded as assaults, maltreatment, or sensitive claims, mainly occurring in the home.
- Hospital admissions – admissions coded for maltreatment or assault by a known person.
- interRAI Home Care Assessments – clinical indicators of risk of abuse (not definitive cases).
- NZCVS – self-reported victimisation data, 2018–2022.

Administrative datasets only capture incidents visible to public services – police reports, hospital admissions, or ACC claims. This excludes most psychological, financial, and cultural & spiritual forms of abuse, and any cases that do not result in contact with services. By contrast, the NZCVS captures a wider range of victimisation experiences, although it still omits some forms such as financial abuse.

A range of administrative data sources are used to determine disability status (disabled or not disabled). For example, self-reported WGSS information in the 2018 and 2023 Censuses, supplemented with administrative indicators in needs assessment data.

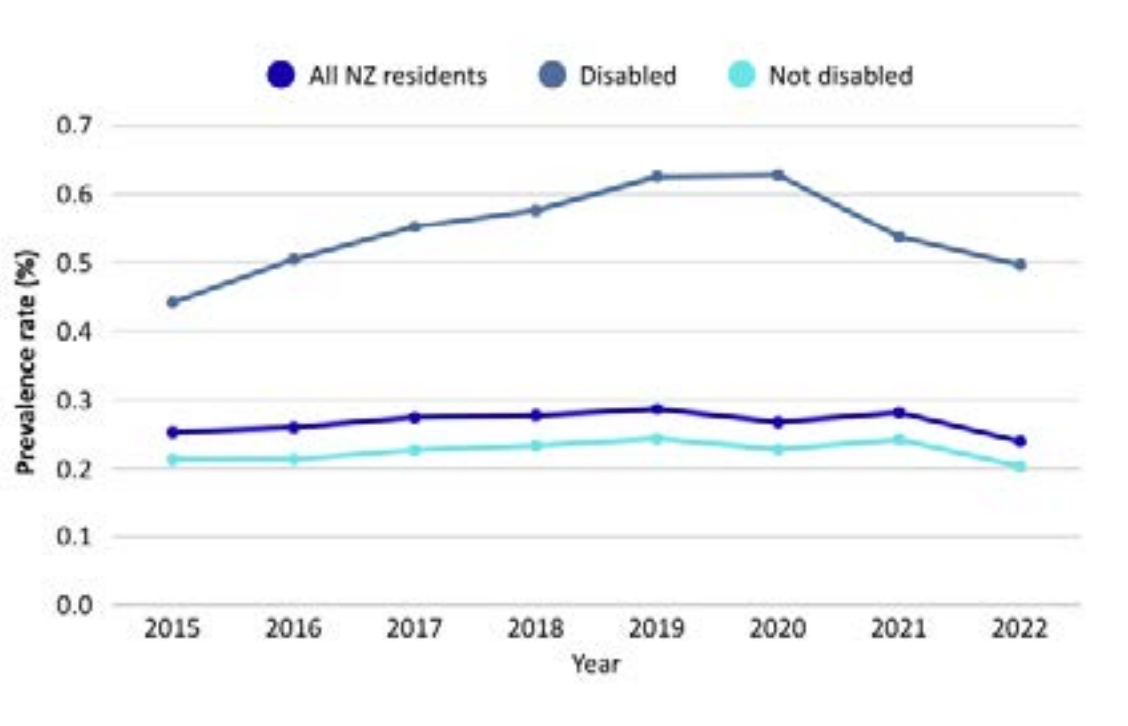
We measure prevalence by person-years: the share of people aged 55+ who experienced AOP in a given year. A single incident may appear in more than one

dataset (e.g. a case recorded by both police and a hospital), and ongoing abuse may be recorded more than once. To avoid this complexity, we focus on whether someone experienced at least one incident in a year. This provides annual prevalence but not a measure of intensity.

## 4.1 IDI prevalence estimates

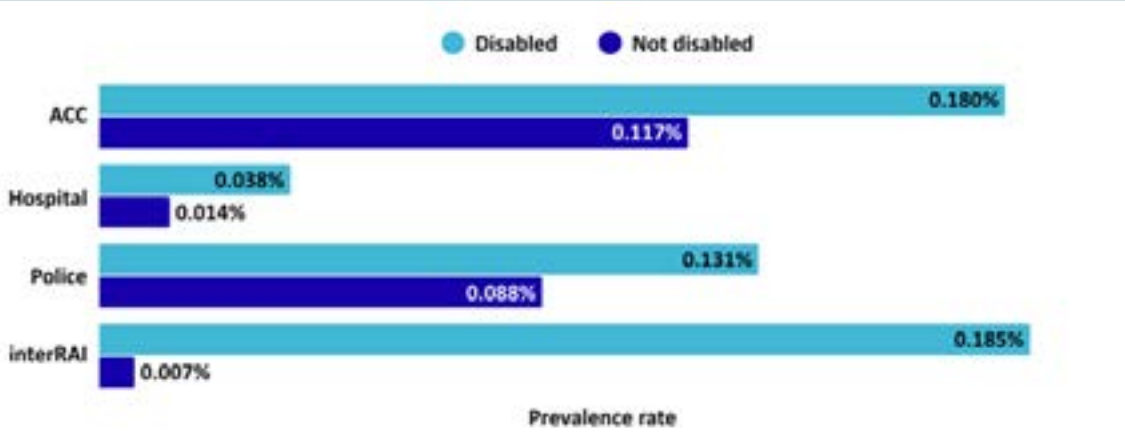
As Figure 8 shows, the prevalence of AOP for people with a disability is two to three times that of people without disability throughout the study period (0.40% to 0.60% compared to about 0.20%). This pattern is present in all data sources but is most extreme in interRAI data (see Figure 9).

Figure 8: IDI overall prevalence, by disability status, 2015–2022




Note: Underlying AOP counts each year varied from 831–990 (disabled), 2,067–2,901 (not disabled), and 2,955–3,882 (total).

Figure 9: IDI AOP prevalence, by data sources and disability status, 2022




Note: Underlying 2022 AOP counts by data source were 1,749 (ACC), 234 (Hospital), 1,308 (Police), 399 (interRAI), 3,363 (Total).

# 5. CONCLUDING REMARKS

## Disabled older people bear a disproportionate burden of abuse

Both survey and administrative data show that disabled older people experience higher rates of harm. Survey rates were almost twice as high among those with high functional limitations, while administrative rates were two to three times higher for disabled older people. Qualitative findings highlighted the multi-layered and complex patterns of abuse disabled older people experience. Inequity is consistent across multiple forms of harm and highlights that abuse is not simply about individual relationships, but reflects structural drivers such as ageism, ableism, and social exclusion.

## Intersectionality compounds risk

Not all disabled older people experience abuse in the same way. Māori, Pacific peoples, and neurodivergent participants reported compounded risks arising from colonisation, racism, stigma, and service inequities.[6] Addressing these requires culturally safe, disability-responsive, and trauma-informed approaches, co-designed with Disabled People's Organisations (DPOs) and community leadership.

## Further research is needed to ensure disabled older people are heard

The *National Study's* inclusion criteria (55+ year olds with cognitive capacity living in the community) means not all disabled older people's experiences are captured in the survey or qualitative data. Those with limited cognitive capacity or unable to participate in the survey or interview due to their disability are excluded from these findings. Further research is required for these groups.

## Carer support and effective AOP responses are critical

Our interviews showed that dependence on others can heighten vulnerability to harm, while safe and supportive carers act as a vital protective factor. Only one in

6 For a more detailed discussion on intersectional inequity and its impact on various cohorts, including disabled older people, refer to the full ***Qualitative Interviews Report***.

six community-dwelling older people with high functional limitations in the survey reported having a professional carer at home. Reliance on family and other informal sources of care increases risk factors while limiting help-seeking, leaving disabled older people vulnerable to harm. Legal safeguards are inadequate, excluding older people from decision-making and leaving them vulnerable to exploitation by those responsible for harm. Ensuring all carers – professional or not – are well-supported and better monitored is important for AOP prevention.

## Action is urgently needed

Improving prevention and responses to the abuse of disabled older people requires coordinated action across government, health, disability, and community sectors. Priorities include:

- Embedding monitoring that identifies disabled people within AOP data collections.
- Reviewing legislation and policy frameworks for adequacy of protection, especially the Protection of Personal and Property Rights (PPPR) Act 1988 and Property (Relationships) Act 1976.
- Expanding carer support, training, and oversight.
- Partnering with DPOs, Māori and Pacific providers, and neurodivergent communities in the co-design of support, response, and services.
- Investing in further research, including aged residential care and long-term AOP impacts.

Disabled older New Zealanders are more exposed to harm, less protected, and more often overlooked. Addressing these inequities is not just a matter of safety and wellbeing, but a moral imperative grounded in equity and social justice.

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