NEW ZEALAND POLICY RESEARCH INSTITUTE
TE KĀHUI RANGAHAU MANA TAURITE

AUT

NATIONAL STUDY OF ABUSE OF OLDER PEOPLE:

Prevalence survey on the abuse of older people in Aotearoa New Zealand

Prepared for Ministry of Social Development | Te Manatū Whakahiato Ora by the New Zealand Policy Research Institute, AUT



October 2026

Authors

Dr Lisa Meehan, Dr Ayesha Scott, Dr Leon Iusitini, Professor Denise Wilson, Dr Wei-Lin Chen, Professor Gail Pacheco, and Professor Corina Naughton

Acknowledgements

We are grateful to everyone who participated in the survey for generously sharing their experiences, insights, and perspectives – thank you.

The study was funded by the Ministry of Social Development (MSD) as part of the National Study on the Abuse of Older People. We thank the MSD project team, especially Tim Foote, for their collaboration, agency reviewers for their constructive input, and the external peer reviewers for their subject matter expertise and insight. We also thank the Ministry of Justice for allowing us access to the NZ Crime & Victims Survey re-contact panel, and for their expert input. The research methodology was supported by Stats NZ, whose expertise is acknowledged with thanks, and the survey conducted by Ipsos, whose collaborative approach was greatly appreciated by the research team.

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.

Suggested citation

Meehan, L., Scott, A., Iusitini, L., Wilson, D., Chen, W-L., Pacheco, G., & Naughton, C. (2026). *National Study of Abuse of Older People: Prevalence survey on the abuse of older people in Aotearoa New Zealand.* NZ Policy Research Institute. Auckland, NZ.

Contents

EXECUTIVE SUMMARY 13

1 INTRODUCTION 16

1.1 Study aims and definition of AOP 17

2 Design, scope, and sample 20

2.1 Target population 20

2.2 Sample design 22

2.3 Characteristics of the sample 22

3 OVERALL PREVALENCE 24

3.1 Overall prevalence 24

3.2 Sensitivity of overall prevalence to threshold choice 26

3.3 International comparisons 29

4 PREVALENCE BY HARM SUBTYPE 32

4.1 Neglect 33

Prevalence 33

Background/context 35

4.2 Financial harm 38

Prevalence 39

4.3 Psychological harm 41

Prevalence 43

4.4 Physical harm 44

Prevalence 44

4.5 Sexual harm 47

Prevalence 47

4.6 Cultural & spiritual harm 48

Prevalence 50

5 WHO IS RESPONSIBLE FOR HARM? 53

5.1 Relationship of the person responsible for harm to the respondent 54
5.2 Characteristics of those responsible for harm 59
Gender 59
Age 59
Living situation 59
Summary 60
5.3 Circumstances of the person responsible for harm 61
6 CO-OCCURRENCE OF DIFFERENT HARM SUBTYPES 64
7 HELP-SEEKING 68
7.1 How many older people experiencing harm sought help? 68
7.2 Reasons why those who experienced harm did not seek help 69
7.3 Who did those who experienced harm turn to for help? 72
7.4 What actions were taken in response to the harm? 74
7.5 What help would older people have liked to receive? 78
7.6 Summary 79
8 PREVALENCE BY RESPONDENT CHARACTERISTICS 80
8.1 Gender 80
8.2 Age 84
8.3 Ethnicity 89
8.4 Takatāpui and Rainbow communities 91
8.5 Household size 92
8.6 Living with their partner 93
8.7 Living with their children 94
8.8 Home ownership 96
8.9 Household income 97
8.10 Qualification level 98
8.11 Employment status 99
8.12 Disability status 101

8.13 Health status 104
8.14 Support networks 107
8.15 Past harm 110
8.16 Summary 111
9 MULTIVARIATE ANALYSIS 114
9.1 All harm 115
Gender differences 117
9.2 Harm subtypes 119
Neglect 119
Financial harm 121
Psychological harm 123
Physical harm 125
Sexual harm 127
Cultural & spiritual harm 129
9.3 Co-occurrence of harm subtypes 131
9.4 Main person responsible for harm 133
Partner or ex-partner 134
Child 136
9.5 Help-seeking 138
Did you seek help? 138
Did you want help? 141
9.6 Summary 143
10 DISCUSSION 144
10.1 Framing and limitations of the survey definition of AOP 144
Limitations of the 'known person' criterion and exclusion of institutional harm 145
Ambiguity in the power imbalance criterion 146
Self-neglect and the boundary of unmet need 147
Misuse of legal safeguards enables harm 148

Ambiguity around subtypes of harm 150
Age-related harm versus general harm: The example of workplace harm 151
10.2 Younger older people (aged 55–64 years) 153
The challenge of aged-based definitions 153
Prevalence of AOP for younger older people 154
10.3 Intersecting trajectories: Intimate partner violence (IPV) and AOP 155
Other forms of family violence 157
10.4 Gender 158
10.5 Help-seeking 160
11 CONCLUSION AND RECOMMENDATIONS 163
Recommendations 163
Future work 165
REFERENCES 166
Appendix 1: Characteristics of the sample 173
Appendix 2: Contextual information on care arrangements 175
Appendix 3: Sources of harm by relationship 176
Appendix 4: Additional regression results 177

List of Figures

Figure 1: How many people experience AOP? 25
Figure 2: Overall prevalence rates using different definitions and thresholds 29
Figure 3: Prevalence of neglect in the last 12 months 33
Figure 4: Neglect prevalence rate by Cumulative Harm Index 35
Figure 5: In the last 12 months, did you require any help with day-to-day activities? 36
Figure 6: Prevalence of financial harm 40
Figure 7: Psychological prevalence rate by Cumulative Harm Index 42
Figure 8: Experienced psychological harm in the last 12 months 43
Figure 9: Prevalence of physical harm in the last 12 months 45
Figure 10: Prevalence of sexual harm in the last 12 months 48
Figure 11: Cultural & spiritual prevalence rate by Cumulative Harm Index 50
Figure 12: Prevalence of cultural & spiritual harm in the last 12 months 51
Figure 13: Relationship between people experiencing harm and those responsible, overall AOP 54
Figure 14: Share of those experiencing harm who sought help, by harm subtype 69
Figure 15: Reasons for not seeking help, % of those experiencing harm who did not seek help 70
Figure 16: Sources of help or advice sought, % who experienced harm and sought help 72
Figure 17: Actions taken by respondents in response to harm, % who experienced harm 75
Figure 18: Share of those experiencing harm who said the response was effective, by harm subtype 77
Figure 19: Whether those who experienced harm would have liked additional help or advice (%) 78
Figure 20: Prevalence by gender 81
Figure 21: Relationship of main person responsible for harm by respondent gender 82
Figure 22: Prevalence by age 85
Figure 23: Overall prevalence rates by ethnicity 89
Figure 24: Prevalence by Takatāpui and Rainbow status 92
Figure 25: Prevalence by household size 93
Figure 26: Prevalence by whether or not respondent lives with their partner 94
Figure 27: Prevalence by whether or not respondent lives with their child/ren 95
Figure 28: Prevalence by home ownership status 97
Figure 29: Prevalence by employment status 100
Figure 30: Prevalence by disability status 102
Figure 31: Prevalence by neurodivergent status 103
Figure 32: Prevalence by self-rated physical health status 105

Figure 33: Prevalence by mental health status 106
Figure 34: Prevalence by Kessler psychological distress 107
Figure 35: Prevalence by number of people a respondent can rely on for help 108
Figure 36: Prevalence by how easy it is to get practical help from people respondent knows 109
Figure 37: Prevalence by whether respondent received care from a professional carer 110
Figure 38: Prevalence by whether respondent experienced past harm by known person 111

List of Tables

Table 1: Age, gender, and ethnicity distribution of the sample 23
Table 2: Overall AOP prevalence 25
Table 3: Overall prevalence rates using different definitions and thresholds 28
Table 4: Overall AOP prevalence among people aged 65+ 30
Table 5: Prevalence rates from international surveys (%) 31
Table 6: Summary of harm subtype prevalence rates and threshold applied 33
Table 7: Which activities did you need help with in the last 12 months? 38
Table 8: Unmet need, self-neglect versus neglect 38
Table 9: Types of financial harm 41
Table 10: Types of psychological harm 44
Table 11: Types of physical abuse 46
Table 12: Types of sexual harm 48
Table 13: Types of cultural & spiritual harm 52
Table 14: Relationship between people experiencing harm and those responsible, by harm subtype 57
Table 15: Demographic characteristics of main person responsible for harm, overall and by harm subtype 60
Table 16: Respondent-reported circumstances of those responsible for harm 62
Table 17: Number of harm subtypes experienced in past 12 months 65
Table 18: Co-occurrence of different harm subtypes, % of those experiencing relevant harm subtype 65
Table 19: Co-occurrence of harm subtypes 67
Table 20: Reasons for not seeking help by harm subtype, % of those who did not seek help 71
Table 21: Sources of help or advice sought by harm subtype, % of those who sought help 73
Table 22: Actions taken in response to harm, by harm subtype, % who experienced harm 76
Table 23: Effectiveness of response actions, by harm subtype, % of those experiencing harm 77
Table 24: Types of support wanted by those who experienced harm and wanted additional support 79
Table 25: Relationship of the main person responsible for harm, by respondent gender and harm subtype 83
Table 26: Relationship of main person responsible to those experiencing harm, by respondent age (%) 86
Table 27: Prevalence for types of psychological harm, by age (% of all respondents) 87
Table 28: Social exposure factors by age: Employment, household size, and interactions with others (%) 88
Table 29: Prevalence by (prioritised) ethnicity (% of all respondents) 90
Table 30: Prevalence by household income, overall and by harm subtype 98
Table 31: Prevalence by qualification level, overall and by harm subtype 99

Table 32: Relationship of main person responsible to those experiencing harm, by respondents' employment status 101
Table 33: Predicted probabilities from logit regression (All harm) 117
Table 34: Predicted probabilities from logit regression (Neglect) 120
Table 35: Predicted probabilities from logit regression (Financial) 122
Table 36: Predicted probabilities from logit regression (Psychological) 124
Table 37: Predicted probabilities from logit regression (Physical) 126
Table 38: Predicted probabilities from logit regression (Sexual) 128
Table 39: Predicted probabilities from logit regression (Cultural & spiritual) 130
Table 40: Predicted probabilities from logit regression: Co-occurrence of 2+ harm subtypes 132
Table 41: Predicted probabilities from logit regression: Main person responsible (partner or ex-partner) 135
Table 42: Predicted probabilities from logit regression: Main person responsible (child) 137
Table 43: Predicted probabilities from logit regression: Did you seek help? 139
Table 44: Logit regression predicted probabilities: Was there any type of help/advice you wanted? 142

Glossary

Term	Definition
Accident Compensation Corporation (ACC)	Crown-owned entity that administers NZ's no-fault accident compensation scheme.
Aged residential care (ARC)	Facilities that provide housing and care for older people who are no longer able to live independently in the community
Back-coding	Where the verbatim responses to questions with an 'Other (specify)' response option were coded to the original response options or additional categories.
Blended sample design	A survey sampling method combining participants from multiple sources – in this report, from the NZ Crime & Victims Survey and the Electoral Roll.
Culturally and Linguistically Diverse (CALD)	Groups of people who are from different cultural or language backgrounds.
Computer-Assisted Telephone Interviewing (CATI)	A method of conducting surveys via phone, with interviewers entering responses directly into a computer system.
Co-occurrence	Experience of two or more forms of harm in the last 12 months.
Community dwelling	Residing in a private dwelling or independent-living retirement village (as opposed to residing in institutional care including ARC, a hospital etc).
Confidence interval	A confidence interval is a range of values, derived from sample data, that is likely to contain the true value of an unknown population parameter. It reflects the degree of uncertainty or certainty associated with a sample estimate. For example, a 95% confidence interval suggests that if the same study were repeated many times, 95% of the calculated intervals would be expected to contain the true value.
Cumulative Harm Index (CHI)	A method used to measure the overall level of harm a person has experienced within a particular harm type (e.g. psychological harm or neglect). It assigns scores to individual experiences of harm based on how often they occurred, then sums those scores across all the relevant experiences.
Enduring Power of Attorney (EPOA)	A legal document that gives someone the authority to make decisions on behalf of another person. In NZ, there are two types of EPOA: one for personal care and welfare, and one for property. EPOAs are governed by the Protection of Personal and Property Rights Act 1988.
Functional limitations	Difficulties a person may have in performing basic activities due to physical, sensory, cognitive, or other impairments. In this report, measured using the Washington Group Short Set.
Integrated Data Infrastructure (IDI)	A large research database maintained by Stats NZ that links together a range of administrative and survey data sources about people in NZ.

Term	Definition
interRAI	interRAI is an internationally developed suite of clinically validated assessment tools designed for older people who require support with daily living.
Intimate partner	An intimate partner is someone you have, or have had, a close personal relationship with that involves emotional or romantic connection. This includes a current or former spouse, partner, boyfriend, or girlfriend. The relationship can be ongoing or have ended.
Jackknife method/Jackknife standard errors	The jackknife method is a statistical technique used to estimate standard errors (a measure of how accurate the results are). It works by creating many slightly different versions of the dataset – using replicate weights – and then re-running the analysis on each one. This helps show how much the results might change if the survey had sampled different people.
New Zealand Crime & Victims Survey (NZCVS)	A nationally representative survey that collects data on people's experiences of crime in NZ.
Older person	Defined for this research as a person aged 55 and over.
Prevalence	The proportion of the population that has experienced a particular type of abuse or harm over a specific time period. In this report, prevalence refers to how many older people in NZ have experienced abuse, harm, or neglect in the last 12 months.
Takatāpui and Rainbow communities	*Takatāpui and Rainbow communities*[1] include: people with innate sex characteristics that do not fit normative medical or social ideas for male or female bodies; people who have a gender identity or expression that does not match the sex they were assigned at birth, including those who do not fit typical binary gender norms; and/or people who are not heterosexual. *Rainbow* is an umbrella term for sex, sexuality, and gender diversity.
Replicate weights	Replicate weights are sets of alternative weights derived from the original sample. Each set corresponds to a 'replicate' or subset of the data, created to estimate the variability (standard errors) of survey estimates. They allow for the estimation of sampling variability by simulating the process of drawing multiple samples from the population. This survey used 100 replicate weights.
Sample weight	In general, a *sample weight* is a number used in survey analysis to make sure the results better represent the whole population – not just the people who were actually surveyed. This is important when some groups are over-represented or under-represented in the survey. In this report, *sample weights* were applied to adjust the survey results so they reflect the broader population of older people in

[1] We adopt the wording developed by Hohou Te Rongo Kahukura – Outing Violence (https://kahukura.co.nz/whakapapa/ "The words we use").

Term	Definition
	NZ. For example, the survey deliberately included more Māori, Pacific, and Asian respondents to ensure there was enough data to analyse these groups. Sample weights correct for this over-representation and differences in response rates, so the final results give an accurate picture of the national population aged 55 and over.
Standard error	The standard error shows how precise a survey estimate is. It tells us how much the result (like a percentage) might change if the survey were repeated with a different sample. A smaller standard error means more confidence in the estimate; a larger one means more uncertainty. Standard errors are used to calculate confidence intervals and test if differences between groups are statistically meaningful.
Statistical significance	Statistical significance tells us whether a result from the survey is likely to reflect a real difference or relationship in the wider population, rather than being due to chance. If a result is statistically significant, it means we can be reasonably confident it is not just a random finding. However, a result that is not statistically significant can still be important – it may still reflect a real issue but with more uncertainty due to factors like small sample size.
Threshold (in prevalence measurement)	A threshold is a rule used to help decide which experiences are counted when estimating how common abuse is. It may consider how often the behaviour happened or how serious it was for the person affected. Thresholds are used to distinguish between harmful behaviours that were infrequent and/or not considered serious by the respondent, and those that reflect a more sustained pattern of abuse.
Washington Group Short Set (WG-SS)	The Washington Group Short Set is a set of six standard questions used internationally to identify people with disabilities. It asks about difficulties with everyday activities like seeing, hearing, walking, remembering, self-care, and communicating. People are asked whether they have no difficulty, some difficulty, a lot of difficulty, or cannot do the activity at all. In this report, the WG-SS is used to understand the level of functional limitation among older people.

Definitions of abuse used in this report

Term	Definition
Abuse of older people (AOP)	AOP refers to any action – or lack of action – that causes harm or distress to an older person and is done by someone they know, such as a family member, friend, or caregiver. It includes situations where the older person depends on or trusts the person who causes the harm, or where there is a power imbalance. It can take many forms, including physical, emotional, financial, sexual, or neglect, as well as cultural & spiritual abuse. It does not include harm by strangers.
Neglect	Neglect is when an older person does not get the help they need with everyday tasks – such as meals, housework, transport, or personal care – from someone who is supposed to be helping them. This may happen once or repeatedly and can cause harm or distress.
Financial abuse	Financial abuse involves someone the older person knows misusing their money, property, or financial arrangements. It can include taking money without permission, pressuring them to give or lend money, misusing an EPOA, or failing to pay agreed expenses.
Psychological abuse	Psychological abuse includes behaviours that cause emotional harm, such as insulting, belittling, threatening, isolating, or controlling an older person. It can also include behaviours like using guilt or fear to manipulate them or making them feel like a burden.
Physical abuse	Physical abuse is when someone causes physical harm to an older person. This can include hitting, pushing, restraining, giving too much or withholding medication, or using physical force to control them.
Sexual abuse	Sexual abuse is any unwanted or non-consensual sexual contact or behaviour. This includes touching, sexual acts, or comments that the older person did not want and that caused distress or harm.
Cultural & spiritual abuse	Cultural & spiritual abuse is when someone disrespects or mistreats an older person because of their culture, language, or spiritual beliefs. This can include making fun of their beliefs, stopping them from practising their customs or speaking their language, or using religion or culture to shame or control them. It's a form of harm that targets identity and belonging.

EXECUTIVE SUMMARY

One in six older people living in the community experienced abuse in the past year

This survey is the first nationally representative study on the abuse of older people (AOP) in Aotearoa New Zealand (NZ). It focused on people aged 55 and over living in the community, excluding those in aged residential care. A total of 5,613 interviews were completed by phone. The survey asked about harm by someone known to the respondent. Forms of harm included psychological, financial, physical, sexual, cultural & spiritual, and neglect.

The findings from the survey provide estimates of how many people aged 55 and over experienced abuse in the last 12 months. Around one in six (16.7%) older people reported experiencing harm in the past 12 months at a level that met the study's threshold for AOP. This equates to over one-quarter of a million people when applied to the national population. This estimate reflects the scope of the survey, which focused on harm by people known to the respondent. It does not include harm by strangers (such as scams) or in institutional settings, meaning the overall prevalence of harm affecting older people in NZ is likely to be higher.

Psychological harm was most common, followed by financial harm

Most older people who experienced harm reported one form only (68% or 174,100 people). About one in five experienced two subtypes (21.4% or 54,800), and one in 10 (10.5% or 20,600) experienced three or more forms of harm. Psychological harm was the most common (12.4% or 189,600 people), followed by financial (4.0% or 61,200), cultural & spiritual (3.2% or 49,300), physical (2.8% or 42,600), neglect (1.2% or 17,600), and sexual harm (0.9% or 12,900).

Partners and children were most often identified as the people responsible for harm

For those who experienced harm, the person most often responsible was a partner or ex-partner (21.9%), followed by a child (20.6%), sibling (10.3%), and friends (14.4%). Work-related contacts and other family members (e.g. in-laws, grandchildren) were also frequently mentioned (16.0% each). Patterns varied by harm subtype: psychological harm more often involved partners or ex-partners, financial harm and neglect more often involved adult children, and cultural & spiritual harm more often involved work-related contacts. Indeed, work-related contacts were reported most often in relation to psychological and cultural & spiritual harm and were very rarely identified for financial harm.

Many older people experiencing harm did not seek help

Just 56.2% of older people who experienced harm said they sought help or advice. People were most likely to seek help for physical harm (60.3%) and least likely for sexual (28.2%) or cultural & spiritual harm (36.3%). The most common reason for not seeking help was a desire to handle it themselves (52.2%), followed by not needing help (33.2%) or feeling it was a private matter (21.3%).

Older people mostly turned to family or friends for support

Of those who sought help, 38.6% turned to whānau or family, and 32.0% to friends. Use of services varied. Formal services like police or legal advice were more commonly used for physical (48.5%) and financial harm (40.9%). Many older people who did seek help still reported unmet needs, particularly emotional support, counselling, and general advice. About one in four experiencing harm (27.5%) said they would have liked some kind of support (irrespective of whether they sought help for one or more AOP experiences).

Younger respondents, Māori, disabled, and neurodiverse people were more likely to experience harm

Harm was more common among people aged 55–64 (23.3%) than those aged 75+ (7.9%). Māori reported higher rates of harm than NZ European or Asian respondents. AOP rates were also higher among neurodiverse respondents and those with functional limitations or mental health conditions. People living in larger or multi-generational households, or who didn't own their home, were also more likely to experience harm.

Prior harm was linked to higher risk of experiencing harm again

Older people who had experienced harm in the past (before the previous 12 months) by someone they knew were more likely to experience AOP in the last 12 months. This finding supports further exploration of life course patterns of harm.

Tailored responses are needed to reduce harm and support recovery

This report highlights both the scale of harm experienced by older people and the importance of accessible, meaningful support. While many older people who experience harm turn to family or friends, a large share do not seek help, often because they want to manage it themselves or are unsure of who to turn to.

Even when help is sought, unmet needs are common. Emotional support, counselling, and clear information are commonly mentioned gaps. These findings point to the need for a more responsive

support system that recognises the diverse experiences of older people and offers safe, trusted, and culturally appropriate options.

Groups with higher rates of harm, such as disabled older people, those experiencing social isolation, members of the Takatāpui and Rainbow communities, and younger older people (aged 55–64) may benefit from tailored responses and targeted outreach. Strengthening the way professionals and systems respond to older people – especially in legal, financial, or caregiving contexts – is also key to upholding dignity, autonomy, and safety in later life.

The findings from this survey offer a strong foundation for action. With the right support, many older people can navigate difficult situations effectively. Ensuring that support is available, effective, and timely will be critical in preventing harm and promoting wellbeing.

1 INTRODUCTION

This report is part of the *National Study of Abuse of Older People in Aotearoa New Zealand* commissioned by the Ministry of Social Development (MSD) as part of its Prevention of Abuse of Older People (AOP) work programme. It presents findings from Aotearoa New Zealand's (NZ's) first *Prevalence Survey on the Abuse of Older People*. This nationally representative survey is a key component of a broader MSD-led project to understand the prevalence and context of abuse experienced by people aged 55 and over in NZ.

The *National Study* was completed 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 outline of 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.
3. Survey findings report, presenting results from the *Prevalence survey on the abuse of older people in Aotearoa New Zealand* (this report).
4. Survey 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. 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 *Aged Residential Care – Evidence from the Integrated Data Infrastructure (IDI)* report.
8. *Findings from qualitative interviews with NZ European, Māori, Pacific, and disabled older people who have experienced abuse* report, presenting 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.

This report proceeds as follows: next, we summarise the aims of the *Prevalence Survey* and define AOP in this context. Section 2 then outlines the design, including the target population and sample characteristics, before Section 3 summarises the overall AOP prevalence estimates. Section 4 presents the survey results by abuse subtype, beginning with neglect, then financial, psychological, physical, sexual, and cultural & spiritual harm. Section 5 describes who is most often responsible for harm against older people. Section 6 examines co-occurring forms of AOP. Section 7 presents the help-seeking data, including who is more likely to seek help and from where, and who is less likely to and why. Respondent characteristics are explored in terms of AOP prevalence in Section 8 (univariate analysis), then explored further in a multivariate setting in Section 9. Finally, the results are positioned within a wider context in the discussion (Section 10), including limitations of the study and international comparisons. Section 11 concludes with recommendations and opportunities for future research.

1.1 Study aims and definition of AOP[2]

The main aim of the survey was to collect population-level data on the prevalence of AOP in NZ and estimate a reliable national prevalence rate. Secondary aims include providing estimates of the prevalence of harm subtypes and understanding the distribution of harm across the population.

[2] Further details of the survey design and methodology are available in the *Prevalence Survey of Abuse of Older People: Methodology Report*, prepared by Ipsos (Tee et al., 2025).

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 study of AOP prevalence survey done 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).

The 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 surveys, the 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. Further discussion of grey areas is provided in Section 10.

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.

2 Design, scope, and sample

This section outlines the survey design, methodology, and sampling. Box 1 provides a summary of the survey methodology; further information can be found in an accompanying *Prevalence survey of abuse of older people: Methodology report* (Tee et al., 2025). The section also provides detail on the target population and its rationale, before reporting descriptive statistics of the resulting sample.

Box 1: Survey methodology

The survey was officially titled the *National Prevalence Survey on the Abuse of Older People*. However, it was conducted in the field under the more neutral title *Health and Wellbeing of Older New Zealanders Survey*. This public-facing name was chosen to help create a safe and respectful context for participation, particularly given the sensitive nature of the subject matter. It aimed to minimise potential distress, avoid stigma, and protect the privacy of respondents – especially in cases where someone causing harm might be in the same household.

The survey was conducted in field via computer-assisted telephone interviewing (CATI), using a 'blended' sample design. The 'blended' sample design consisted of previous respondents of the NZCVS who had agreed to take part in future research and people sampled from the Electoral Roll for whom a phone number was obtained via tele-matching.

A pilot version of the questionnaire was developed and tested in the field with 157 respondents in July 2024 (response rate 20%). Minor changes were then made, with the most substantive revision being the removal of questions to shorten the interview time. The main study was conducted in the field from September to December 2024 with a further 5,456 interviews (response rate approximately 23%), resulting in a final sample size of 5,613.

The survey oversampled Māori, Pacific, and Asian respondents to facilitate sub-population analysis for these groups. Survey weights are applied to ensure the reported results are representative of the target population by adjusting for differences in selection probability and response rates. Throughout this report, standard errors are calculated using the jackknife method with 100 replicate weights.

The *National Prevalence Study of Abuse of Older People* was approved by the AUT Ethics Committee (AUTEC Application: 24/30).

Source: Tee, N., Gates, S., Briggs, E., & Hinton, A. (2025). *Prevalence survey of abuse of older people: Methodology report*. Ipsos New Zealand, Auckland, NZ.

2.1 Target population

The target population for the national *Prevalence Survey* was individuals aged 55 and over living in the community. It excludes those living in aged residential care facilities, but includes those living independently in retirement villages.

International AOP prevalence surveys typically include individuals aged 60 or 65 and over. However, this study adopted a lower threshold of 55+ for two main reasons. First, it recognises that ageing-related risk factors, including poorer health and earlier dependence on care, often occur at younger ages for some groups, particularly Māori and Pacific peoples, who on average have a lower life expectancy than

Europeans. Setting the eligibility criterion at 55+ allows these groups to be represented within the *Prevalence Survey* in a way that may better reflect their lived experience. Second, this approach aligns with other NZ research and policy analysis that highlights ethnic differences in lifespan and the need to recognise ageing earlier for priority populations (MSD, 2023).

Including people aged 55–64 across all ethnic groups means that some in the target population may not see themselves as 'older people'. A single age cut-off was nevertheless chosen to ensure consistency across the sample and to avoid applying different definitions by ethnicity. This approach reflects practice in other NZ studies of ageing, such as the Health, Work and Retirement Study, which begins at age 55 (Alpass et al., 2020). It is also consistent with the Canadian national elder abuse survey, which adopted a 55+ threshold in recognition of similar issues for Indigenous populations (NICE, 2015).

As with most international AOP prevalence surveys, the target population excluded those living in aged care facilities. This exclusion recognises the distinct nature of abuse in institutional settings and the need for separate investigative approaches.

By concentrating on community-dwelling older adults, the survey aims to provide an understanding of AOP in settings where individuals maintain a degree of independence and where abuse dynamics may differ markedly from those in institutional care. For example, AOP in aged care facilities may involve interactions between residents and staff or organisational shortcomings, which may be influenced by institutional policies and staffing practices (see Yon et al., 2019 for an international review). In contrast, community-dwelling older adults may be at increased risk of abuse from family members, friends, or acquaintances, with dynamics rooted in personal relationships and social networks.

Other considerations include that residents of aged care facilities are more likely to have significant health issues, including cognitive impairment, posing additional barriers to participation in standard survey interviews and disclosing abuse (Yon et al., 2019). As a result, different approaches – such as proxy reporting or observational methods – may be more appropriate to capture residents' experiences. These research methods differ from those used in community-based surveys and bring additional ethical and methodological considerations.

Future research initiatives may focus specifically on aged care facilities to address the unique challenges and forms of abuse present in those environments.

2.2 Sample design

The survey used a 'blended' sample design consisting of previous respondents of the NZCVS who had agreed to take part in future research, and people sampled from the Electoral Roll with a tele-matched phone number.

In total, 5,613 interviews were completed. The survey oversampled Māori, Pacific, and Asian respondents to facilitate sub-population analysis for these groups. Survey weights are applied to ensure the reported results are representative of the target population by adjusting for differences in selection probability and response rates. Standard errors are calculated using the jackknife method with 100 replicate weights.

2.3 Characteristics of the sample

Table 1 presents the age, gender, and ethnicity profile of survey respondents, using both unweighted and weighted data. A more detailed breakdown of sample characteristics is provided in Appendix Table 1 and discussed throughout Section 8.

Based on the weighted data, 47.5% of respondents were men and 52.4% were women, with a small number identifying as another gender or selecting "Refuse" or "Don't know". The average age of respondents was 68.5 years. At the time of the survey, 41.4% were aged 55–64, 32.6% were aged 65–74, and 26.0% were aged 75 and over. In terms of ethnicity, 74.0% identified as European, followed by Māori (10.0%), Asian (9.0%), Pacific peoples (4.1%), and Middle Eastern, Latin American and African (MELAA) or Other ethnicities (2.9%).[3]

The unweighted data indicates that respondents aged 55–64 were under-represented in the raw sample compared to their share in the weighted population (30.0% versus 41.4%), while older age groups were over-represented. Māori, Pacific, and Asian respondents were deliberately oversampled to allow for robust subgroup analysis (see Section 2.2). Slightly more men than women were interviewed in the unweighted sample, but weighting adjusted this to reflect the actual population distribution, in which women slightly outnumber men.

[3] Prioritised ethnicity reported, where the order of prioritisation is Māori, Pacific, Asian, MELAA and Other, NZ European. 'MELAA and Other' ethnicity includes Middle Eastern, Latin American & African and Other ethnicity.

Table 1: Age, gender, and ethnicity distribution of the sample

	% weighted sample (standard error)	% unweighted sample (standard error)
Age group		
55–64 years	41.42 (0.93)	30.04 (0.61)
65–74 years	32.58 (0.87)	38.04 (0.65)
75+ years	26.00 (0.84)	31.93 (0.62)
Average age at the time of survey (years)	68.52 (0.18)	70.21 (0.12)
Ethnicity		
European	74.04 (0.78)	66.54 (0.63)
Māori	10.02 (0.49)	12.49 (0.44)
Pacific	4.05 (0.27)	8.87 (0.38)
Asian	9.01 (0.54)	9.64 (0.39)
MELAA and Other	2.88 (0.32)	2.46 (0.21)
Don't know/Refuse	0.23 (0.10)	0.23 (0.06)
Gender		
Male	47.52 (0.94)	52.63 (0.67)
Female	52.42 (0.94)	47.30 (0.67)
Another gender/Don't know/Refuse	s.	s.
Observations	**1,530,700**	**5,613**

Note: Prioritised ethnicity where the order of prioritisation is Māori, Pacific, Asian, MELAA and Other, European. 'MELAA and Other' ethnicity includes Middle Eastern, Latin American & African and Other ethnicity. 's.' indicates cell was suppressed due to small underlying count.

3 OVERALL PREVALENCE

Summary

- Around one in six people aged 55+ in NZ (16.7%, about 256,000) experienced harm in the past year.
- Subtype prevalence was psychological harm (12.4%), financial (4%), cultural & spiritual (3.2%), physical (2.8%), neglect (1.2%), and sexual harm (0.9%).
- Each harm subtype represents tens of thousands of older people affected (e.g. around 190,000 experienced psychological harm and more than 60,000 experienced financial harm).

This section presents the overall prevalence rate of AOP, explores how this varies under different threshold definitions, and includes some international comparisons.

3.1 Overall prevalence

Overall, 16.7% of respondents reported experiencing some form of AOP in the past 12 months – this includes psychological, financial, physical, sexual, cultural & spiritual harm, and/or neglect (Table 2). Section 4 outlines how the abuse subtypes are defined using behaviourally-specific items tailored for survey measurement.

The most common form of harm reported was psychological (12.4%), followed by financial (4.0%), physical (2.8%), cultural & spiritual (3.2%), neglect (1.2%), and sexual harm (0.9%). Note that the total number of completed interviews was 5,613, but some respondents chose not to answer some prevalence questions (selected ”Don’t know” or ”Refused”). These responses are treated as missing and therefore the base populations for each harm subtype vary slightly.

These prevalence rates translate to approximately 256,000 individuals aged 55 and over – about one in six older New Zealanders – who experienced some form of harm in the past year (Table 2 and Box 2). Specifically, an estimated 189,600 experienced psychological harm, 61,200 financial harm, 42,600 physical harm, 49,300 cultural & spiritual harm, 17,600 neglect, and 12,900 sexual harm.

Table 2: Overall AOP prevalence

Harm type	Population prevalence	Number of people affected (mean estimate)	Number of people affected (low estimate - high estimate)
All harm types	16.72%	256,000	235,500 – 276,400
Neglect	1.15%	17,600	12,200 – 23,000
Financial	4.00%	61,200	50,900 – 71,500
Psychological	12.43%	189,600	171,200 – 208,000
Physical	2.78%	42,600	33,800 – 51,400
Sexual	0.87%	12,900	8,500 – 17,400
Cultural & spiritual	3.23%	49,300	40,200 – 58,400
Total number of older people (weighted count)		**1,530,700**	
Total number of respondents (unweighted count)		**5,613**	

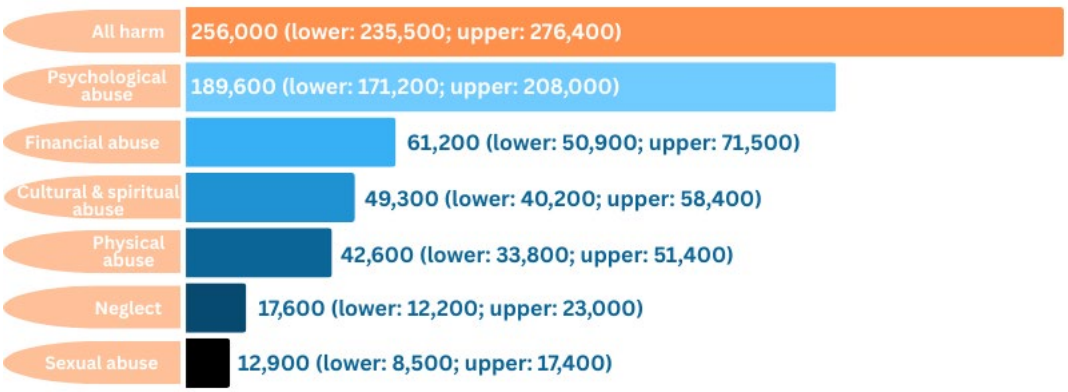
Note: Estimated numbers of people affected (weighted counts) are rounded to the nearest 100. Low and high estimates reflect 95% confidence intervals. Due to missing responses, the base populations vary slightly by harm subtype: neglect: 5,580 unweighted/1,525,000 weighted; financial: 5,611 unweighted/1,530,100 weighted; psychological: 5,581 unweighted/1,524,500 weighted; sexual: 5,467 unweighted/1,494,600 weighted; cultural & spiritual: 5,601 unweighted/1,528,300 weighted. Prevalence rates for harm subtypes add to more than the overall prevalence, as some people experience more than one type of harm.

Box 2: How many people experience AOP?

Prevalence estimates from the survey allow us to calculate how many older people in the NZ population are affected by abuse each year (as in Figure 1). These figures are based on weighted survey results and should be interpreted as estimates, not exact counts.

Each estimate includes a confidence interval – a range that reflects the statistical uncertainty inherent in using a sample to represent a larger population. A 95% confidence interval means we can be 95% confident that the true population prevalence falls within the stated range, assuming the survey sample accurately reflects the community-dwelling population aged 55 and over.

Figure 1: How many people experience AOP?



3.2 Sensitivity of overall prevalence to threshold choice

We apply a threshold to define respondents' experiences and estimate the prevalence rates in Section 3.1, consistent with international practice for measuring AOP prevalence. We refer to this thresholding approach as the Cumulative Harm Index – Very Serious (CHI–Very Serious). It is used to distinguish between harmful behaviours that were infrequent and/or not considered serious by the respondent, and those that reflect a more sustained pattern of abuse.

While a single instance of physical, financial, or sexual harm can have serious consequences for the older person and thus constitutes abuse, other forms of harm – such as psychological, cultural & spiritual harm, or neglect – depend more on frequency, duration, or context to be meaningfully identified as abuse. For example, not receiving help when it was needed once in the previous year and the respondent reporting this incident as not serious to them is not classified as neglect. Multiple instances of not receiving help across either a range of activities or repeatedly for one activity are required for the experience to be classified as neglect. Similarly, being spoken to in a way that was offensive or aggressive once or twice, with these instances not perceived as serious for the respondent, is not classified as psychological abuse. Experiencing a range of behaviours that indicate psychological or emotional harm, or one behaviour occurring multiple times in the previous year, is required for it to be classified as psychological abuse and indicates a pattern of behaviour aligned with the AOP definition.

In contrast, for physical or sexual abuse, any occurrence constitutes abuse and is included in the prevalence rate irrespective of frequency, number of harms experienced, or severity. For financial harm, more than one experience may indicate a pattern of behaviour, or one experience may be financially catastrophic for a respondent. The range of behaviours reported by respondents, and their frequency, may be an unreliable measure in this case. Further, the limitation of a quantitative survey instrument in capturing the context of an experience and its outcome supports a cautious approach to applying thresholds.

Details on how the Cumulative Harm Index–Very Serious (CHI–Very Serious) threshold was determined and applied are provided in a supplementary *Thresholds Report* (Scott et al., 2026a), with threshold-setting further outlined in Table 3 and explained in Section 4. Box 3 summarises key findings from the supplementary report, which draws on international practice, expert consultation, and *Prevalence Survey* data.

Box 3: Harm thresholds

Establishing appropriate thresholds for the AOP prevalence measures is a critical part of the analysis for data collected in the *Prevalence Survey*. Put simply, a threshold is a rule used to help decide which experiences are counted when estimating how common abuse is. It may consider how often the behaviour happened or how serious it was for the person affected. In international AOP prevalence studies, thresholds are often used to distinguish between harmful behaviours that were infrequent and/or not considered serious by the respondent, and those that reflect a more sustained pattern of abuse.

There is no consensus approach to threshold-setting across international prevalence studies – different methods are used depending on the type of harm, research objectives, and available data. To ensure threshold settings for the *Prevalence Survey* are informed by international work, appropriate theory, and the survey data itself, supplementary research was conducted (refer to the *Thresholds Report*; Scott et al., 2026a). The project involved three components: a literature review, consultation with a panel of experts, and analysis to test the impact of thresholds using the survey data.

In line with prior research and expert opinion, no thresholds were used to estimate the prevalence of financial, physical, or sexual harm. For neglect, psychological harm, and cultural & spiritual harm, a CHI approach was used to distinguish between those behaviours reported by survey participants as one-off or infrequent occurrences and those indicating a pattern of harmful behaviour experienced over the 12 months prior to the survey. Further, perceived severity was captured with the inclusion of those respondents who did not meet the CHI–Core threshold of 3 or more but characterised their experience as "very serious". The resulting CHI–Very Serious measure for neglect, psychological harm, and cultural & spiritual harm was chosen as the main estimate of the prevalence rate of AOP and its subtypes.

Source: Scott, A., Mung, Z. S., Nicholson, K., Meehan, L., & Wilson, D. (2026). *Defining thresholds for measuring prevalence of abuse of older people in Aotearoa New Zealand*. New Zealand Policy Research Institute, Auckland, NZ.

As there is no international consensus on threshold-setting in prevalence studies, methods vary by harm type, research goals, and data availability. In this study, we examine variation in frequency and seriousness for abuse subtypes requiring thresholds by applying three variants of the CHI. This approach, used in several international studies (e.g. Qu et al., 2021; see Scott et al., 2026a), assigns scores to behaviours within neglect, psychological harm, and cultural & spiritual harm based on occurrence. These scores are summed to produce a CHI–Core total. Table 3 presents overall AOP prevalence estimates using various threshold definitions based on harm frequency and, in some cases, perceived seriousness – also visualised in Figure 2.

The three Cumulative Harm Indices tested were:

1. CHI–Core: Respondents were included if they experienced physical, financial, or sexual harm (no threshold applied), or scored three or more on the CHI for neglect, psychological, or cultural & spiritual harm.
2. CHI–Very Serious: This extends the CHI–Core to also include respondents who did not meet the CHI–Core threshold of three but described the harm they experienced as "very serious".

3. **CHI–Expanded Seriousness**: This further includes respondents who described their experiences as at least "somewhat or moderately serious", even if they did not meet the CHI–Core frequency threshold.

As described above and in line with international practice, no thresholds were applied to financial, physical, or sexual harm. These forms of harm are generally considered serious enough that any occurrence, regardless of frequency, is counted in prevalence estimates. Thresholding these subtypes could risk underestimating their prevalence and impact.

If no threshold is applied, one in four respondents (24.3%) reported experiencing some form of harm – neglect, financial, psychological, physical, sexual, and/or cultural & spiritual – in the previous 12 months. The CHI–Core yields a lower estimate of 16.1%. The CHI–Very Serious increases this prevalence slightly to 16.7% and the CHI–Expanded Seriousness increase it further to 20.2% (Table 3).

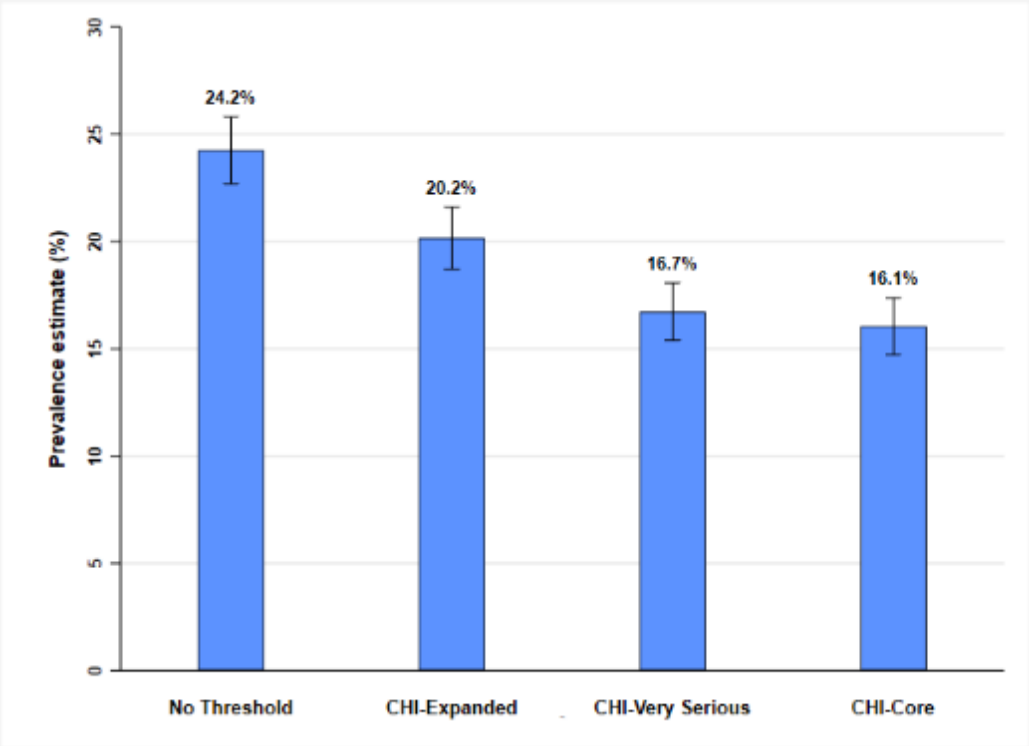
This study uses the CHI–Very Serious variant as the main prevalence estimate. As discussed in Box 3 and explained in detail in the supplementary *Thresholds Report* (Scott et al., 2026a), this decision was informed by international literature, expert consultation, and analysis of the survey data.

Table 3: Overall prevalence rates using different definitions and thresholds

Threshold	Description	Prevalence rate % (standard error)
No threshold	None; experienced any harmful behaviour	24.25 (0.79)
Cumulative Harm Index–Expanded Seriousness	• Experienced financial, physical or sexual harm; and/or • Experienced neglect, psychological, and/or cultural & spiritual harm with a score of 3 or more on the CHI–Core; and/or • Respondent indicated the neglect, psychological, and/or cultural & spiritual harm was "very serious" or "somewhat or moderately serious" to them	20.16 (0.74)
Cumulative Harm Index–Very Serious (main estimate)	• Experienced financial, physical or sexual harm; and/or • Experienced neglect, psychological, and/or cultural & spiritual harm with a score of 3 or more on the CHI–Core; and/or • Respondent indicated the neglect, psychological, and/or cultural & spiritual harm was "very serious" to them	**16.72** (0.68)
Cumulative Harm Index–Core	• Experienced financial, physical, or sexual harm; and/or • Experienced neglect, psychological, and/or cultural & spiritual harm with a score of 3 or more on the CHI	16.05 (0.67)

Notes: Based on unweighted count of 5,613 and weighted count of 1,530,700.

Figure 2: Overall prevalence rates using different definitions and thresholds



Notes: Based on unweighted/weighted counts of 5,613/1,530,700.

3.3 International comparisons

A systematic review of AOP in community settings estimates that the worldwide prevalence rate is one in six older adults (Yon et al., 2017). While this is consistent with the finding for NZ, direct comparisons of international prevalence surveys are challenging due to differences in survey design, definitions of abuse and thresholds, question wording, and target populations. Among existing studies, the NZ survey is most comparable to the Australian *National Elder Abuse Prevalence Study* (Qu et al., 2021). However, several key differences may influence variations observed in prevalence rates.

For example, the NZ survey includes 10 behavioural items to assess psychological harm, while the Australian survey includes only seven.[4] The age eligibility criteria also differ: the Australian survey includes people aged 65 and over, whereas the NZ survey includes those aged 55 and over. Given that the NZ results show higher prevalence among those aged 55–64 (see Section 8.2), the broader age range likely contributes to the higher overall prevalence reported, at least in part.

[4] Refer to the supplementary *Thresholds Report* for a detailed comparison of the behaviours included in this survey and those included in international prevalence studies (Scott et al., 2026a).

At this stage, we do not attempt a direct comparison – such as recalculating the NZ estimate using the Australian parameters. In future work we plan to explore comparisons using Australian unit record data, although the methodological differences will remain a limitation.

However, we do calculate prevalence estimates for people aged 65 and over only (Table 4); while imperfect, this allows comparison without the different age criterion. The 65+ estimates provide a closer match to the age thresholds used in most international prevalence studies. For this group, the overall prevalence of AOP was 12.1%, equating to around 185,000 people. This is lower than the 16.7% prevalence observed for the broader 55+ population, reflecting that harm was most common among those aged 55–64 (see Section 8.2).

Despite these constraints, Table 5 presents headline prevalence rates from a selection of international studies, with further detail in Box 4. These comparisons are indicative only and should be interpreted with caution.

Table 4: Overall AOP prevalence among people aged 65+

Harm type	Population prevalence (people aged 65+)	Number of people affected (mean estimate)	Number of people affected (low estimate – high estimate)
All harm types	12.06%	108,100	95,800 – 121,700
Neglect	0.76%	6,800	4,100 – 11,100
Financial	2.98%	26,700	20,900 – 34,200
Psychological	8.35%	74,700	64,300 – 86,500
Physical	1.52%	13,700	9,800 – 19,000
Sexual	0.55%	4,800	2,900 – 8,000
Cultural & spiritual	1.75%	15,600	11,600 – 21,000
Total number of older people (weighted count)		**896,700**	
Total number of respondents (unweighted count)		**3,927**	

Note: Estimated numbers of people affected (weighted counts) are rounded to the nearest 100. Low and high estimates reflect 95% confidence intervals. Due to missing responses, the base populations vary slightly by harm subtype: neglect: 3,902 unweighted/893,000 weighted; financial: 3,925 unweighted/896,100 weighted; psychological: 3,909 unweighted/894,600 weighted; physical: 3,927 unweighted/896,700 weighted; sexual: 3,822 unweighted/873,900 weighted; cultural & spiritual: 3,920 unweighted/895,300 weighted. Prevalence rates for harm subtypes add to more than the overall prevalence, as some people experience more than one type of harm.

Box 4: International AOP surveys

Table 5 provides prevalence estimates from a selection of international surveys. These surveys vary in how AOP is defined and measured, limiting direct comparison. For more detailed information of each, including research design, interview method, and age group, see the supplementary *Thresholds Report* (Scott et al., 2026a).

Australia's prevalence estimate is 14.8%, which is within the 95% confidence interval for NZ's estimate using the CHI–Core for those aged 55+ (16.1%, CI is 14.7%–17.8%), and slightly higher than the NZ estimate for those aged 65+ (12.1%, CI is 10.7%–13.6%). However, the main prevalence estimates for NZ (16.7%, CI is 15.4%–18.1%) is almost two percentage points higher than the Australian study. While it is reasonable to suggest that the prevalence of AOP in NZ is higher than that in Australia, and the NZ survey is most comparable to the Australian study, key differences remain beyond age of target population (55+ versus 65+). For example, the NZ survey includes cultural & spiritual harm in its overall prevalence rate, whereas the Australian survey does not. The definition of psychological harm also differs: the NZ survey uses 10 items, compared to seven in the Australian survey. That said, the Australian estimate (11.7%) is within the lower bound of the NZ confidence interval for psychological harm (CI is 11.2%–13.6%) suggesting the additional items do not make a significant contribution to the higher prevalence rate for this subtype.

Other jurisdictions report lower overall prevalence rates, ranging from 2.2% in Ireland to 11.0% in the US. In terms of harm subtypes, the NZ prevalence rate is most like Canada for neglect and physical harm which used the same age eligibility criterion of 55 years and above. In contrast, the Australian study reports a higher rate of neglect (2.9%) and lower rate of physical harm (1.8%). Sexual harm is similar between NZ and Australia (0.9% versus 1.0%), and lower than Canada (1.6%). Of note is the higher prevalence of financial harm reported in NZ (4.0%, CI is 3.3%–4.7%) relative to Australia (2.1%) and Canada (2.6%); the NZ rate appears more in line with that reported for New York (4.2%) and the US (5.2%). This is perhaps surprising, given the similarities between the NZ and Australian survey for this form of AOP (the same eight behaviours were asked in both questionnaires). On this point and others mentioned above, further analysis and more detailed comparisons are left for future research.

Table 5: Prevalence rates from international surveys (%)

	Overall	Psychological	Physical	Sexual	Financial	Neglect	Cultural & Spiritual
NZ, 55+	16.7	12.4	2.8	0.9	4.0	1.2	3.2
NZ, 65+	12.1	8.4	1.5	0.6	3.0	0.8	1.8
Australia[1]	14.8	11.7	1.8	1.0	2.1	2.9	3.9***
Canada[2]	7.5	2.7	2.2	1.6	2.6	1.2	N/A
Ireland[3]	2.2	1.2	0.5	0.05	1.3	0.3	N/A
New York[4]	7.6	1.6	2.2**		4.2	1.8	N/A
United States[5]	11.0*	4.6	1.6	0.6	5.2	5.1	N/A
United Kingdom[6]	2.6	0.4	0.4	0.2	0.7	1.1	N/A

Note: * The overall prevalence rate reported in the US study contains psychological, physical, sexual abuse and neglect, but does not include financial abuse.
** For the New York study, physical and sexual abuse data were combined in the survey (Lifespan of Greater Rochester Inc., 2011).
*** Cultural & spiritual abuse questions were only asked of CALD respondents in the Australian survey, whereas these questions were asked of all respondents in the NZ survey.
1. Qu et al. (2021); 2. NICE (2015); 3. Naughton et al. (2010); 4. Lifespan of Greater Rochester Inc. (2011); 5. Acierno et al. (2009); 6. O'Keeffe et al. (2007).

4 PREVALENCE BY HARM SUBTYPE

Summary

- Psychological harm was most common (12.4%), covering behaviours such as insults, exclusion, manipulation, or threats.
- Financial harm (4.0%) often involved money or property being taken without permission, or pressure to provide financial support.
- Neglect (1.2%) was counted only where a respondent had unmet needs and a responsible person.
- Physical (2.8%) and sexual harm (0.9%) were less common, but even single incidents can be serious.
- Cultural & spiritual harm (3.2%) included experiences of exclusion, disrespect, or misuse of language, culture, or spirituality.

This section presents prevalence rates for each harm subtype included in the survey: neglect, financial, psychological, physical, sexual, and cultural & spiritual. The first five subtypes are based on internationally recognised definitions and measurement approaches, drawn from major AOP prevalence studies, but have been adapted for the NZ context to ensure cultural relevance.

The cultural & spiritual harm subtype is a relatively novel addition in this survey. This type of harm is not commonly included in international prevalence studies, although a related concept – CALD abuse – was included in the Australian survey and asked of CALD respondents. In contrast, the NZ survey asked cultural & spiritual harm questions of all respondents,[5] reflecting an inclusive approach that recognises these forms of harm may be relevant across a broad range of cultural, language, and spiritual backgrounds. This avoids presupposing who may or may not be affected, and acknowledges that exclusion from cultural, spiritual, or language practices can be harmful regardless of cultural identity.

As detailed at the beginning of each harm subtype results section, prevalence estimates for neglect, psychological harm, and cultural & spiritual harm are based on the CHI –Very Serious. This includes respondents who either met the CHI–Core threshold or reported experiences that did not meet the frequency threshold, but were reported as “very serious” by the respondent. In contrast, financial, physical, and sexual harm are reported without thresholds, as described in Section 3.2. Unless otherwise stated, these are the definitions and thresholds used throughout this section (summarised in Table 6).

[5] One item, “Mis-translated between English and your preferred language on purpose, when talking about financial or legal documents”, was only asked of those whose preferred language was not English.

Table 6: Summary of harm subtype prevalence rates and threshold applied

Harm subtype	Population prevalence	Threshold
Neglect	1.15%	Cumulative Harm Index–Very Serious
Financial	4.00%	None
Psychological	12.43%	Cumulative Harm Index–Very Serious
Physical	2.78%	None
Sexual	0.87%	None
Cultural & spiritual	3.23%	Cumulative Harm Index–Very Serious

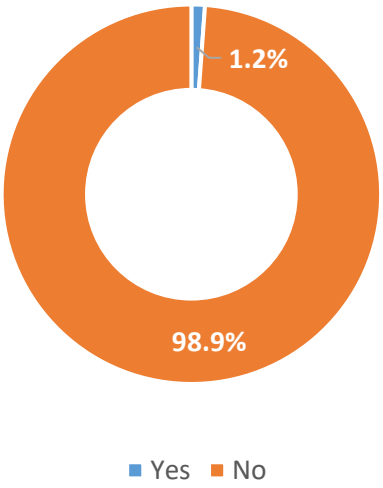
4.1 Neglect

Neglect refers to others failing to provide necessary support with daily living activities. Because neglect is only possible when someone needs help, its measurement depends on identifying both the need for assistance and whether that need was met by those responsible for providing help. This subsection outlines how neglect was defined and measured in the survey (Box 5), provides contextual data on care needs and sources of support, and presents the main prevalence findings.

Prevalence

Of the 31.6% of respondents who said they needed some form of help (see Figure 5), around one in 10 experienced some level of neglect in the last 12 months. Applying the CHI–Very Serious threshold, which focuses on repeated or serious neglect, reduces this to an overall prevalence rate of 1.2% (Figure 3), which is used as the main estimate in this report (see Section 3.2).

Figure 3: Prevalence of neglect in the last 12 months



Note: Based on CHI–Very Serious definition. Based on unweighted/weighted observation counts of 5,580/1,525,000.

Box 5: Definition and measurement of neglect

Respondents were asked whether they had needed help in the past 12 months with any of the following 10 day-to-day activities:

- Preparing meals
- Shopping for groceries or clothes
- Doing routine housework
- Travel or transport
- Personal care such as washing or bathing
- Getting to and using the toilet
- Getting in and out of bed
- Taking the right amount of medicine at the right times
- Eating, including cutting up food
- Any other day-to-day activities

These activities reflect internationally recognised measures of functional support needs, commonly referred to as Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) (Katz et al., 1963; Lawton & Brody, 1969).

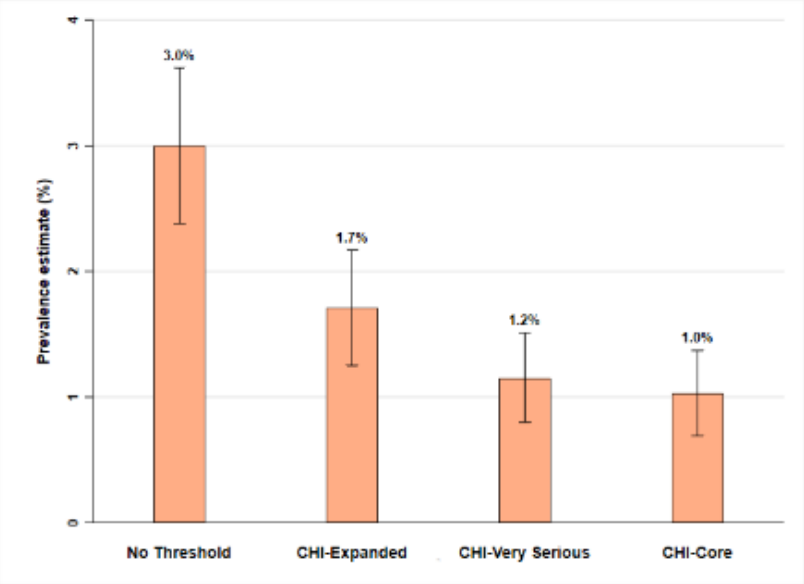
For each activity they were asked how often help was needed (None, Rarely, Some of the time, All of the time), who was mainly responsible for helping, and whether help was always received. If not, they were asked how often help was missed: Once, A few times, Many times, or Every day or almost every day.

Neglect prevalence was estimated using a CHI, which takes account of how often help was not received when needed for each activity. A score of 0 was given if no help was needed or help was always received; 1 if help was missed once; 2 for a few times; 3 for many times; and 4 for every day or almost every day. Scores were summed across all activities, and a total score of 3 or more defined the CHI–Core threshold.

Two broader thresholds were also estimated. CHI–Very Serious included people with an index under 3 who said the experience was “very serious”. CHI–Expanded Seriousness also included those who said it was “somewhat or moderately serious”. The main estimate used in this report is CHI–Very Serious, based on international literature, consultation with experts, and analysis of the survey data (see the supplementary *Thresholds Report* for a full discussion, Scott et al., 2026a).

Threshold choice affects the estimated prevalence of neglect. With no threshold, the rate is 3% (Figure 4). CHI–Core lowers it to 1.0%. Including “very serious” cases lifts the rate to 1.2% and further including “somewhat or moderately serious” cases raises it to 1.7%.

Figure 4: Neglect prevalence rate by Cumulative Harm Index



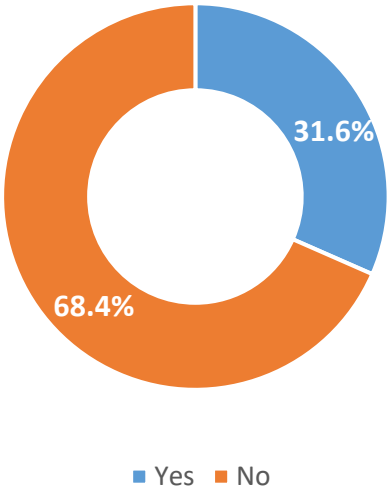
Note: The number of observations differs by threshold due to missing ("Don't know" and "Refused to answer") responses. Based on unweighted/weighted counts of No threshold: 5,589/1,526,600; CHI-Expanded Seriousness and CHI–Very Serious: 5,580/1,525,000; CHI-Core: 5,584/1,526,000.

Background/context

When measuring neglect prevalence, determining whether a respondent requires help with day-to-day activities is the first step. By definition, individuals who do not need assistance with these activities cannot be classified as having experienced neglect.

To assess this, the survey asked respondents how often they needed help with a range of everyday tasks – such as preparing meals, shopping, or doing housework. Just over two-thirds of respondents reported not needing help with any of the listed activities (68.4%). However, nearly one-third (31.6%) reported needing some level of assistance and therefore may be at risk of neglect (Figure 5).

Figure 5: In the last 12 months, did you require any help with day-to-day activities?



Note: The shares for Yes and No are as follows (standard errors in parentheses): Yes 31.58% (0.87); No 68.42% (0.87), Don't know/Refused 0.39% (0.10). Based on unweighted/weighted observation count of 5,602/1,529,300.

Of those requiring help, the activity with the highest proportion of need was doing routine housework (54.8%; or 17.3% of all survey respondents), followed by travel or transport (50.2%; or 15.8% for all respondents). In contrast, the lowest levels of reported need were for getting to and using the toilet (7.1%; or 2.3% for all) and eating (including cutting up food) (8.4%; or 2.7% for all) (Table 7). These patterns are consistent with expectations of the survey population, as respondents live in the community rather than in aged residential care (ARC).

Once the need for help is established, the definition of neglect requires that there is someone responsible for providing that help.[6] Respondents who reported requiring help were asked who was mainly responsible for providing that help (see Appendix 2 for data on who provides care to older adults living in the community). Finally, respondents were asked if the person mainly responsible for helping them with a given activity always provided that help. If a respondent answered "no", they were asked how often this occurred. However, it is possible that a respondent stated they required help for one or more activities, but that "no-one" is responsible for helping them for one or more of these activities. Table 7 reports the share of all survey respondents who had any unmet need at 4.6% (equivalent to 70,200 older people). It also shows the shares who reported having no-one to help with any activity, and the share who identified someone as responsible for helping but did not always receive that help.

[6] If a respondent named "an organisation", it was re-categorised as professional carer or medical professional where appropriate (e.g. where a home-help organisation was identified).

The 1.6% of respondents who reported not always getting help when they needed it, with no-one responsible for helping them – equating to 24,300 older people living in the community – are defined as experiencing "self-neglect" (as there is no identified person responsible for helping them). Under the study's definition, neglect requires both an unmet need for help with daily activities and a person responsible for providing help. Where no-one is responsible, the situation is classified as self-neglect and excluded from the prevalence rate (see Scott et al., 2026a). The remaining 3% of survey respondents, equivalent to 45,800 older people, are included in the "no threshold" neglect prevalence rate (Figure 4; see Table 3 for threshold definitions).

Among those who experienced neglect, the most common activity respondents did not receive help for was travel or transport (75.4%, or 13,300 older people living in the community) – experienced by three-quarters of those experiencing neglect (CHI–Very Serious threshold) – followed by routine housework, reported by just over two-thirds of respondents experiencing neglect (68.6%). It is worth noting that the most common activities respondents needed help with are broadly those where their need for help was unmet, while there are differences for activities reported less often.

For example, getting to and using the toilet was the least common activity for respondents reporting they required help. For those experiencing neglect, one in four reported not receiving the help they needed with toileting (25.4%) – a higher share than help getting in and out of bed (21.6%), eating (including cutting up food) (18.6%), and taking the correct dose of medication at the correct time (18.1%). The types of activities older people identify as needing help with less often are "basic" (see Naughton et al., 2010), suggesting a higher level of care need compared to more "complex" activities, like shopping or transport. Understanding these differences for those who experience neglect versus those who always receive the help they need may help target interventions that support community-dwelling older adults.

Table 7: Which activities did you need help with in the last 12 months?

	% of those who needed help (standard error)	% of those who experienced neglect (standard error)
Doing routine housework	54.84 (1.66)	68.60 (8.42)
Travel or transport	50.21 (1.67)	75.41 (6.04)
Shopping for groceries or clothes	35.60 (1.58)	56.06 (8.35)
Preparing meals	34.49 (1.60)	40.93 (7.96)
Personal care such as washing, dressing, or undressing	19.93 (1.34)	40.65 (8.02)
Taking the right amount of medicine at the right times	14.81 (1.17)	18.06 (5.76)
Getting in and out of bed	9.47 (0.95)	21.57 (6.03)
Eating, including cutting up food	8.41 (0.91)	18.60 (6.94)
Getting to and using the toilet	7.14 (0.85)	25.37 (6.68)
Any other day-to-day activities	32.74 (1.55)	55.88 (8.45)
Observations (unweighted)	**1,854**	**73**
Observations (weighted)	**483,000**	**17,600**

Note: Includes those who indicated they needed help "Rarely", "Some of the time", and "All the time". Percentage of those who needed help and percentage of those who experienced neglect according to the CHI–Very Serious threshold. Percentages may sum to more than 100% as respondents could choose multiple categories. Due to "Don't know/Refuse" responses, the underlying unweighted/weighted counts for each item varied from 1,846/480,800 to 1,853/482,700 for shares of those who needed help and from 72/17,200 to 73/17,600 for shares of those who experienced neglect according to the CHI–Very Serious threshold.

Table 8: Unmet need, self-neglect versus neglect

	Prevalence % (standard error)	95% Confidence interval (%)	Observations (unweighted/weighted)
Required any help with day-to-day activities			
No	68.42 (0.87)	66.70 – 70.13	3,748/1,046,300
Yes	31.58 (0.87)	29.87 – 33.30	1,854/483,000
Any unmet need			
No	95.40 (0.39)	94.64 – 96.17	5,345/1,456,400
Yes	4.60 (0.39)	3.83 – 5.36	244/70,200
Self-neglect ("No-one" responsible for help)			
No	98.41 (0.24)	97.94 – 98.87	5,513/1,502,300
Yes	1.59 (0.24)	1.13 – 2.06	76/24,300
Neglect (Someone responsible for help)			
No	97.00 (0.32)	96.38 – 97.62	5,421/1,480,800
Yes	3.00 (0.32)	2.38 – 3.62	168/45,800

Note: Includes all survey respondents, with percentages for those who did not always receive help from "no-one" or someone responsible for helping; no threshold applied. The underlying unweighted/weighted counts are 5,589/1,526,600.

4.2 Financial harm

Financial harm encompasses a range of behaviours that interfere with an older person's control over their money, property, or financial decisions. This section presents the prevalence and types of financial

harm reported by respondents (see Box 6). In line with international practice, any instance of financial harm is included in the prevalence measure, regardless of frequency or perceived seriousness (see Scott et al., 2026a for further discussion). This reflects evidence that even a single occurrence may have severe financial consequences for an older person, so frequency is not a reliable indicator of severity.

An additional component of the *National Study* examines financial AOP specifically, primarily aiming to capture the perspectives of financial and legal professionals – this contextual analysis provides supplementary information on respondents' financial and legal arrangements. For example, whether they have a will or EPOA, or whether they need help managing their money and why. See the *Perspectives on Financial AOP Report* (Scott et al., 2026b).

Box 6: Definition and measurement of financial harm

Financial harm was measured based on whether respondents reported experiencing at least one incident of financial abuse in the last 12 months by someone they knew. In line with international practice (e.g. Qu et al., 2021; Yon et al., 2017), frequency and self-reported seriousness were not used to determine whether financial harm had occurred. Specifically, respondents were asked whether in the last 12 months someone they knew had:

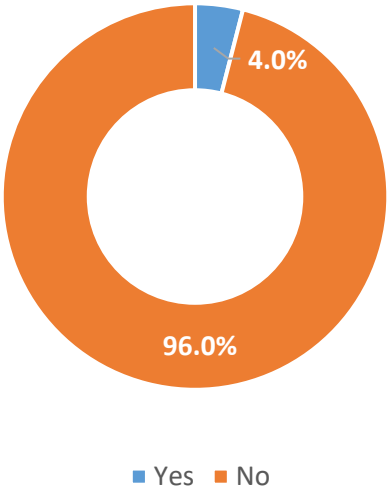
- Taken your money, possessions, or property without your permission.
- Deliberately prevented you from accessing or using your money, possessions, or property.
- Pressured you into giving or loaning them money, possessions, or property.
- Pressured you to make or change your will.
- Made financial decisions for you without your permission.
- Misused an EPOA/EPA (*asked only of respondents who had an EPOA).*
- Not contributed to household expenses such as rent or food, or aged care/home service fees where this was previously agreed.
- Done anything else to harm you financially.

If a respondent reported any of these behaviours, they were counted as having experienced financial harm. The items align closely with those used in the Australian *National Elder Abuse Prevalence Study* (Qu et al., 2021), with some adaptations to reflect the NZ legal and social context.

Prevalence

In total, 4.0% of respondents reported experiencing financial harm in the past 12 months, while 96.0% did not (Figure 6).

Figure 6: Prevalence of financial harm



Note: Based on unweighted/weighted observation counts of 5,611/1,530,100.

The most common form of financial harm was someone taking their money, possessions, or property without permission (42.5% of those who reported financial AOP, equivalent to 25,700 older people). This was followed by pressure to give or loan money or property (29.1%) and failure to contribute to household expenses when agreed (26.9%). Nearly one in four (24.6%) reported other types of financial harm not captured in the specified items (Table 9).

Less common behaviours, like deliberately restricting access to financial resources (11.6%), making financial decisions without permission (10.4%), or being pressured to make or change a will (7.6%) also point to a lack of autonomy for older people experiencing financial harm and are suggestive of financial control.

Table 9: Types of financial harm

	% of those experiencing financial harm	Standard error
Taken your money, possessions, or property without your permission	42.53	4.39
Pressured you into giving or loaning them money, possessions, or property	29.09	3.91
Not contributed to household expenses such as rent or food, or aged care/home service fees where this was previously agreed	26.92	3.93
Deliberately prevented you from accessing or using your money, possessions, or property	11.60	2.80
Made financial decisions for you without your permission	10.44	2.84
Pressured you to make or change your will	7.56	2.23
Misused an Enduring Power of Attorney (EPOA)	s.	s.
Done anything else to harm you financially	24.64	3.75
Observations (unweighted/weighted)	**250/61,200**	

Note: 's.' indicates suppressed values due to small underlying counts. Due to "Don't know/Refuse" responses, the underlying unweighted/weighted counts for each item varied from 247/59,700 to 250/61,200. "Misused an EPOA" was only asked of those who had an EPOA.

4.3 Psychological harm

Psychological harm is one of the most prevalent forms of harm among older people, both in NZ and internationally. It encompasses a broad range of behaviours that may cause psychological and emotional distress, including verbal insults, threats, manipulation, and social isolation. Because these behaviours can vary widely in frequency, severity, and context, the survey used a CHI to help distinguish between one-off or infrequent incidents and more sustained patterns of mistreatment. As with neglect, additional consideration was given to the respondent's perception of seriousness, which informed the main prevalence estimate used in this report. Box 7 outlines the definition and measurement approach used for psychological harm.

Box 7: Definition and measurement of psychological harm

Respondents were asked whether anyone they knew had done any of the following in the past 12 months:

- Insulted you, called you names, or swore at you in a way you found offensive or aggressive
- Excluded you or repeatedly ignored you
- Undermined or belittled what you do in public (i.e. in front of others)
- Undermined or belittled what you do in private
- Threatened to harm others that you care about (e.g. pets, children, relatives, friends)
- Threatened to harm themselves if you don't do what they ask
- Prevented or restricted you seeing or contacting family members or friends
- Made you feel that you are just free labour (e.g. doing most of household work, or providing childcare, etc)
- Prevented or restricted you seeing or contacting your doctor/nurse or other professional
- Done anything else to cause you emotional distress.

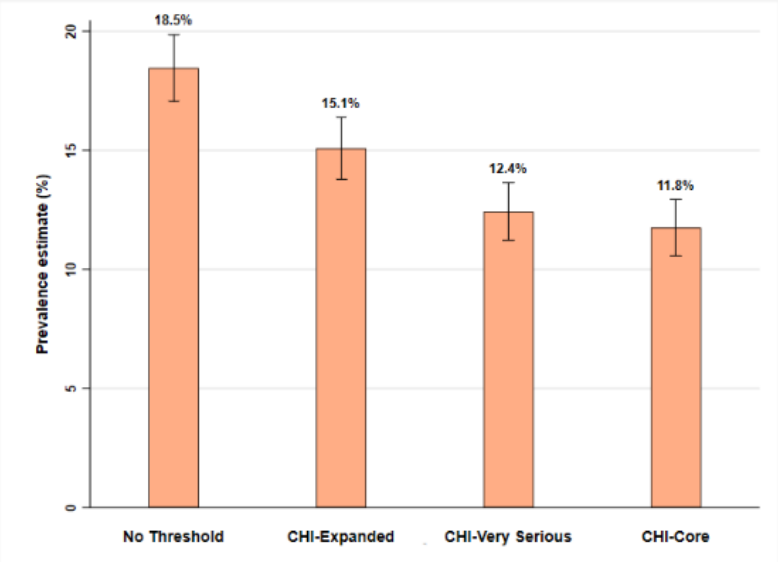
These items were selected in line with international studies, particularly the Australian *National Elder Abuse Prevalence Study* (Qu et al., 2021), with some adaptations to reflect the NZ context.

If any of these occurred, respondents reported how often: Once, A few times, Many times, or Every day or almost every day. Each item was scored: 0 if not experienced; 1 if once; 2 if a few times; 3 if many times; and 4 if every day or almost every day. Scores were added across all items to create a Cumulative Harm Index–Core (CHI–Core). A total score of 3 or more defines psychological harm for the prevalence estimates.

As with neglect, two broader definitions were tested. CHI–Very Serious includes people with a score under 3 who said the experience was "very serious". CHI–Expanded Seriousness also includes those who rated it as "somewhat or moderately serious". The main estimate is CHI–Very Serious, based on international practice and expert advice (see Scott et al., 2026a).

Figure 7 shows how prevalence changes by threshold. Without a threshold, the rate is 18.5%. Using CHI–Core lowers it to 11.8%. Including "very serious" cases (CHI–Very Serious) raises it to 12.4%, and including at least "somewhat or moderately serious" cases (CHI–Expanded Seriousness) lifts the rate to 15.1%.

Figure 7: Psychological prevalence rate by Cumulative Harm Index

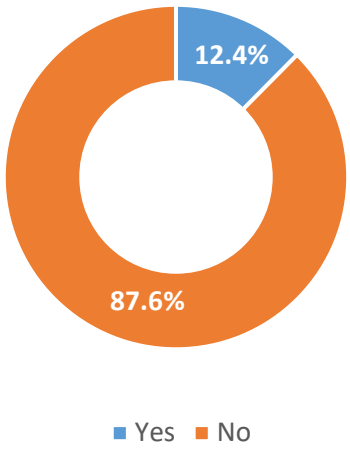


Note: The number of observations differs by threshold due to missing ("Don't know" and "Refused") responses. Based on unweighted/weighted counts of No threshold: 5,611/1,530,100; CHI-Expanded Seriousness and CHI–Very Serious: 5,581/1,524,500; CHI-Core: 5,605/1,528,800.

Prevalence

Based on the CHI–Very Serious definition (see Box 7), an estimated one in eight older people (12.4%) experienced psychological harm in the past 12 months (Figure 8).

Figure 8: Experienced psychological harm in the last 12 months



Note: Based on CHI–Very Serious definition. Based on unweighted/weighted observation counts of 5,581/1,524,500.

Of those who experienced psychological harm under the CHI–Very Serious threshold, the most commonly reported behaviour was being insulted, called names, or sworn at in a way the respondent found offensive or aggressive (65.8%) (Table 10). Other frequently reported behaviours included being undermined or belittled in private (59.1%), being excluded or repeatedly ignored (53.9%), and being undermined or belittled in public (35.3%).

While some behaviours – such as threats to harm others (7.9%), emotional manipulation like threats of self-harm (7.2%), or restriction of access to medical professionals (1.9%) – were less frequently reported, they may reflect more overt forms of controlling behaviour. Conversely, behaviours like repeated belittling or social exclusion are potentially less visible and can accumulate, causing significant emotional distress, particularly when they occur in close or trusted relationships. The varied types of harm experienced highlight that psychological abuse is not solely defined by dramatic or singular events, but patterns of behaviour that erode wellbeing over time. All reported experiences reflect forms of mistreatment that can be harmful and warrant attention, even when their impact may be shaped by context, normalisation, or relationship dynamics.

Table 10: Types of psychological harm

	% of those experiencing psychological harm	Standard error
Insulted you, called you names or swore at you in a way you found offensive or aggressive	65.76	2.48
Undermined or belittled you in private	59.09	2.59
Excluded you or repeatedly ignored you	53.91	2.65
Undermined or belittled you in public (i.e. in front of others)	35.26	2.55
Made you feel that you are just free labour	22.02	2.20
Prevented or restricted you from seeing or contacting family members or friends	13.34	1.65
Threatened to harm others that you care about (e.g. pets, children, relatives, friends)	7.85	1.38
Threatened to harm themselves if you don't do what they ask	7.15	1.34
Prevented or restricted you from seeing or contacting your doctor/nurse or other professional	1.89	0.91
Done anything else to cause you emotional distress	19.40	2.13
Observations (unweighted/weighted)	**652/189,600**	

Note: Based on those experiencing psychological harm according to the CHI–Very Serious threshold. Due to "Don't know/Refuse" responses, the underlying unweighted/weighted counts for each item varied from 647/187,200 to 651/189,500 for the share of those experiencing financial harm.

4.4 Physical harm

This section presents findings on the prevalence and nature of physical harm experienced by older people. Physical harm refers to acts of violence or coercion that result in or have the potential to result in bodily injury, pain, or distress. In line with international practice, the prevalence measure does not apply a frequency or perceived severity threshold – any single instance of physical harm is included. This reflects the understanding that even one occurrence of physical violence, including threats, can have serious consequences and is considered sufficient to meet the threshold for abuse. Box 8 describes how physical harm was defined and measured in the survey.

Prevalence

In the past 12 months, 2.8% of respondents experienced at least one form of physical abuse (Figure 9).

Box 8: Definition and measurement of physical harm

Physical harm was measured based on whether respondents reported experiencing one or more incidents of physical violence in the past 12 months, involving someone they knew. In accordance with international practice, the definition does not incorporate frequency or self-reported seriousness – any single occurrence of physical harm is included in the prevalence estimate, due to the inherently serious nature of such behaviours.

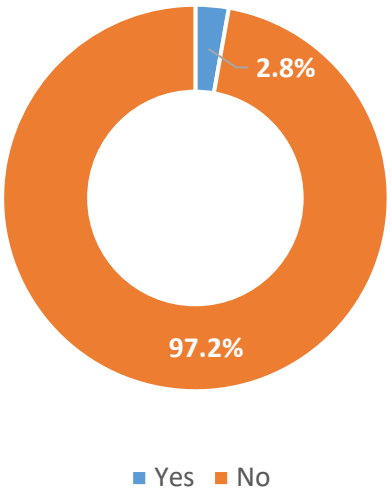
Respondents were asked the following question:

"In the past 12 months, has someone you know…":

- Tied or held you down, or restrained you in any other way, or locked you up.
- Grabbed, pushed, or shoved you.
- Hit, punched, kicked, or slapped you.
- Threatened you with a weapon (e.g. knife, gun, or any other objects).
- Injured you with a weapon (e.g. knife, gun, or any other objects).
- Threatened to harm you in any way.
- Given you drugs or too much medicine on purpose.
- Ignored or failed to respect your Advanced Directive (*asked if respondent had an Advanced Directive).*
- Hurt you physically in any other way.

Each item was treated as a discrete indicator of physical harm. Respondents who reported experiencing any of these behaviours were classified as having experienced physical harm. The items align closely with those used in the Australian *National Elder Abuse Prevalence Study* (Qu et al., 2021), with adaptations for the NZ context (e.g. the inclusion of Advance Directives).

Figure 9: Prevalence of physical harm in the last 12 months



Note: Based on unweighted/weighted observation counts of 5,613/1,530,700.

Table 11 shows the specific forms of physical harm experienced by those who reported at least one such incident in the past 12 months. The most common experiences were being grabbed, pushed, or shoved (55.5% of those who experience physical harm) and being threatened with physical harm (53.3%). These results indicate that for many, physical harm involved direct physical intimidation or contact – behaviours

that may not always result in visible injury but still represent significant breaches of safety and wellbeing. Over one-third (38.9%) of respondents who experienced physical harm reported being hit, punched, kicked, or slapped, indicating that overt violence was also relatively common within this group.

Smaller but still notable proportions of those who experienced physical harm reported more severe incidents. About one in five (19.2%) said they had been threatened with a weapon, and about one in 10 had been tied down or physically restrained (11.4%), injured with a weapon (9.5%), or physically hurt in some other way (9.7%). While less frequently reported, these forms of harm likely represent high-impact experiences.

A smaller subset of respondents reported medication-related harm, including being given too much medication on purpose (7.6%), or having prescribed medication withheld (5%). These behaviours may reflect relatively more serious controlling dynamics, particularly in caregiving contexts, that may have severe adverse health consequences for the older person. No respondents reported that an Advance Directive (a legal document setting out a person's wishes about future medical treatment if they become unable to decide for themselves) had been ignored, although this may reflect the specific characteristics of the survey population, who were all living in the community and needed capacity to consent to take part. According to data on financial and legal arrangements asked in the survey, around 10% of respondents had an Advance Directive, and in about 95% of those cases, the directive had never been used. As such, the absence of reported breaches may reflect limited opportunities for these plans to be activated rather than an absence of risk.

Table 11: Types of physical abuse

	% of those experiencing physical abuse	Standard error
Grabbed, pushed, or shoved you	55.49	5.33
Threatened to physically harm in any way	53.28	5.45
Hit, punched, kicked, or slapped	38.87	5.33
Threatened with a weapon (e.g. knife, gun, or other object)	19.22	4.40
Tied or held you down, or restrained you in any other way, or locked you up	11.35	3.56
Injured with a weapon (e.g. knife, gun, or other object)	9.45	3.30
Gave drugs or too much medicine on purpose	7.63	3.26
Withheld prescribed or needed medicine	4.97	2.65
Ignored or failed to respect Advanced Directive	s.	s.
Hurt you physically in any other way	9.65	3.37
Observations (weighted/unweighted)	**154/42,600**	

Note: 's.' indicates suppressed values due to small underlying counts. Due to "Don't know/Refuse" responses, the underlying unweighted/weighted counts for each item varied from 152/42,400 to 154/42,600. "Ignored or failed to respect your Advanced Directive" was only asked of those who had an Advanced Directive.

4.5 Sexual harm

Like physical and financial harm, sexual harm is defined in this study as the occurrence of any listed behaviour, regardless of frequency or self-reported severity. How sexual harm was defined and measured in the survey is outlined in Box 9.

Box 9: Definition and measurement of sexual harm

Sexual harm was measured based on whether respondents experienced one or more specific behaviours in the past 12 months involving someone they knew. In line with international practice, no threshold was applied for frequency or self-perceived seriousness – any reported occurrence was counted as sexual harm.

Respondents were asked:
"In the past 12 months, has someone you know…":

- Talked to you in a sexual way when you did not want them to.
- Made you watch pornography against your will.
- Touched you in a sexual way against your will.
- Forced you to engage in sexual acts against your will.
- Tried to engage you in any other unwanted sexual experience/s.

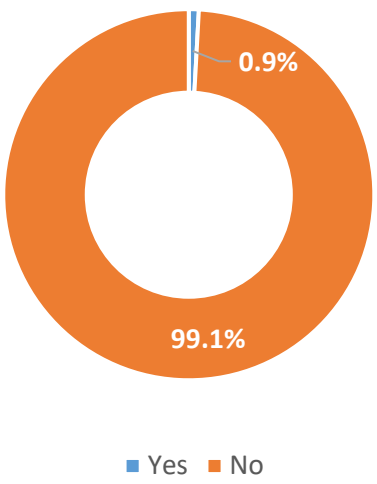
This approach means that even single incidents are recognised in prevalence estimates, reflecting the inherently serious nature of sexual harm. The items align closely with those used in the Australian *National Elder Abuse Prevalence Study* (Qu et al., 2021).

Prevalence

In the last 12 months, less than 1% of respondents (0.9%) experienced sexual harm by someone they knew (Figure 10). It is worth noting that, as with other forms of harm, the prevalence of sexual harm may be under-reported due to stigma, shame, or a reluctance to disclose sensitive experiences. This under-reporting may be particularly pronounced for sexual harm, given the intimate and taboo nature of the topic, and the added barriers people may face in recognising, naming, or discussing such experiences. In the case of the survey, more respondents declined to answer these prevalence questions than for other AOP subtypes (2.6% answered "Don't know" or "Refuse", giving an unweighted observation count of 146 lower than for physical harm).

Among those reporting experiences of sexual harm, almost nine in 10 reported being spoken to in an unwelcome sexual manner (87.6%), and almost half were touched in a sexual way against their will (48.7%); see Table 12. About one-third experienced attempt(s) to engage them in another type of unwanted sexual experience (36.6%), while just over one in six were forced to engage in sexual acts against their will (17.4%).

Figure 10: Prevalence of sexual harm in the last 12 months



Note: Based on unweighted/weighted observation counts of 5,467/1,494,600.

Table 12: Types of sexual harm

	% of those experiencing sexual harm	Standard error
Talked to you in a sexual way when you did not want them to	87.58	7.28
Touched you in a sexual way against your will	48.73	9.30
Forced you to engage in sexual acts against your will	17.44	6.90
Made you watch pornography against your will	s.	s.
Tried to engage you in any other unwanted sexual experience/s	36.60	9.36
Observations (unweighted/weighted)	**51/12,900**	

Note: 's.' indicates suppressed values due to small underlying counts.

4.6 Cultural & spiritual harm

Cultural & spiritual harm includes behaviours that disrespect, undermine, or exclude people because of their cultural identity, language preferences, age-based roles, or spiritual beliefs and practices. The cultural & spiritual harm measure was developed to reflect the importance of these dimensions to wellbeing and identity for many older people in NZ and is used for the first time in this survey. This section outlines how it is defined and presents key findings.

Box 10: Definition and measurement of cultural & spiritual harm

In the *Prevalence Survey* respondents were asked whether, in the past 12 months, someone they knew had done any of the following:

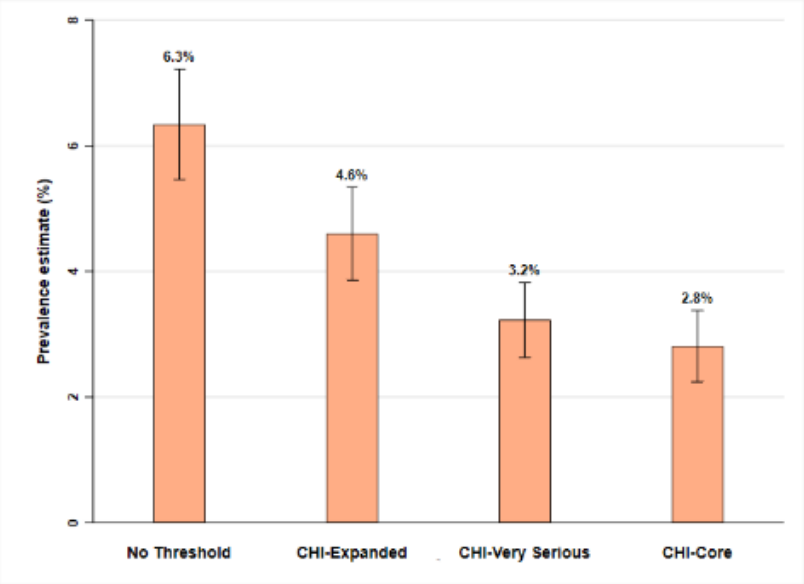
- Not respected you when talking to you because of your culture or ethnicity.
- Not respected you or your role in the family because of your age.
- Mis-translated between English and your preferred language on purpose when talking about financial or legal documents (*only asked of those whose preferred language was not English*).
- Denied you access to important information in your preferred language.
- Talked to you in a language that you are not familiar with on purpose or prevented you from speaking your preferred language.
- Limited or restricted your contact with your friends or others from the same cultural background, including friends and relatives overseas.
- Limited or restricted your access to culturally familiar activities (e.g. attending certain events or ceremonies, watching or listening to shows in your preferred language).
- Prevented you from practising your cultural customs or beliefs.
- Used your religious, spiritual, or cultural beliefs to manipulate or bully you.
- Used religious texts, customs, or beliefs to justify causing you harm.
- Harmed or mistreated you in any other way relating to your religious, spiritual, or cultural beliefs.

If any of these occurred, respondents reported how often: Once, A few times, Many times, or Every day or almost every day. Each item was scored: 0 if not experienced; 1 if once; 2 if a few times; 3 if many times; and 4 if every day or almost every day. These scores were added to create a CHI–Core. A total score of 3 or more defines cultural & spiritual harm for prevalence estimates.

As with other harm types, two broader thresholds were used. CHI–Very Serious includes those with lower scores who described the harm as “very serious”. CHI–Expanded Seriousness also includes those who said the harm was “somewhat or moderately serious”. The CHI–Very Serious definition is the main estimate used in this report.

Figure 11 shows how prevalence changes by threshold. Without applying any threshold, the prevalence is 6.3%. CHI–Core gives a lower estimate of 2.8%. Including “very serious” experiences raises this to 3.2%, and at least “somewhat or moderately serious” experiences (CHI–Expanded Seriousness) increase it to 4.6%.

Figure 11: Cultural & spiritual prevalence rate by Cumulative Harm Index



Note: The number of observations differs by threshold due to missing ("Don't know" and "Refused") responses. Based on unweighted/weighted counts of No threshold: 5,612/1,530,200; CHI-Expanded Seriousness and CHI–Very Serious: 5,601/ 1,528,300; CHI-Core: 5,604/1,528,800.

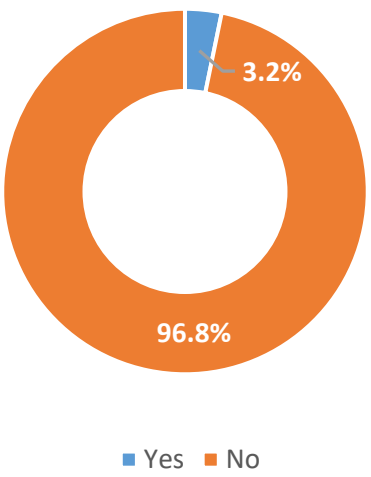
The questions were designed to be inclusive across cultural groups. A comparable but more limited set of items was used in the Australian study, where they were asked only of CALD respondents (Qu et al., 2021). In contrast, in this survey, cultural & spiritual harm items were asked of all respondents, recognising that such harm is not confined to any one group and may occur across diverse cultural, language, or spiritual backgrounds. Refer to the supplementary *Thresholds Report* for a detailed comparison with the Australian version (Scott et al., 2026a).

As with psychological harm and neglect, prevalence estimates were derived using a CHI to capture frequency, then expanded to include perceived seriousness (see Box 10).

Prevalence

About 3.2% of respondents experienced cultural & spiritual harm, applying the CHI–Very Serious threshold (Figure 12).

Figure 12: Prevalence of cultural & spiritual harm in the last 12 months



Note: Based on CHI–Very Serious definition. Based on unweighted/weighted observation counts of 5,601/1,528,300.

Among those who experienced cultural & spiritual harm, the most common experience was not being respected when spoken to because of their culture or ethnicity, reported by 45.8% (Table 13). The next most common was spiritual belief or practices being disrespected or ridiculed, reported by just over one-third of respondents (35.7%), followed by a lack of respect for the older person or their family role due to their age (30.4%) and being prevented from speaking their preferred language or deliberately spoken to in an unfamiliar language (28%). These types of harm may not always be overt but can significantly affect a person's dignity, identity, and sense of belonging, particularly within family or cultural settings.

About one in 10 older people experiencing this harm subtype reported their cultural or spiritual beliefs had been used to manipulate or bully them (11.8%) or they had been prevented from practising their cultural customs or beliefs (9.2%). Also, about 8.8% of respondents reported being restricted from contact with others from the same cultural background, and 7.1% reported being restricted from culturally familiar activities. These behaviours may operate through subtle exclusion or marginalisation, undermining cultural & spiritual wellbeing over time, and can be deeply distressing.

Language-related harm also emerged, with 5.3% denied access to important information in their preferred language. Although only a small proportion of respondents overall reported a non-English preferred language (7.8%), this group is at heightened risk for culturally-specific harm and may face increased barriers to help-seeking.

Less commonly, respondents reported being prevented from attending religious services (3.2%) or having religious texts or customs used to justify harm (2.1%). Although less frequent, these actions may indicate coercive or isolating dynamics, particularly in religious or intergenerational contexts.

Taken together, these findings illustrate that cultural & spiritual harm can take many forms, ranging from disrespect to more deliberate attempts to isolate, silence, or control. The nature of these harms often targets a person's identity, autonomy, and ability to participate fully in their cultural & spiritual lives.

Table 13: Types of cultural & spiritual harm

	% of those experiencing cultural & spiritual harm	Standard error
Not respected you when talking to you because of your culture or ethnicity	45.82	4.86
Disrespected, shamed, made fun of, or ridiculed your spiritual beliefs or practices	35.72	4.84
Not respected you or your role in the family because of your age	30.42	4.60
Talked to you in a language that you are not familiar with on purpose or prevented you from speaking your preferred language	28.03	4.47
Used your religious, spiritual, or cultural beliefs to manipulate or bully you	11.83	3.29
Prevented you from practising your cultural customs or beliefs	9.23	2.90
Limited or restricted your contact with your friends or others from the same cultural background, including friends and relatives overseas	8.78	2.83
Limited or restricted your access to culturally familiar activities (e.g. attending certain events or ceremonies, watching or listening to shows in your preferred language)	7.09	2.77
Denied you access to important information in your preferred language	5.29	2.06
Prevented you from attending church or practising your religion how you want to (e.g. not allowing you to worship or pray)	3.21	1.23
Used religious texts, customs, or beliefs to justify causing you harm	2.10	0.99
Mis-translated between English and your preferred language on purpose when talking about financial or legal documents	s.	s.
Harmed or mistreated you in any other way relating to your religious, spiritual, or cultural beliefs	4.39	1.54
Observations (unweighted/weighted)	**197/49,300**	

Note: Based on those experiencing cultural & spiritual harm according to the CHI–Very Serious threshold. Due to "Don't know/Refuse" responses, the underlying unweighted/weighted counts for each item varied from 193/48,800 to 197/49,300 for the share of those experiencing cultural & spiritual harm. "Mis-translated between English and your preferred language" was only asked of respondents whose preferred language was not English.

5 WHO IS RESPONSIBLE FOR HARM?

Summary

- Partners or ex-partners (21.9%) and children (20.6%) were most often identified as the main people responsible for harm.
- Other people responsible for harm included siblings (10.3%), friends (14.4%), and work-related contacts, with patterns varying by harm type.
- For example, children were more often responsible for financial harm and neglect, while partners/ex-partners were more often linked to psychological harm. Work-related contacts were more frequently identified for cultural & spiritual harm and psychological harm, especially among those aged 55–64.

This section looks at the people who caused harm to the respondents. As outlined in Section 1.1, the AOP definition used in this study does not include or 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 person responsible for causing the harm may not recognise the impact of their behaviour.

Respondents were asked about their relationship to all people responsible for each AOP subtype. For example, a respondent could have said that they were financially harmed by their partner and their son. They were then asked to identify the person who had affected them the most – in this example, the respondent may have said their son. A series of additional questions were then asked about the main person responsible for harm, including whether they were living with the respondent at the time, their age, gender, and whether they had issues with alcohol, finances, and so forth.

All the results in this section are based on:

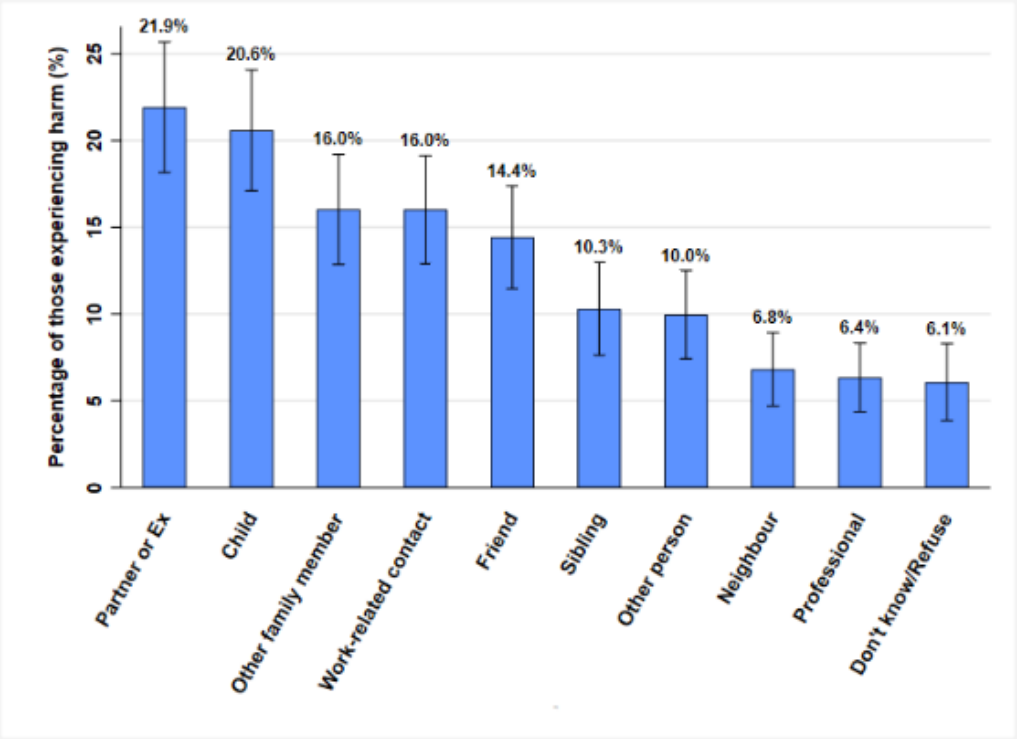
- Respondents who experienced harm that met the CHI–Very Serious threshold if applicable (in line with the headline estimates in Table 2), and
- Information about the main person responsible for harm only.

We report results in this way as they are broadly similar across the possible alternatives (main person responsible versus all people responsible, and no threshold versus CHI–Very Serious). Appendix 3 provides a detailed comparison, confirming that the main findings do not change substantially. For clarity and consistency, we focus here on the main prevalence threshold (see Section 3.1) and the main person responsible.

5.1 Relationship of the person responsible for harm to the respondent

Figure 13 shows the relationship between the respondent and the main person responsible for harm, for all respondents who experienced AOP. Note that the total adds to more than 100%, because respondents could identify a different main person responsible for each type of harm. For example, a respondent might have reported their partner as the main person responsible for psychological harm and their daughter as the main person causing financial harm. This respondent would have two main persons responsible discussed in the results presented here.

Figure 13: Relationship between people experiencing harm and those responsible, overall AOP



Notes: Percentage of those experiencing harm according to the CHI–Very Serious threshold. Vertical bars are 95% confidence intervals. Figures are based on the main person responsible; categories sum to more than 100% as respondents could identify one main person per harm subtype experienced. Thus, those who experienced multiple harm subtypes could identify multiple main persons responsible.

In the raw data, around 30% of those responsible for harm were described as "Other" (i.e. their relationship to the respondent did not match any of the standard response categories). In these cases, the respondent selected "Other" and provided a free-text description; back-coding these descriptions to the predefined list resulted in the creation of a new relationship category "Work-related contact" and the "Other" relationship category falling to one in 10 main persons responsible (10% in Figure 13). See Box 11 for more detail on how these were back-coded as well as for analysis of the raw free-text fields.

The most common relationship type was a partner or ex-partner (21.9%), followed by child (20.6%). One in 10 main persons responsible were siblings (10.3%). Other family members, a category including in-laws, parents, grandchildren, and other family relationships, were identified as causing the most harm as often as work-related contacts – both 16%. Friend was also a common response (14.4%), with neighbours (6.8%) and professionals (a category including professional carers, medical, finance, and other professionals) being reported less frequently (6.4%). In 6.1% of cases, the respondent did not know the relationship or declined to answer.

As mentioned above, the "Work-related contact" category was created during analysis to capture the large number of free-text responses such as "colleague", "workmate", "supervisor", "client", or similar. Most of these referred to workplace colleagues, while some involved professional or service-based relationships where harm occurred in a work setting. We did not break down the work-related category further, such as distinguishing between "colleague" and "supervisor", due to ambiguity in how respondents used these terms. For example, "workmate" could refer to a peer, subordinate, or manager, and such distinctions were often unclear in the free-text responses.

Table 14 shows how the relationship between the older person and the person responsible for harm varies across different harm subtypes. It focuses on the main person responsible for each harm subtype, applying the CHI–Very Serious threshold (if applicable). While some relationship patterns are consistent across harm types, there are also notable differences. Categories with small counts are suppressed (denoted 's.').

Partners or ex-partners was the only category to be listed as the main person responsible for harm across all subtypes, followed by respondents' children, although relationship patterns appear specific to particular harm subtypes. Neglect stood out for involving a higher share of partners (35.3%), children (23.6%), and professionals (22.6%) compared to other forms of harm. The latter comprises mostly professional carers (13.4%) and medical professionals (7.2%).[7] This reflects that neglect often occurs in caregiving contexts, including within families and formal care arrangements.

Aside from their role in neglect, partners/ex-partners and children warrant further discussion across the other harm subtypes. Children are listed as the main person responsible for about one in four respondents experiencing financial (18.2%), psychological (19.8%), or physical (22.4%) harm. They are less likely to be the primary cause of cultural & spiritual harm, being named as the main person responsible by less than one in 12 respondents experiencing this subtype. Partners or ex-partners were

[7] There may be broader service delivery issues or other factors contributing to a professional not providing care when needed for an older person, and exploring these is left for future research.

named as the main person responsible for psychological harm by about one in five respondents (20.6%), a similar proportion to those who identified a child (19.80%). They were less often identified as the main person responsible for financial harm (11.8%) or physical harm (14.2%) compared with (adult) children. We return to the topic of partners and ex-partners as the source of AOP in Section 10.3, in our discussion of intimate partner violence (IPV) and AOP.

Siblings and other family members also featured across harm types, although to a lesser extent. For instance, siblings accounted for 8.7% of psychological harm and 7.4% of cultural & spiritual harm. Other family members also accounted for 7.6% of cultural & spiritual harm, only marginally more than professionals (7%) and the ”Don’t know” or ”Refused to answer” category (7%). However, other family members were more frequently named as the main personal responsible (compared to siblings) for psychological harm (14.4% versus 8.7%), being the main person responsible almost three times more often for financial harm (14.8% versus 4.8%), and over five times more often for physical harm (16.7% versus 3.2%).

Friends were identified as the main person responsible across a range of subtypes, but most notably in sexual harm where they represented a little over one-third of people who affected the respondent the most (36.9%), followed by about one in four identified as a partner or ex-partner (26.7%). Approximately one in 10 respondents reporting sexual harm identified a neighbour (9.8%) or someone categorised as “Other person” (11%).

Friends also caused cultural & spiritual harm (14%), financial harm (13.7%), physical harm (10%), and psychological harm (7.8%). The pattern differed to that of neighbours, who were reported most often for physical harm (11.7%, similar to friends), but about half as often as friends for psychological (3.9%) and accounted for only 4.2% of financial harm. Financial harm, like physical, psychological, and cultural & spiritual harm, had a diverse range of main persons responsible, and notably, the highest number of “Don’t know” or “Refused” responses (14.7%).

Work-related contacts – including colleagues, clients, students and supervisors – were grouped into a single category (see Section 5.1). These relationships were more prominent in cultural & spiritual harm (21.4%) and psychological harm (13.7%) than other categories. They were more often identified by people aged 55–64, contributing to the higher prevalence rate observed in this age group compared with older cohorts (see Section 8.2).

Table 14: Relationship between people experiencing harm and those responsible, by harm subtype

	All	Neglect	Financial	Psychological	Physical	Sexual	Cultural & spiritual
Partner or ex-partner	21.90 (1.92)	35.34 (8.52)	11.76 (3.05)	20.62 (2.21)	14.23 (4.12)	26.70 (9.07)	11.70 (3.68)
Child	20.59 (1.77)	23.60 (6.21)	18.24 (3.03)	19.80 (2.10)	22.41 (4.65)	s.	8.20 (2.57)
Other family member	16.03 (1.62)	s.	14.80 (3.15)	14.35 (1.87)	16.67 (4.33)	s.	7.56 (2.19)
Work-related contact	16.02 (1.59)	s.	3.20 (1.37)	13.70 (1.84)	5.32 (1.64)	s.	21.35 (3.76)
Friend	14.43 (1.51)	s.	13.71 (3.04)	7.80 (1.34)	10.01 (3.32)	36.93 (9.13)	14.02 (3.53)
Sibling	10.31 (1.37)	s.	4.79 (1.67)	8.68 (1.48)	3.18 (1.42)	s.	7.35 (2.39)
Other person	9.97 (1.30)	s.	10.63 (2.84)	5.21 (1.17)	9.35 (2.58)	10.98 (4.80)	12.81 (3.19)
Neighbour	6.82 (1.08)	s.	4.21 (1.71)	3.90 (0.90)	11.68 (3.73)	9.83 (4.77)	3.01 (1.16)
Professional	6.35 (1.01)	22.62 (5.65)	3.93 (1.83)	1.05 (0.58)	3.43 (1.82)	s.	7.02 (2.13)
Don't know/Refuse	6.08 (1.13)	s.	14.72 (3.37)	4.90 (1.16)	3.73 (1.43)	s.	6.98 (3.00)
Observations (unweighted)	**956**	**73**	**250**	**652**	**154**	**51**	**197**
Observations (weighted)	**256,000**	**17,600**	**61,200**	**189,600**	**42,600**	**12,900**	**49,300**

Notes: Based on main person responsible for harm and those who experienced harm according to the CHI–Very Serious definition. "All harm" can add to more than 100% due to different main person responsible being identified for different harm subtypes. 's.' indicates suppressed due to small counts.

To a lesser extent, work-related contacts were also the main person responsible for physical (5.3%) and financial (3.2%) harm for some respondents, although for these subtypes other relationship categories were more common. Work-related contacts were therefore most often reported in relation to psychological and cultural & spiritual harm and rarely identified for causing financial harm. It is clear, however, that AOP does not only occur in private or familial settings, but also in public or professional environments.

Psychological harm tended to involve those with close personal ties, especially partners (20.6%), children (19.8%), other family members (14.4%), siblings (8.7%), and friends (7.8%). In contrast, cultural & spiritual harm showed the broadest spread across relationship types, with meaningful shares across almost all categories. This may reflect the many ways that cultural identity and values can be undermined or disrespected by a wide range of people, both within and outside the family. As discussed earlier, sexual harm was more likely to involve individuals outside the immediate family.

Overall, while some relationships – particularly partners or ex-partners and children – are consistently reported across all harm types, others appear to be more context-specific. For example, professionals are more often linked to neglect, while friends appear more often in cases of sexual, financial, and cultural & spiritual harm. These findings underline the need to understand the nature of the relationship between the person experiencing harm and the person causing it, to inform targeted prevention and support efforts.

Box 11: Description and analysis of "Other" person responsible for harm category

Respondents who experienced harm were asked to describe their relationship to the person who caused the harm. The survey offered 19 pre-defined categories, such as “partner/spouse”, “friend”, “child”, and so on. If the respondent felt none of the listed categories applied, they could select “Other” and describe the relationship in their own words using a free-text field.

Where possible, an “Other” free-text response was back-coded to one of the 19 pre-defined categories. In some cases, the respondent said “a stranger” or similar, and these were excluded as not in scope for the study. Any corresponding harms were also re-coded in this case. For example, if the respondent had only experienced psychological harm involving a stranger and no-one else, their psychological harm information was re-coded to indicate that they had not experienced psychological harm as per the AOP definition in Section 1.1.

A sizeable share of respondents who experienced harm indicated that the relationship did not fall into one of the 19 pre-defined categories (approximately 30%). We analysed the raw free-text fields (before any back-coding or re-coding took place), after correcting misspellings or similar. For example, “colleage” was changed to “colleague”.

Analysis across all harm subtypes (for terms mentioned five or more times) showed that “colleague” was the most common free-text response. This was common enough to warrant the creation of a new relationship category of “Work-related contact”, which also included responses such as “work supervisor”, “workmate”, “client”, or similar. The next most common response was “friend”, which was re-categorised to the pre-defined category. Similarly, we re-categorised several other relationships such as “daughter”, “grandchild”, “partner”, or “doctor”.

In some cases, respondents named organisations, or members of organisations, such as “the police”. Note that other government organisations were named less than five times; these responses were excluded from analysis. In some instances, organisations were able to be re-categorised as “professional carer” or another professional (e.g. if a home-care provider was named). In other cases, while these responses may reflect harms experienced from interactions with government agencies and/or “the system”, the survey was not designed to capture institutional or systemic harm. In fact, it was designed to exclude it by asking about behaviours by “someone they [the respondent] know”. As we cannot predict how respondents understood the concept of “knowing” someone, the survey is not a valid tool for measuring institutional harm.

However, the *Qualitative Interviews Report* (Wilson et al., 2026) suggests systemic or institutional harms were, for some participants, a significant part of their overall experience of AOP. See Section 10 for further discussion.

5.2 Characteristics of those responsible for harm

Table 15 presents demographic information about the main person responsible across the harm subtypes. It includes data on their gender, age, and whether they lived with the respondent at the time the harm occurred. All figures are based on harm that met the CHI–Very Serious threshold, if applicable.

These questions were only asked after harm had already been identified. They were designed to understand the broader context in which harm occurs, not to excuse or justify it.

Gender

Men were more likely than women to be identified as the main person responsible for harm across all AOP subtypes, except for psychological harm (52.0% female). This pattern was particularly strong for sexual harm (87.6% male), physical harm (72.5% male), and neglect (63.6% male). In contrast, psychological and cultural & spiritual harm showed a more even gender distribution.

Age

Most of those responsible for harm were aged between 30–69 years, with over half aged 50–69 for all harm types combined (51.3%). The latter age group had the highest share across all harm subtypes and were particularly dominant in cases of sexual (51.1%), psychological (47.2%), and cultural harm (40.7%), relative to other subtypes. People responsible for harm were commonly aged 30–49 – making up a little over one in three of the main people responsible for all harm (35.6%) and physical harm (35.4%), and slightly less for financial harm (32.2%) and cultural & spiritual harm (30.4%).

Among the small number of sexual harm cases, nearly one in three of the main people responsible were aged 70 or older (29.7%). By contrast, those mainly responsible who were aged 70+ were less commonly identified in cases of physical harm (5.1%). Younger adults (aged 18–29) were identified as the main person causing cultural & spiritual harm less often than other age groups (3.9%), but were the third most common for neglect, financial, and physical harm. Few people under 18 years of age were identified as the main person responsible – particularly in cases of neglect, financial, sexual, and cultural & spiritual harm – although this group was involved in a relatively high share of physical harm (8.5%) and less frequently psychological harm (3.3%).

Living situation

In most cases, the person responsible did not live with the person experiencing harm. This was most pronounced for cultural harm (81.9% lived separately) and sexual harm (75.4%). However, for neglect,

the share was more even – around two in five of those mainly responsible lived with the respondent at the time the harm occurred (39.0%), reflecting the role of cohabiting family members or carers in cases of neglect.

Summary

Overall, these results suggest that those responsible for harm against older people are more often male, in mid to later adulthood, and not living with the older person. Following the findings in Section 5.1 above, where partners or ex-partners and respondents' children were commonly identified as the person causing the most harm, these characteristics make sense. However, there is variation by harm type. For example, psychological harm is more likely to involve women, and neglect is more often associated with co-habiting than other harm subtypes.

Table 15: Demographic characteristics of main person responsible for harm, overall and by harm subtype

Characteristic	All	Neglect	Financial	Psychological	Physical	Sexual	Cultural & spiritual
Gender							
Male	62.64 (2.23)	63.62 (7.29)	56.66 (4.70)	47.45 (2.75)	72.49 (5.40)	87.57 (7.27)	53.76 (4.93)
Female	56.03 (2.28)	28.22 (6.51)	42.73 (4.70)	52.02 (2.75)	27.26 (5.40)	11.91 (7.27)	44.51 (4.92)
Other/Don't know/Refuse	0.67 (0.24)	8.16 (3.90)	s.	s.	s.	s.	0.67 (0.24)
Age							
Under 18	4.03 (0.93)	s.	s.	3.28 (0.94)	8.49 (3.29)	s.	s.
18–29	12.28 (1.49)	14.65 (4.67)	15.08 (3.42)	10.66 (1.75)	10.74 (2.87)	s.	3.87 (1.51)
30–49	35.55 (2.16)	24.11 (6.31)	32.19 (4.23)	25.69 (2.29)	35.35 (5.70)	18.15 (6.58)	30.41 (4.71)
50–69	51.30 (2.30)	31.90 (8.38)	34.33 (4.44)	47.20 (2.77)	38.55 (5.97)	51.05 (9.46)	40.68 (4.82)
70+	13.38 (1.48)	13.17 (6.34)	7.75 (2.57)	10.71 (1.62)	5.07 (1.85)	29.67 (8.80)	10.41 (2.89)
Don't know/Refuse	4.04 (0.89)	10.80 (4.32)	9.20 (3.32)	2.47 (0.78)	s.	s.	11.64 (3.06)
Lived with respondent experiencing harm							
Yes	33.84 (2.15)	38.99 (8.08)	29.49 (4.01)	32.69 (2.53)	36.54 (5.29)	24.65 (8.95)	17.88 (4.17)
No	78.23 (1.93)	61.01 (8.08)	66.43 (4.25)	67.14 (2.53)	62.48 (5.30)	75.35 (8.95)	81.94 (4.17)
Don't know/Refuse	s.	s.	s.	s.	s.	s.	s.
Observations (unweighted)	**956**	**73**	**250**	**652**	**154**	**51**	**197**
Observations (weighted)	**256,000**	**17,600**	**61,200**	**189,600**	**42,600**	**12,900**	**49,300**

Notes: Based on main person responsible and those who experienced harm according to the CHI–Very Serious definition. "All harm" can add to more than 100% due to different main person responsible being identified for different harm subtypes. 's.'

indicates suppressed due to small counts. The observation counts for age and gender were slightly lower due to a survey data capture error whereby a small number of relevant respondents were not asked these questions. Observation counts (unweighted/weighted) for age and gender: All harm: 886/237,600; Neglect: 73/17,600; Financial: 217/53,200; Psychological: 602/175,400; Physical: 129/35,700; Sexual: 49/12,500; Cultural: 187/48,000.

5.3 Circumstances of the person responsible for harm

For each AOP subtype, respondents were asked whether, to the best of their knowledge, the person who harmed them was experiencing any particular circumstances at the time. They were able to select all that applied from a pre-defined list, including alcohol or drug use, gambling, mental health, physical health, or financial difficulties.

Table 16 presents information on how many of those responsible for harm were facing such circumstances, as reported by survey respondents. Overall, 44.4% of the main people responsible were not reported as experiencing any of the listed circumstances. The most common issue noted was mental health challenges, affecting over one in three people causing harm (34.5%). For physical harm in particular, respondents reported that more than half of the main people responsible had mental health challenges (55.6%).

Some respondents reported that the person responsible for harm had problems with alcohol or drugs at the time. Overall, almost one in five (19.4%) said alcohol was an issue and 14.6% said drugs were an issue. Together with mental health challenges, substance use was especially common in cases of physical and sexual harm. For physical harm, just under one-third of the main people responsible were reported to have a problem with drugs, while alcohol was an issue for just under one in five. For sexual harm, roughly one in five were reported to have problems with alcohol and/or drugs, and one in four with mental health challenges.

Unsurprisingly, physical health issues were most often reported for those responsible for neglect (about one-third, 33.1%). This may reflect situations where people with their own health needs were also expected to provide care for another person, making it harder to meet that person's needs. Financial difficulties were most reported among those responsible for financial harm (about one in four, 26.4%), which may reflect financial stress contributing to these behaviours. The "Don't know/Refuse" responses were also relatively high, especially for financial (19.6%) and cultural & spiritual harm (23.6%), in line with earlier results. This indicates that these types of harm often involved a wider range of relationships to the respondent. For example, cultural & spiritual harm was more often linked to work-related contacts, which may explain the lower number of circumstances reported by respondents. In such cases,

respondents may simply not have known whether the people responsible were experiencing issues such as addiction, ill health, or financial stress.

A new category, "neurodiversity or intellectual disability" was created, as this captured the remaining "other" responses after back-coding to the pre-defined list. While the smallest category overall (1.7%), it is worthy of mention here, in light of findings on the care burden of older people highlighted in the *Qualitative Interviews Report* (see Wilson et al., 2026). That report highlighted the significant care burden carried by some older people who are responsible for supporting adult children or grandchildren with neurodiverse conditions or intellectual disabilities, often with little external support.

These patterns suggest that AOP often occurs in complex personal and social contexts. Challenging life circumstances, especially when perceived as being a problem for the person responsible at the time harm occurred, likely increase risk for older people in close or caregiving relationships. Understanding the situational contexts of those involved with harm, including risk factors and potential stressors, can inform prevention and response strategies. Addressing underlying factors that contribute to and potentially exacerbate AOP enables a focus on not only stopping harm, but also supporting victim-survivors and the relationships important to them.

Table 16: Respondent-reported circumstances of those responsible for harm

	All	Neglect	Financial	Psychological	Physical	Sexual	Cultural & spiritual
None	44.35 (2.27)	35.06 (7.65)	27.50 (4.07)	31.90 (2.54)	16.67 (4.24)	35.28 (9.33)	45.86 (4.91)
Alcohol	19.44 (1.85)	s.	14.45 (3.22)	18.09 (2.14)	18.98 (4.43)	23.52 (7.55)	11.12 (3.25)
Drugs	14.56 (1.58)	s.	18.86 (3.54)	13.50 (1.80)	31.23 (5.30)	20.72 (7.52)	6.07 (2.22)
Gambling	4.52 (0.84)	s.	4.70 (1.41)	4.57 (1.06)	7.91 (2.94)	s.	4.88 (1.81)
Mental health	34.45 (2.21)	19.20 (7.17)	26.37 (4.13)	35.32 (2.63)	55.59 (5.79)	24.49 (8.65)	20.51 (4.40)
Physical health	15.97 (1.76)	33.14 (8.42)	10.81 (3.29)	14.52 (2.01)	12.61 (3.62)	9.94 (5.05)	8.44 (3.34)
Finances	16.32 (1.74)	11.66 (4.67)	26.38 (4.07)	14.65 (2.00)	12.26 (3.35)	s.	12.83 (3.96)
Neurodiversity or Intellectual disability	1.72 (0.57)	s.	s.	0.01 (0.01)	s.	s.	s.
Don't know/Refuse	10.33 (1.45)	13.32 (4.65)	19.55 (4.14)	11.34 (1.87)	10.19 (3.59)	9.25 (4.66)	23.64 (3.99)
Observations (unweighted)	**886**	**73**	**217**	**602**	**129**	**49**	**187**
Observations (weighted)	**237,600**	**17,600**	**53,200**	**175,400**	**35,700**	**12,500**	**48,000**

Notes: Based on main person responsible and those who experienced harm according to the CHI–Very Serious definition. For "All harm", if any one main person responsible was reported to have a given issue, they are counted; "All harm" can add to more

than 100% due to different main persons responsible being identified for different harm subtypes. ‘s.’ indicates suppressed due to small counts. The observation counts are slightly lower than the total number experiencing harm due to a survey data capture error whereby a small number of relevant respondents were not asked these questions.

6 CO-OCCURRENCE OF DIFFERENT HARM SUBTYPES

Summary

- Many older people experienced more than one type of AOP. About one in three of those harmed reported two or more subtypes.
- Psychological harm was the most common subtype among those experiencing multiple forms of harm, particularly alongside financial and cultural & spiritual harm.
- Co-occurrence highlights the complexity of AOP and the need to view harms in combination rather than isolation.

Distinguishing between different types of harm is useful for comparing older people's experiences, including by prevalence rate (see Section 3.1) and who caused the harm (as in Section 5). However, some behaviours may be experienced alongside others from another subtype, referred to as co-occurrence.[8] For example, a respondent experiencing neglect may also be financially harmed.

Also, understanding how different harms overlap gives more complete insights into older adults' lived experiences. Subtype ambiguity (i.e. how some behaviours may be used to measure a particular subtype but depending on context could reasonably be included in the definition of another) also provides rationale for looking at co-occurrence. For example, cultural & spiritual harm could be viewed as context-specific psychological abuse or neglect (e.g. if an older person requires help to attend their place of worship). For further discussion on this point, see Section 10.1, or refer to the supplementary *Thresholds Report* (Scott et al., 2026a).

This section considers how often people who reported harm experienced more than one subtype – such as financial, psychological, or physical harm – and gives further insight into AOP and its complexity. Understanding which types of harm are more likely to happen alongside others allows support services to be designed to respond to people's complex experiences, as well as AOP's impact on their wellbeing.

Table 17 shows how many people experienced more than one type of harm. It includes only those who reported experiencing harm in the past 12 months, using the CHI–Very Serious threshold for neglect,

[8] An alternative, similar concept to co-occurrence is 'polyvictimisation', often used in child abuse and neglect studies to describe the experience of multiple victimisations across a range of harms (Radford et al., 2013). It can also refer to victimisation caused by multiple people. In this study, we use the term 'co-occurrence' because the harms we examine are all subtypes of AOP. By contrast, polyvictimisation may also include an older people's experiences of other harms outside the scope of the *National Study*'s AOP definition (e.g. by strangers, institutions, or others not known to the older person).

psychological, and cultural & spiritual harm (as outlined in Section 3.2). Most respondents who experienced any type of harm experienced one harm subtype in the previous 12 months (68%), corresponding to a little over one in 10 for all survey respondents (11.4%). Just over one-fifth (21.4%; 3.6% of all respondents) experienced two, 8% experienced three, and 2.5% experienced four or more.

Table 17: Number of harm subtypes experienced in past 12 months

	% of participants who experienced any harm subtype	Prevalence (% of all participants)
One	68.02 (2.05)	11.37 (0.62)
Two	21.42 (1.78)	3.58 (0.33)
Three	8.06 (1.25)	1.35 (0.22)
Four or more	2.49 (0.59)	0.42 (0.10)
Observations (unweighted)	**956**	**5,613**
Observations (weighted)	**256,000**	**1,530,700**

Note: Participants who experienced any harm subtype is based on those who experienced each harm type according to the CHI–Very Serious threshold. Standard errors are in parentheses.

Table 18: Co-occurrence of different harm subtypes, % of those experiencing relevant harm subtype

	All	Neglect	Financial	Psychological	Physical	Sexual	Cultural & spiritual
One	68.02 (2.05)	31.21 (6.51)	39.36 (4.29)	60.06 (2.56)	27.02 (4.96)	35.24 (8.86)	29.58 (4.25)
Two	21.42 (1.78)	29.91 (8.32)	32.07 (4.15)	26.25 (2.25)	30.79 (4.84)	21.69 (6.53)	38.69 (4.76)
Three	8.06 (1.25)	28.78 (7.83)	19.54 (3.63)	10.32 (1.64)	28.28 (5.09)	23.78 (8.77)	20.63 (4.19)
Four or more	2.49 (0.59)	10.10 (4.70)	9.02 (2.23)	3.36 (0.80)	13.91 (3.39)	19.29 (7.11)	11.10 (2.78)
Observations (unweighted)	**956**	**73**	**250**	**652**	**154**	**51**	**197**
Observations (weighted)	**256,000**	**17,600**	**61,200**	**189,600**	**42,600**	**12,900**	**49,300**

Note: Percentages based on those who experienced each harm type according to the CHI–Very Serious threshold, when applicable. Standard errors are in parentheses.

Table 18 shows how co-occurrence varies by harm subtype. People who experienced one AOP subtype were most likely to report psychological harm – 60.1% reported no other types of harm. This was followed by financial (39.4%) and sexual harm (35.2%); despite being the next highest rates after psychological harm, both were much lower. Neglect and cultural & spiritual harm were lower still, occurring in isolation at about half the rate of psychological harm (31.2% and 29.6%, respectively).

In contrast, people who experienced physical harm were least likely to experience it on its own. While over one in four (27%) reported physical harm as the only form of AOP, a further 30.8% experienced it alongside one other subtype. Almost the same number reported physical harm alongside two other harms (28.3%), and the remaining 13.9% with three or more harms. Except for sexual harm, which had the highest rate of co-occurrence with three or more other harms (almost one in five, 19.3%), physical harm co-occurs with most other harm subtypes.

This pattern differs for other subtypes; roughly one in 10 older people experiencing neglect or cultural & spiritual harm do so alongside three or more other harm subtypes, followed by 9% of those who experienced financial harm. In stark contrast, only 3.4% of those reporting psychological harm do so alongside more than three other harms.

For those experiencing one harm subtype alone, these results do not necessarily mean that they did not experience one-off or infrequent instances of neglect, psychological, or cultural & spiritual harm alongside another form of AOP. If the respondent experienced three or more separate behavioural items per subtype, or perceived these additional (infrequent) behaviours as very serious for them, they are included in the CHI–Very Serious prevalence estimate. Those not perceived as serious by the respondent, and were one-off or infrequent, were additional experiences that did not meet the threshold for neglect, psychological, or cultural & spiritual harm. It should be noted that no threshold is applied to financial, physical, or sexual harm.

Exploring co-occurrence patterns shows that some types of harm are more often only one aspect of an older person's experience of AOP. This has important implications for services – those affected may need support for multiple, overlapping abuses, not only the harm identified (perhaps by screening or risk assessment) or that they disclose.

To analyse what harms are more likely to co-occur, Table 19 shows prevalence rates for subtype combinations for those who experienced two or more subtypes. It only includes those who reported experiencing harm in the past 12 months, using the CHI–Very Serious threshold; combinations with small underlying counts are not reported. Unsurprisingly, given its higher relative prevalence (see Section 3.1), all combinations reported in Table 19 include psychological harm.

Slightly less than one in five respondents experiencing co-occurring harms report psychological harm alongside financial harm (19.8%) or cultural & spiritual harm (18.2%). For about one in eight, their experience includes physical harm (with psychological; 12.8%), and a further 4.9% also report financial harm in addition to psychological and physical harm. A similar rate (4.7%) report cultural & spiritual harm co-occurring with psychological and financial harm, rather than physical AOP.

Taken together, these findings highlight the importance of using screening or risk assessment tools that can pick up on additional forms of harm that might not be immediately disclosed or apparent. For instance, if someone reports financial, physical, cultural & spiritual, or neglect-related harm, it may be particularly important to ask about other experiences as well. Further, the detection and disclosure of various harm subtypes may happen in different contexts. For example, physical harm may be more likely to be screened for in a healthcare setting versus financial harm, which may rely more on victim-survivor disclosure or an astute finance (or legal) professional to identify its occurrence. See Section 10.1 for a more in-depth discussion.

Table 19: Co-occurrence of harm subtypes

Harm subtypes	% of participants who experienced 2+ harm subtypes	Standard error
Psychological + Neglect	4.77	2.05
Psychological + Financial	19.80	3.71
Psychological + Physical	12.84	2.85
Psychological + Sexual	2.20	0.84
Psychological + Cultural & Spiritual	18.22	3.48
Psychological + Neglect + Cultural & Spiritual	1.47	0.78
Psychological + Financial + Physical	4.89	1.76
Psychological + Financial + Cultural & Spiritual	4.65	1.95
Psychological + Physical + Cultural & Spiritual	3.30	1.29
Psychological + Financial + Physical + Cultural & Spiritual	3.18	1.24
Observations (unweighted/weighted)	**297/81,800**	

Note: Percentages based on those who experienced two or more harm subtypes according to the CHI–Very Serious threshold, where applicable. Standard errors are in parentheses. Only subtypes with a reasonable number of underlying counts are presented – most subtype combinations are not presented due to small counts.

7 HELP-SEEKING

Summary

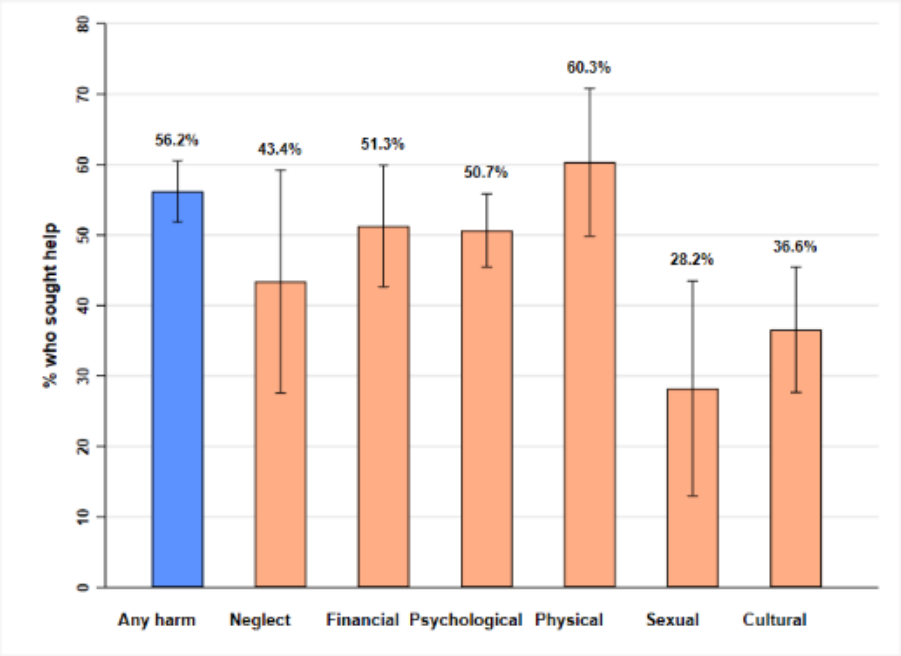
- Just over half of older people who experienced harm (56.2%) sought help or advice.
- Help-seeking was most common for physical harm (60.3%) and least common for sexual harm (28.2%) and cultural & spiritual harm (36.3%).
- Family/whānau and friends were the most common sources of support. Formal services such as police, legal, health, or counselling were used less often, and many older people reported unmet needs for emotional support, counselling, and advice.

This section looks at whether older people who experienced harm sought help or advice. It also examines why some did not seek help, who they turned to if they did, and what kind of support they would have liked to receive. These insights can help improve access to support and tailor responses to the needs of older people experiencing harm.

7.1 How many older people experiencing harm sought help?

Just over half (56.2%) of those who experienced any harm said they asked for help or advice (Figure 14), but this varied widely by harm subtype. People were most likely to seek help after physical harm (60.3%), followed by financial harm (51.3%), psychological harm (50.7%), and neglect (43.4%). A much lower share – less than one-third – sought help after sexual harm (28.2%), while a little over one-third sought help for cultural & spiritual harm (36.3%).

Figure 14: Share of those experiencing harm who sought help, by harm subtype



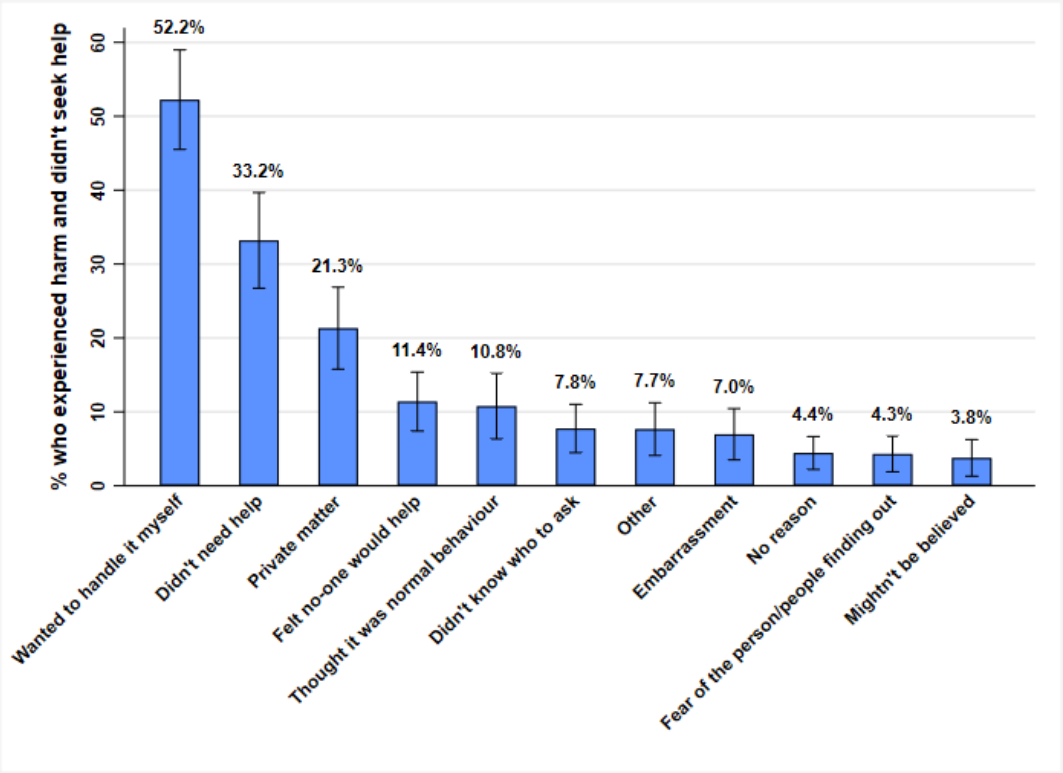
Notes: Vertical bars are 95% confidence intervals. Percentage of those experiencing each subtype of abuse, using CHI–Very Serious threshold where relevant.

7.2 Reasons why those who experienced harm did not seek help

Respondents who experienced harm but did not seek help (43.3%) were asked why (Figure 15 for all harm; Table 20 by subtype). This question allowed more than one response, so percentages add to more than 100%.

The most common reason given was wanting to handle it themselves, given by a little over half of those who did not seek help. One in three older people who did not seek help for the harm they experienced advised they didn't need help (33.2%), followed by one in five who said it was a private matter (21.3%). About one-tenth said they felt no-one would help (11.4%) and/or they thought the harm was normal behaviour (10.8%).

Figure 15: Reasons for not seeking help, % of those experiencing harm who did not seek help



Note: Percentages based on those who experienced harm according to the CHI–Very Serious threshold and who did not seek help (unweighted/weighted observation count: 413/110,900). Vertical lines represent 95% confidence intervals.

Wanting to handle it themselves was especially common among those who had experienced financial harm (55.5%), with lower – but similar – shares for physical harm (47.3%), psychological harm (47.2%), and cultural & spiritual harm (46.8%). This could reflect a sense of independence and self-reliance, supported by those respondents saying they didn't need help. While a much lower share than wanting to handle it themselves, it was the second most common response for most harm subtypes. A notable exception is sexual harm, where not needing help was a reason given by 41.4% of respondents who did not seek help for their experience.

It is also possible that handling it themselves was, at least in part, driven by embarrassment or shame. Embarrassment was the most common emotional and social barrier mentioned, especially by those experiencing physical harm (14.9%) or neglect (10.5%). However, fear or feeling they would not be believed were also reported – notably, by those experiencing cultural & spiritual harm (9% of whom answered they were afraid).

Table 20: Reasons for not seeking help by harm subtype, % of those who did not seek help

Reason	All	Neglect	Financial	Psychological	Physical	Sexual	Cultural & spiritual
Wanted to handle it myself	52.24 (3.43)	41.63 (12.37)	55.45 (6.17)	47.19 (3.82)	47.32 (9.24)	39.09 (10.51)	46.81 (6.42)
Didn't need help	33.20 (3.30)	16.29 (7.55)	21.35 (5.28)	24.08 (3.40)	25.02 (9.24)	41.37 (11.41)	18.28 (5.00)
Private matter	21.32 (2.83)	s.	23.73 (5.28)	21.21 (3.14)	s.	12.08 (6.34)	14.04 (5.40)
Felt no-one would help	11.39 (2.04)	24.82 (9.39)	8.58 (2.88)	10.28 (2.37)	8.65 (3.59)	s.	17.37 (4.93)
Thought it was normal behaviour	10.77 (2.26)	s.	s.	9.37 (2.36)	8.43 (4.20)	s.	16.10 (5.67)
Didn't know who to ask	7.75 (1.67)	16.12 (7.32)	6.61 (2.61)	6.11 (1.72)	s.	s.	13.36 (4.49)
Other	7.67 (1.82)	s.	4.57 (1.86)	5.73 (1.64)	s.	s.	7.72 (3.87)
Embarrassment	6.97 (1.77)	10.47 (5.34)	5.09 (2.05)	7.14 (2.02)	14.86 (6.88)	s.	3.12 (1.61)
No reason	4.44 (1.14)	s.	4.01 (1.96)	1.29 (0.55)	s.	s.	s.
Fear of the person/people finding out	4.30 (1.23)	s.	s.	2.83 (1.02)	s.	s.	8.98 (3.42)
Mightn't be believed	3.77 (1.26)	s.	s.	3.24 (1.38)	s.	s.	s.
Don't know/Refuse	s.	s.	s.	s.	s.	s.	s.
Observations (unweighted)	**413**	**37**	**128**	**320**	**62**	**34**	**115**
Observations (weighted)	**110,900**	**9,900**	**29,700**	**92,600**	**16,500**	**9,300**	**31,000**

Notes: Percentages based on those who experienced harm according to the CHI–Very Serious threshold and did not seek help. More than one response was allowed, so percentages can add to more than 100%. Standard errors in parentheses. 's.' indicates the estimate was suppressed due to small sample size.

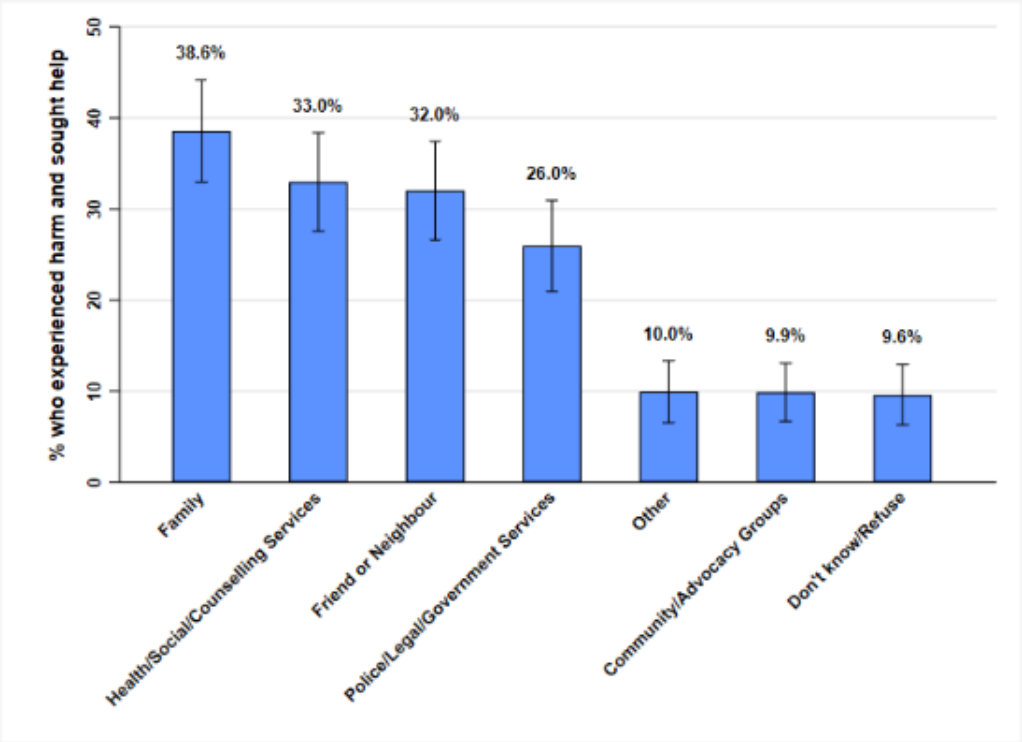
In addition to reporting self-reliance, some older people may not want the person who harmed them to get into trouble – a reason that was highlighted by several research participants in the qualitative work undertaken as part of the *National Study*, particularly in cases where the person responsible was someone close to them, especially their child (Wilson et al., 2026).

Older people experiencing financial or psychological harm and who did not seek help more commonly said it was a private matter (23.7% and 21.2%, respectively). Some respondents said they felt no-one would help or did not know who to ask. These barriers were more common among those who experienced neglect – one-quarter of these respondents thought no-one would help (24.8%) – or cultural & spiritual harm. For the latter, 17.4% thought no-one would help and 13.4% did not know who to ask; for neglect, 16.1% did not know who to ask for help. A similar share of those experiencing cultural & spiritual harm thought the behaviour was normal, which may reflect experiences of long-term exclusion or discrimination.

7.3 Who did those who experienced harm turn to for help?

Figure 16 presents information on older people who sought help or advice from after experiencing harm. Older people most often turned to people they knew personally. Of those who sought help, the most common source of support was family or whānau (38.6%), with friends also having a large share (32%). These informal sources were particularly important for those who experienced psychological or cultural & spiritual harm, and neglect (see Table 21). Those experiencing physical harm tended to turn to family or whānau for support more often than friends (31.2% versus 17.6%).

Figure 16: Sources of help or advice sought, % who experienced harm and sought help



Note: Percentages based on those who experienced harm according to the CHI–Very Serious threshold and sought help (unweighted/weighted observation count: 538/143,800). Vertical lines are 95% confidence intervals. Combined categories reported to ensure adequate observation counts. Organisations were grouped into broad categories based on their main function for reporting purposes. In practice, many providers operate across multiple areas (e.g. combining advocacy with health or social services), so there is overlap between categories.

Use of health, social and counselling support services was mixed across the harm subtypes (see Table 21); these sources of help and advice were much higher for neglect (77.7%) than for cultural & spiritual and financial harm (15.3% and 10.4%, respectively). Those experiencing physical harm accessed this support about twice as much as turning to friends for help and advice (37.6% versus 17.6%). Formal support like that from police, legal, or government services was most common for those experiencing physical harm (48.5%) and financial harm (40.9%). For the latter, legal advice (both lawyers and Citizens Advice or Community Law Centres) contributed over half the share, possibly reflecting that financial harm often

involves legal instruments and entitlements, and that remedies may therefore require legal advice or intervention. See the *Perspectives on Financial AOP Report* for additional insights on help-seeking for experiences of financial harm (Scott et al., 2026b).

Community or advocacy groups (such as Grey Power, Age Concern, a church or other community organisation) tended to be accessed most by those experiencing cultural & spiritual harm, a subtype that had a wide diversity of help sources with high shares. Very few respondents experiencing neglect said they sought help from a community or advocacy group, perhaps indicative of the barriers present for those with higher care needs to access social and advocacy support outside the home.

A very small share of respondents used specialist elder support services, such as Elder Abuse Response Services (EARS), Age Concern, Grey Power, or helplines. This suggests these services may not be well known or accessible to many older people, respondents may not have recognised these names as the organisation they sought help from, or may not have recognised their situation as one that qualifies for such support. These services are dedicated to supporting older people, and it is perhaps surprising that few respondents mentioned accessing these supports.

Overall, the findings highlight the important role of both personal relationships and trusted professionals in supporting older people experiencing harm. However, they also point to gaps in visibility and access to formal services, especially for culturally-specific or non-physical forms of harm.

Table 21: Sources of help or advice sought by harm subtype, % of those who sought help

Source of help or advice	All	Neglect	Financial	Psychological	Physical	Cultural & spiritual
A family or whānau member	38.56 (2.85)	30.72 (12.72)	19.19 (4.48)	38.02 (3.58)	31.18 (6.5)	32.63 (7.23)
Health/Social/Counselling	32.97 (2.76)	77.72 (8.65)	10.38 (3.58)	35.46 (3.54)	37.55 (6.94)	15.26 (4.5)
A friend or neighbour	32.00 (2.76)	32.63 (13.66)	19.51 (4.79)	32.72 (3.52)	17.59 (5.15)	30.43 (7.21)
Police/Legal/Government	25.96 (2.55)	s.	40.88 (6.24)	18.45 (2.69)	48.54 (6.94)	19.79 (6.83)
Other	9.95 (1.74)	s.	s.	8.69 (2.06)	5.86 (2.3)	14.78 (5.56)
Community/Advocacy Groups	9.88 (1.62)	s.	7.36 (2.6)	9.34 (2.03)	9.2 (3.18)	17.41 (5.83)
Don't know/Refuse	9.60 (1.69)	s.	27.46 (6.04)	6.17 (1.41)	s.	7.34 (3.06)
Observations (unweighted)	**538**	**35**	**121**	**330**	**90**	**80**
Observations (weighted)	**143,800**	**7,600**	**31,400**	**96,000**	**25,700**	**18,000**

Notes: Percentages based on those who experienced harm and sought help. More than one response was allowed, so percentages can add to more than 100%; combined categories reported to ensure adequate observation counts. Standard errors

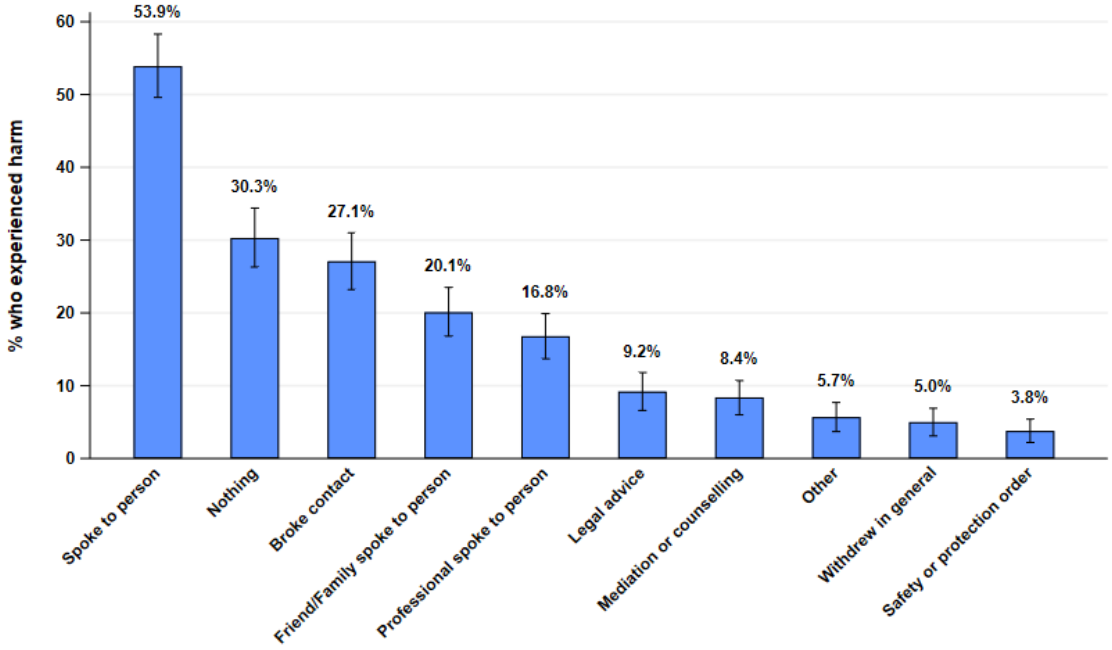
in parentheses. 's.' indicates the estimate was suppressed due to small sample size. Sexual harm omitted due to a small number of underlying responses. Organisations were grouped into broad categories based on their main function for reporting purposes. In practice, many providers operate across multiple areas (e.g. combining advocacy with health or social services), so there is overlap between categories.

7.4 What actions were taken in response to the harm?

Figure 17 shows what actions were taken by respondents, or by others on their behalf, in response to harm (irrespective of whether they sought help); Table 22 displays results by subtype.

Just over half (53.9%) who experienced harm said they spoke directly to the person who had caused the harm. This was the most common response across all harm types – especially for financial harm where over half of respondents spoke to the person responsible (52.8%) – except for cultural & spiritual harm where a higher share of respondents took no action (37.4% versus 34.6% for speaking to the person). Speaking to the person themselves was also relatively less common for those experiencing neglect (37.7%), which may partly reflect that neglect and cultural & spiritual harm were more likely than other harm subtypes to involve professionals or others outside close personal relationships (see Section 5). In the case of neglect, a higher proportion of the main person responsible lived with the older person needing care compared with other types of AOP. These circumstances may mean that directly engaging with the person causing harm is more difficult or unsafe; it is also worth noting very few respondents experiencing neglect said they broke contact or avoided the person causing harm. The older person may have been unable to avoid those who were responsible for helping them but failed to do so and instead relied on others – professionals (11.7%) or family/whānau/friends (18.2%) – to speak to the person instead.

Figure 17: Actions taken by respondents in response to harm, % who experienced harm



Note: Percentages based on those who experienced any type of harm according to the CHI–Very Serious threshold (unweighted/weighted observations: 956/256,000). Vertical lines are 95% confidence intervals. Percentages sum to more than 100% as respondents could choose multiple categories, except for "Nothing", which was a mutually exclusive category. "Don't know/Refuse" not included due to small underlying counts.

Having others speak to the person responsible for harm on the older person's behalf, especially family/whānau or a friend, tended to be common across the subtypes – ranging between 16.5% for financial harm up to 23.8% for physical harm; the exception is cultural & spiritual harm (6.8%). Professionals also spoke to the person responsible on the older person's behalf, especially for those experiencing physical harm (30.2%) – over double the shares of the other subtypes.

Seeking legal advice – perhaps linked to the professional speaking to the person causing harm – was a relatively common response, and higher for financial harm (11.3%) than physical (9.6%), psychological (8.4%), or cultural & spiritual (6.8%) harm. This legal advice may be linked to having a protection order made against the person responsible for those experiencing physical harm (10.5%). Seeking formal support or advice from mediation or counselling was mentioned by some respondents, but with lower shares, except for psychological harm which had a similar share to obtaining legal advice (8.5%).

The findings suggest older people experiencing harm tend to act through informal channels, with the majority opting to do something rather than nothing at all. The reliance on friends or family to speak with the person causing harm on the respondent's behalf suggest formal referral options may also be needed by those supporting an older person experiencing harm. For those experiencing neglect, options for support may be more limited, and complicated by the older person's need for care. Given so many –

almost one in three – took no action in response to the harm they experienced, ensuring support options are well-known and accessible is key to responding to older people's experiences of harm.

Table 22: Actions taken in response to harm, by harm subtype, % who experienced harm

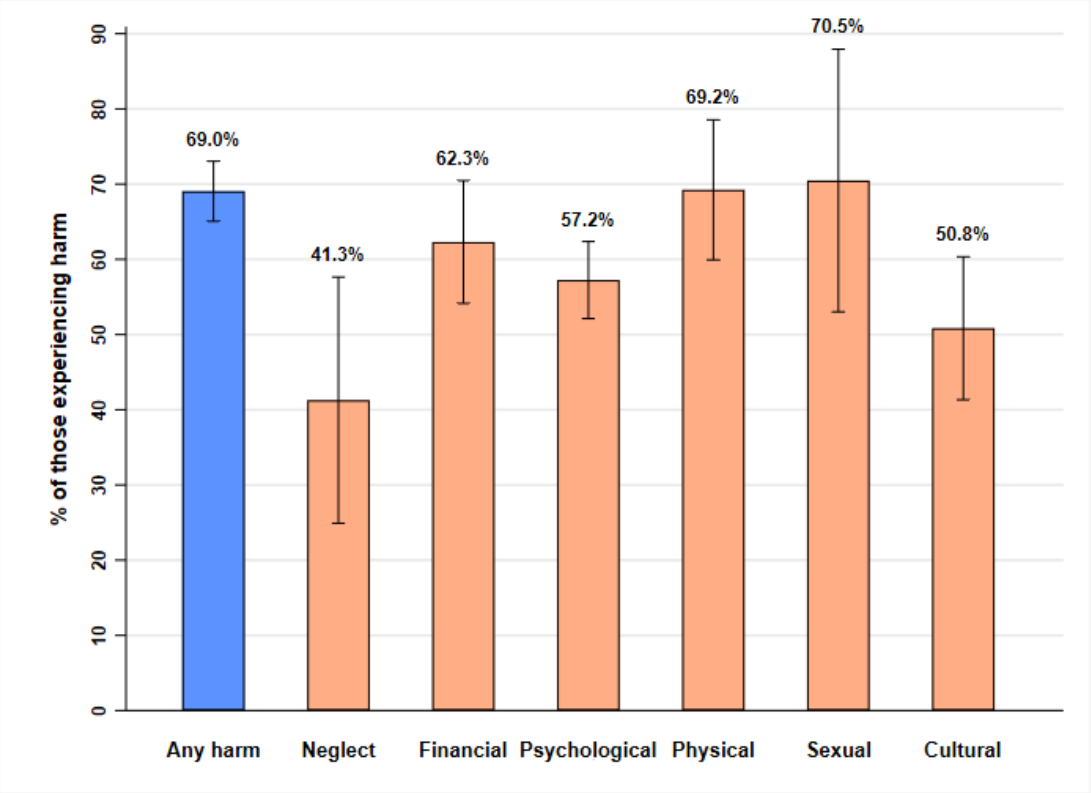
Action taken	All	Neglect	Financial	Psychological	Physical	Sexual	Cultural & spiritual
You spoke to the person	53.9 (2.2)	37.7 (8.0)	52.8 (4.4)	44.5 (2.6)	39.1 (5.3)	44.9 (9.0)	34.6 (4.6)
Nothing (no action)	30.3 (2.1)	29.6 (7.5)	9.3 (2.1)	19.7 (2.2)	10.4 (3.1)	25.6 (9.7)	37.4 (4.9)
You broke contact/avoided the person	27.1 (2.0)	s.	17.8 (3.6)	25.0 (2.3)	27.8 (4.9)	36.9 (8.5)	16.8 (3.5)
Family/whānau or friend spoke to the person	20.1 (1.7)	18.2 (6.8)	16.5 (2.9)	17.7 (1.9)	23.8 (5.0)	s.	6.8 (2.1)
Professional spoke to the person	16.8 (1.6)	11.7 (4.9)	11.8 (2.5)	13.1 (1.8)	30.2 (5.1)	8.0 (4.0)	9.7 (2.9)
You sought legal advice	9.2 (1.3)	s.	11.3 (2.9)	8.4 (1.5)	9.6 (3.7)	s.	6.8 (2.7)
You sought mediation/counselling	8.4 (1.2)	s.	3.4 (1.4)	8.5 (1.5)	5.8 (2.4)	s.	3.5 (1.5)
Other	5.7 (1.0)	6.4 (3.8)	8.6 (3.0)	0.8 (0.3)	6.8 (2.9)	s.	5.5 (1.9)
You stopped going out/withdrew	5.0 (1.0)	s.	4.2 (1.6)	5.2 (1.2)	7.5 (3.3)	s.	s.
A safety or protection order was made against the person	3.8 (0.8)	s.	3.3 (1.4)	4.4 (1.1)	10.5 (3.4)	s.	s.
Observations (unweighted)	**956**	**72**	**250**	**652**	**154**	**51**	**197**
Observations (weighted)	**256,000**	**17,500**	**61,200**	**189,600**	**42,600**	**12,900**	**49,300**

Notes: Percentages based on those who experienced harm. More than one response was allowed, so percentages can add to more than 100%. Standard errors in parentheses. 's.' indicates the estimate was suppressed due to small sample size.

Older people who experienced harm were asked whether they thought the response had been effective, regardless of whether they actively sought help or not (see Figure 18 and Table 23). Most respondents (69%) said their response was effective, while 8.1% did not know or declined to answer. This pattern was broadly consistent across most harm types, although less so for cultural & spiritual harm where only about half (50.8%) said their response was effective, 39% said it was not, and 10.1% did not know or refused. The main exception was neglect, where more respondents judged their response to be ineffective (48.3%) than effective (41.3%), with 10.5% not knowing or refusing. This result is consistent with the findings above, as older people experiencing neglect may face fewer options for responding and may feel that no-one will help (see Section 7.2).

The group who said they did not know whether the response had been effective or chose not to answer – about one in 10 depending on harm type – may reflect that outcomes were mixed or unclear. Given the survey asked about experiences in the last 12 months, it is possible the situation remained unresolved.

Figure 18: Share of those experiencing harm who said the response was effective, by harm subtype



Note: Percentages based on those who experienced any type of harm according to the CHI–Very Serious threshold (unweighted/weighted observations: 956/256,000). Vertical lines are 95% confidence intervals.

Table 23: Effectiveness of response actions, by harm subtype, % of those experiencing harm

	All	Neglect	Financial	Psychological	Physical	Sexual	Cultural & spiritual
Effective	69.05 (2.04)	41.27 (8.35)	62.3 (4.17)	57.25 (2.61)	69.24 (4.75)	70.48 (8.91)	50.84 (4.85)
Not effective	35.62 (2.1)	48.27 (8.22)	30.01 (3.96)	30.18 (2.36)	18.38 (3.97)	21.05 (8.54)	39.02 (4.81)
Don't know/Refuse	8.08 (1.29)	10.46 (4.47)	7.70 (1.94)	12.57 (1.88)	12.39 (3.19)	s.	10.14 (2.64)
Observations (unweighted)	**956**	**72**	**250**	**652**	**154**	**51**	**197**
Observations (weighted)	**256,000**	**17,500**	**61,200**	**189,600**	**42,600**	**12,900**	**49,300**

Notes: Percentages based on those who experienced harm according to the CHI–Very Serious threshold. "All" column can sum to more than 100% due to different responses across harm subtypes. Standard errors in parentheses.

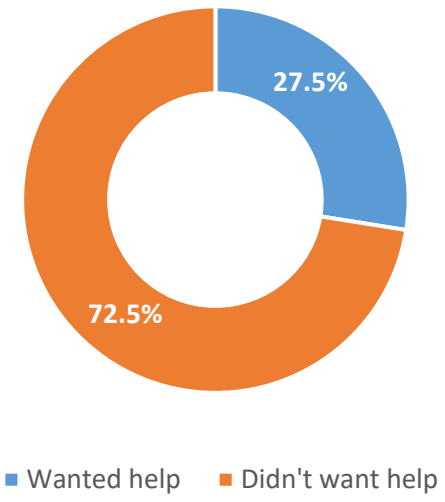
7.5 What help would older people have liked to receive?

Older people who experienced harm were asked whether there was any type of help or advice they would have liked to receive. This question was asked near the end of the survey and invited respondents to reflect on all their experiences of harm, rather than linking their answers to a specific type of harm.

A little over one in four (27.5%) said yes, while most (72.5%) said no (Figure 19). Among those who said yes, emotional support was the most common need (37.4%), followed by counselling (31.1%), and information and advice (29.9%); see Table 24. Practical help, such as housework or meals, a conversation with either a person known or anonymous, and legal advice were mentioned by roughly one in five respondents. Advice on how to keep safe and medical help were also mentioned, although with smaller shares, followed closely by additional culturally appropriate support and formal responses, like police.

These findings show that even when older people did seek help for their experience, many still had unmet needs – both for emotional and practical support. This highlights the importance of offering a wide range of support options that are visible, trusted, and easy to access.

Figure 19: Whether those who experienced harm would have liked additional help or advice (%)



Note: Based on unweighted/weighted observation counts of 901/242,200.

Table 24: Types of support wanted by those who experienced harm and wanted additional support

Type of help	%	Standard error
Personal emotional support	37.38	4.21
Professional counselling	31.07	4.00
Information and advice	29.89	3.90
Practical help (e.g. meals, housework)	21.01	3.60
Someone to talk to who I don't know (i.e. someone anonymous who is not involved)	19.92	3.39
Legal advice	18.69	3.37
Someone to talk to that I know (e.g. family, whānau, friends or neighbour)	18.37	3.28
Advice about how to keep safe	12.26	2.95
Medical help	11.51	2.72
Someone to talk to with the same cultural background	10.97	2.55
Wanted help from other organisation (e.g. police)	10.94	2.92
Financial help	8.97	2.12
Help with transport	4.96	1.76
Other form of help	3.61	1.72
Help with language or translation	s.	s.
Don't know/Refuse	5.78	1.78
Observations (unweighted)/Observations (weighted)	**247/66,700**	

Note: Percentages based on those who experienced harm according to the CHI–Very Serious threshold and who would have liked to have received additional help or advice. Percentage column sums to more than 100 as respondents could choose multiple categories. 's.' indicates estimates are suppressed due to small underlying counts.

7.6 Summary

Together, these findings show that while just over half of older people who experienced harm did seek help or advice, a large proportion did not – often due to a desire to handle things themselves or uncertainty about where to turn. Those who did seek help mainly turned to people they knew personally, such as family or friends, with relatively low use of formal or specialist services. Actions taken were also more often informal, and many said they took no action at all.

These findings highlight the importance of ensuring that older people not only have options for responding to harm, but also that the support they receive is likely to make a difference. In cases where people felt the action(s) taken were not effective, this may indicate a gap in the quality, timeliness, or appropriateness of available responses. When people did seek help, some still recognised unmet needs. Around one in four of those who experienced harm said there was help or advice they would have liked to receive – most often emotional support, counselling, or general advice. Filling these gaps is important to ensure older people have relevant help when they need it most.

8 PREVALENCE BY RESPONDENT CHARACTERISTICS

Summary

- Prevalence of AOP was highest among people aged 55–64 (23.3%), compared with those aged 65–74 (15.5%) and those aged 75+ (7.9%).
- Māori reported higher rates (25.8%) than Pacific (20.7%), European (15.8%), or Asian older people (10.6%).
- Prevalence was higher among disabled, neurodivergent, Rainbow respondents, and those with a history of past harm. Higher prevalence was also seen among those in rented housing and in households with more complex living arrangements.
- Gender differences in overall prevalence were small, but women were more likely to experience financial and psychological harm involving their children, while men more often reported harm from partners/ex-partners or work-related contacts.

This section examines prevalence rates by demographic and socioeconomic characteristics of survey respondents, such as age, ethnicity, and disability status. Unless otherwise stated, prevalence rates are based on the CHI–Very Serious threshold (see Section 3.2) and respondent characteristics. For respondent gender, age, and employment status, we also report on the relationship between the respondent and the main person responsible for harm. For all other characteristics, we do not provide this breakdown to maintain adequate sample sizes.

8.1 Gender

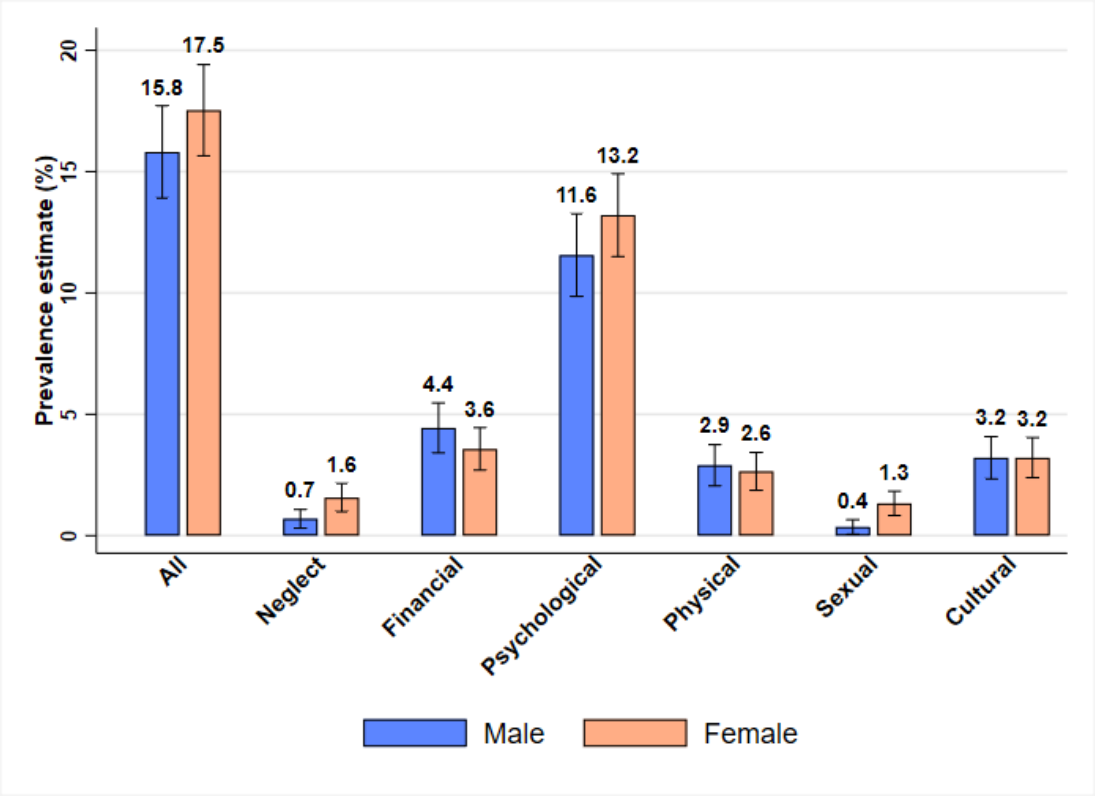
In total, one in six older people aged 55 years and over experienced harm in the 12 months prior to the survey (16.7%, using the CHI–Very Serious threshold; see Table 2). The rate was higher for women (17.5%) than men (15.8%), but this difference is not statistically significant – illustrated by the overlapping 95% confidence intervals in Figure 20.

There are differences for some AOP subtypes. While most differences are not statistically significant, for sexual harm the rate of 1.3% for women was over three times higher than that for men (0.4%) and statistically significant at the 10% level. Neglect was also more prevalent for female respondents than males (1.6% versus 0.7%), but the difference is not statistically significant. Similarly, psychological harm

was also reported more often by women (13.2% versus 11.6%), but the gender difference is not statistically significant.

In contrast, physical harm and financial harm were slightly more common among men, although these differences are also not statistically significant. Cultural & spiritual harm was experienced at the same rate for both male and female respondents (3.2%).

Figure 20: Prevalence by gender



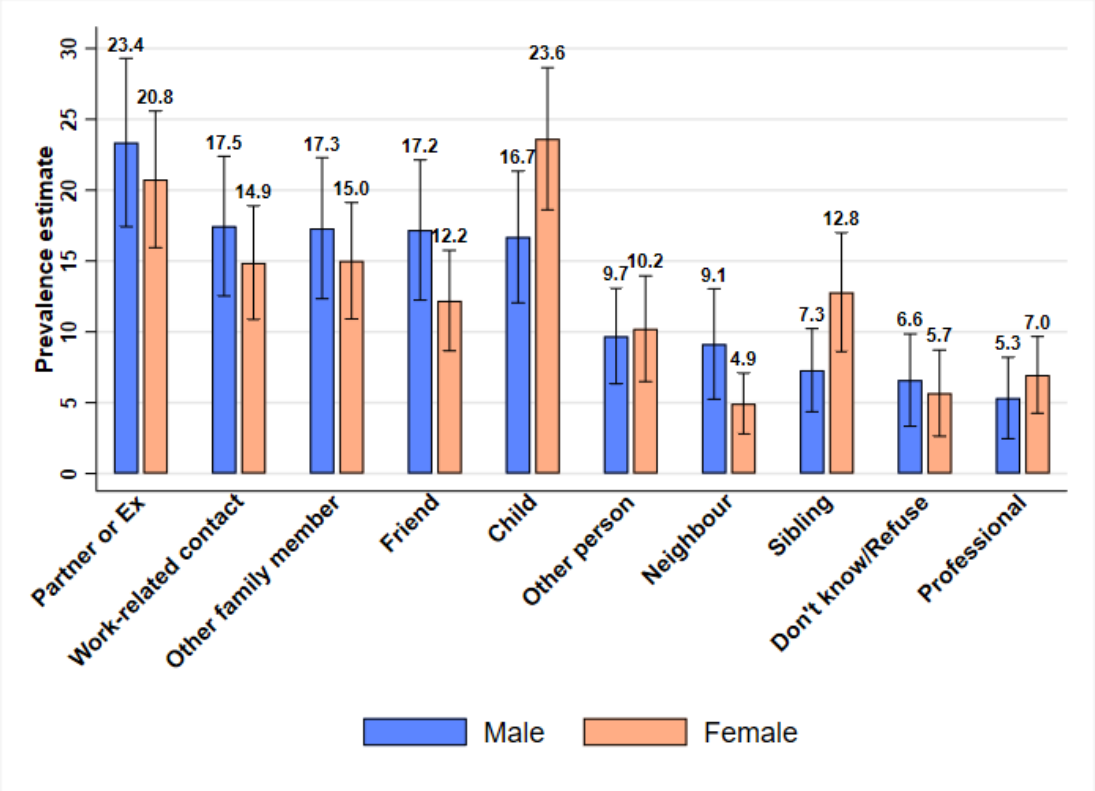
Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on the CHI–Very Serious threshold where relevant.

The relationship between the person who affected the respondent the most and the older person varies somewhat by gender, but the overall patterns are similar (Figure 21). For men who experienced harm, the most common person named as causing it was their partner or ex-partner (23.4%; equates to 26,900 men aged 55+). While for women experiencing harm, the main person responsible was most often their child (23.6%, i.e. 33,200 women aged 55+). A work-related contact or another family member (i.e. any family member other than their partner/ex-partner, child or sibling) were the next most common relationships reported by men (17.5% and 17.3%, respectively) and, while also common among women, the rates were somewhat lower (14.9% and 15%). In the case of a work-related contact, the difference may reflect lower employment rates and lower propensity to work full-time among female respondents

(50.9% for men, including 37.2% in full-time employment versus 42.5% for women, including 24.8% in full-time employment). However, these differences are not statistically significant.

A friend was reported as the main person responsible by men at a similar rate as the previous categories (17.2%), followed closely by their child (16.7%); for women – who experienced harm involving a child more commonly than men – a friend or sibling were the next most common (12.2% and 12.8%, respectively). A sibling was listed as affecting male respondents the most at a lower rate (7.3%) than another person (someone who did not fit a pre-defined category; 9.7%) or neighbour (9.1%). About one in 10 women who experienced harm listed "other person" (10.2%), similar to male respondents, but named a neighbour about half as often as male respondents (4.9% versus 9.1%).

Figure 21: Relationship of main person responsible for harm by respondent gender



Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on the CHI–Very Serious threshold.

Table 25 presents the relationship of the main person responsible for harm to the respondent by gender and harm subtype. For neglect, partners and ex-partners were far more likely to be identified by women than men. Almost half of women who experienced neglect reported their partner or ex-partner as responsible (44.9%), compared with a much lower share for men, with the difference statistically significant. Professionals – a combined category of medical and finance professionals, carers, and other

professionals – were also more frequently linked to neglect for women (26.6%) than men (12.8%). By contrast, men were more likely to report neglect involving their children (39.7%).

For financial harm, children featured more strongly as being the main person responsible for harm reported by women (24.4%) than for men (13%), a statistically significant gap. Other relationships, including partners and ex-partners, siblings, other family members, friends, other (unrelated) people, and professionals, showed no statistically significant gender differences for this subtype.

For psychological harm, children again showed a gendered pattern, with 23.5% of women reporting harm compared to 14.8% of men. Partners and ex-partners were the most common person responsible for men (24.9%) and a frequent source of harm for women (17.3%), with the difference being statistically significant at the 10% level. Neighbours were more often reported by male respondents than female (5.9% versus 2.3%), although the relatively small sample size means this result should be treated with caution. Other family members, friends, and work-related contacts showed no notable gender variation for psychological harm.

Differences by relationship were generally small for physical harm, although men were slightly more likely to report harm from work-related contacts (8.7%) than women. Physical harm from partners or ex-partners, children, or other family members, friends, and neighbours showed no statistically significant gender differences.

For sexual harm, figures for men are suppressed due to low numbers, but women most often identified partners or ex-partners (33.5%) or a friend (29.6%) as the main person responsible (see Section 5.1). No statistically valid gender comparisons can be made due to small sample sizes for sexual harm.

Lastly, there were no statistically significant gender differences across any relationship type for cultural & spiritual harm – both men and women identified work-related contacts as the most common main person responsible of this type of harm (23.6% for men, 19.5% for women).

Table 25: Relationship of the main person responsible for harm, by respondent gender and harm subtype

		All	Neglect	Financial	Psychological	Physical	Sexual	Cultural & spiritual
Partner or ex-partner	Male	23.36	s.	11.52	24.92	8.9	s.	15.51
	Female	20.76	44.9	12.17	17.26	19.69	33.45	8.37
	p-value	*0.50*	*0.02*	*0.91*	*0.08*	*0.20*	*0.09*	*0.32*
Work-related contact	Male	17.46	s.	s.	14.81	8.7	s.	23.61
	Female	14.87	s.	s.	12.85	s.	s.	19.51
	p-value	*0.42*	*s.*	*s.*	*0.60*	*0.05*	*s.*	*0.59*
Other family member	Male	17.31	s.	14.86	14.43	14.78	s.	4.74
	Female	15.01	s.	14.89	14.33	18.75	s.	10.20

		All	Neglect	Financial	Psychological	Physical	Sexual	Cultural & spiritual
	p-value	*0.48*	*s.*	*1.00*	*0.98*	*0.65*	*s.*	*0.18*
Friend	Male	17.19	s.	16.17	9.23	12.76	s.	13.61
	Female	12.20	s.	11.10	6.69	s.	29.64	14.54
	p-value	*0.10*	*s.*	*0.40*	*0.35*	*0.41*	*0.09*	*0.90*
Child	Male	16.7	39.66	12.96	14.84	18.06	s.	10.74
	Female	23.63	17.13	24.39	23.54	25.75	s.	5.99
	p-value	*0.05*	*0.10*	*0.04*	*0.04*	*0.41*	*s.*	*0.34*
Other person	Male	9.69	s.	13.30	4.33	11.83	s.	12.43
	Female	10.22	s.	7.75	5.92	7.00	s.	13.28
	p-value	*0.84*	*s.*	*0.35*	*0.50*	*0.32*	*s.*	*0.89*
Neighbour	Male	9.14	s.	s.	5.93	13.41	s.	4.73
	Female	4.94	s.	s.	2.29	10.11	s.	s.
	p-value	*0.04*	*s.*	*s.*	*0.04*	*0.64*	*s.*	*0.12*
Sibling	Male	7.3	s.	3.70	6.72	s.	s.	5.39
	Female	12.79	s.	6.08	10.26	s.	s.	9.21
	p-value	*0.03*	*s.*	*0.48*	*0.21*	*s.*	*s.*	*0.39*
Professional	Male	5.33	12.81	5.63	s.	s.	s.	4.47
	Female	6.96	26.58	s.	s.	s.	s.	8.37
	p-value	*0.43*	*0.22*	*0.17*	*s.*	*s.*	*s.*	*0.31*
Don't know/Refuse	Male	6.6	s.	17.53	3.46	s.	s.	4.77
	Female	5.68	s.	10.79	6.04	s.	s.	s.
	p-value	*0.68*	*s.*	*0.31*	*0.26*	*s.*	*s.*	*0.38*

Note: Percentage of all respondents in relevant gender category based on the CHI–Very Serious threshold. Some relationship categories have been combined to ensure sufficient counts, consistent with Section 5.1. Reported p-values are based on χ^2 tests, which assess whether the distributions across groups are likely to reflect real differences, rather than chance.

8.2 Age

The overall AOP prevalence rate tends to decrease with age (Figure 22). It was 23.3% for those aged 55–64, 15.3% for those aged 65–74, and 7.9% for those aged 75 and over. The differences are statistically significant.

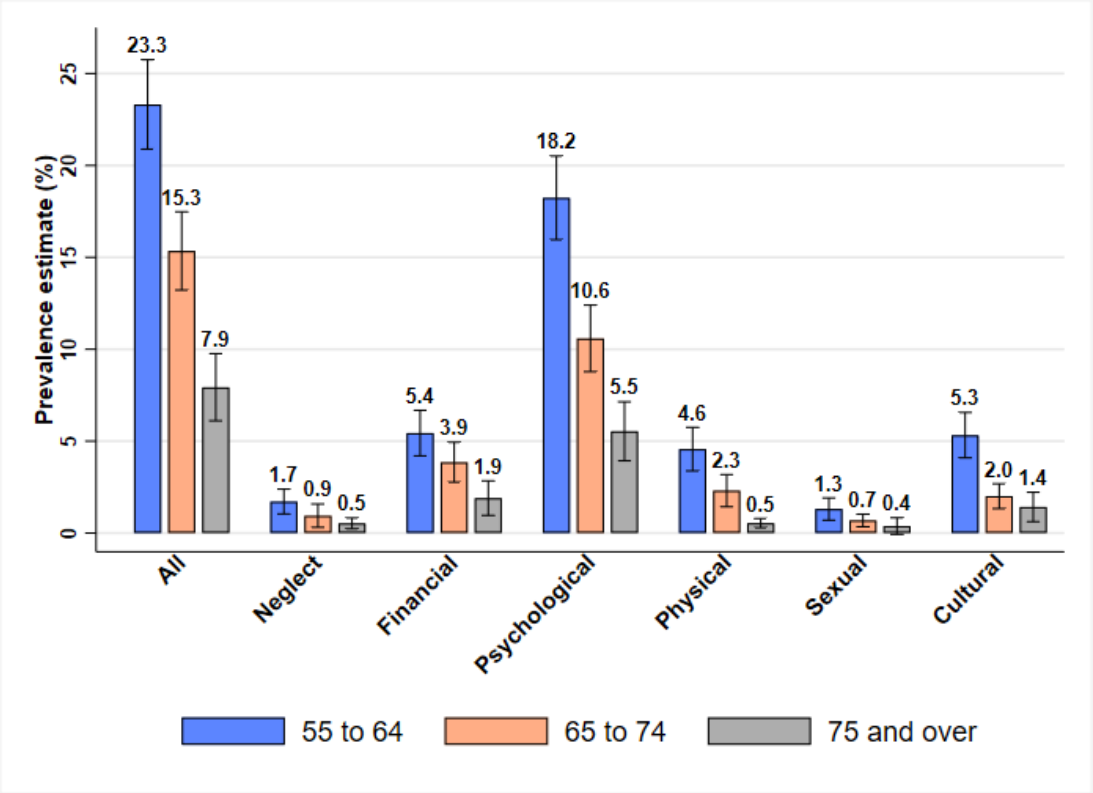
This pattern is consistent across most harm subtypes. For example, for psychological harm, the most common subtype, the prevalence rate was 18.2% for those aged 55–64, falling almost half for those aged 65–74 (10.6%) and then again for those aged 75 and over (5.5%). Likewise, neglect prevalence rates were 1.7% for those aged 55–64 years, 0.9% for those aged 65–74, and 0.5% for those aged 75 and over; sexual harm followed a similar pattern (1.3% versus 0.7% and 0.4%).

Financial harm also showed a clear age gradient. It affected 5.4% of people aged 55–64, compared to 3.9% of those aged 65–74, and 1.9% of respondents aged 75+ years. Younger respondents experienced

cultural & spiritual harm at a similar rate (5.3%) to financial AOP – again higher than older respondents – but the prevalence rates were more similar for the 65–74 and 75+ age groups (2% and 1.4%, respectively).

Lastly, physical harm was also more prevalent for the youngest age group – 4.6% compared to 2.3% (65–74) and 0.5% (75+).

Figure 22: Prevalence by age



Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant age category based on the CHI–Very Serious threshold where relevant.

There are some statistically significant differences in main person responsible between the respondent age groups (Table 26). Likely reflecting higher employment rates for younger respondents, the main person responsible was more likely to be a work-related contact for those aged 55–64 years (21.2% versus 11.8% for those aged 65–74 years). A sibling was also more likely to be the person causing harm for the 55–64 age group (13.6% versus 7% for 65–74-year-olds and 2.7% for those aged 75+).

A professional – a combination of financial, medical, carers and other professionals – was more likely to be the main person responsible for those aged 75+ (15.8% versus 5.5% for those 55–64 years old and 4.2% for those aged 65–74 years). This finding is in line with expectations, as older respondents are more likely to receive professional care compared to younger age groups.

It is also worth noting that respondents aged 55–64 years were less likely to decline to answer or respond "don't know" when asked about the person who caused them harm.

Table 26: Relationship of main person responsible to those experiencing harm, by respondent age (%)

	55–64 years	65–74 years	75+ years	p-value
Partner or ex-partner	23.85	20.66	15.81	*0.34*
Work-related contact	21.24	11.83	s.	*0.00*
Child	20.38	17.91	28.05	*0.22*
Other family member	16.91	14.45	15.72	*0.78*
Friend	15.91	11.98	13.41	*0.46*
Sibling	13.61	7.04	2.74	*0.00*
Other person	8.35	13.47	9.08	*0.19*
Neighbour	6.11	8.83	5.28	*0.41*
Professional	5.46	4.16	15.84	*0.00*
Don't know/Refuse	3.21	10.17	9.63	*0.01*
Observations (unweighted)	**395**	**367**	**194**	
Observations (weighted)	**147,800**	**76,500**	**31,600**	

Note: Percentage of respondents in relevant category who experienced harm based on the CHI–Very Serious threshold. Some relationship categories have been combined to ensure sufficient counts, consistent with earlier analyses. Reported p-values are based on χ^2 tests, which assess whether the distributions across groups are likely to reflect real differences, rather than chance.

Given the stark differences in overall harm rates by age – and noting that much of this variation is driven by psychological harm – it is useful to consider how the different behaviours indicative of psychological harm differ across age groups (Table 27).

Psychological harm is consistently more common among people aged 55–64 and declines steadily with age. Verbal insults or offensive language were the most reported behaviour, affecting 12.5% of those aged 55–64, compared with 7% of those aged 65–74 and just 2.5% of those aged 75 and over. Being undermined or belittled showed a similar pattern, both in private (11.2% for 55–64, falling to 3.3% for 75+) and in public (7.3% dropping to 1.2%).

Social exclusion followed the same trend, with almost one in 10 respondents aged 55–64 reporting they had been excluded or ignored (9.9%), compared with 5.2% of those aged 65–74 and 3.6% of those aged 75+. Other, less common, experiences also fit this pattern. These include being made to feel like "free labour" (4.1% at 55–64 versus 0.7% at 75+) and threats of harm to others (1.4% versus 0.5%). Items reported by very few people – such as threats of self-harm and restrictions on contact with professionals – could not be reliably compared across ages due to small sample counts.

These patterns show that the higher rates of psychological harm among those aged 55–64 reflect a broad range of experiences, especially verbal abuse, belittling, and social exclusion. The prevalence of these

behaviours falls consistently with age, contributing to the much lower overall rates of psychological harm among those aged 75 and over.

Table 27: Prevalence for types of psychological harm, by age (% of all respondents)

	55–64 years	65–74 years	75+ years
Insulted you, called you names or swore at you in a way you found offensive or aggressive	12.51	7.01	2.49
Undermined or belittled you in private	11.23	5.64	3.33
Excluded you or repeatedly ignored you	9.90	5.15	3.56
Undermined or belittled you in public (i.e. in front of others)	7.26	3.31	1.15
Made you feel that you are just free labour	4.10	2.57	0.74
Prevented or restricted you seeing or contacting family members of friends	2.14	1.49	1.07
Threatened to harm others that you care about (e.g. pets, children, relatives, friends)	1.40	0.81	0.52
Threatened to harm themselves if you don't do what they ask	1.25	0.82	s.
Prevented or restricted you seeing or contacting your doctor/nurse or other professional	s.	s.	s.
Done anything else to cause you emotional distress	3.53	2.16	0.94
Observations (unweighted)	**1,672**	**2,123**	**1,784**
Observations (weighted)	**629,900**	**497,400**	**397,000**

Note: Percentage of all respondents. Observation counts differ slightly by item due to variation in the number of "Don't know/Refuse" responses.

The higher rates of psychological harm among people aged 55–64 may reflect their greater exposure to social interactions compared with older groups (Table 28). Most people in this age group remain in the workforce, with almost three-quarters (73.5%) employed, compared with 41.2% of those aged 65–74 and fewer than one in 10 of those aged 75+ (9.7%). Employment increases contact with co-workers, clients, and others, which can create both opportunities for connection and exposure to conflict or mistreatment. As shown in Table 26, a significant number of main person responsible identified as work-related contacts, which helps explain some of the difference in psychological harm by age. Also, to capture these patterns, the survey distinguished between those "not employed" (e.g. unemployed, unable to work due to illness or disability, or outside the labour force for other reasons) and those who are "retired". This recognises that retirement is more common in the older age groups and could have different implications for social exposure.

People aged 55–64 are also more likely to live in larger households, with two in five (39.7%) living with three or more people compared to only one in five (21.8% for 65–74 year olds) and just one in 10 (10.4%) of those aged 75 and over. Larger households may bring more frequent – and potentially more complex – interactions, along with more opportunities for tension or interpersonal harm.

Older age groups, by contrast, are more likely to live alone or with only one other person. About one-third of those aged 75+ live alone (32.9%), while over half live in two-person households (56.7%). These living arrangements reduce day-to-day interactions, which may partly explain their lower rates of psychological harm.

Despite these differences in employment and household size, the frequency of interactions outside the home does not vary as widely. Across all age groups, about half of respondents have contact with others outside their household at least several times a week. This suggests that differences in work and household structure are more likely to drive variations in social exposure – and by extension, potential for psychological harm – than general social contact. It is also possible that the older person is choosing to spend time and stay in touch with those family, whānau, and friends they want to, rather than those who may cause them harm.

Table 28: Social exposure factors by age: Employment, household size, and interactions with others (%)

Social exposure factor		55–64 years	65–74 years	75+ years
Employment status	Employed	73.49	41.19	9.69
	Not employed	20.87	4.51	3.21
	Retired	5.07	54.06	87.04
	Don't know/Refuse	0.57	s.	s.
Household size	One person	17.11	21.04	32.89
	Two people	42.96	57.04	56.67
	Three or more	39.74	21.88	10.37
	Don't know/Refuse	s.	s.	s.
Frequency of interactions with people outside household	Everyday	12.99	12.34	15.37
	Several times a week	31.02	37.82	37.48
	About once a week	25.72	24.69	26.78
	2-3 times a month	14.12	12.28	10.35
	About once a month	6.23	6.13	4.34
	1-2 times every 3 months	4.35	3.24	2.55
	Less than once every 3 months	5.21	3.08	2.76
	Don't know/Refuse	s.	0.42	0.38
Observations (unweighted)		**1,686**	**2,135**	**1,792**
Observations (weighted)		**634,000**	**498,700**	**398,000**

Note: Percentage of all respondents.

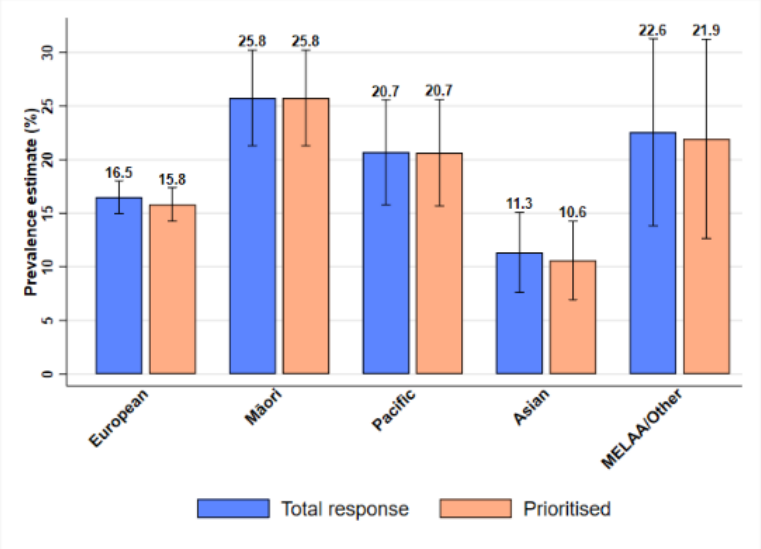
8.3 Ethnicity

Figure 23 shows the overall prevalence rates by ethnicity, using both total response and prioritised ethnicity.[9] There is little difference between the estimates based on total response and prioritised ethnicity; for ease of interpretation, we use prioritised ethnicity throughout this section.

Asian respondents had the lowest prevalence of AOP, at 10.6% (Figure 23). This was followed by European (15.8%), Pacific (20.7%), MELAA & Other ethnicities (21.9%), and Māori (25.8%). The pattern is consistent with earlier NZ evidence from the NZ Longitudinal Study of Ageing (Waldegrave, 2015a; Waldegrave, 2015b), which found higher reported levels of "elder abuse and neglect" among Māori than non-Māori. However, that study used the Vulnerability to Abuse Screening Scale (VASS) with people aged 65+, capturing vulnerability and coercion rather than specific behaviours, so results are not directly comparable.

In contrast, this study used behavioural measures of distinct harm subtypes with thresholds applied. When we control for age, gender, health, and socio-economic factors in multivariate regressions (see Section 9), ethnicity is not a statistically significant predictor of overall harm. This suggests that the raw differences by ethnicity likely reflect broader inequalities in health and social determinants rather than ethnicity itself.

Figure 23: Overall prevalence rates by ethnicity



Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on the CHI–Very Serious threshold. MELAA is Middle Eastern, Latin American & African.

[9] 'Prioritised ethnicity' is where people are allocated to a single ethnic group in an order of priority, even if they identified with more than one ethnicity. Prioritised ethnicity is ordered as Māori, Pacific peoples, Asian, MELAA & Other, NZ European.

Patterns of harm differed across ethnic groups for each subtype of harm (Table 29). Almost one-fifth of Māori respondents experienced psychological harm (19.6%), followed closely by MELAA & Other ethnicities (19%), almost double that of NZ Europeans (11.7%). The rate among Pacific respondents was 13.7%, while Asian respondents had the lowest prevalence of psychological harm (8.1%). These differences were statistically significant according to the chi-squared test (p-value of 0.0), which measures whether observed differences between groups are likely to reflect true variation in the population, rather than being due to chance.

Financial harm was also more common among Māori respondents, more than double the prevalence rate for the NZ European group (8% versus 3.9%). Pacific respondents also experienced a higher rate relative to NZ European and Asian respondents (5.8% versus 3.9% and 2.3%, respectively). A similar pattern is seen for cultural & spiritual harm; Māori respondents had the highest reported rate at 7.2%, well over twice the rate of NZ Europeans (2.6%). Pacific (4.7%) and MELAA & Other ethnicity (5.6%) respondents also reported higher rates, compared to NZ European respondents, while Asian respondents reported cultural & spiritual harm at a similar rate to financial harm (2.3%). These differences are statistically significant.

Following a similar pattern is physical harm; more common among Māori respondents (5.3%) and Pacific respondents (3.8%), compared to NZ Europeans (2.7%), while Asian respondents report the lowest rate (1.1%). These differences were also statistically significant.

In contrast, neglect was reported at similar rates across most groups, ranging from 1%–1.4%, and the differences across ethnic groups were not statistically significant. The small number of underlying counts means that only the rates for NZ European respondents are reported in Table 28 for sexual harm, limiting the ability to detect meaningful differences by ethnicity.

These findings show that Māori respondents reported higher rates of nearly all forms of harm compared to NZ European respondents. Asian respondents consistently reported the lowest rates. These differences likely reflect broader inequities, emphasising the need for culturally appropriate prevention and support.

Table 29: Prevalence by (prioritised) ethnicity (% of all respondents)

Harm subtype	NZ European	Māori	Pacific	Asian	MELAA & Other	*p-value*
All	15.83	25.76	20.65	10.59	21.95	*0.00*
Neglect	1.18	0.96	1.02	1.35	s.	*0.96*
Financial	3.67	7.95	5.75	2.31	s.	*0.00*
Psychological	11.68	19.55	13.66	8.09	19.00	*0.00*
Physical	2.65	5.27	3.81	1.14	s.	*0.01*

Harm subtype	NZ European	Māori	Pacific	Asian	MELAA & Other	*p-value*
Sexual	0.98	s.	s.	s.	s.	*0.60*
Cultural & spiritual	2.63	7.19	4.7	2.3	5.61	*0.00*
Observations (unweighted)	**3,735**	**701**	**498**	**541**	**138**	
Observations (weighted)	**1,133,300**	**153,400**	**61,900**	**138,000**	**44,100**	

Note: Percentage of all respondents based on the CHI–Very Serious threshold where relevant. Exact observation counts differ by harm subtype due to variation in the number of "Don't know/Refuse" responses. Reported p-values are based on χ^2 tests, which assess whether the distributions across groups are likely to reflect real differences, rather than chance.

8.4 Takatāpui and Rainbow communities

Next, we examine whether there are differences between non-Rainbow and Rainbow older people. Members of the Takatāpui and Rainbow communities were identified based on a question about their sexual identity – not heterosexual or straight (i.e. gay or lesbian, bisexual, or another identity) – and/or if their sex at birth was different from their gender identity. This yields 2% of respondents who identify as Rainbow.

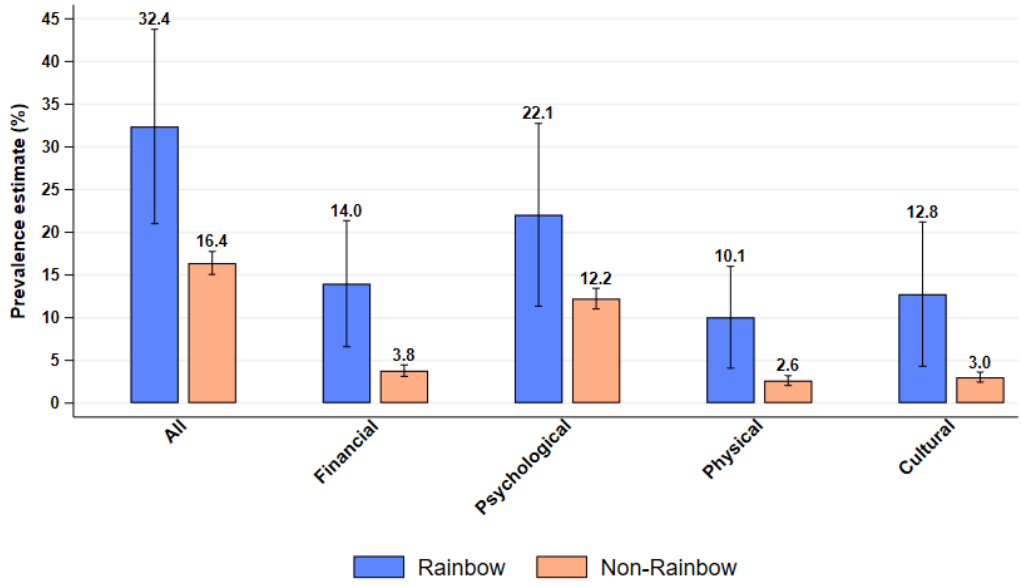
Older people who identify as Rainbow were more likely to report experiencing harm than those who do not (Figure 24). Overall, almost one-third of Takatāpui and Rainbow respondents (32.4%) said they had experienced at least one form of harm in the past 12 months, about twice the prevalence rate for non-Rainbow respondents (16.4%). Despite the wide confidence interval for the Takatāpui and Rainbow communities' prevalence rate due to the small number of underlying counts, it was still statistically significantly higher than non-Rainbow.

This pattern is consistent across harm subtypes. Psychological harm was most common, experienced by slightly over one in five Rainbow respondents (22.1%) versus 12.2% for non-Rainbow respondents, although the difference was not statistically significant. Statistically significant differences were found for the remaining subtypes in Figure 24, except for neglect and sexual harm, which are not displayed due to the small number of underlying counts for the Rainbow group. Financial harm rates were about 10 percentage points higher for Rainbow older people, compared to non- Rainbow (14% versus 3.8%), followed by cultural & spiritual harm (12.8% versus 3%), and physical harm (10.1% versus 2.6%). For these harm subtypes, older people in the Takatāpui and Rainbow communities are approximately four times more likely to experience harm than non-Rainbow.

The higher prevalence of AOP across harm subtypes reflects the compounding effects of marginalisation and social exclusion over time. These findings are consistent with international research showing that members of the Takatāpui and Rainbow communities may face greater risks of harm due to past discrimination, fractured support networks, or reduced access to services that feel safe or inclusive

(Almack & King, 2019; Fredriksen-Goldsen, 2011; Knochel et al., n.d.). The data underline the importance of ensuring that AOP prevention and response efforts actively consider and include the needs of Takatāpui and Rainbow communities.

Figure 24: Prevalence by Takatāpui and Rainbow status



Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on the CHI–Very Serious threshold where relevant. Sexual harm and neglect omitted due to small underlying counts.

8.5 Household size

Overall rates of harm were significantly higher for people living alone (20.4%), or in households with three or more people (19.1%), compared with those living with one other person (13.9%) (Figure 25). Prevalence rates are not reported for sexual harm, due to small underlying counts.

The harm subtypes follow a similar pattern. Psychological harm was most common among those living alone (14.6%) and in larger households (14.2%), and lower among people living with one other person (10.6%). Likewise, physical harm was also highest among people living alone (4.9%) and lowest in two-person households (1.5%).

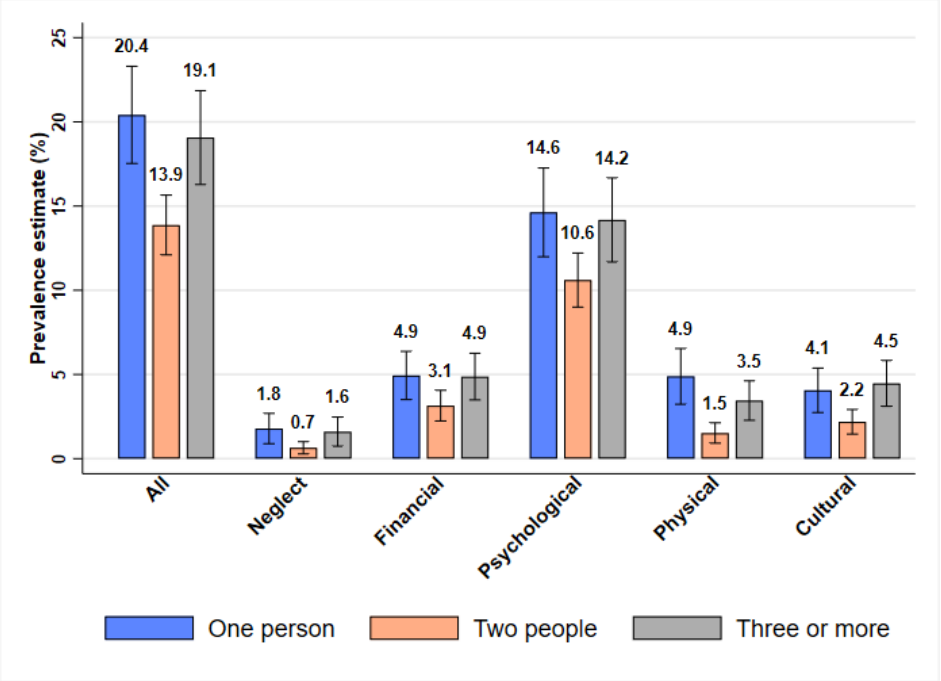
It is possible that many people living with one other person are living with a partner or spouse, potentially explaining the lower overall prevalence of harm in this group. This is examined in Section 8.6. For many, having a trusted partner at home may reduce isolation, provide emotional support, and offer protection against some forms of harm. In contrast, those living alone may have fewer informal supports available, and be more at risk of harm from people outside their household. On the other end of the

spectrum, larger households may involve more complex family dynamics or caregiving roles, which could introduce other risks.

Neglect and financial harm were slightly more common among people living alone than two-person households, possibly reflecting greater reliance on others for support or assistance. Perhaps reflecting the risks mentioned previously, cultural & spiritual harm was more common in larger households (4.5%) and among those living alone (4.1%) than in two-person households (2.2%).

These findings highlight the need to consider both the protective and risk factors that come with different household arrangements. Support services and harm prevention strategies should be responsive to these dynamics. This ensures that those living alone are not socially isolated or overlooked, and that older people in larger or multi-generational households have safe avenues for support if harm is occurring within the home.

Figure 25: Prevalence by household size



Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on the CHI–Very Serious threshold where relevant. Sexual harm excluded due to small underlying counts.

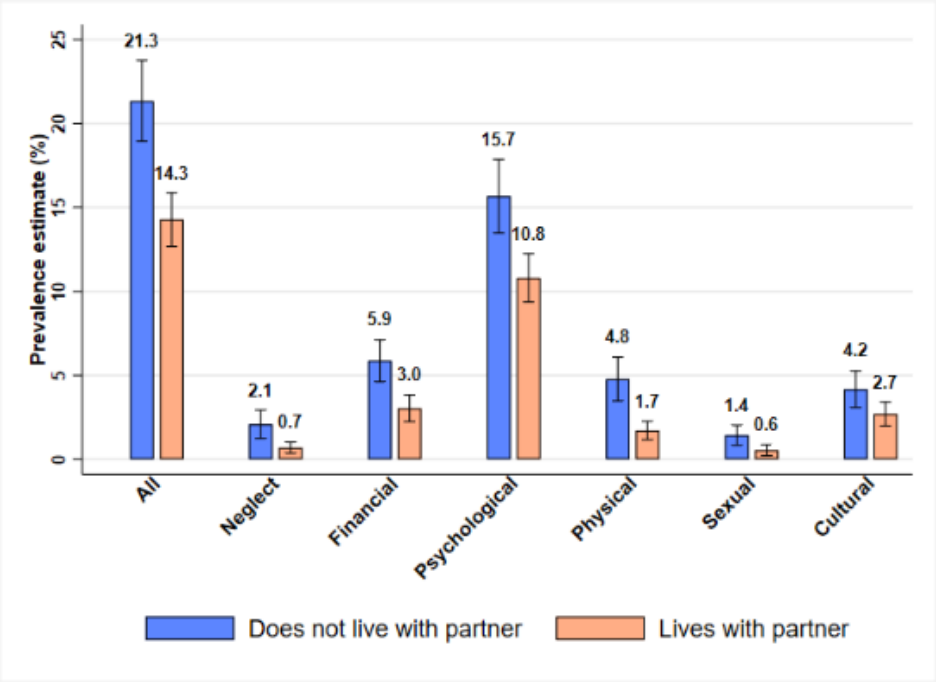
8.6 Living with their partner

Consistent with the results in Section 8.5 that those in two-person households have significantly lower rates of harm, Figure 26 shows those living with their partner or ex-partner have lower overall rates of harm (14.3%) than those not living with a partner or ex-partner (21.3%). This pattern is repeated across

all harm subtypes. For example, the rate of neglect is 2.1% for those not living with a partner, over double than the 0.7% for those living with a partner. For financial harm, the comparison is similar (5.9% versus 3%) and sexual harm (1.4% versus 0.6%) – the difference is starker for physical harm (4.8% versus 1.7%). Those living with a partner are also less likely to experience psychological harm (15.7% versus 10.8%), as is the case for cultural & spiritual harm (4.2% versus 2.7%).

For many respondents, living with a partner appears to offer a protective effect against harm. Across all subtypes, those living with a partner consistently reported lower rates of harm than those who were not. Although intimate partners (and ex-partners) were commonly reported as the main person causing harm (see Section 5.1), the findings suggest that for many older people, living with a partner may reduce exposure to harm.

Figure 26: Prevalence by whether or not respondent lives with their partner



Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on the CHI–Very Serious threshold where relevant.

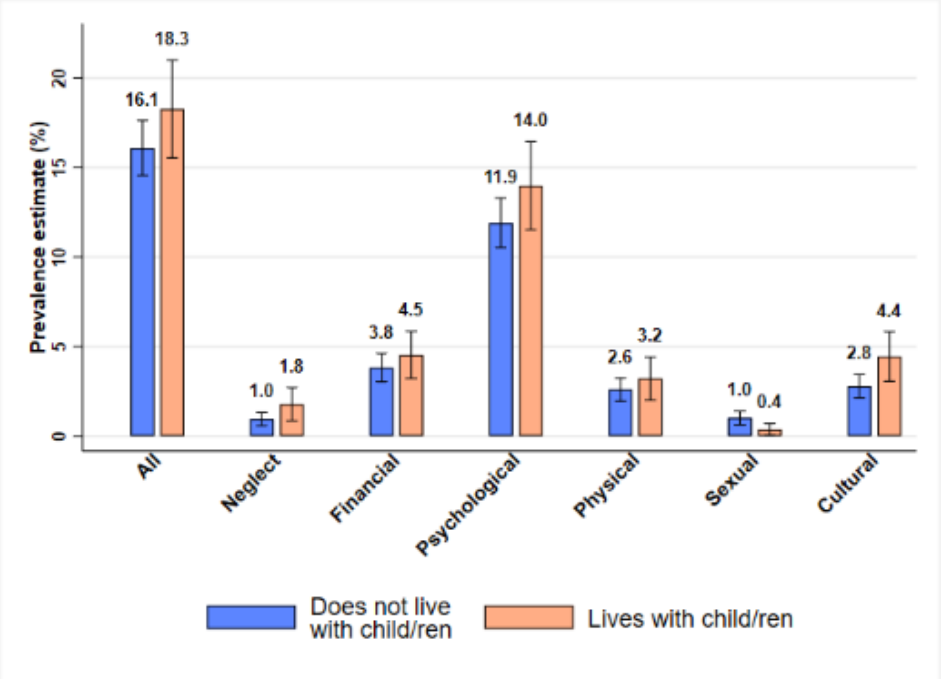
8.7 Living with their children

Older people who live with their children reported slightly higher rates of harm than those who do not (Figure 27), although the differences are not statistically significant. Overall, 18.3% of those living with their children said they experienced some form of harm in the past 12 months, compared to 16.1% of those who do not live with their children.

This pattern held for several types of harm, with sexual harm the only subtype where the prevalence rate among those living with children (0.4%) was lower than those not living with their children (1%). Psychological harm was reported by 14% of those living with children, compared to 11.9% of those who do not. Financial harm was also slightly higher among those living with children (4.5% versus 3.8%). Cultural & spiritual harm was reported by 4.4% of those living with children, compared to 2.8% of those who do not. Likewise, rates of neglect were higher among those living with children (1.8% versus 0.9%), as were rates of physical harm (3.2% versus 2.6%). However, none of these differences were statistically significant.

This variation may reflect the complex dynamics that can arise in multi-generational households. While living with family can offer support, it can also bring increased exposure to harm, particularly in situations where roles and expectations are unclear, caregiving is involved, financial stress is shared or financial resources exploited. It may also reflect a broader range of interactions between people in the home. Understanding the context of co-residence with children, and ensuring that older people in these households have access to appropriate support if harm is occurring, is important for prevention and response to AOP.

Figure 27: Prevalence by whether or not respondent lives with their child/ren



Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on the CHI–Very Serious threshold where relevant.

8.8 Home ownership

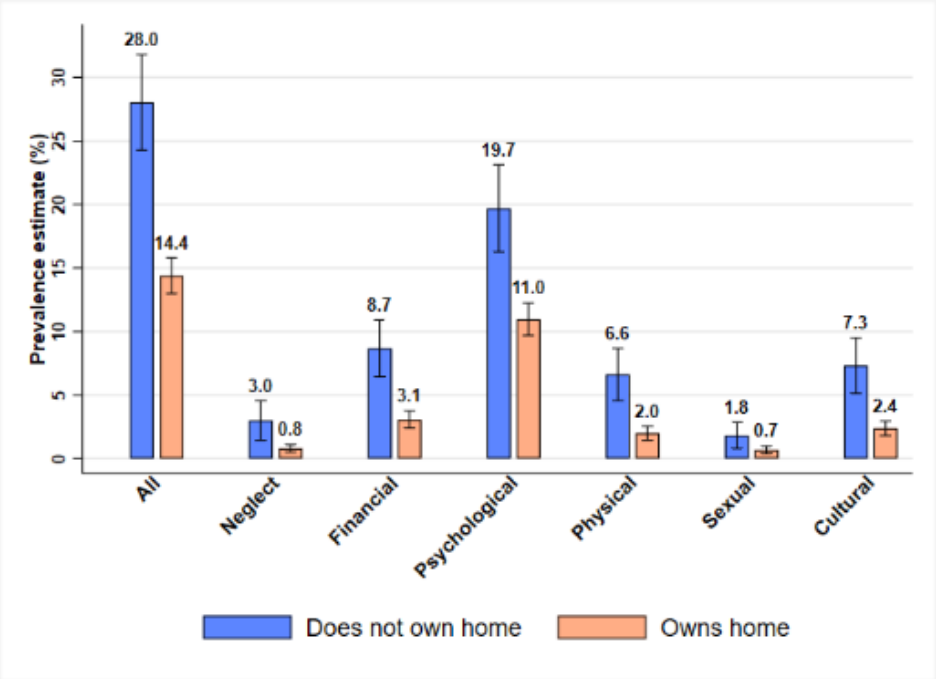
Older people who do not own their home[10] reported much higher rates of harm than those who do (Figure 28). Overall, over one-quarter of non-homeowners experienced some form of harm in the past 12 months (28.0%), compared to 14.4% of homeowners. The difference is statistically significant.

This pattern was consistent across all harm subtypes, with non-homeowners having statistically significant higher rates of harm. Psychological harm was the most common subtype, reported by almost one-fifth of non-homeowners (19.7%) – about double the rate of homeowners (11%). Financial harm (8.7% versus 3.1%), physical harm (6.6% versus 2%), and cultural & spiritual harm (7.3% versus 2.4%) were all roughly three times more common for those who do not own their home. Neglect was reported by 3% of non-homeowners, compared with 0.8% of homeowners, and sexual harm by 1.8% versus 0.7%.

These findings suggest that older people who do not own their home may face increased risks of harm across multiple areas. Housing insecurity, lower material resources, or dependence on others for accommodation may contribute to power imbalances or limit the ability to seek help. Non-homeowners may also be more likely to live in shared, intergenerational, or unstable housing arrangements where harm is more likely to occur or be harder to avoid. These results highlight the importance of considering housing status in AOP prevention and support efforts. Given wider trends of declining home ownership among older New Zealanders (BERL, 2024; Saville-Smith, 2019), housing tenure may become an increasingly important factor in future risk profiles.

[10] We define a homeowner as including those who own the home they live in with or without a mortgage or family trust and/or have a right to occupy their home in a retirement village.

Figure 28: Prevalence by home ownership status



Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on the CHI–Very Serious threshold where relevant. "Owns home" includes those who own the home they live in with or without a mortgage or family trust and/or have a right to occupy their home in a retirement village

8.9 Household income

There was no strong or consistent pattern between household income and rates of harm (Table 30). People with household incomes of less than $50,000 and between $50,000–$100,000 had slightly higher overall rates of harm (16.7% and 17.9%, respectively) than those earning more than $100,000 (14.9%). However, these differences were not statistically significant.

The only harm subtype with a (marginal) statistically significant difference between the income groups was financial harm, where the rates were higher among those with incomes under $50,000 (4.5%) and those who did not provide income information (4.9%) compared to those earning $50,000–$100,000 (3.8%) and more than $100,000 (2.5%).

One explanation for the weak association between income and harm may be that income does not accurately reflect financial wellbeing later in life. Many older people are on fixed incomes, particularly those over 65 receiving NZ Superannuation, but may own their homes outright or have other financial assets. Conversely, older people with higher household incomes may still face financial pressures due to debt, care costs, or family obligations. This could help explain why the patterns by income differ from those based on home ownership, where the differences in harm were more pronounced and consistent.

It is also important to note that a relatively large share of respondents either did not know or refused to provide their household income. This "Don't know/Refuse" group reported a similar rate of harm (17.4%) as the mid-income range. While we cannot directly assess their financial situation, the high non-response rate may reflect economic uncertainty, privacy concerns, or complex household arrangements – all of which can relate to risk of harm.

Overall, these findings suggest that household income is a limited indicator of AOP risk for older people. A more complete picture would consider income alongside other factors such as net worth, financial responsibilities and expenses, housing security, social connection, caregiving roles, and access to support.

Table 30: Prevalence by household income, overall and by harm subtype

	Less than $50k	$50k–$100k	More than $100k	Don't know/Refuse	p-value
All	16.64	17.86	14.89	17.40	*0.45*
Neglect	1.62	1.46	0.52	1.09	*0.15*
Financial	4.54	3.78	2.53	4.89	*0.07*
Psychological	12.50	13.55	12.44	11.60	*0.73*
Physical	3.13	2.82	2.06	3.07	*0.55*
Sexual	0.79	0.91	0.68	1.04	*0.83*
Cultural	3.08	3.86	2.62	3.36	*0.56*
Observations (unweighted)	**1,071**	**1,167**	**1,568**	**1,807**	
Observations (weighted)	**369,000**	**333,100**	**350,900**	**477,800**	

Note: Percentage of all respondents based on the CHI–Very Serious threshold where relevant. Exact observation counts differ by harm subtype due to variation in the number of "Don't know/Refuse" responses. Reported p-values are based on χ^2 tests, which assess whether the distributions across groups are likely to reflect real differences, rather than chance.

8.10 Qualification level

There were no statistically significant differences in overall harm prevalence by qualification level (Table 31). Rates were broadly similar across groups: 15.3% among those with secondary education or less, 18.5% for those with post-school qualifications, and 16.7% for those with a bachelor's degree or higher. This pattern held across all harm subtypes, with no clear trend indicating higher or lower risk based on education. While sexual harm appeared slightly more common among those with higher qualifications (1.4%), this difference was not statistically significant and may reflect small underlying sample sizes. Overall, these findings suggest that qualification level is not strongly associated with experiences of harm.

These results could also be read alongside age. Younger respondents (aged 55–64) are more likely to hold post-school or tertiary qualifications, and they also have higher employment rates and income from work, as well as having the highest AOP prevalence rates. Education, employment, and age are related,

and the patterns shown in Table 31 may reflect these correlations rather than an independent qualification effect. Regression analysis presented in Section 9 confirms that qualification is not a significant predictor of harm once other factors are controlled for.

Table 31: Prevalence by qualification level, overall and by harm subtype

	Secondary or less	Post-school	Bachelor's or higher	Don't know/ Refuse	p-value
All	15.26	18.53	16.73	10.10	*0.12*
Neglect	0.97	1.67	0.81	s.	*0.20*
Financial	3.71	4.77	3.52	s.	*0.30*
Psychological	11.37	13.78	12.49	s.	*0.18*
Physical	2.60	3.01	2.85	s.	*0.79*
Sexual	0.73	0.59	1.41	s.	*0.10*
Cultural	3.05	3.29	3.41	s.	*0.96*
Observations (unweighted)	**2,313**	**1,871**	**1,375**	**54**	
Observations (weighted)	**590,300**	**519,300**	**409,300**	**11,800**	

Note: Percentage of all respondents based on the CHI–Very Serious threshold where relevant. Exact observation counts differ by harm subtype due to variation in the number of "Don't know/Refuse" responses. Reported p-values are based on χ^2 tests, which assess whether the distributions across groups are likely to reflect real differences, rather than chance.

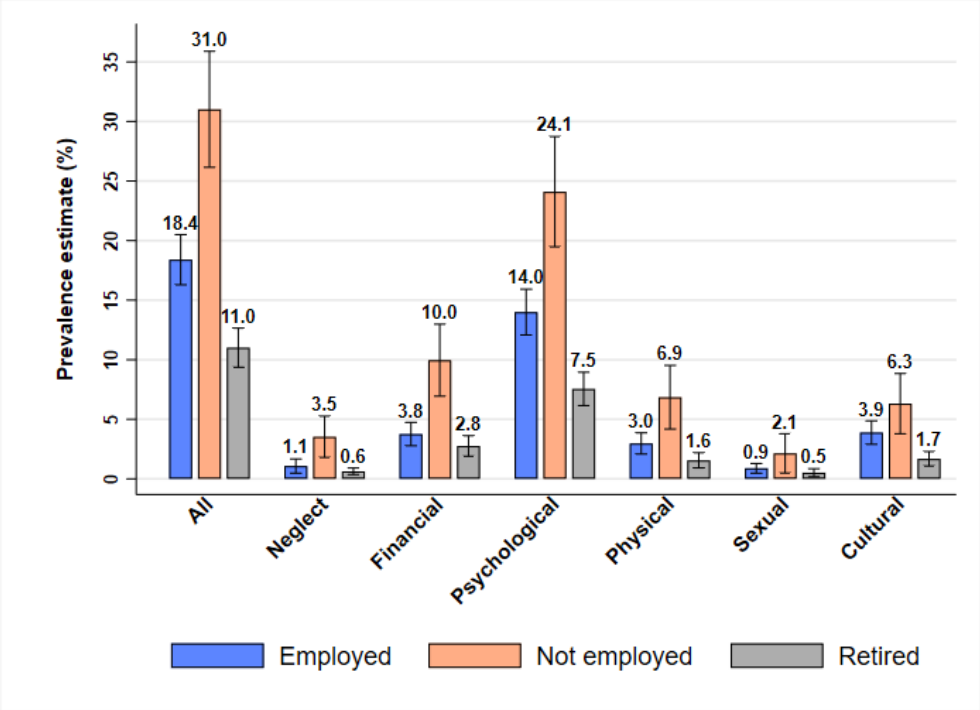
8.11 Employment status

There are clear differences in AOP prevalence rates by employment status (Figure 29). Those who are not employed (whether not in the labour force, or unemployed) had the highest overall prevalence rate of nearly one-third (31%), followed by those who are employed (18.4%), while those who are retired had the lowest rate (11%).

All harm subtypes follow a similar pattern. The differences for psychological harm are particularly stark because overall prevalence is higher than for other harm types. Prevalence rates are almost one-quarter for those who are not employed (24.1%), 10 percentage points higher than employed respondents (14%), and lower again for retirees (7.5%).

As discussed in Section 8.2, those who are employed may face greater exposure to social interactions that increase the risk of interpersonal harm, particularly within work settings. For those who are not employed, higher rates of harm may also reflect greater risk linked to financial stress, health issues, or reliance on others for support. In contrast, the lower prevalence among retired individuals may reflect both reduced exposure to social conflict and greater stability in living arrangements and relationships.

Figure 29: Prevalence by employment status



Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on the CHI–Very Serious threshold where relevant.

Reflecting this, for employed respondents, the most common relationship between the main person responsible for harm and the older person is a work-related contact (27% of those experiencing harm), almost four times higher than for those who are not employed (7%), and just 2.6% for those who are retired (Table 32). While these rates might be expected to be zero for older people not currently employed, this likely reflects timing differences – some may have experienced harm while still employed within the past 12 months. For retired respondents, it may also indicate that they are primarily retired but undertake part-time, casual, or volunteer roles. It is also possible that some maintain contact with former colleagues or workplace associates, meaning that employment-related relationships continue to be relevant even after formal retirement.

Another notable – and statistically significant – difference is the main person responsible was more likely to be a friend for those who were not employed (20.9% versus 11.2% for those who were employed and 14.7% for retirees). The main person responsible was also less likely to have been a sibling for those who are retired (4.8% versus 13.2% for employed respondents and 10.9% for those who are not employed). Note, however, that the "employed" category is skewed by work-related perpetrators, who account for 27% of harm in this group but very little in the other categories.

Table 32: Relationship of main person responsible to those experiencing harm, by respondents' employment status

	Employed	Not employed	Retired	p-value
Work-related contact	26.97	6.95	2.60	*0.00*
Partner or ex-partner	21.92	25.94	19.55	*0.52*
Child	16.41	23.98	25.53	*0.11*
Other family member	13.60	21.49	16.88	*0.13*
Sibling	13.24	10.90	4.80	*0.05*
Friend	11.15	20.91	14.70	*0.02*
Other person	10.16	8.99	10.61	*0.89*
Professional	5.41	5.45	8.89	*0.48*
Neighbour	5.00	8.91	8.73	*0.22*
Don't know/Refuse	5.77	3.84	8.45	*0.46*
Observations (unweighted)	**408**	**166**	**376**	
Observations (weighted)	**130,600**	**52,000**	**71,400**	

Note: Main person responsible for harm. Percentage of respondents in relevant category who experienced harm based on the CHI–Very Serious threshold. Reported p-values are based on χ^2 tests, which assess whether the distributions across groups are likely to reflect real differences, rather than chance.

8.12 Disability status

Disability status is based on the Washington Short Set questions; neurodivergent status is assessed separately and is also included in this section. 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).
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.).[11]

AOP prevalence rates are much higher for those with high functional limitations than those with no or low functional limitations (Figure 30). The overall prevalence rate is over one in four for those with high functional limitations (27.7%); prevalence almost halves for those with no or low functional limitations

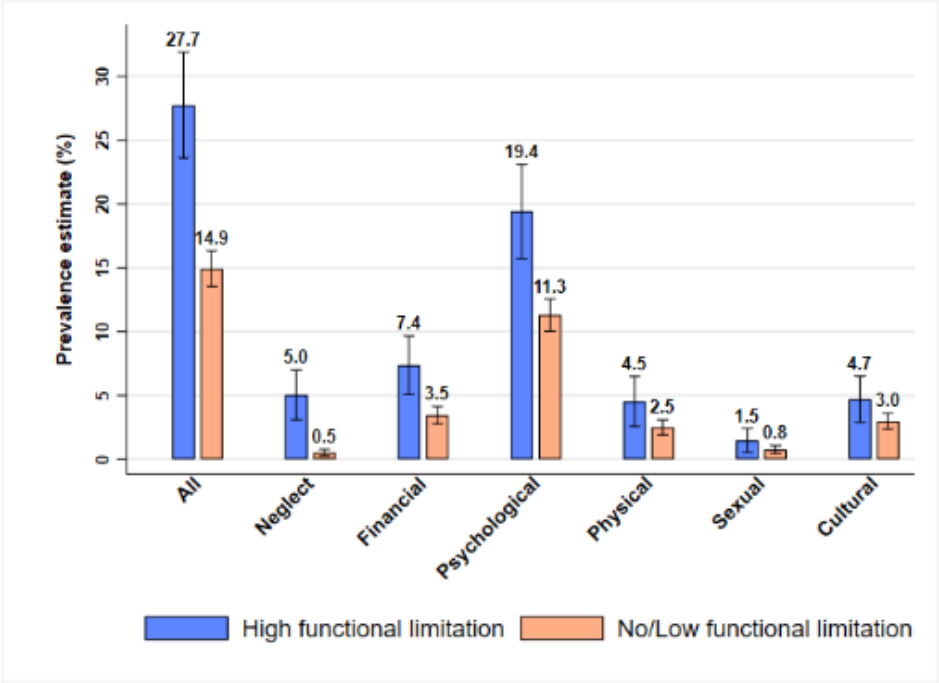
[11] The Washington Short Set is an internationally recognised tool for measuring disability; it is used in the NZ Census and other official surveys. The Social Investment Agency classification is widely used in NZ research and policy, allowing for comparability with other datasets.

(14.9%). The patterns are similar for all harm subtypes, and statistically significant for neglect, financial and psychological harm.

There is very little neglect among respondents with no or low functional limitations (0.5%), about one-tenth of that for those with high functional limitations (5%). Those with functional limitations are more reliant on others to assist them with their day-to-day activities and are therefore more at risk of 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 these activities.

Financial harm is also more prevalent among those with high functional limitations (7.4% versus 3.5%), as is psychological harm (19.4% versus 11.3%), physical harm (4.5% versus 2.5%), sexual harm (1.5% versus 0.8%), and cultural harm (4.7% versus 3%).

Figure 30: Prevalence by disability status



Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on the CHI–Very Serious threshold where relevant.

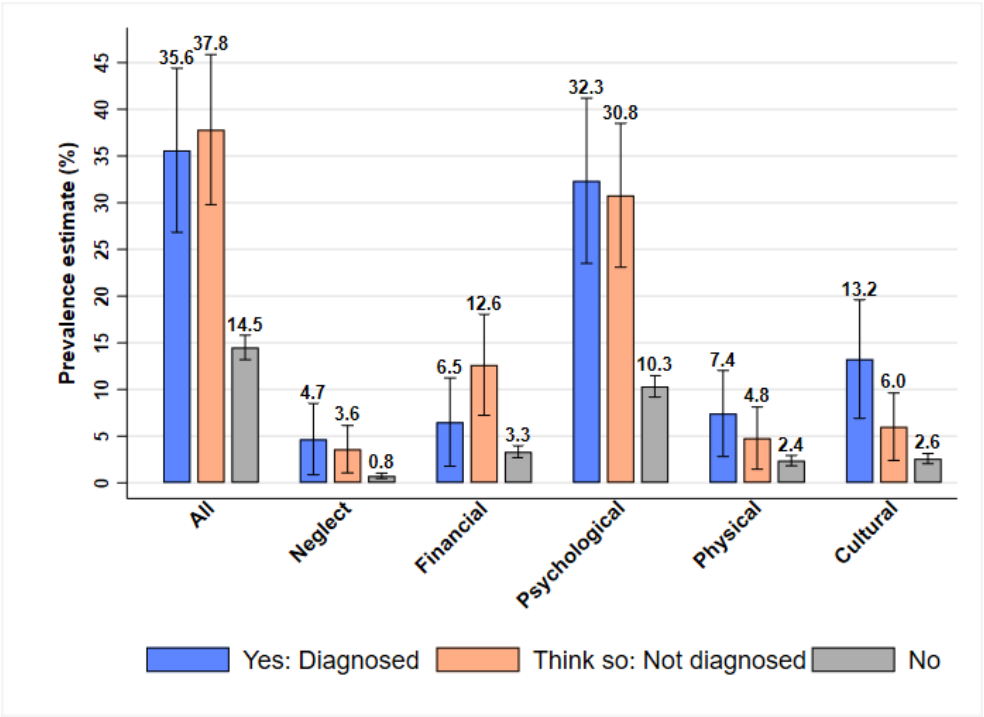
There are also clear differences by neurodivergent status (Figure 31). The overall harm rates among those with a diagnosed neurodivergent condition (such as autism or ADHD), or a suspected but undiagnosed one, are similar at slightly over one-third (35.6% and 37.8%, respectively). This is more than twice that of those who do not have a neurodivergent condition (14.5%).

There are clear differences in harm prevalence by neurodivergent status. Around one in three people who identified as neurodivergent – whether diagnosed (35.6%) or suspected but undiagnosed (37.8%) – experienced harm, compared with 14.5% of those who did not identify as neurodivergent.

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 suspected (30.8%) 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) and for cultural & spiritual harm (13.2% for diagnosed versus 2.6% for non-neurodivergent). 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.

However, these results should be interpreted with caution. The number of respondents identifying as neurodivergent was relatively small – around 9% of the total sample, split between those with a diagnosis and those who suspected they were but had not been diagnosed. This limits the precision of estimates, especially when looking at harm subtypes. Due to limited sample size, neurodivergence is not included in the multivariate regression analysis in Section 9 and is instead reported descriptively.

Figure 31: 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. Sexual harm omitted due to small underlying counts.

8.13 Health status

This section considers three measures of health status: self-rated physical health, mental health status, and psychological distress. For some measures, sexual harm is not reported due to small sample sizes.

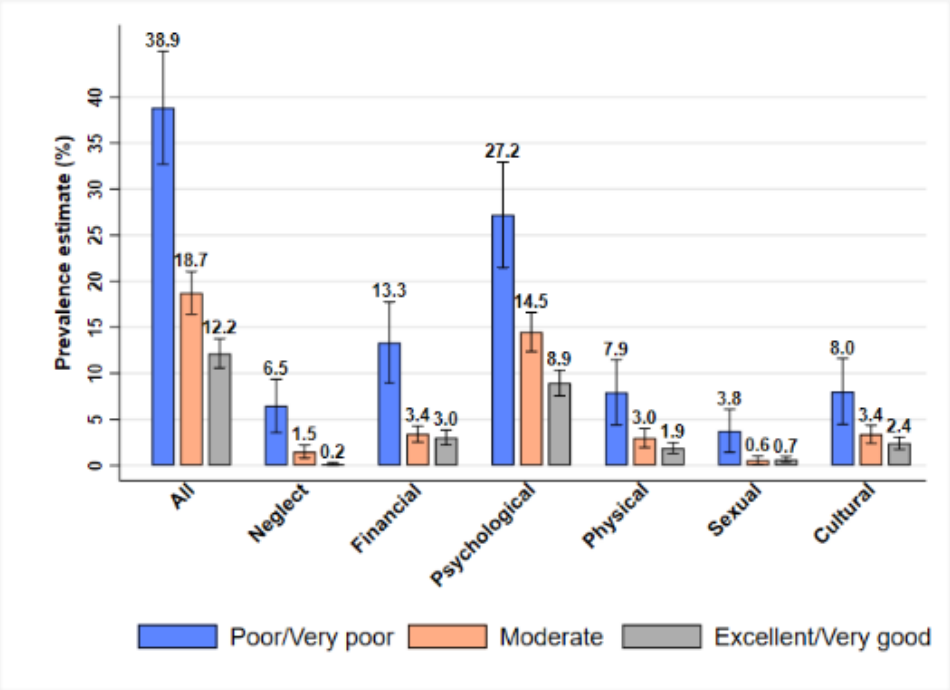
Taken together, the findings discussed here highlight the association between harm and mental health challenges. However, the direction of this relationship cannot be determined from the survey data. It is possible that poor mental health increases the risk of harm, while harm itself may also contribute to or worsen mental health difficulties. Further research is needed to better understand this association and the pathways linking harm and mental wellbeing.

As with disability status, there are clear differences by self-rated physical health (Figure 32). Those with poor or very poor self-rated physical health had an overall AOP prevalence rate of 38.9%, roughly twice that of those who rated their health as moderate (18.7%), and about three times higher than those who rated it as very good or excellent (12.2%).

All harm subtypes follow a similar pattern. The differences are particularly stark for neglect (6.5% for those with poor or very poor health versus 1.5% for those with moderate health and 0.2% with very good or excellent health). As with disability, those with poor health may be more at risk of neglect because they are more reliant on others to assist them with their day-to-day activities. More than two-thirds (68.4%) of those with poor or very poor self-rated physical health need help with day-to-day activities, versus 41.4% of those with moderate health, and 19.6% of those with very good or excellent health.

The differences are also stark for financial harm. Those in poor or very poor health have an almost 4.5 times greater risk of financial harm than those in very good or excellent health (13.3% versus 3.0%). The much higher rate of financial harm among those in poor health may reflect increased dependence on others, reduced oversight of financial matters, or opportunistic behaviour by those around them. As people become more unwell, they may be seen as more vulnerable, leading some to take advantage of the situation.

Figure 32: Prevalence by self-rated physical health status

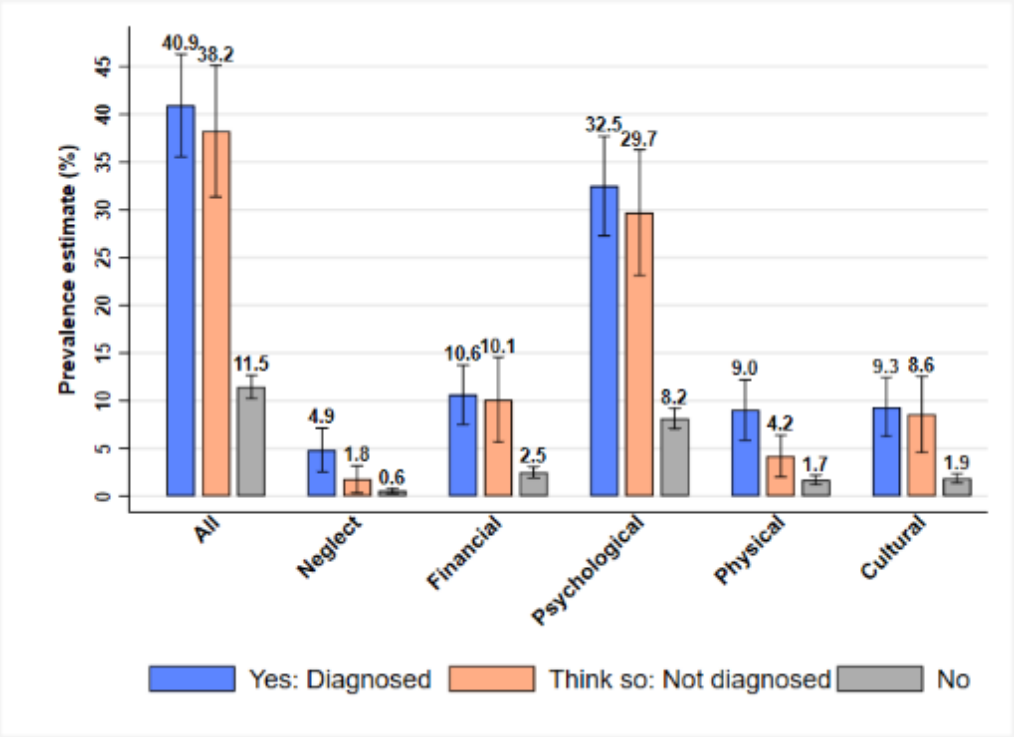


Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on the CHI–Very Serious threshold where relevant.

The overall pattern of harm is also striking when broken down by mental health status (Figure 33). While only 11.5% of people without a mental health condition experienced harm, this rate was much higher among those with a diagnosed condition (40.9%) and those with a suspected but undiagnosed condition (38.2%).

The differences are especially large – and statistically significant – for psychological harm. Nearly one-third of people with a diagnosed or suspected mental health condition experienced psychological harm (32.5% and 29.7%, respectively), compared with just 8.2% of those without. Statistically significant differences were also found for financial harm (around 10% for those with a condition or suspected condition, compared with 2.5% for those without) and for cultural & spiritual harm (9.3% and 8.6% for those with diagnosed or suspected conditions, versus 1.9% for those without).

Figure 33: Prevalence by mental health status



Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on the CHI–Very Serious threshold where relevant. Sexual harm excluded due to small underlying counts.

The differences are even more marked by psychological distress, as measured by the Kessler K6 scale (Figure 34).[12] Those who have a moderate or high level of psychological distress have an overall prevalence rate that is about three times higher than that of those who are likely to be well (37.6% versus 12.0%). Almost all differences by harm subtype are statistically significant. The difference for psychological harm is particularly large, with those experiencing psychological distress having a prevalence rate of 29.4% versus 8.7% among those who are likely to be well.

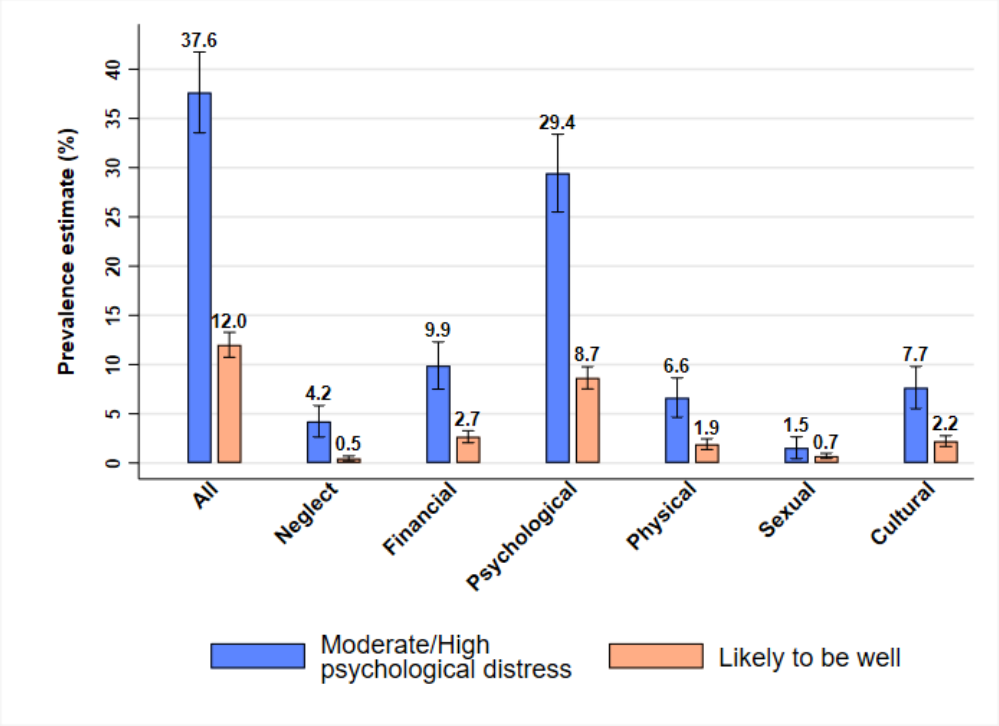
Psychological distress is distinct from having a diagnosed mental health condition. A person may experience distress without meeting criteria for a condition, while others with a diagnosed condition may not report high current distress. This means the two measures capture related but different aspects of wellbeing.

As with the mental and self-rated physical health findings presented above, these results show a strong association between psychological distress and AOP. The survey cannot determine the direction of this

[12] The Kessler Psychological Distress Scale (K6) is a short international screening tool designed to capture non-specific psychological distress in population surveys. Scores range from 0–24. Scores of 0–4 indicate someone is "likely to be well", while scores of 5–24 indicate moderate or high distress (moderate 5–12 combined with high 13–24).

relationship. It is possible that distress increases vulnerability to harm, while experiencing harm may also contribute to distress. Further research is needed to understand these pathways more clearly.

Figure 34: Prevalence by Kessler psychological distress



Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on the CHI–Very Serious threshold where relevant.

8.14 Support networks

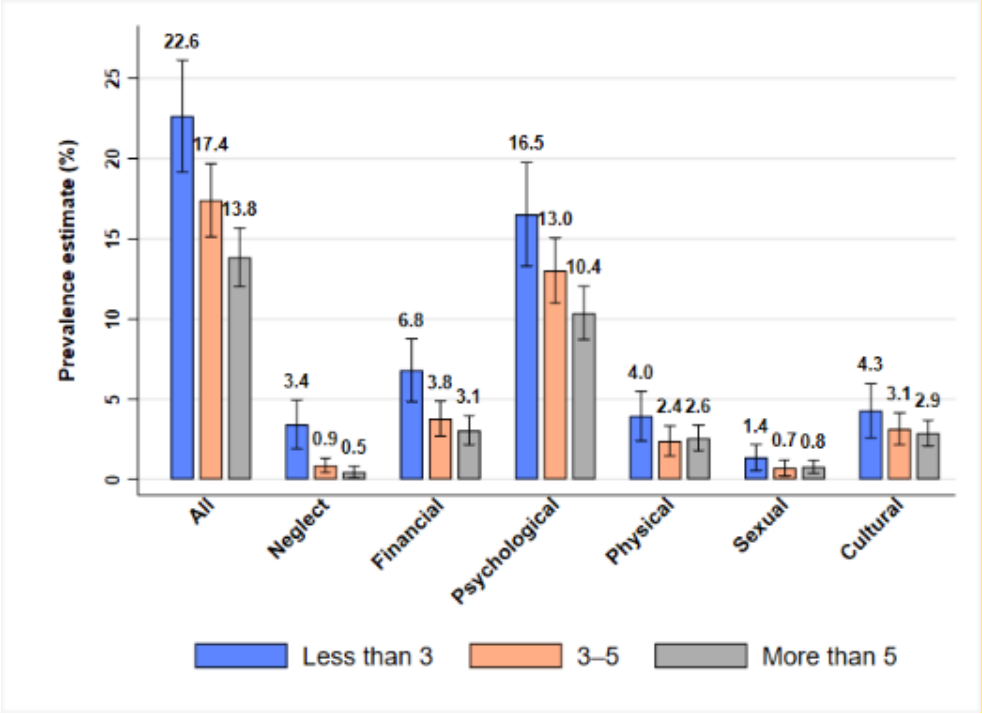
This section looks at AOP by the number of people that the respondent can rely on for help, the ease with which the respondent can get practical help from their family, whānau, and social network, and whether they receive (paid) professional care.

Those who have more people they can rely on for help tend to have lower AOP prevalence, although not all the differences are statistically significant (Figure 35). The overall prevalence rate for those with less than three people they can rely on was 22.6%, versus 17.4% for those who have between three and five people, and 13.8% for those who have more than five people. While not all differences are statistically significant, the pattern is consistent across most harm subtypes.

For example, neglect was more common among those with limited support networks. The neglect rate was 3.4% among those who had less than three people to rely on, versus 0.9% for those who had between three and five people, and 0.5% among those who had more than five people. Financial harm

displays a similar pattern – it is more prevalent for those with fewer than three people to rely on for help if they have a problem (6.8%), almost double the rate for those with wider support networks (3.8% for those who can rely on three to five people; 3.1% for those with more than five people to help).

Figure 35: Prevalence by number of people a respondent can rely on for help



Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on the CHI–Very Serious threshold where relevant.

Differences in prevalence rates by how easy it is for the respondent to get practical help from their familial or social network were even more pronounced (Figure 36). Those who find it difficult or very difficult to get practical help had an overall prevalence rate of 48.6%, versus 34.9% for those who find it possible to get practical help, and 13.0% for those who find it easy or very easy.

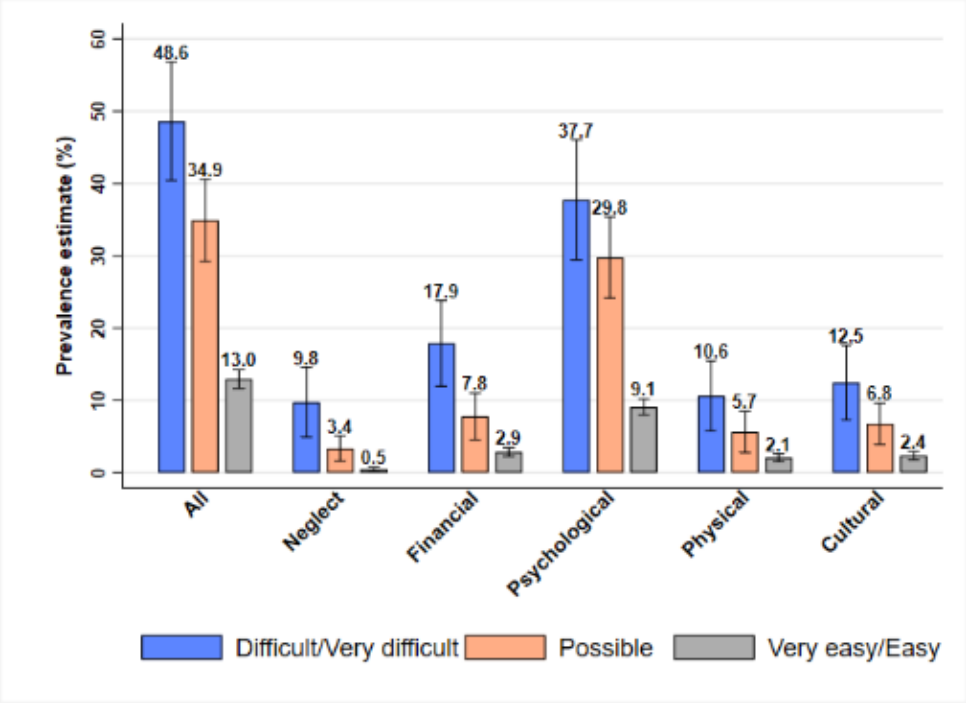
The patterns for harm subtypes were similar, although not all the differences were statistically significant. For example, those who find it difficult or very difficult to get practical help had a neglect rate of 9.8% versus 0.5% among those who find it easy or very easy. As was the case for support networks, financial harm followed neglect – a little over one in six of those experiencing financial harm find it difficult or very difficult to receive practical help from family, whānau, friends or neighbours, the rate falling by over half for those who said it was possible to receive practical help (7.8%). For those who said it was easy or very easy to access practical help from those in their family and social network, less than 3% reported financial harm. The differences for psychological harm are particularly large, ranging from 37.7% for those who find it difficult or very difficult to get practical help, to 9.1% for those who find it easy or very easy – the

latter is about one-third of the prevalence rate compared to those who said it was possible for them to receive practical help (29.8%).

The importance of practical, reliable support in relation to harm is clear. While not all associations are statistically significant, the gap between those who find it difficult to receive practical or reliable help from people they know and those who find it easy is large. This shows a strong association between the strength and accessibility of one's support network and the likelihood of experiencing AOP, although the survey cannot determine causality.

However, much like physical and mental wellbeing, the relationship may also work in the opposite direction, particularly for neglect. Older people who experience harm, such as being let down or excluded by those they know, may rate their support network as smaller or less reliable as a result. In this way, harm may reduce trust or access to help, contributing to the pattern of limited support being linked with higher rates of harm.

Figure 36: Prevalence by how easy it is to get practical help from people respondent knows

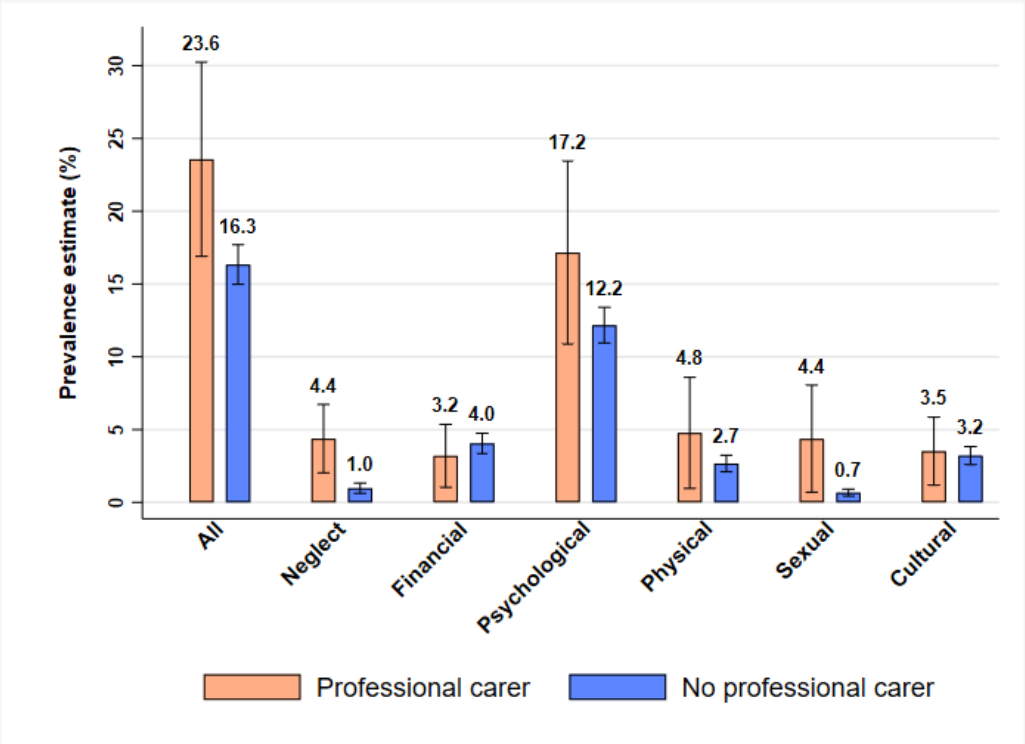


Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on the CHI–Very Serious threshold where relevant. Sexual harm excluded due to small underlying counts.

There are also differences in whether or not the older person receives care at home from a professional carer, although the confidence intervals are wide for those who receive professional care due to small underlying counts for this group (Figure 37). However, there are statistically significant differences for neglect. Those who receive care from a professional carer have a neglect rate of 4.4%, more than four times higher than those who do not. This may reflect challenges in care relationships, including unmet

expectations or gaps in service provision. It may also be linked to higher levels of need among those receiving care, which can increase reliance on others and raise the risk of harm if support is inadequate.

Figure 37: Prevalence by whether respondent received care from a professional carer



Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on the CHI–Very Serious threshold where relevant.

8.15 Past harm

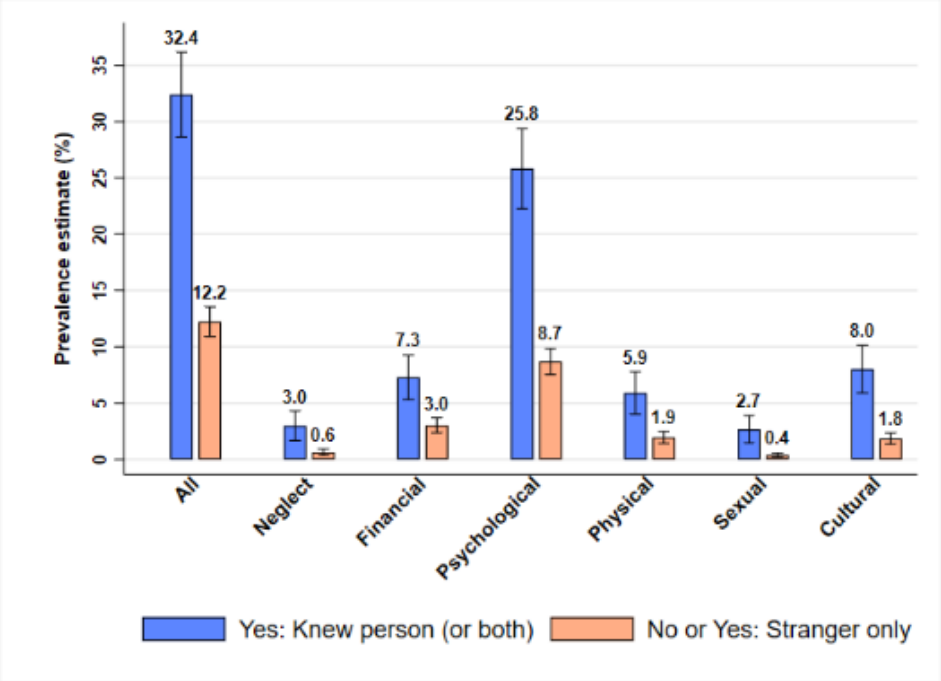
There are very large differences in AOP rates among those who have experienced harm in the past by either a known person, or a known person as well as a stranger, versus those who have either not experienced any past harm, or experienced past harm by a stranger only (Figure 38). The overall prevalence rate was almost three times higher among those who had experienced past harm by a known person (32.4%) versus those who had not (12.2%). The same patterns hold by harm subtype, with the differences all statistically significant.

For example, one-quarter of those with a history of harm by a known person reported psychological harm (25.8%), compared to just 8.7% of those without such a history. Rates of cultural & spiritual harm also differed markedly (8.0% versus 1.8%), while those reporting past harm experienced neglect and physical harm at roughly three times the rate of those who did not (3.0% versus 0.6% and 5.9% versus 1.9%, respectively). For financial harm, the rate was more than double for those who knew the

person/people who harmed them in the past compared to those with no history of harm or harm caused by a stranger (7.3% versus 3.0%).

The survey did not ask whether the person responsible for past harm was the same as the current main perpetrator, so these links cannot be drawn directly. However, the distinction between harm by someone known and harm by a stranger appears important. The results show a clear association between past harm by someone known and higher prevalence of current harm. While the survey cannot explain why this pattern occurs, wider research suggests several possible mechanisms. These include long-standing relationship dynamics that continue into later life, the normalisation of harmful behaviour within families or close networks, and reduced ability or willingness to seek help or set boundaries after earlier experiences of harm. These themes also arose in the qualitative interviews undertaken as part of the *National Study* (Wilson et al., 2026). Findings from the IDI analysis also showed that outcomes were worse when harm involved someone known (Chen et al., 2026b). This is consistent with international research on elder harm and family violence (e.g. Acierno et al., 2010; Dong, 2015; Yon et al., 2017).

Figure 38: Prevalence by whether respondent experienced past harm by known person



Note: Vertical bars are 95% confidence intervals. Percentage of all respondents in relevant category based on CHI–Very Serious threshold where relevant.

8.16 Summary

Exploring prevalence rates, both total AOP and by subtype, by respondents' demographic and socioeconomic characteristics, helps paint a fuller picture of who may be more at risk of experiencing

AOP and its potential impacts. The findings outlined in this section also provide a useful starting point for the more in-depth analysis contained in the next section (Section 9).

For example, prevalence rates do not differ greatly by gender (except for sexual harm). However, the experience of AOP does vary by gender. Women were more likely to identify their child as being responsible for the harm, especially financial and psychological harm. For men, experiences of psychological harm more often involved partners, ex-partners, or neighbours, while for women, physical harm was more often linked to work-related contacts.

Age made a difference, with younger respondents experiencing higher rates of AOP, as did ethnicity – Māori respondents experienced harm at higher rates than NZ European or Asian (supported by analysis of administrative data, see Chen et al., 2026b). The two characteristics may be related, further motivating multivariate – rather than univariate – regression analysis. Marginalisation and social exclusion are possible explanations for the higher AOP prevalence for older people in the Takatāpui and Rainbow communities, relative to non-Rainbow respondents. Having people to rely on and call upon for practical help was also identified as important for older people, although those living in multi-generational or large households reported experiencing AOP at higher rates than those living with their partner in a two-person household. Owning their own home also appears to make a significant difference and may be a more useful indicator of financial stability than income for older people.

Education does not appear to matter, but employment status does. Older people who are not employed, versus those who are or are retired, reported higher rates of total AOP and most harm subtypes. In line with prior family violence and AOP research, and that contained in the *Qualitative Interviews Report* (Wilson et al., 2026) for the *National Study*, those older people with high functional limitations experience significantly higher rates of neglect, and financial and psychological harm. Neurodiverse respondents, either diagnosed formally or not, also experienced AOP more often than those respondents who did not report neurodiversity. This is apparently driven by psychological harm, which neurodiverse respondents experienced at a rate three times higher than non-neurodiverse older people.

Physical and mental wellbeing, including diagnosed or undiagnosed mental health conditions and psychological distress, also indicate striking differences for AOP prevalence. As with disability status, the relationship between harm and respondent circumstances may go both ways: having poor health or high functional limitations may increase the risk of harm and also be a consequence of experiencing harm as an older person.

Lastly, experiencing harm in the past – more than 12 months ago at the time of the survey – involving someone known to the respondent (versus a stranger, or no history of harm) was also associated with

experiencing harm as an older person. This finding is also supported by the qualitative component of the *National Study* (Wilson et al., 2026), and life course analyses are worthy of further research beyond this study.

9 MULTIVARIATE ANALYSIS

Summary

- Regression models show higher risk of AOP for Māori and those with mental health conditions, and younger older people, even after controlling for other factors. Limited support networks and a history of past harm were also linked with higher risk.
- Other demographic and socioeconomic variables, such as education, income, and birthplace, were generally not significant once other factors were considered.
- For help-seeking, after controlling for other factors, women, Māori, and those with mental health conditions were more likely to seek help, while Pacific and Asian respondents were less likely.

This section presents findings from a series of multivariate analyses, to further explore the factors identified in Section 8. Multivariate analysis allows us to examine how different factors are associated with the likelihood of experiencing harm, while considering the influence of other variables. This approach helps show which factors are most closely associated with harm and related outcomes, beyond overlaps between characteristics (e.g. age and employment status, or age and ethnicity).

The results in this section focus first on any harm, showing how demographic, social, and health characteristics are associated with the probability of experiencing AOP overall. Analyses for the different subtypes of harm follow, before we explore co-occurrence of harm. Specifically, we aim to identify characteristics linked to experiencing multiple types of harm, then examine who the main people responsible for harm are, focusing on cases where a partner or ex-partner or a child is identified as the person who caused the most harm. Finally, we assess help-seeking behaviours among people who experienced harm, including whether they sought help and whether there was additional help or advice they would have liked to receive.

The regression models include explanatory variables such as age, gender, ethnicity, disability status, qualification level, household structure, employment status, and housing tenure. Rainbow identity was not included due to the small number of respondents identifying in this group. Results for respondents in the Takatāpui and Rainbow communities are thus presented only in univariate analyses (see Section 8.4).

Together, these analyses provide a more complete picture of how harm is distributed across the population aged 55 and over, and who faces the greatest risks and challenges in accessing support.

9.1 All harm

Table 33 shows the predicted probabilities of experiencing harm for different groups. In each category, the first group listed is the reference group (base category) that the other relevant groups are compared with. Shaded rows show statistically significant differences, where the confidence intervals do not overlap with the base group. The figures represent model-adjusted probabilities, not raw percentages from the survey. Appendix Table 3 provides the underlying marginal effects for these results.

There is little difference between men and women after controlling for other factors, in line with the findings in Section 8.1. The predicted probability of experiencing AOP for men is 16.0%, compared with 16.3% for women. This suggests that AOP does not vary by gender, even after controlling for other demographic and social variables.

Predicted probabilities from the regression show that the likelihood of experiencing harm declines steadily with age (Table 33). People aged 55–64 have the highest estimated probability at 18.8%, which drops to 10.9% for those aged 65–74, and 6.0% among those aged 75 and over. These age patterns hold even after accounting for differences in gender, ethnicity, health, income, and other socio-economic factors, suggesting that other influences are at play. People in their late 50s and early 60s may have greater exposure to complex family and household dynamics – such as supporting adult children, caring for older relatives, or experiencing separation or other relationship changes – that increase the risk of harm by someone they know. Generational differences in recognising or reporting experiences could also contribute, although the survey was designed to reduce this effect by asking about specific behaviours rather than relying on personal definitions of harm.

There is also variation by ethnicity, although the differences between each of the ethnicities and the base category of NZ European are not statistically significant (also see Figure 23 in Section 8.3). Māori have a predicted probability of 19.9%, which is higher than that of NZ Europeans (15.9%), but their confidence intervals overlap so this difference is not statistically significant. Pacific peoples also show a higher predicted probability (18.7%) with overlapping confidence intervals. Asian older people have an estimated probability of 11.3%, which is lower than NZ Europeans, but again with overlapping intervals. MELAA & Other ethnic groups sit near the overall average at 16.4%. These findings reflect the adjusted effects of ethnicity after accounting for other characteristics such as age, gender, and income. While formal comparisons are made with the NZ European group, the largest differences in estimated probabilities are seen for Māori and Asian older people.

Previous experiences of harm are strongly associated with AOP risk (also see Section 8.15). People who have been harmed in the past by someone they knew have a predicted probability of 23.2%, compared

with 13.6% among those without such a history. Similarly, those with moderate or high psychological distress, as measured by the Kessler scale, have a predicted probability of 23.3%, compared with 13.8% among those who are likely to be well. These two factors – past harm and psychological distress – stand out as the strongest indicators of elevated risk in the multivariate model, with the differences being statistically significant in both cases. Also significant is the higher predicted probability for those with a diagnosed or suspected mental health condition (25.0%) compared to those without (13.3%).

It is important to note that these findings reflect associations rather than causation. For example, psychological distress may act as a risk factor for experiencing harm, but it may also be a consequence of abuse or other negative life events. Likewise, a history of past harm is not necessarily a cause of current harm, but is strongly correlated with ongoing risk. These results highlight groups at greater risk but cannot, on their own, identify the direction of the relationship.[13]

Other variables in Table 33 suggest higher risk among some groups, although most differences are not statistically significant. For example, people with poor self-rated physical health (20.2%) have higher predicted probabilities of harm than those in better health (15.6%), but this difference is not statistically significant. People who find it hard to get practical help (25.2%) are much more likely to experience harm than those who can access help easily (14.2%), and this difference is statistically significant.

For disability status, like the univariate analysis (see Section 8.12), older people with high functional limitations reported much higher prevalence of harm than those with no or low limitations. However, in the multivariate model, the predicted probabilities for those with high limitations (17.8%) are not statistically different from those with no or low limitations (15.8%). This suggests that the higher prevalence observed in the descriptive results is explained by other factors that overlap strongly with disability, such as age and health. Once these characteristics are accounted for, disability status on its own is no longer a significant predictor of harm.

Overall, these findings highlight that while age, ethnicity, and some social factors shape differences in predicted harm, the largest gaps are seen for those with poor health, difficulties accessing help, prior experiences of harm, and current psychological or mental health issues.

[13] Excluding the Kessler psychological distress and mental health condition variables from the model does not change the overall findings. The patterns and group differences remain qualitatively the same. The only noticeable change is that some predicted probabilities and marginal effects shift slightly upwards. This is because the mental health variables account for part of the variation in harm risk, and when they are removed, other variables capture slightly more of this association.

Gender differences

To explore whether predictors of harm vary by gender, separate regressions were run for men and women (Appendix Table 5 and Appendix Table 6).

For men, the main predictors of experiencing any harm were similar to those identified in the overall regression. Older age was linked to a lower likelihood of harm, and those who had experienced harm in the past were much more likely to experience it again. Men with moderate or high psychological distress or a mental health condition also faced higher probabilities of harm. Difficulty getting practical help from others increased the likelihood of harm from around 15%–24%.

For women, the pattern appeared more varied, with more predictors reaching statistical significance. As with men, younger women, those reporting past harm, and those experiencing psychological distress were at greater risk. However, self-rated physical health stood out as an additional predictor for women only: those rating their health as poor or very poor were far more likely to experience harm (27%) than women reporting moderate, very good, or excellent health (16%).

There was also some indication that higher education may be associated with a greater likelihood of experiencing harm among women. Although differences in predicted probabilities were not statistically significant at the 95% confidence level, the underlying regression coefficients suggest a positive relationship between qualification level and harm risk.[14] This pattern was not observed for men.

Although speculative, poorer physical health may create greater dependence on others for daily support, which may increase exposure to harm. This appears to affect women more strongly, as they tend to live longer with disability and are more likely to rely on informal or family care rather than formal services. This pattern aligns with findings from the *Qualitative Interviews Report* that older women often depend on family or informal care arrangements, and that this reliance can increase exposure to harm (Wilson et al., 2026).

Table 33: Predicted probabilities from logit regression (All harm)

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
Age group	55–64	18.78	16.48	21.08
	65–74	10.91*	9.27	12.55
	75+	6.02*	4.14	7.90
Gender	Male	15.98	14.17	17.79

[14] Statistical significance in the logit model (on the log-odds scale) does not always translate directly into non-overlapping confidence intervals for predicted probabilities. This is because the non-linear transformation from log-odds to probabilities can compress differences and produce wider confidence intervals.

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
	Female	16.25	14.54	17.96
Ethnicity	NZ European	15.88	14.34	17.42
	Māori	19.86	16.31	23.41
	Pacific peoples	18.65	13.69	23.62
	Asian	11.27	6.73	15.81
	MELAA & Other	16.36	9.90	22.83
Partnership status	Not partnered	16.87	14.31	19.42
	Partnered	15.70	13.96	17.46
Region	Auckland	16.28	14.46	18.11
	Waikato	15.98	10.76	21.19
	Wellington	15.69	12.46	18.92
	Canterbury	17.18	13.41	20.96
	Rest of North Island	15.13	12.46	17.81
	Rest of South Island	16.31	11.05	21.58
	Unknown/Don't know/Refuse	17.23	9.83	24.64
Children (biological, adopted, or step)	None	13.33	10.11	16.56
	Has child/ren	16.58	15.27	17.89
Birthplace	Born in NZ	16.99	15.42	18.56
	Born overseas	13.61	10.88	16.35
Household size	1 person	17.30	13.87	20.73
	2 people	15.07	13.18	16.97
	3 or more people	16.88	14.35	19.42
Professional carer at home	No professional carer	15.94	14.67	17.20
	Professional carer	19.52	13.53	25.50
Home ownership	Doesn't own home	18.26	15.36	21.16
	Owns home	15.58	14.22	16.94
Employment status	Employed	17.63	15.79	19.82
	Not employed	15.08	9.01	18.36
	Retired	14.48	11.89	16.87
Household income	0-50k	16.88	13.73	20.03
	50k-100k	16.32	13.64	19.00
	100k+	14.71	12.19	17.22
	Don't know/Refuse	16.82	14.26	19.38
Highest qualification	Secondary school or below	13.96	12.14	15.79
	Post-school	17.34	15.21	19.47
	Bachelor's or higher	17.85	15.11	20.59
Self-rated physical health status	Moderate/Very good/Excellent	15.61	14.29	16.94
	Poor/Very poor	20.23	15.58	24.88
How many people can rely on?	Less than 3	15.71	12.92	18.49
	3-5	16.90	14.84	18.96
	5+	15.70	13.78	17.62
How difficult to get practical help?	Very easy/Easy	14.18	12.82	15.55
	Possible/Difficult/Very difficult	25.45*	21.13	29.78
Disability status	No/Low functional limitations	15.78	14.45	17.11
	High functional limitations	17.77	14.08	21.47
Past harm by known person	No	13.60	12.22	14.98
	Yes	23.19*	20.24	26.15
Kessler psychological distress	Likely to be well	13.82	12.38	15.26
	Moderate or High distress	23.34*	20.02	26.66

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
Mental health condition	No	13.29	11.88	14.69
	Yes (diagnosed) or Think so (not)	25.03*	21.47	28.59
Observations (unweighted)		5,322		

Note: Predicted probabilities from logistic regression of any harm according to the CHI–Very Serious threshold. Excludes those with missing information for any of the relevant variables (approximately 5% of the sample). Predicted probabilities show the expected likelihood of experiencing harm for each group, holding all other characteristics (such as age, gender, ethnicity, income, and health) constant at their average values. These probabilities represent model-adjusted estimates rather than raw percentages. In each category, the first group listed is the reference group (base category) that all other relevant groups are compared to. For age, the model included both age and age squared to reflect non-linear patterns. Predicted probabilities for the three age groups (55–64, 65–74, and 75+) were then estimated by holding other characteristics at their average levels across the sample. All other variables are categorical. Shaded rows and * indicate statistical significance where the confidence intervals do not overlap with the base category.

9.2 Harm subtypes

Neglect

Table 34 shows the predicted probabilities of experiencing neglect, based on a logistic regression model. Appendix Table 3 provides marginal effects from the regression. The model estimates the likelihood of neglect for different groups, holding other factors constant.

Neglect was relatively rare across all groups. Predicted probabilities were very low – generally below 2% – and all confidence intervals overlapped. This means there were no statistically significant differences between groups once other factors were controlled for.

In a few cases, the lower end of the confidence interval is shown as negative. Prevalence cannot be less than zero; this simply reflects the challenge of estimating rare events precisely. These results should be read as indicating that the true prevalence is close to zero.

For age, the model suggests very small differences, with slightly higher estimated probabilities among people aged 55–64 (around 0.3%) and lower probabilities for those aged 75 and over (around 0.1%). However, these differences are not statistically significant.

While predicted probabilities are somewhat higher for women, people with poor or very poor self-rated health, those with high functional limitations, and those receiving help from a professional carer, none of these differences are statistically significant. The same applies for groups with different income levels, household sizes, or difficulty getting practical help.

The lack of clear statistical differences likely reflects both the small number of people who reported neglect and the resulting wide confidence intervals. In practice, this means the model cannot distinguish confidently between groups, even though the patterns point in the same direction as the univariate results shown in Section 8.

Overall, the results suggest that neglect is relatively uncommon for community-dwelling older people and that the main factors shaping risk – such as disability, poor health, and the need for support – may overlap closely with those influencing the likelihood of experiencing any form of harm.

Table 34: Predicted probabilities from logit regression (Neglect)

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
Age group	55–64	0.34	0.01	0.67
	65–74	0.15	-0.01	0.31
	75+	0.13	-0.02	0.28
Gender	Male	0.59	0.20	0.98
	Female	1.51	0.56	2.45
Ethnicity	NZ European	1.17	0.61	1.73
	Māori	0.93	-0.16	2.02
	Pacific peoples	0.63	-0.03	1.30
	Asian	1.20	-0.61	3.01
	MELAA & Other	0.67	0.04	1.30
Partnership status	Not partnered	1.07	0.24	1.91
	Partnered	1.11	0.29	1.94
Region	Auckland	1.07	0.31	1.83
	Waikato	2.34	-0.42	5.11
	Wellington	2.07	0.38	3.75
	Canterbury	0.83	-0.10	1.76
	Rest of North Island	0.33	-0.24	0.91
	Rest of South Island	1.15	-0.14	2.44
	Unknown/Don't know/Refuse	0.43	-0.52	1.37
Children (biological/adopted/step)	None	0.82	-0.12	1.76
	Has child/ren	1.13	0.54	1.71
Birthplace	Born in NZ	1.01	0.41	1.60
	Born overseas	1.33	0.51	2.14
Household size	1 person	0.77	0.21	1.32
	2 people	0.96	0.15	1.78
	3 or more people	1.87	0.26	3.47
Professional carer at home	No professional carer	0.95	0.39	1.50
	Professional carer	2.39	0.55	4.22
Home ownership	Doesn't own home	1.51	0.39	2.63
	Owns home	0.92	0.42	1.42
Employment status	Employed	1.18	-0.10	2.46
	Not employed	1.28	0.36	2.20
	Retired	0.83	0.10	1.56
Household income	0-50k	1.47	-0.25	3.19
	50k-100k	2.07	0.47	3.67

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
	100k+	0.74	-0.30	1.79
	Don't know/Refuse	0.61	0.18	1.04
Highest qualification	Secondary school or below	0.84	0.34	1.34
	Post-school	1.58	0.47	2.70
	Bachelor's or higher	0.84	0.06	1.62
Self-rated physical health status	Moderate/Very good/Excellent	0.88	0.33	1.43
	Poor/Very poor health	1.68	0.27	3.08
How many people can rely on?	Less than 3	1.38	0.39	2.37
	3-5	0.86	0.27	1.46
	5+	0.98	0.06	1.90
How difficult to get practical help?	Very easy/Easy	0.68	0.07	1.29
	Possible/Difficult/Very difficult	1.88	0.76	3.00
Disability status	No/Low functional limitations	0.70	0.17	1.22
	High functional limitations	1.89	0.68	3.11
Past harm by known person	No	0.87	0.31	1.43
	Yes	1.46	0.49	2.44
Kessler psychological distress	Likely to be well	0.77	0.15	1.40
	Moderate or High distress	1.48	0.55	2.40
Mental health condition	No	0.91	0.35	1.47
	Yes (diagnosed) or Think so (not)	1.32	0.29	2.35
Observations (unweighted)		**5,294**		

Note: Predicted probabilities from logistic regression of any harm according to the CHI–Very Serious threshold. Excludes those with missing information for any of the relevant variables (approximately 5% of the sample). Predicted probabilities show the expected likelihood of experiencing harm for each group, holding all other characteristics (such as age, gender, ethnicity, income, and health) constant at their average values. These probabilities represent model-adjusted estimates rather than raw percentages. In each category, the first group listed is the reference group (base category) that all other relevant groups are compared to. For age, the model included both age and age squared to reflect non-linear patterns. Predicted probabilities for the three age groups (55–64, 65–74, and 75+) were then estimated by holding other characteristics at their average levels across the sample. All other variables are categorical. Shaded rows and * indicate statistical significance where the confidence intervals do not overlap with the base category.

Financial harm

Table 35 presents predicted probabilities of experiencing financial harm. The likelihood of financial harm is highest among those aged 55–64 (3.0%) and declines sharply with age, reaching just 1.0% for those aged 75 and over. The difference between the 55–64 and 75+ age groups is statistically significant.

Most of the other differences between groups are not statistically significant. Predicted probabilities are slightly higher for men (4.5%) than women (3.3%), and for Māori (5.9%) compared with NZ Europeans (3.9%), but the confidence intervals overlap. Small apparent differences by partnership status, income, or home ownership are likewise not statistically meaningful once other factors are controlled for.

People who report poor or very poor health, psychological distress, or difficulty getting practical help also have somewhat higher predicted probabilities of financial harm, but again these estimates are not statistically significant. The only other significant factor in the model is having a mental health condition,

which is associated with a higher predicted probability of financial harm (6.0%) compared with those without a mental health condition (2.9%).

Taken together, these findings suggest that financial harm is more common among those with poorer mental health and younger respondents, but that differences by gender, ethnicity, income, or social support are less clear once other factors are considered.

Table 35: Predicted probabilities from logit regression (Financial)

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
Age group	55–64	3.12	1.98	4.27
	65–74	2.33	1.40	3.27
	75+	0.99*	0.42	1.56
Gender	Male	4.49	3.30	5.68
	Female	3.33	2.38	4.28
Ethnicity	NZ European	3.87	2.90	4.84
	Māori	5.93	3.45	8.42
	Pacific peoples	3.60	1.74	5.47
	Asian	1.92	-0.32	4.16
	MELAA & Other	1.59	-0.68	3.86
Partnership status	Not partnered	4.98	3.51	6.44
	Partnered	3.16	2.15	4.16
Region	Auckland	3.85	2.77	4.93
	Waikato	5.16	1.59	8.74
	Wellington	4.63	2.64	6.61
	Canterbury	4.90	2.32	7.49
	Rest of North Island	3.54	1.80	5.28
	Rest of South Island	3.04	0.12	5.96
	Unknown/Don't know/Refuse	0.55*	-1.03	2.13
Children (biological, adopted, or step)	None	2.79	1.50	4.08
	Has child/ren	4.03	3.18	4.88
Birthplace	Born in NZ	3.70	2.77	4.62
	Born overseas	4.35	2.49	6.21
Household size	1 person	3.08	1.81	4.35
	2 people	3.93	2.73	5.13
	3 or more people	4.58	3.05	6.11
Professional carer at home	No professional carer	3.95	3.16	4.74
	Professional carer	2.39	0.26	4.53
Home ownership	Doesn't own home	4.71	3.09	6.32
	Owns home	3.53	2.67	4.38
Employment status	Employed	3.99	2.59	5.39
	Not employed	3.82	2.16	5.48
	Retired	3.66	1.92	5.40
Household income	0-50k	4.46	2.64	6.29
	50k-100k	3.22	1.91	4.52
	100k+	2.76	1.21	4.31
	Don't know/Refuse	4.66	2.89	6.43
Highest qualification	Secondary school or below	3.15	2.21	4.09

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
	Post-school	4.38	3.06	5.71
	Bachelor's or higher	4.31	2.62	5.99
Self-rated physical health status	Moderate/Very good/Excellent	3.35	2.60	4.09
	Poor/Very poor	6.68	3.88	9.47
How many people can rely on?	Less than 3	4.21	2.79	5.63
	3-5	3.65	2.54	4.77
	5+	3.78	2.51	5.05
How difficult to get practical help?	Very easy/Easy	3.29	2.47	4.12
	Possible/Difficult/Very difficult	5.72	3.65	7.79
Disability status	No/Low functional limitations	3.94	3.08	4.81
	High functional limitations	3.55	2.21	4.88
Past harm by known person	No	3.44	2.59	4.28
	Yes	4.77	3.34	6.21
Kessler psychological distress	Likely to be well	3.26	2.41	4.11
	Moderate or High distress	5.11	3.58	6.64
Mental health condition	No	2.92	2.17	3.67
	Yes (diagnosed) or Think so (not)	6.00*	4.11	7.90
Observations		**5,320**		

Note: Predicted probabilities from logistic regression of any harm according to the CHI–Very Serious threshold. Excludes those with missing information for any of the relevant variables (approximately 5% of the sample). Predicted probabilities show the expected likelihood of experiencing harm for each group, holding all other characteristics (such as age, gender, ethnicity, income, and health) constant at their average values. These probabilities represent model-adjusted estimates rather than raw percentages. In each category, the first group listed is the reference group (base category) that all other relevant groups are compared to. For age, the model included both age and age squared to reflect non-linear patterns. Predicted probabilities for the three age groups (55–64, 65–74, and 75+) were then estimated by holding other characteristics at their average levels across the sample. All other variables are categorical. Shaded rows and * indicate statistical significance where the confidence intervals do not overlap with the base category.

Psychological harm

The predicted probability of psychological harm is highest among those aged 55–64 (13.3%) and decreases sharply with age, dropping to 7.3% for those aged 65–74 and 4.1% for those aged 75 and over (Table 36). These differences are statistically significant. Women (12.3%) have slightly higher predicted probabilities than men (11.6%), but the difference is small and not statistically significant. Māori (15.2%) and Pacific peoples (13.8%) have higher predicted probabilities than NZ Europeans (11.4%), while Asian people (9.8%) have lower predicted probabilities. However, the confidence intervals overlap between these ethnic groups and the NZ European base category.

Psychological harm is more likely among people who find it possible, difficult, or very difficult to access practical help (21.3%) compared with those who find help easy to get (9.9%). People with moderate or high psychological distress (17.9%), or a diagnosed or suspected mental health condition (18.5%), also show substantially higher predicted probabilities compared with those who are well (9.9%) or without a mental health condition (9.6%). Those who have experienced harm in the past by someone they knew also face a much higher predicted probability (18.5%) than those without past experiences (9.6%).

Overall, psychological harm follows a similar pattern to overall harm, with risk concentrated among younger people, those with previous experiences of harm, those struggling to access help, and those experiencing psychological distress or poorer mental health.

Table 36: Predicted probabilities from logit regression (Psychological)

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
Age group	55–64	13.34	11.30	15.38
	65–74	7.30*	5.98	8.62
	75+	4.05*	2.30	5.80
Gender	Male	11.56	9.92	13.19
	Female	12.26	10.66	13.86
Ethnicity	NZ European	11.44	10.07	12.80
	Māori	15.24	12.00	18.48
	Pacific peoples	13.75	8.81	18.69
	Asian	9.79	4.88	14.70
	MELAA & Other	13.54	7.36	19.72
Partnership status	Not partnered	12.70	10.24	15.16
	Partnered	11.51	9.90	13.11
Region	Auckland	12.29	10.58	13.99
	Waikato	9.87	5.50	14.25
	Wellington	10.54	7.66	13.43
	Canterbury	14.15	10.60	17.69
	Rest of North Island	11.49	9.01	13.97
	Rest of South Island	10.70	5.96	15.44
	Unknown/Don't know/Refuse	13.98	7.22	20.75
Children (biological, adopted, or step)	None	9.28	6.52	12.04
	Has child/ren	12.38	11.15	13.60
Birthplace	Born in NZ	12.86	11.37	14.34
	Born overseas	9.28	6.90	11.67
Household size	1 person	11.92	8.92	14.91
	2 people	11.57	9.79	13.36
	3 or more people	12.56	10.20	14.91
Professional carer at home	No professional carer	11.78	10.61	12.94
	Professional carer	14.97	9.31	20.63
Home ownership	Doesn't own home	12.39	9.82	14.95
	Owns home	11.82	10.56	13.09
Employment status	Employed	12.89	10.92	14.87
	Not employed	12.40	9.26	15.54
	Retired	10.29	8.04	12.54
Household income	0-50k	12.92	9.99	15.85
	50k-100k	12.21	9.72	14.70
	100k+	11.89	9.37	14.42
	Don't know/Refuse	11.05	8.94	13.16
Highest qualification	Secondary school or below	10.72	9.04	12.41
	Post-school	12.70	10.67	14.72
	Bachelor's or higher	12.76	10.40	15.12
Self-rated physical health status	Moderate/Very good/Excellent	11.82	10.58	13.06

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
	Poor/Very poor	12.81	8.95	16.66
How many people can rely on?	Less than 3	10.65	8.12	13.18
	3-5	12.40	10.57	14.24
	5+	12.21	10.39	14.04
How difficult to get practical help?	Very easy/Easy	9.91	8.66	11.17
	Possible/Difficult/Very difficult	21.31*	16.92	25.69
Disability status	No/Low functional limitations	11.87	10.63	13.11
	High functional limitations	12.27	9.07	15.47
Past harm by known person	No	9.67	8.41	10.92
	Yes	17.90*	15.20	20.60
Kessler psychological distress	Likely to be well	9.90	8.57	11.23
	Moderate or High distress	17.85*	14.78	20.91
Mental health condition	No	9.61	8.33	10.90
	Yes (diagnosed) or Think so (not)	18.50*	15.22	21.78
Observations		**5,298**		

Note: Predicted probabilities from logistic regression of any harm according to the CHI–Very Serious threshold. Excludes those with missing information for any of the relevant variables (approximately 5% of the sample). Predicted probabilities show the expected likelihood of experiencing harm for each group, holding all other characteristics (such as age, gender, ethnicity, income, and health) constant at their average values. These probabilities represent model-adjusted estimates rather than raw percentages. In each category, the first group listed is the reference group (base category) that all other relevant groups are compared to. For age, the model included both age and age squared to reflect non-linear patterns. Predicted probabilities for the three age groups (55–64, 65–74, and 75+) were then estimated by holding other characteristics at their average levels across the sample. All other variables are categorical. Shaded rows and * indicate statistical significance where the confidence intervals do not overlap with the base category.

Physical harm

The predicted probability of physical harm is highest for people aged 55–64 (2.6%), and falls with age to 1.4% for those aged 65–74 and 0.4% for those aged 75 and over (Table 37), although only the difference between those aged 75+ and the base case of 55–64 is significant. Men (3.1%) are more likely than women (2.3%) to experience physical harm, but the difference is not statistically significant. Māori (3.9%) have higher predicted probabilities than NZ Europeans (2.8%), while Asian (0.9%) and MELAA & Other (1.2%) groups have lower rates. However, some of these differences are not statistically significant due to wide confidence intervals.

Physical harm is also more common among people who do not own their home (3.8% versus 2.2%), those with a diagnosed or suspected mental health condition (3.9% versus 2.1%), those who find it possible, difficult, or very difficult to access practical help (4.2% versus 2.3%), and those who have experienced harm in the past by someone they knew (3.7% versus 2.2%). However, none of these differences are statistically significant.

These findings show that physical harm, while less common than other forms of harm, follows a similar risk pattern – being more likely among younger members of the 55+ group, men, and people facing social, mental health, and support-related vulnerabilities.

Table 37: Predicted probabilities from logit regression (Physical)

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
Age group	55–64	2.55	1.61	3.49
	65–74	1.40	0.76	2.03
	75+	0.42*	0.14	0.70
Gender	Male	3.14	2.03	4.25
	Female	2.30	1.49	3.11
Ethnicity	NZ European	2.77	1.85	3.69
	Māori	3.86	1.85	5.87
	Pacific peoples	2.24	0.55	3.93
	Asian	0.85*	-0.06	1.75
	MELAA & Other	1.22*	0.67	1.76
Partnership status	Not partnered	2.64	1.46	3.81
	Partnered	2.67	1.48	3.85
Region	Auckland	2.75	1.69	3.82
	Waikato	2.96	0.53	5.39
	Wellington	2.39	0.83	3.95
	Canterbury	1.49	-0.11	3.09
	Rest of North Island	2.72	1.46	3.97
	Rest of South Island	2.13	-0.08	4.34
	Unknown/Don't know/Refuse	5.38	0.42	10.34
Children (biological, adopted, or step)	None	2.43	0.65	4.20
	Has child/ren	2.70	1.96	3.43
Birthplace	Born in NZ	2.63	1.87	3.40
	Born overseas	2.72	1.05	4.39
Household size	1 person	4.49	1.80	7.18
	2 people	1.58	0.78	2.38
	3 or more people	2.89	1.59	4.18
Professional carer at home	No professional carer	2.55	1.86	3.24
	Professional carer	4.47	-0.47	9.40
Home ownership	Doesn't own home	3.85	2.30	5.40
	Owns home	2.24	1.44	3.05
Employment status	Employed	2.58	1.53	3.62
	Not employed	2.59	1.18	3.99
	Retired	2.88	1.12	4.64
Household income	0-50k	2.61	1.35	3.86
	50k-100k	2.37	1.22	3.52
	100k+	2.39	0.91	3.86
	Don't know/Refuse	3.14	1.60	4.68
Highest qualification	Secondary school or below	2.42	1.50	3.34
	Post-school	2.72	1.53	3.91
	Bachelor's or higher	2.93	1.49	4.37
Self-rated physical health status	Moderate/Very good/Excellent	2.49	1.74	3.24

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
	Poor/Very poor	3.53	1.04	6.01
How many people can rely on?	Less than 3	2.24	1.23	3.25
	3-5	2.43	1.38	3.48
	5+	3.13	1.98	4.27
How difficult to get practical help?	Very easy/Easy	2.26	1.55	2.97
	Possible/Difficult/Very difficult	4.16	2.32	6.01
Disability status	No/Low functional limitations	2.79	1.88	3.70
	High functional limitations	2.21	0.73	3.68
Past harm by known person	No	2.18	1.41	2.94
	Yes	3.70	2.21	5.18
Kessler psychological distress	Likely to be well	2.45	1.59	3.31
	Moderate or High distress	3.05	1.80	4.30
Mental health condition	No	2.08	1.33	2.82
	Yes (diagnosed) or Think so (not)	3.93	2.44	5.41
Observations (unweighted)		**5,322**		

Note: Predicted probabilities from logistic regression of any harm according to the CHI–Very Serious threshold. Excludes those with missing information for any of the relevant variables (approximately 5% of the sample). Predicted probabilities show the expected likelihood of experiencing harm for each group, holding all other characteristics (such as age, gender, ethnicity, income, and health) constant at their average values. These probabilities represent model-adjusted estimates rather than raw percentages. In each category, the first group listed is the reference group (base category) that all other relevant groups are compared to. For age, the model included both age and age squared to reflect non-linear patterns. Predicted probabilities for the three age groups (55–64, 65–74, and 75+) were then estimated by holding other characteristics at their average levels across the sample. All other variables are categorical. Shaded rows and * indicate statistical significance where the confidence intervals do not overlap with the base category.

Sexual harm

Predicted probabilities are very low across all groups, reflecting the rarity of reported sexual harm in the survey. Estimated rates are highest among people aged 55–64 (0.3%) and decline slightly with age, to 0.2% for those aged 65–74 and 0.1% for those aged 75 and over (Table 38). However, these differences are not statistically significant.

Women (1.2%) have a higher predicted probability of sexual harm than men (0.4%), but the confidence intervals overlap, indicating that this difference is not statistically significant. Small apparent differences by ethnicity, region, home ownership, and household characteristics should also be interpreted cautiously, as the confidence intervals are wide and overlap substantially.

Some groups have higher point estimates (e.g. people with a professional carer at home (4.1%), those with a mental health condition (1.1%), and those who have experienced harm previously (1.7%)). However, again, none of these differences are statistically significant. The wide confidence intervals reflect small sample sizes and the very low overall prevalence of sexual harm.

Overall, sexual harm is rare in this study population, and while the direction of results is broadly consistent with the univariate findings (see Section 8) – showing somewhat higher rates for women and

people with prior harm – none of these differences are statistically significant. The low numbers of respondents affected make it difficult to draw strong conclusions about group differences.

Table 38: Predicted probabilities from logit regression (Sexual)

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
Age group	55–64	0.32	0.06	0.58
	65–74	0.21	0.04	0.38
	75+	0.08	-0.09	0.25
Gender	Male	0.41	-0.06	0.89
	Female	1.21	0.50	1.92
Ethnicity	NZ European	0.99	0.43	1.55
	Māori	0.44	-0.28	1.17
	Pacific peoples	0.61	-0.17	1.40
	Asian	0.37	0.02	0.72
	MELAA & Other	1.55	0.08	3.02
Partnership status	Not partnered	1.01	0.22	1.79
	Partnered	0.75	0.08	1.41
Region	Auckland	0.99	0.35	1.64
	Waikato	0.92	-0.37	2.22
	Wellington	0.75	-0.17	1.67
	Canterbury	1.23	-0.81	3.28
	Rest of North Island	0.33	0.02	0.63
	Rest of South Island	0.95	-0.43	2.32
	Unknown/Don't know/Refuse	0.86	0.12	1.60
Children (biological, adopted, or step)	None	1.28	-0.18	2.74
	Has child/ren	0.78	0.38	1.18
Birthplace	Born in NZ	0.87	0.32	1.42
	Born overseas	0.86	0.25	1.48
Household size	1 person	0.94	0.07	1.80
	2 people	1.16	0.23	2.09
	3 or more people	0.29	-0.07	0.65
Professional carer at home	No professional carer	0.67	0.31	1.04
	Professional carer	4.13	0.16	8.11
Home ownership	Doesn't own home	1.27	0.10	2.44
	Owns home	0.75	0.28	1.23
Employment status	Employed	0.87	0.22	1.52
	Not employed	1.06	0.24	1.87
	Retired	0.71	0.10	1.33
Household income	0-50k	0.71	-0.06	1.47
	50k-100k	0.84	-0.25	1.93
	100k+	0.95	0.02	1.89
	Don't know/Refuse	0.97	0.34	1.59
Highest qualification	Secondary school or below	0.64	-0.02	1.31
	Post-school	0.63	0.16	1.10
	Bachelor's or higher	1.53	0.59	2.46
Self-rated physical health status	Moderate/Very good/Excellent	0.63	0.29	0.96
	Poor/Very poor	2.95	-0.19	6.09
How many people can rely on?	Less than 3	1.08	0.19	1.96

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
	3-5	0.68	0.24	1.13
	5+	0.93	0.16	1.70
How difficult to get practical help?	Very easy/Easy	0.88	0.29	1.47
	Possible/Difficult/Very difficult	0.83	0.18	1.48
Disability status	No/Low functional limitations	1.05	0.26	1.83
	High functional limitations	0.50	0.06	0.94
Past harm by known person	No	0.47	0.16	0.78
	Yes	1.67	0.53	2.81
Kessler psychological distress	Likely to be well	1.00	0.48	1.51
	Moderate or High distress	0.67	-0.11	1.45
Mental health condition	No	0.73	0.25	1.21
	Yes (diagnosed) or Think so (not)	1.11	0.29	1.94
Observations (unweighted)		**5,196**		

Note: Predicted probabilities from logistic regression of any harm according to the CHI–Very Serious threshold. Excludes those with missing information for any of the relevant variables (approximately 5% of the sample). Predicted probabilities show the expected likelihood of experiencing harm for each group, holding all other characteristics (such as age, gender, ethnicity, income, and health) constant at their average values. These probabilities represent model-adjusted estimates rather than raw percentages. In each category, the first group listed is the reference group (base category) that all other relevant groups are compared to. For age, the model included both age and age squared to reflect non-linear patterns. Predicted probabilities for the three age groups (55–64, 65–74, and 75+) were then estimated by holding other characteristics at their average levels across the sample. All other variables are categorical. Shaded rows and * indicate statistical significance where the confidence intervals do not overlap with the base category.

Cultural & spiritual harm

The predicted probability of cultural & spiritual harm is highest among those aged 55–64 (3.1%) and declines with age, to 1.4% for those aged 65–74 and 0.7% for those aged 75 and over (Table 39). These differences are statistically significant. Rates are similar for men (3.4%) and women (3.0%). Māori (5.6%) and Pacific peoples (3.3%) have higher predicted probabilities than NZ Europeans (2.6%), but the differences are not statistically significant. MELAA & Other ethnic groups (6.5%) have the highest estimated rate, although this figure should be interpreted with some caution due to small underlying counts and the resulting wide confidence interval.

Cultural & spiritual harm is more likely among those who have experienced harm in the past by someone they knew (5.5% versus 2.1%). People with a diagnosed or suspected mental health condition also show a markedly higher predicted probability (5.2%) compared with those without (2.3%).

These results show that cultural and spiritual harm is more common than physical or sexual harm and follows a pattern similar to overall AOP, with higher rates among those with social or economic risk factors, people with past experiences of harm, and those with mental health conditions. As described elsewhere, these findings are associations only and not causal – some of the risk factors may be a result of the harm itself, at least partially.

Table 39: Predicted probabilities from logit regression (Cultural & spiritual)

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
Age group	55–64	3.07	2.15	3.99
	65–74	1.35*	0.84	1.87
	75+	0.66*	0.26	1.06
Gender	Male	3.37	2.31	4.44
	Female	2.97	2.08	3.86
Ethnicity	NZ European	2.62	1.81	3.43
	Māori	5.55	3.06	8.04
	Pacific peoples	3.33	1.32	5.33
	Asian	2.64	0.64	4.65
	MELAA & Other	6.49	0.74	12.25
Partnership status	Not partnered	3.10	1.91	4.30
	Partnered	3.18	1.98	4.39
Region	Auckland	3.49	2.47	4.51
	Waikato	2.77	0.28	5.27
	Wellington	3.75	1.87	5.62
	Canterbury	3.29	0.87	5.72
	Rest of North Island	2.16	1.00	3.32
	Rest of South Island	2.45	0.16	4.73
	Unknown/Don't know/Refuse	3.52	-1.53	8.57
Children (biological, adopted, or step)	None	3.54	1.68	5.40
	Has child/ren	3.08	2.32	3.85
Birthplace	Born in NZ	3.33	2.44	4.23
	Born overseas	2.58	1.26	3.91
Household size	1 person	3.40	1.70	5.09
	2 people	2.56	1.57	3.56
	3 or more people	3.73	2.29	5.17
Professional carer at home	No professional carer	3.15	2.40	3.90
	Professional carer	3.13	0.59	5.67
Home ownership	Doesn't own home	4.78	2.76	6.80
	Owns home	2.62	1.85	3.40
Employment status	Employed	3.81	2.50	5.11
	Not employed	2.21	1.10	3.33
	Retired	2.87	1.54	4.21
Household income	0-50k	3.42	1.64	5.20
	50k-100k	3.62	2.17	5.08
	100k+	2.41	1.17	3.65
	Don't know/Refuse	3.27	1.63	4.90
Highest qualification	Secondary school or below	2.94	1.89	3.99
	Post-school	3.27	2.10	4.45
	Bachelor's or higher	3.28	1.81	4.76
Self-rated physical health status	Moderate/Very good/Excellent	2.94	2.20	3.68
	Poor/Very poor	4.42	1.78	7.06
How many people can rely on?	Less than 3	2.59	1.37	3.80
	3-5	3.04	1.90	4.18
	5+	3.64	2.48	4.79
How difficult to get practical help?	Very easy/Easy	2.63	1.87	3.38

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
	Possible/Difficult/Very difficult	5.08	3.07	7.09
Disability status	No/Low functional limitations	3.32	2.43	4.22
	High functional limitations	2.55	1.18	3.91
Past harm by known person	No	2.12	1.45	2.80
	Yes	5.50*	3.75	7.25
Kessler psychological distress	Likely to be well	2.78	1.94	3.63
	Moderate or High distress	3.90	2.35	5.46
Mental health condition	No	2.27	1.57	2.97
	Yes (diagnosed) or Think so (not)	5.16*	3.15	7.16
Observations (unweighted)		**5,313**		

Note: Predicted probabilities from logistic regression of any harm according to the CHI–Very Serious threshold. Excludes those with missing information for any of the relevant variables (approximately 5% of the sample). Predicted probabilities show the expected likelihood of experiencing harm for each group, holding all other characteristics (such as age, gender, ethnicity, income, and health) constant at their average values. These probabilities represent model-adjusted estimates rather than raw percentages. In each category, the first group listed is the reference group (base category) that all other relevant groups are compared to. For age, the model included both age and age squared to reflect non-linear patterns. Predicted probabilities for the three age groups (55–64, 65–74, and 75+) were then estimated by holding other characteristics at their average levels across the sample. All other variables are categorical. Shaded rows and * indicate statistical significance where the confidence intervals do not overlap with the base category.

9.3 Co-occurrence of harm subtypes

Table 40 shows the predicted probabilities of experiencing two or more types of harm (co-occurrence) among those who experienced any harm. These estimates reflect the likelihood of multiple harms across demographic and social groups, holding other factors at their average levels. Appendix Table 4 provides marginal effects from the logistic regression.

The likelihood of co-occurrence is highest among people aged 55–64 (34.8%) and decreases with age, to 26.9% for those aged 65–74 and 19.0% for those aged 75 and over, with the latter difference being statistically significant. Men (33.9%) have slightly higher predicted probabilities than women (30.9%), although the difference is not statistically significant. Among ethnic groups, Asian people (48.3%) and MELAA & Other ethnicities (33.2%) have the highest predicted probabilities, although these estimates have wide confidence intervals due to smaller sample sizes.

Co-occurrence is more common among those with poor or very poor self-rated health (40.7% versus 30.1% for those with moderate, very good or excellent self-rated health), those who find it possible, difficult, or very difficult to get practical help (40.7% versus 28.0%), and those who do not own their home (38.6 versus 29.7%). It is also higher among people with a diagnosed or suspected mental health condition (35.8 versus 29.0%) and those who have experienced harm in the past by someone they knew

(36.6% versus 28.7%). However, none of these differences are statistically significant, and should be interpreted with caution.

Taken together with the survey results (see Section 6), these results suggest that co-occurrence of harm is particularly associated with younger older people within the 55+ group, poorer health, barriers to support, prior experiences of harm, and certain social and housing factors. For some groups – such as Asian and MELAA ethnicities – the estimates are very high but uncertain and warrant further investigation.

Table 40: Predicted probabilities from logit regression: Co-occurrence of 2+ harm subtypes

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
Age group	55–64	34.75	28.60	40.89
	65–74	26.93	20.47	33.39
	75+	19.03*	9.92	28.14
Gender	Male	33.89	27.06	40.73
	Female	30.88	25.10	36.66
Ethnicity	NZ European	30.54	25.27	35.80
	Māori	35.65	24.57	46.74
	Pacific peoples	26.24	13.65	38.83
	Asian	48.30	22.06	74.54
	MELAA & Other	33.17	5.20	61.15
Partnership status	Not partnered	33.06	24.77	41.36
	Partnered	31.46	24.41	38.51
Region	Auckland	31.68	24.85	38.51
	Waikato	39.18	20.68	57.68
	Wellington	37.59	24.87	50.30
	Canterbury	34.46	19.36	49.56
	Rest of North Island	30.67	19.91	41.42
	Rest of South Island	17.86	3.99	31.73
	Unknown/Don't know/Refuse	33.13	5.06	61.21
Children (biological, adopted, or step)	None	34.31	20.42	48.20
	Has child/ren	31.86	27.19	36.53
Birthplace	Born in NZ	31.93	26.69	37.17
	Born overseas	33.06	22.11	44.02
Household size	1 person	28.45	18.83	38.07
	2 people	32.92	25.41	40.43
	3 or more people	34.69	25.16	44.21
Professional carer at home	No professional carer	31.69	27.19	36.19
	Professional carer	38.10	16.87	59.33
Home ownership	Doesn't own home	38.62	28.67	48.56
	Owns home	29.67	24.50	34.83
Employment status	Employed	32.72	25.36	40.08
	Not employed	35.53	24.71	46.36
	Retired	28.06	17.60	38.53
Household income	0-50k	36.77	25.92	47.63
	50k-100k	30.92	21.61	40.23

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
	100k+	33.02	21.91	44.14
	Don't know/Refuse	29.11	20.46	37.76
Highest qualification	Secondary school or below	34.50	26.86	42.14
	Post-school	30.74	23.25	38.23
	Bachelor's or higher	31.23	22.56	39.91
Self-rated physical health status	Moderate/Very good/Excellent	30.07	24.93	35.21
	Poor/Very poor	40.69	28.92	52.46
How many people to rely on?	Less than 3	30.28	21.62	38.94
	3-5	26.38	19.84	32.91
	5+	39.50	31.27	47.73
How difficult to get practical help?	Very easy/Easy	28.02	22.65	33.40
	Possible/Difficult/Very difficult	40.71	31.89	49.53
Disability status	No/Low functional limitations	33.64	28.40	38.87
	High functional limitations	27.70	18.94	36.47
Past harm by known person	No	28.74	23.08	34.40
	Yes	36.59	29.34	43.85
Kessler psychological distress	Likely to be well	33.90	27.37	40.43
	Moderate or High distress	30.07	23.43	36.71
Mental health condition	No	29.04	23.10	34.99
	Yes (diagnosed) or Think so (not)	35.82	28.19	43.46
Observations (unweighted)		**884**		

Note: Predicted probabilities from logistic regression of experiencing 2+ harm subtypes for those experiencing any form of AOP according to the CHI–Very Serious threshold. Excludes those with missing information for any of the relevant variables (approximately 7.5% of the sample). Predicted probabilities show the expected likelihood of experiencing harm for each group, holding all other characteristics (such as age, gender, ethnicity, income, and health) constant at their average values. These probabilities represent model-adjusted estimates rather than raw percentages. In each category, the first group listed is the reference group (base category) that all other relevant groups are compared to. For age, the model included both age and age squared to reflect non-linear patterns. Predicted probabilities for the three age groups (55–64, 65–74, and 75+) were then estimated by holding other characteristics at their average levels across the sample. All other variables are categorical. Shaded rows and * indicate statistical significance where the confidence intervals do not overlap with the base category.

9.4 Main person responsible for harm

This section considers who causes harm, and if there are factors that may indicate those groups most at risk from two of the commonly named sources of harm in the survey: partner or ex-partner, and child (see Section 5.1 for a full description of the survey data). As noted above, predicted probabilities are modelled estimates derived from logistic regression, controlling for other factors. They should not be interpreted as the actual share of survey respondents reporting a partner or ex-partner, for example, but as the estimated likelihood for groups with particular characteristics.

Partner or ex-partner

Table 41 presents the predicted probability that the main person responsible for harm was a partner or ex-partner among those who experienced any type of harm. Appendix Table 4 provides marginal effects from the logistic regression.

The model suggests that, on average, about one in five cases of harm are likely to involve a partner or ex-partner. This probability is similar for men (20.6%) and women (18.0%). Those aged 55–64 and 65–74 have probabilities of around 18%–19%, while those aged 75 and above have a lower predicted probability (8.2%). However, these differences are not statistically significant.

Ethnic differences are wide but imprecise. NZ Europeans have a predicted probability of 21.2%, and Māori 23.7%, but these estimates have overlapping confidence intervals. Pacific peoples (8.7%) and Asian respondents (10.7%) have much lower point estimates, although the confidence intervals are wide. MELAA & Other also have a broad confidence range. In all cases, confidence intervals overlap with the NZ European group, meaning none of these differences are statistically significant.

Other patterns emerge for relationship status, health, and social circumstances. People currently partnered have a predicted probability of 22.1%, compared to 12.4% – this is perhaps expected given the outcome of interest is that the main person responsible is a partner or ex-partner. Those reporting poor or very poor physical health have a substantially higher probability (28.1%), compared with 18.6% for those in moderate or good health. People who had previously experienced harm by someone they knew also show higher probabilities (23.9% versus 17.9%). Those who are not employed (24.4%) also have a somewhat higher probability compared with those employed (19.2%), possibly because some main persons responsible are work-related contacts for those who are employed. These factors are generally similar to those presented in the previous section, although mental health factors appear to be less strongly associated with who causes harm than with the likelihood of experiencing harm as an older person. However, none of these differences are statistically significant, and results should be interpreted with caution.

Table 41: Predicted probabilities from logit regression: Main person responsible (partner or ex-partner)

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
Age group	55–64	18.46	11.44	25.49
	65–74	19.41	12.17	26.64
	75+	8.12	0.12	16.12
Gender	Male	20.57	14.22	26.92
	Female	17.96	11.50	24.42
Ethnicity	NZ European	21.17	15.56	26.77
	Māori	23.68	11.44	35.92
	Pacific peoples	8.71	0.67	16.76
	Asian	10.65	-5.32	26.62
	MELAA & Other	20.68	-0.33	41.68
Partnership status	Not partnered	12.41	4.23	20.59
	Partnered	22.06	16.12	28.00
Region	Auckland	21.92	15.01	28.84
	Waikato	16.37	-6.35	39.09
	Wellington	20.31	10.43	30.19
	Canterbury	30.03	13.58	46.48
	Rest of North Island	9.99	3.48	16.50
	Rest of South Island	15.64	0.93	30.36
	Unknown/Don't know/Refuse	14.33	-6.78	35.45
Children (biological, adopted, or step)	None	11.45	1.24	21.66
	Has child/ren	20.30	14.95	25.66
Birthplace	Born in NZ	17.02	11.88	22.17
	Born overseas	25.80	15.47	36.13
Household size	1 person	16.43	5.89	26.97
	2 people	19.88	13.68	26.09
	3 or more people	19.62	10.19	29.06
Professional carer at home	No professional carer	19.35	14.22	24.47
	Professional carer	17.64	0.59	34.69
Home ownership	Doesn't own home	20.91	9.90	31.92
	Owns home	19.01	13.96	24.05
Employment status	Employed	19.28	12.29	26.27
	Not employed	24.49	13.23	35.76
	Retired	17.79	9.86	25.73
Household income	0-50k	18.44	8.50	28.38
	50k-100k	23.31	12.60	34.02
	100k+	17.83	9.21	26.45
	Don't know/Refuse	18.29	10.96	25.62
Highest qualification	Secondary school or below	16.52	9.86	23.19
	Post-school	19.02	10.79	27.26
	Bachelor's or higher	23.01	15.10	30.91
Self-rated physical health status	Moderate/Very good/Excellent	18.61	13.46	23.75
	Poor/Very poor	28.12	14.80	41.44
How many people can rely on?	Less than 3	23.69	12.10	35.28
	3-5	18.10	11.63	24.57
	5+	18.64	11.82	25.46
How difficult to get practical help?	Very easy/Easy	18.76	13.39	24.13

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
	Possible/Difficult/Very difficult	22.50	12.45	32.54
Disability status	No/Low functional limitations	20.31	15.20	25.41
	High functional limitations	13.06	4.80	21.33
Past harm by known person	No	17.96	12.67	23.24
	Yes	23.92	14.80	33.05
Kessler psychological distress	Likely to be well	19.18	13.86	24.50
	Moderate or High distress	19.71	10.67	28.75
Mental health condition	No	19.32	13.64	25.01
	Yes (diagnosed) or Think so (not)	19.12	11.49	26.75
Observations (unweighted)		**884**		

Note: Predicted probabilities from logistic regression of main person responsible being partner or ex-partner for those experiencing any form of AOP according to the CHI–Very Serious threshold. Excludes those with missing information for any of the relevant variables (approximately 7.5% of the sample). Predicted probabilities show the expected likelihood of experiencing harm for each group, holding all other characteristics (such as age, gender, ethnicity, income, and health) constant at their average values. These probabilities represent model-adjusted estimates rather than raw percentages. In each category, the first group listed is the reference group (base category) that all other relevant groups are compared to. For age, the model included both age and age squared to reflect non-linear patterns. Predicted probabilities for the three age groups (55–64, 65–74, and 75+) were then estimated by holding other characteristics at their average levels across the sample. All other variables are categorical. Shaded rows and * indicate statistical significance where the confidence intervals do not overlap with the base category.

Child

Table 42 shows the predicted probability that the main person responsible for harm was a biological, adopted, or stepchild among people who experienced harm. Women have a higher probability that their child was the main person responsible (22.8%) compared with men (16.1%). Among age groups, those 75 and older show the highest predicted probability (20.5%), although confidence intervals are wide, while those aged 65–74 are lowest at 14.3%. However, none of the differences are statistically significant.

There are large differences by ethnicity, although many estimates are imprecise. Māori have a predicted probability of 24.8%, higher than NZ Europeans at 18.2%, while Pacific peoples (16.0%) are close to the overall average. Asian respondents show a very high predicted probability (31.1%), but this result has a very wide confidence interval and is based on a small sample size.

Other factors also relate to higher probabilities. Those not partnered (25.5%) have higher predicted probabilities than those partnered (17.1%). Those with larger households (three or more people) have a 27.1% probability, compared with 18.6% for two-person households and 15.3% for those living alone. People who report difficulty accessing practical help show a markedly higher probability (28.1%) than those who find help easy to access (18.4%). Finally, those with a diagnosed or suspected mental health condition have a higher predicted probability (23.0%) compared with those without (19.0%).

While none of these differences reach statistical significance, the directional patterns are generally consistent with earlier results – suggesting that poorer health, greater support needs, and social risk

factors may increase the likelihood that a child is identified as the main person responsible for harm. These findings should be interpreted with caution given the limited sample size.

Table 42: Predicted probabilities from logit regression: Main person responsible (child)

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
Age group	55–64	16.00	10.23	21.77
	65–74	14.27	8.66	19.87
	75+	20.45	6.89	34.00
Gender	Male	16.10	9.14	23.07
	Female	22.76	16.02	29.50
Ethnicity	NZ European	18.20	12.47	23.94
	Māori	24.77	12.91	36.63
	Pacific peoples	15.97	3.99	27.94
	Asian	31.05	1.59	60.50
	MELAA & Other	17.66	-3.79	39.10
Partnership status	Not partnered	25.47	15.13	35.81
	Partnered	17.14	11.12	23.16
Region	Auckland	21.42	14.07	28.76
	Waikato	3.34*	-1.25	7.93
	Wellington	16.50	5.46	27.54
	Canterbury	15.16	2.29	28.03
	Rest of North Island	19.89	10.31	29.47
	Rest of South Island	19.21	2.94	35.49
	Unknown/Don't know/Refuse	38.62	8.43	68.81
Birthplace	Born in NZ	21.00	13.82	28.19
	Born overseas	16.20	8.14	24.27
Household size	1 person	15.26	7.18	23.35
	2 people	18.58	11.01	26.16
	3 or more people	27.09	16.90	37.28
Professional carer at home	No professional carer	20.38	14.54	26.22
	Professional carer	10.90	0.69	21.12
Home ownership	Doesn't own home	14.38	7.73	21.02
	Owns home	20.92	14.85	26.99
Employment status	Employed	16.11	9.42	22.81
	Not employed	20.63	10.05	31.21
	Retired	23.47	14.61	32.33
Household income	0-50k	19.51	9.23	29.80
	50k-100k	18.76	10.05	27.48
	100k+	21.14	10.56	31.72
	Don't know/Refuse	19.58	11.00	28.16
Highest qualification	Secondary school or below	23.71	16.05	31.37
	Post-school	19.87	12.03	27.71
	Bachelor's or higher	13.84	5.41	22.27
	Moderate/Very good/Excellent	20.07	14.36	25.79
Self-rated physical health status	Poor/Very poor	16.29	7.36	25.21
	Less than 3	18.49	8.73	28.26
How many people can rely on?	3-5	18.84	11.89	25.79
	5+	21.01	13.59	28.44

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
How difficult to get practical help?	Very easy/Easy	18.41	12.51	24.31
	Possible/Difficult/Very difficult	28.10	17.28	38.93
Disability status	No/Low functional limitations	18.95	13.26	24.64
	High functional limitations	24.31	13.87	34.76
Past harm by known person	No	19.47	13.38	25.57
	Yes	20.66	13.13	28.18
Kessler psychological distress	Likely to be well	20.43	14.36	26.50
	Moderate or High distress	16.95	9.68	24.21
Mental health condition	No	19.00	13.14	24.87
	Yes (diagnosed) or Think so (not)	23.00	14.11	31.89
Observations (unweighted)			**886**	

Note: Predicted probabilities from logistic regression of main person responsible for harm being the respondent's biological, adopted or stepchild for those experiencing any form of AOP according to the CHI–Very Serious threshold. Excludes those with missing information for any of the relevant variables (approximately 7.3% of the sample). Predicted probabilities show the expected likelihood of experiencing harm for each group, holding all other characteristics (such as age, gender, ethnicity, income, and health) constant at their average values. These probabilities represent model-adjusted estimates rather than raw percentages. In each category, the first group listed is the reference group (base category) that all other relevant groups are compared to. For age, the model included both age and age squared to reflect non-linear patterns. Predicted probabilities for the three age groups (55–64, 65–74, and 75+) were then estimated by holding other characteristics at their average levels across the sample. All other variables are categorical. Shaded rows and * indicate statistical significance where the confidence intervals do not overlap with the base category.

9.5 Help-seeking

Did you seek help?

Table 43 presents the predicted probability of seeking help among people who reported experiencing harm (see Section 7 for a description of the survey data). Women (62.9%) are more likely to seek help than men (52.4%). By age, those aged 75 and older show the highest predicted probability (64.1%), while those aged 55–64 and 65–74 sit closer to 56%–57%. None of these differences are statistically significant.

Differences by ethnicity are more pronounced. Māori have the highest predicted probability (68.4%), while NZ Europeans sit at 60.8%. Pacific peoples (45.0%) and Asian respondents (38.2%) have much lower predicted probabilities, and these estimates are well below the NZ European baseline, although the confidence intervals are wide, particularly for Asian and MELAA & Other groups. This finding supports those of the *Qualitative Interviews Report*, see Wilson et al. (2026), for Pacific communities' preference to not seek help or discuss AOP outside the family or community.

Although the regression results suggest a slightly higher predicted probability of help-seeking among overseas-born respondents, this difference is not statistically significant and should be interpreted with caution. In simple univariate results, overseas-born respondents were somewhat less likely to report

seeking help than those born in NZ (46.6% versus 50.2%). The apparent reversal in the regression model reflects the strong correlation between birthplace and ethnicity. For example, over 90% of Asian respondents and around three-quarters of Pacific respondents were born overseas, compared with fewer than one in five NZ Europeans and virtually no Māori. Because Pacific and Asian respondents also have the lowest help-seeking rates overall, most of the variation is attributed to ethnicity once both variables are included in the model, leaving little independent effect for birthplace.

Other patterns are less clear. People with bachelor's degrees or higher (66.7%) are more likely to seek help compared with those with only secondary education (54.1%). People with a diagnosed or suspected mental health condition are also more likely to seek help (64.3%) than those without (56.5%). Conversely, people with moderate or high psychological distress have a lower predicted probability (50.2%) than those likely to be well (59.8%).

Despite few of the probability differences being statistically significant, taken together with the findings discussed earlier and those in Section 7, these results again highlight the barriers to help-seeking some older people face. The somewhat mixed findings in Table 43 tentatively provide two insights. First, those older people who experience abuse may be able to seek help from those around them more easily if they are well and have people in their support network. Second, those more likely to be in contact with professionals and/or "the system", whether that be due to age, disability or a mental health condition, may have additional avenues to find help for the harm they are experiencing than those who are living more independently.

Table 43: Predicted probabilities from logit regression: Did you seek help?

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
Age group	55–64	56.19	48.76	63.62
	65–74	56.70	49.06	64.33
	75+	64.14	51.09	77.18
Gender	Male	52.41	44.44	60.38
	Female	62.94	56.04	69.83
Ethnicity	NZ European	60.76	54.35	67.16
	Māori	68.44	56.68	80.20
	Pacific peoples	44.95	26.40	63.50
	Asian	38.21	17.39	59.02
	MELAA & Other	21.58	-1.13	44.29
Partnership status	Not partnered	57.90	46.95	68.85
	Partnered	57.98	51.04	64.93
Region	Auckland	61.69	54.33	69.05
	Waikato	64.80	45.98	83.61
	Wellington	47.54	34.34	60.73
	Canterbury	60.50	44.56	76.43
	Rest of North Island	54.08	41.61	66.56

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
	Rest of South Island	60.17	40.35	80.00
	Unknown/Don't know/Refuse	49.69	21.33	78.05
Children (biological, adopted, or step)	None	59.63	45.45	73.82
	Has child/ren	57.73	51.89	63.58
Birthplace	Born in NZ	56.27	49.54	63.00
	Born overseas	62.65	51.35	73.95
Household size	1 person	63.70	52.19	75.21
	2 people	57.05	48.80	65.30
	3 or more people	54.88	44.52	65.24
Professional carer at home	No professional carer	58.22	52.41	64.03
	Professional carer	52.88	33.05	72.71
Home ownership	Doesn't own home	62.66	51.72	73.61
	Owns home	57.07	51.06	63.09
Employment status	Employed	57.08	48.68	65.49
	Not employed	65.54	52.92	78.15
	Retired	56.92	47.05	66.78
Household income	0-50k	53.37	40.78	65.95
	50k-100k	59.21	48.64	69.77
	100k+	61.05	50.21	71.89
	Don't know/Refuse	57.80	48.54	67.06
Highest qualification	Secondary school or below	54.10	45.54	62.66
	Post-school	55.26	46.74	63.78
	Bachelor's or higher	66.73	57.21	76.25
Self-rated physical health status	Moderate/Very good/Excellent	58.10	52.33	63.87
	Poor/Very poor	56.28	42.43	70.13
How many people can rely on?	Less than 3	55.88	44.61	67.15
	3-5	58.62	50.71	66.52
	5+	58.24	49.99	66.49
How difficult to get practical help?	Very easy/Easy	58.73	52.70	64.77
	Possible/Difficult/Very difficult	53.00	41.95	64.04
Disability status	No/Low functional limitations	57.32	51.41	63.22
	High functional limitations	61.91	50.82	72.99
Past harm by known person	No	58.94	52.67	65.21
	Yes	54.25	45.09	63.41
Kessler psychological distress	Likely to be well	59.70	53.46	65.94
	Moderate or High distress	50.02	39.98	60.06
Mental health condition	No	56.52	50.33	62.72
	Yes (diagnosed) or Think so (not)	64.31	54.67	73.95
Observations (unweighted)			**880**	

Note: Predicted probabilities from logistic regression of whether sought help for those experiencing any form of AOP according to the CHI–Very Serious threshold. Excludes those with missing information for any of the relevant variables (approximately 7.9% of the sample). Predicted probabilities show the expected likelihood of experiencing harm for each group, holding all other characteristics (such as age, gender, ethnicity, income, and health) constant at their average values. These probabilities represent model-adjusted estimates rather than raw percentages. In each category, the first group listed is the reference group (base category) that all other relevant groups are compared to. For age, the model included both age and age squared to reflect non-linear patterns. Predicted probabilities for the three age groups (55–64, 65–74, and 75+) were then estimated by holding other characteristics at their average levels across the sample. All other variables are categorical. Shaded rows and * indicate statistical significance where the confidence intervals do not overlap with the base category.

Did you want help?

Table 44 presents the predicted probability that people who experienced harm said there was some form of help or advice they would have liked to receive. Women (22.5%) were somewhat more likely than men (18.8%) to have wanted help or advice. By age, those who are 55–64 (21.4%) and 65–74 (20.3%) show similar probabilities, while those 75 and older (11.7%) report much lower levels of wanting support. However, none of these differences are statistically significant.

Differences by ethnicity are mixed. NZ Europeans (19.6%), Māori (20.7%), and Pacific peoples (19.1%) are similar, although Māori and Pacific estimates are imprecise due to smaller samples. Asian respondents stand out, with a much higher predicted probability of 35.9%, although this estimate has a wide confidence interval.

Some social and health factors also matter. People who reported difficulty accessing practical help have the highest predicted probability (35.1%), nearly twice that of those who found help easy to access (18.2%). Those with high functional limitations also had a higher likelihood of wanting help or advice (27.1% versus 19.8% for those with no and low functional limitations), as do people with a diagnosed or suspected mental health condition (30.1%) compared with those without (18.6%). Those who experienced harm from someone they knew are also more likely to say they wanted more help or advice (24.1%) than those who did not (19.8%). However, most of these differences are not statistically significant.

In addition to the survey findings discussed in Section 7.5, the unmet need for support is most acute for those who have fewer options for help (e.g. those who have no children or live alone). While the differences are not all statistically significant, the pattern points in a consistent direction, suggesting that supporting older people living in the community, particularly those without a reliable network of people to call upon when they need, may reduce the risk of harm and may provide support when it occurs.

Table 44: Logit regression predicted probabilities: Was there any type of help/advice you wanted?

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
Age group	55–64	21.36	15.09	27.62
	65–74	20.29	13.39	27.20
	75+	11.74	3.44	20.03
Gender	Male	18.83	12.92	24.74
	Female	22.49	16.07	28.90
Ethnicity	NZ European	19.55	14.11	24.98
	Māori	20.69	10.55	30.83
	Pacific peoples	19.07	5.96	32.17
	Asian	35.90	13.34	58.46
	MELAA & Other	8.08	-3.77	19.92
Partnership status	Not partnered	24.10	14.04	34.15
	Partnered	19.20	13.66	24.75
Region	Auckland	22.33	15.68	28.97
	Waikato	22.46	5.94	38.98
	Wellington	19.70	10.36	29.04
	Canterbury	18.14	6.01	30.26
	Rest of North Island	19.87	10.67	29.07
	Rest of South Island	13.01	2.63	23.39
	Unknown/Don't know/Refuse	25.17	-1.54	51.88
Children (biological, adopted, or step)	None	30.17	15.76	44.58
	Has child/ren	19.44	14.71	24.16
Birthplace	Born in NZ	21.64	16.16	27.13
	Born overseas	18.56	9.59	27.53
Household size	1 person	18.42	9.18	27.66
	2 people	19.98	13.48	26.48
	3 or more people	24.46	15.46	33.46
Professional carer at home	No professional carer	21.22	16.10	26.34
	Professional carer	12.71	3.05	22.36
Home ownership	Doesn't own home	20.30	12.11	28.48
	Owns home	20.88	15.47	26.29
Employment status	Employed	21.00	13.84	28.15
	Not employed	21.70	11.23	32.17
	Retired	20.19	11.02	29.36
Household income	0-50k	19.51	11.32	27.70
	50k-100k	19.17	10.84	27.50
	100k+	25.88	14.86	36.91
	Don't know/Refuse	18.67	10.89	26.45
Highest qualification	Secondary school or below	22.75	15.18	30.32
	Post-school	21.54	14.22	28.87
	Bachelor's or higher	17.43	10.42	24.45
Self-rated physical health status	Moderate/Very good/Excellent	21.09	16.05	26.13
	Poor/Very poor	17.84	8.54	27.13
How many people can rely on?	Less than 3	21.14	12.28	30.00
	3-5	19.11	12.61	25.62
	5+	21.97	14.85	29.08
How difficult to get practical help?	Very easy/Easy	18.35	13.15	23.54

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
	Possible/Difficult/Very difficult	35.07*	23.94	46.20
Disability status	No/Low functional limitations	19.78	14.81	24.76
	High functional limitations	27.05	16.40	37.70
Past harm by known person	No	19.77	14.49	25.05
	Yes	24.11	16.08	32.15
Kessler psychological distress	Likely to be well	21.53	16.04	27.02
	Moderate or High distress	18.13	11.28	24.98
Mental health condition	No	18.55	13.07	24.02
	Yes (diagnosed) or Think so (not)	30.05	21.27	38.83
Observations (unweighted)		**837**		

Note: Predicted probabilities from logistic regression of whether wanted any type of help/advice for those experiencing any form of AOP according to the CHI–Very Serious threshold. Excludes those with missing information for any of the relevant variables (approximately 12.4% of the sample). Predicted probabilities show the expected likelihood of experiencing harm for each group, holding all other characteristics (such as age, gender, ethnicity, income, and health) constant at their average values. These probabilities represent model-adjusted estimates rather than raw percentages. In each category, the first group listed is the reference group (base category) that all other relevant groups are compared to. For age, the model included both age and age squared to reflect non-linear patterns. Predicted probabilities for the three age groups (55–64, 65–74, and 75+) were then estimated by holding other characteristics at their average levels across the sample. All other variables are categorical. Shaded rows and * indicate statistical significance where the confidence intervals do not overlap with the base category.

9.6 Summary

The multivariate analysis shows that some factors are strongly associated with a higher likelihood of experiencing harm among people aged 55 and older. Age is a key factor, with risk highest among those aged 55–64 and lowest among those aged 75 and older, even after accounting for other social, economic, and health factors. Māori, Pacific, and people with poor physical health or functional limitations also have elevated risks compared to their peers. Past experiences of harm, psychological distress, and difficulty accessing practical help stand out as some of the most powerful markers of increased risk.

Patterns are similar across most harm subtypes, although the magnitude of risk factors differs by subtype. Co-occurrence of harm is most common among those with multiple risk factors, including poor health and prior harm. For those who have experienced harm, partners/ex-partners and children were most frequently identified as being responsible, and patterns differ by gender, age, and ethnicity. Help-seeking behaviours vary by group, with some groups – such as women – more likely to report seeking support, but confidence intervals are wide, and few results are statistically significant.

10 DISCUSSION

Summary

- The *Prevalence Survey* highlights that AOP is widespread, complex, and often embedded in close relationships of trust, with partners, children, and other family members frequently identified as responsible.
- The design of the survey shapes what is visible: harm by strangers and in institutions is excluded, and thresholds determine which experiences are included in the headline prevalence rate.
- Links to life course patterns are clear: past harm increases the likelihood of current harm, and some experiences overlap with family violence and IPV.
- Limitations include difficulties in measuring intent, power imbalance, and cultural understandings of harm, as well as small sample sizes for some groups.

This report has outlined the core findings of the *Prevalence Survey*, presenting an estimate of AOP and its various forms, and describing who is causing harm for people aged 55 years and over living in the community. In this section, we position these findings within the existing literature, discuss the limitations of the survey and grey areas present in any study of this nature, and highlight opportunities for the prevention of and response to harm of older people.

10.1 Framing and limitations of the survey definition of AOP

The survey adopted a widely used international definition of AOP. However, there are important conceptual and practical limitations with this approach, particularly when applied in the context of survey research. We note that other components of the *National Study* may shed further light on the issues included here and invite interested readers to refer to those supplementary reports.

Looking ahead, demographic change will also shape the picture. As the population ages, the absolute number of older people experiencing harm will grow even if prevalence rates remain stable. Structural factors such as declining home ownership or increasing demand on services may also create conditions that heighten risk, although further research is needed to assess these potential pressures.

Limitations of the ‘known person’ criterion and exclusion of institutional harm

By design, the survey focussed on harm caused by someone the respondent knows – consistent with international surveys. This aligns with the definition’s emphasis on relationships involving trust or a power imbalance (Qu et al., 2021; WHO, 2008) and helps focus the scope of measurement. However, this criterion does not always neatly reflect the complexity of an older person’s lived experience. For example, AOP may involve people the victim believes they know and trust, yet there is no real personal relationship – placing them in a grey area outside typical AOP definitions. Similarly, some of those responsible are known but not necessarily trusted, such as casual acquaintances, neighbours, or community members. These individuals may not occupy caregiving or familial roles, but can still cause significant harm. Reports involving work-related contacts are likely to fall into this category. They were concentrated in psychological and cultural & spiritual harm, with very few linked to financial harm. These reports may also help explain why prevalence estimates are higher among those aged 55–64 compared with older groups. It is possible that part of this difference reflects workplace bullying or harassment rather than AOP as traditionally understood.

Several international studies highlight the limitations of a narrowly defined “trust-based” scope. In the Irish National Study of Elder Abuse and Neglect, broader definitions that included harm by neighbours and acquaintances led to higher reported prevalence rates, suggesting that conventional definitions may underestimate true prevalence (Naughton et al., 2010). Likewise, in the UK *Study of abuse and neglect of older people*, prevalence rose from 2.6%–4.0% when the definition was expanded beyond trusted relationships to include less intimate or casual contacts (O’Keeffe et al., 2007).

These findings suggest that while the “known person” and “trust/power imbalance” framework is useful for survey clarity, it may exclude forms of abuse that are highly relevant to older people’s lives, especially those involving strangers, weak ties, or institutional systems. Examples include online scams or fraud by strangers, assaults by strangers, or institutional neglect. A broader definitional lens may be needed to fully capture the range of harm experienced.

Also, harm from government agencies or institutional systems was not included, although some respondents did name organisations such as ACC or IRD in open-text responses. These instances reflect systemic or structural power imbalances that can be harmful but fall outside the definition of AOP that was used.

Findings from companion qualitative research (Wilson et al., 2026 and GravitasOPG and Wai Rangahau, 2025) on cultural perspectives of AOP illustrate how institutional mechanisms can be used to facilitate or

legitimise harm. For example, legal mechanisms such as relationship property law may be used strategically in manipulative relationships to deprive older people of assets, despite clear elements of coercion or emotional abuse. Similarly, police responses may be shaped by the assumption that harm within families is private or less serious than those involving strangers, resulting in inaction when abuse is reported. This appears to be particularly true in cases involving financial control or psychological harm. In other cases, professionals such as doctors, lawyers, or social service providers may be drawn into family dynamics, accepting claims of cognitive decline or incapacity without adequate scrutiny. Even when unintentional, this can lead to older people losing autonomy over key decisions about their care, finances, or living arrangements.

These scenarios fall into a grey area where interpersonal abuse intersects with systemic processes. While not systematically captured in the survey, they are nonetheless significant and underscore the need for broader frameworks and safeguards that account for harm beyond conventional definitions of AOP.

Ambiguity in the power imbalance criterion

Another point of conceptual tension lies in the "power imbalance" criterion embedded in the definition of AOP. While the definition implies that harm occurs where there is an expectation of trust and/or a power imbalance, in practice, these dynamics are not always straightforward. For example, a physical altercation between two friends may not involve a clear hierarchy or clear power dynamic yet would still be captured in the survey if one party reports harm. In such situations, there may be mutual conflict or reciprocal harm, which complicates how AOP is classified. This does not diminish the harm experienced but rather highlights how real-life relationships are complex, often involving overlapping roles and blurred boundaries that may shift over time and between situations. Workplace relationships and corresponding dynamics may be similarly ambiguous, and worthy of its own discussion later.

This complexity has also been noted in international research. The Australian *National Elder Abuse Prevalence Study* included both trust and power imbalance in its working definition of AOP. This recognises that abuse may occur in non-familial or culturally complex relationships where an older person may be at risk of harm or dependent on others in non-traditional ways (Qu et al., 2021). Goergen and Beaulieu (2013) similarly argue that power imbalances are often present in trust relationships, but that abuse can also arise outside those bounds, such as when a person exploits an older individual's vulnerabilities without a pre-existing relationship. Recognising this, the Australian Government has commissioned additional targeted research to better understand the abuse and mistreatment experienced by groups with particular vulnerabilities. These groups include: Aboriginal and Torres Strait

Islander older people; older people with cognitive decline; those in regional, rural, and remote areas; and older people in Rainbow communities.

Further complicating this is the phenomenon of victim-perpetrator overlap, where some individuals may be both recipients and instigators of harm. For example, Reisig and Holtfreter (2018), in a study of older adults, found that prior victimisation and personal factors like poor mental health or social disconnection were associated with increased likelihood of engaging in harmful behaviour towards others. Broader research also shows that experiencing harm can increase vulnerability to both future victimisation and, in some cases, to using harm against others (e.g. Leiding et al., 2022; Song et al., 2022). Recognising this overlap does not excuse or minimise responsibilities. Rather, it highlights the need to move beyond binary notions of victim and perpetrator, and to understand that in some peer relationships or adversarial settings, roles and dynamics can be complex.

These complex dynamics are difficult to identify or resolve through large-scale survey data, which necessarily rely on simplified categorisations to ensure clarity and consistency in measurement. Nonetheless, their presence underscores the value of complementary qualitative research and flexible frameworks that can better reflect the realities of older people's experiences.

Self-neglect and the boundary of unmet need

Although the survey was not primarily designed to measure self-neglect, it does capture related experiences to some extent. For example, respondents were asked whether they needed help with day-to-day activities and, if so, who provided that help (see Appendix 2). One of the response options was that no-one had helped, which may indicate situations of unmet need or self-neglect. However, as discussed in Section 4.1 (specifically Table 8), those who chose "no-one" were not included in the measure of neglect as the study explicitly excludes this from the AOP definition.

However, distinguishing between self-neglect, unmet need, and neglect by others is not straightforward. In some cases, a person may lack help because they are socially isolated or unaware of available services. In others, they may refuse support, possibly due to past trauma, distrust, or a desire to maintain independence. Research highlights risk factors for self-neglect include cognitive impairment, disability, psychological distress, and lower levels of social connections (Dong & Simon, 2013; Dong et al., 2009; Dong et al., 2010; Dong et al., 2010). Alternatively, they may expect help from someone in their life – such as a family member or friend – that is not forthcoming, which may then meet the threshold for interpersonal neglect.

This points to a grey area between unmet need and neglect. While our thresholding approach aimed to capture repeated or serious gaps in care as potential neglect, some cases remain ambiguous. From a

policy and service delivery perspective, unmet needs that do not meet the formal threshold for AOP may signal a failure of support systems, representing a risk factor for further harm or declining wellbeing. The results presented in this report also suggest that older people experiencing neglect may face different challenges in acting themselves compared to those experiencing other forms of AOP (see, for example, Section 7 on help-seeking).

Qualitative findings reinforce that barriers to help-seeking – such as shame, fear of not being believed, or the perception that "no-one can help" – can contribute to these situations (Wilson et al., 2026). As such, self-neglect and unmet need may be early indicators of vulnerability, and their presence in the data should be interpreted with attention to both personal and structural contexts.

Misuse of legal safeguards enables harm

Legally sanctioned behaviour can cause harm, as discussed in the *Qualitative Interviews Report* (Wilson et al., 2026) and *Perspectives on Financial AOP Report* (Scott et al., 2026b), particularly in the context of family dynamics and financial control. These include:

- Manipulation of family trusts, wills, or inheritances to exclude or penalise older people
- Use of relationship property law by partners (often in exploitative or emotionally abusive relationships) to lay claim to an older person's assets
- Strategic use of an EPOA to gain control over financial or care decisions
- The use of legal systems to undermine the credibility or autonomy of older people, particularly by asserting cognitive decline without basis.

These behaviours may be technically lawful, yet can be experienced by older people as coercive, isolating, or exploitative. Research has highlighted that legal instruments can sometimes be misused in the context of financial abuse. For example, the Australian *National Elder Abuse Prevalence Study* found that older people with wills or EPOAs were, on average, less likely to report abuse overall, although a small proportion (around 1%–2%) of those with active EPOAs did report experiencing financial abuse linked to misuse of this authority. In contrast, family agreements were associated with a higher prevalence of abuse (21% compared with 15% for those without such agreements), highlighting the risks where informal arrangements are not supported by independent legal advice (Qu et al., 2021).

The Australian Law Reform Commission (2016) similarly notes that pressure to change wills or surrender assets under the guise of familial obligation or care arrangements can be a subtle, but damaging, form of abuse. In Ireland, financial harm has also been shown to be complex to identify and respond to, particularly when legitimate legal instruments are manipulated to the detriment of older individuals (Naughton et al., 2010). These concerns are echoed in both the *National Study* and other NZ-based

research, which highlights that close family members are the most common people responsible for financial abuse, and may sometimes exploit legal mechanisms, such as EPOAs, to control assets and decision-making (Davey & McKendry, 2011).

While the legal structures enabling these actions exist to protect individual autonomy, they can be weaponised by family members or caregivers, especially where oversight is limited. The Law Council of Australia (2023) stresses that legal practitioners themselves may unintentionally become complicit. For example, by witnessing powers of attorney or transfers of property without proper assessment of capacity, voluntariness, or undue influence. These issues are discussed further for the NZ context as part of the *Perspectives on Financial AOP Report* (Scott et al., 2026b).

The harm in these cases arises not only from the immediate material or relational impact, but also from the legitimacy and invisibility these behaviours are afforded by institutional systems. Health or legal professionals may accept family narratives without deeper scrutiny, especially where claims of cognitive decline are made, compounding the harm experienced by the older person and eroding their autonomy.

These examples raise critical systemic questions: Are legal and institutional safeguards sufficient to protect older people from being harmed under the guise of procedural fairness? How well do existing frameworks detect and respond to coercive family dynamics, especially when abuse is hidden under the surface of lawful processes? Also, what accountability mechanisms exist to challenge abuse that is lawful but harmful?

Recent legal guidance has emphasised the need for enhanced protections, including stronger checks on EPOAs, clearer protocols for assessing consent and capacity, and greater awareness among professionals working with older adults (Law Council of Australia, 2023). In NZ, clarity is required on what "best interests" and "supported decision-making" (rather than "substituted decision-making") looks like for older people – especially those with diminished capacity – with calls for a thorough reworking of the relevant legislation (Protection of Personal and Property Rights (PPPR) Act 1988). The NZ Law Commission is currently reviewing the PPPR and the *National Study*'s findings, including the *Qualitative Interviews* (Wilson et al., 2026) and *Financial and Legal Perspectives* (Scott et al., 2026b) reports, recommend this legislation be overhauled urgently.

These findings suggest a need for greater professional vigilance and broader systemic reform – moving beyond criminal thresholds or narrow interpersonal definitions to also consider how legal and structural frameworks can enable abuse. As the Australian Institute of Family Studies (2022) points out and the *National Study* highlights, these issues are often under-reported and poorly understood, yet they are central to how AOP manifests within families and across legal systems.

Ambiguity around subtypes of harm

Categorising abuse into distinct subtypes – such as psychological, cultural & spiritual, financial, physical, sexual, or neglect – is standard in international AOP research and serves a practical purpose in survey design and analysis. It helps structure the questionnaire, guide threshold-setting, and enables comparison across studies (see Scott et al., 2026a, for a review of international prevalence studies).

However, this approach also has important limitations. In practice, abuse is often multifaceted and overlapping, and fixed categories may not fully reflect the ways older people experience or describe harm. For example, being prevented from speaking one's language, participating in cultural or spiritual practices, or seeing one's grandchildren could plausibly be interpreted as psychological, cultural, or spiritual harm – depending on the individual's perspective and context. Further, some studies use distinct subtypes to describe particular types of behaviour, like "social abuse", to characterise situations where an older person is deliberately isolated or experiencing abandonment (Blundell et al., 2017; Yan & Tang, 2001, 2004; Dong et al., 2007). This may be indicative of neglect or psychological abuse, with classification often depending on the research focus of the study.

These complexities are particularly salient across different cultural, spiritual, and social worldviews, where harm may be defined relationally or symbolically, rather than by isolated behaviours. The *National Study's* qualitative component (Wilson et al., 2026) illustrated how cultural expectations – such as reciprocity, respect for elders, or the role of grandparents – are central to understanding when and why harm is experienced.

GravitasOPG and Wai Rangahau's (2025) research into cultural perspectives of AOP reinforces this, particularly in relation to Pacific and Māori participants, who described exclusion from language, cultural rituals, or spiritual spaces as distressing. Pacific research participants highlighted exclusion from church or family events, or being dismissed when speaking their language, was experienced as both cultural and psychological harm. Similarly, Māori participants highlighted that disconnection from te reo (language), tikanga (cultural values and practices), or whakapapa (ancestral connections) was often felt as harm to their wairua (spirit), impacting their emotional wellbeing. While such experiences may not always be recognised or categorised as harm by mainstream services, they were clearly described as harmful by participants.

As mentioned above, international surveys draw these lines differently. Only one study – Qu et al. (2021) for Australia – provides a scale for the cultural and language abuse of older adults and asked these items only of their CALD participants. In that study, while some behaviours could also have been captured through the broader psychological abuse module (e.g. the "anything else to cause you emotional

distress" item), a targeted set of questions was considered appropriate to reflect the experiences of CALD participants. Motivated by these factors, the *National Study* expanded on the Australian scale, incorporated spiritual abuse alongside cultural and language harm, and asked the questions of all older people taking part in the survey.

However, there remains some ambiguity between harm subtypes. For example, the Australian study (Qu et al., 2021) included the question whether, in the last 12 months, someone you knew "[m]ade you feel that you are just free labour (e.g. doing most of the household work or providing childcare, etc)" under harm relating to cultural and language. In contrast, our study classified the same item under psychological harm given this experience is not necessarily culturally-specific and may occur in a wide range of interpersonal contexts (see the supplementary *Thresholds Report* for a direct comparison; Scott et al., 2026a). For instance, Stats NZ reports that one in four children were cared for by grandparents in 2017 (Stats NZ, 2023). Informal childcare or household work arrangements are not limited to specific cultural contexts, although their prevalence and impact may differ for some groups relative to others.

While the subtype framework remains a practical tool, it is important to interpret findings with an understanding of this underlying ambiguity – and to complement quantitative data with qualitative insights that can illuminate the complexity and interconnectedness of abuse in older people's lives.

Age-related harm versus general harm: The example of workplace harm

Like other international studies, the NZ survey defines AOP based on who experiences the harm (i.e. someone aged 55+), rather than why the harm occurs. It does not attempt to distinguish whether a harmful act was motivated by ageism or whether age played any role in the behaviour of the person responsible.

This definitional approach raises important questions about the scope of AOP. For instance, should harm experienced by someone aged 55 or over qualify as AOP if it is not clearly linked to age or age-related vulnerability? Conversely, should harm that is clearly ageist but occurs outside traditional familial or trust-based relationship settings (e.g. the workplace) be included?

The survey was not designed to specifically capture harm experienced in the workplace – a limitation that aligns with other AOP prevalence studies, including those in Australia, Canada, Ireland, and the UK. These studies focus on abuse within relationships of trust or power imbalance, typically involving family members, friends, neighbours, or professionals in caregiving roles. They also (except for the Canadian study) set higher age inclusion criteria, reducing the proportion of working respondents in their samples

relative to our study. As such, workplace harm is not explicitly excluded, but nor is it systematically considered or measured within the design or definitions used.

Nevertheless, a notable number of respondents in the NZ survey referred to workplace-related harm in open-text responses. In fact, this response was common enough to warrant the creation of 'work-related contact' as a separate category. The survey results raise important definitional and practical questions: Does harm experienced at work by someone aged 55 or over qualify as AOP? If so, under what conditions?

A potential issue is that workplace harm may not be related to age, nor occur in relationships that are necessarily characterised by interpersonal trust or power imbalances. For example, a colleague may be known to the respondent but not fall within the definition of a relationship involving trust or a power imbalance. Conversely, some forms of workplace harm – particularly those stemming from age-based discrimination or organisational hierarchies with in-built power imbalances – may align more closely with the AOP definition.

The mention of harm occurring in respondents' workplaces suggests a need for further research into how older workers experience bullying or discrimination – and whether such experiences differ in nature or impact from those reported by younger age groups. Future research may benefit from integrating insights from general workplace bullying studies to explore overlaps and distinctions between workplace mistreatment and AOP, including ageism (see, among others, Sinclair et al., 2024; Previtali et al., 2022).

Further complexity for older workers may be additional caregiving roles that occur alongside paid work. For example, caring for grandchildren (discussed earlier) or ageing parents can present challenges to those balancing care with paid employment (Alpass et al., 2017). As highlighted by the findings presented in this report, multi-generational and/or larger households potentially increase complexity in relationships and may be a risk factor for experiencing harm as an older adult. If caregiving and work also occur alongside these demographic and social factors, it is possible risks compound, particularly for some AOP subtypes like psychological harm.

These findings underscore the complexity of categorising and addressing harm experienced by older individuals, particularly in settings like the workplace that fall outside traditional definitions of AOP. They highlight the importance of nuanced approaches that consider both the nature of the harm and the context in which it occurs.

10.2 Younger older people (aged 55–64 years)

The challenge of aged-based definitions

As discussed in Section 2, a 55+ age threshold was used, consistent with the Canadian survey.[15] This age eligibility criterion was primarily chosen for inclusiveness and the possibility of earlier onset of ageing-related risk, on average, among some populations. However, defining AOP based solely on the age of the victim raises conceptual challenges. In effect, this framing can imply that any harm experienced by someone aged 55+ qualifies as AOP, regardless of whether it relates to their age, risk, or position in a power dynamic.

Alternatives have been put forward (e.g. Blundell et al. (2017) propose definitions focusing on risk and power imbalances rather than solely age). Aligning the age eligibility criterion with the typical retirement age has also been suggested (and appears regularly across the AOP prevalence literature), although as presented in Section 8.11, retirees tend to report experiencing AOP at lower rates than employed or not employed older people. Given this, basing the age criterion on possible retirement risks underestimating the prevalence of harm experienced.

Using age as a defining criterion for AOP becomes particularly problematic in scenarios such as workplace bullying, neighbourhood disputes, or interpersonal conflict, where the harm may have little or nothing to do with the person's age or perceived status as an older person. While these experiences can be harmful and distressing, it is not always clear whether they fit within the objective of AOP frameworks, which focus on abuse that is shaped by age-related power imbalances, care need or dependency, or social positioning.

At the same time, there is a risk of over-restricting definitions and excluding genuine age-related harm, such as situations involving ageism, coercive caregiving relationships, or financial exploitation targeting older people. This highlights a core tension in the field: should AOP be defined by who the person is (e.g. aged 55+), or by why and how the harm occurred?

This study, like most large-scale international prevalence surveys, leans toward the former – defining AOP based on the age of the person experiencing the harm. This approach offers a practical and consistent basis for measurement in a national survey, where nuanced contextual assessment of each situation is

[15] For further discussion of age in prevalence studies, see the supplementary *Thresholds Report* for a review (Scott et al., 2026a).

not feasible. Nonetheless, qualitative findings underscore the importance of recognising and responding to the complexity of abuse experiences, particularly where age is just one of many intersecting factors.

Prevalence of AOP for younger older people

Across all harm subtypes,[16] prevalence rates were notably higher among respondents aged 55–64, compared with those aged 65 and over (see Section 8.2). While the survey was not designed to investigate the causes of this age pattern, we propose possible explanations here with suggestions for future research.

One possibility is that people in this age group are more likely to be socially and economically active, potentially increasing their exposure to a wider range of interpersonal interactions – such as workplace relationships, caregiving responsibilities for both older and younger generations, and shared living arrangements with adult children or other family. Indeed, the survey revealed that, as expected, respondents in this age group were more likely to be employed and tended to live in larger households, on average. This may increase the number of contexts in which harm could occur.

Although highly speculative, another consideration is that individuals in this younger age group may be less likely to normalise or minimise behaviours, particularly in relation to psychological harm. Thus, it is possible that younger respondents were more likely to identify and report certain situations as harmful when prompted.

The survey was intentionally designed to mitigate the influence of subjective labelling or generational differences in recognising harmful behaviour. It presented respondents with a series of behaviourally-specific questions that focused on concrete situations and actions/inactions. This approach reduces the reliance on personal interpretation or self-identification. By asking about experiences directly – such as being insulted, pressured to give money, or prevented from seeing family – the survey captures a wider range of potentially harmful situations, regardless of whether the respondent would label them as "harmful" or "abusive". This strengthens the validity of the finding that rates of certain forms of harm are higher among those aged 55–64. However, despite this approach, it is still possible that age-related differences in perception, recall, or willingness to disclose certain experiences may influence responses across age groups.

[16] Not all differences were statistically significant for 55–64 year olds versus 65–74 year olds, but most were – including overall AOP. Confidence intervals did not overlap for the 55–64 year olds versus those 75+, indicating these differences were statistically significant.

It is also worth noting that this age group often sits in a transitional life stage, where pressures from work, financial strain, family and/or caring responsibilities, and early signs of health decline may intersect in ways that increase both the risk of harm and difficulty in seeking support.

Overall, these findings underscore the importance of not treating "older people" as a homogenous group, and of including younger older adults in prevalence research. The 55–64 age range may represent a particularly under-recognised risk period for interpersonal harm, especially (but not limited to) psychological harm.

10.3 Intersecting trajectories: Intimate partner violence (IPV) and AOP

One important (but underexplored) dimension of AOP is its overlap with IPV. While AOP is often framed as a distinct form of harm, findings from the *National Study* suggest that in some cases (but not all), it may reflect the continuation or transformation of earlier-life harm, particularly in long-term intimate relationships (Mikulionienė & Tamutienė, 2019; McGarry et al., 2014). Distinguishing between AOP and IPV at all, especially for female victim-survivors, remains controversial in the violence against women literature (Bows, 2019). We return to gender in Section 10.4.

In the *Prevalence Survey*, we can gain some insight into IPV prevalence for older adults using the relationship data; across all harm types measured, partners or ex-partners were the most common people responsible (followed closely by adult children, discussed further below). In a separate report, commissioned by MSD as part of their Older People Work Programme, Fanslow and Gulliver (2025) explore the older adult cohort of the New Zealand Family Violence Study (He Koiora Matapopore; 'NZFVS'). It is useful to consider their findings here, in the context of AOP and the *Prevalence Survey*.

The NZFVS asks broadly similar behavioural questions to the AOP *Prevalence Survey*, but the questionnaires differ in two important ways. First, more behavioural items are included for each harm subtype in the AOP survey (32 in total, for the common subtypes) compared to the family violence study (23 harmful acts in total). Neglect and cultural & spiritual harm are not measured in the family violence study, due to neglect's relevance to AOP, rather than general family or IPV, and the novelty of cultural & spiritual harm to the current study. Second, for subtypes that are common to both surveys, the items differ in such a way that limits direct comparisons. For example, the physical harm scale is nine items in the AOP survey and six in the family violence study, and individual acts overlap in the two. The NZFVS asks "slapped you or thrown something at you that could hurt you?", then later "hit with their fist or with

something else that could hurt you?" In the AOP survey, we asked respondents if someone had "hit, punched, kicked or slapped you" and then separately, "injured you with a weapon (e.g. knife, gun, or any other objects)".

With this caveat in mind, both the findings contained in this report, and Fanslow and Gulliver's (2025) analysis of the NZFVS data for individuals aged 55 years and above, highlight that social connections – especially access to a reliable and helpful network – are protective against harm as an older person. Interestingly, the NZFVS data finds that for women, only age and relationship status were linked to recent IPV experiences. In contrast, men's victimisation was associated with age, disability, and their social connections. In Section 8.1, we report that women are more likely than male respondents to report experiencing neglect or sexual harm involving their partner or ex-partner. For men, psychological harm caused by their partner or ex-partner was reported at a higher rate than women (see Section 10.4 for further discussion).

Also, Section 8.15 outlined that experiences of past harm, especially from someone known, may increase the risk of further harm later in life – while we cannot know how a respondent perceived the question of past experiences of harm, it is likely the survey captured some ongoing experiences of abuse, prior to being an "older person". These findings are consistent with international research and the *National Study*'s qualitative interviews, which show that intimate partner relationships are a key site of harm for many older people – whether the abuse is newly emergent or part of a longer-term pattern (Wilson et al., 2026; Mikulionienė & Tamutienė, 2019). Wilson et al. (2026) found that several older people were continuing to experience coercive control, financial manipulation, or psychological abuse from current or former partners. In some cases, these relationships have been harmful for many years; in others, abusive dynamics emerged or escalated in later life, sometimes after a major life change such as retirement, disability, or bereavement.

This evolving dynamic highlights a broader point that risk factors, power, and dependency can shift over time, particularly as ageing and health changes affect one partner more than the other. A partner who had historically held power in a relationship may become more at risk due to illness or cognitive decline. Conversely, a partner who was previously more dependent may assume new forms of control – such as financial, emotional, or social – over the other. Harm in these circumstances may be rooted in long-term relationship dynamics but refracted through the lenses of ageing, caregiving, and changing roles. Due to the nature and scope of the *National Study*, non-fatal forms of harm are the focus. However, the Family Violence Death Review Committee's (2025) recent report on femicide highlights disability and chronic health conditions as contributing to older women's risk of homicide – the Committee notes that as the population ages, such risks may continue to increase.

Also, older adults may face different challenges and barriers to leaving abusive relationships, including financial dependence, reduced health and mobility, loss of social networks, and emotional exhaustion from a lifetime of coping (McGarry, 2019). As one qualitative research participant noted, the emotional and practical resources required to end a relationship may diminish with age, making long-standing IPV even harder to escape in later life (Wilson et al., 2026; Mikulionienė & Tamutienė, 2019).

Research in the UK also raises issues in relation to support and service provision for older people within the context of IPV. McGarry et al. (2011) highlight confusion among agencies as to what constitutes AOP versus IPV in later life, which can act as a barrier to service access and service provision. Recognising the overlap between IPV and AOP has both conceptual and practical implications. It calls for integrated frameworks that recognise abuse across the life course – called for by Fanslow and Gulliver (2025), among others – as well as support services that are responsive to the specific challenges older IPV victim-survivors face. It also suggests that AOP studies should not treat AOP as categorically distinct from IPV, but instead consider how abuse may persist or evolve over time, shaped by changing relational dynamics and ageing itself.

Other forms of family violence

Intimate partners or ex-partners are not the only people involved in cases of AOP – older people identified their (adult) children as being responsible for harm almost as often. For financial and physical harm, children were the main person responsible for harm for roughly one in five respondents (Section 5.1). For older women, as discussed in the next section, their child is named as the person causing them harm more often than other relationship categories. This section briefly discusses other familial relationships and AOP, beyond intimate partners or ex-partners.

Findings on adult children (and other family members) as a common source of AOP are supported by the results on the characteristics of those responsible for harm in Section 5.2, with over one-third aged between 3049 years and more than half aged between 50–69 years. The *Prevalence Survey* also highlights that family dynamics, including complex caregiving arrangements and large, intergenerational households, may complicate relationships and potentially contribute to harm – especially pyschological harm.

In the literature, child-to-parent violence is recognised as understudied and under-reported. Joosten et al. (2019) argue that such intergenerational violence represents a distinct relational dynamic and that interventions geared towards IPV are not always suitable for harm involving an adult child. Often, preserving the relationship and keeping the adult child from getting into trouble are cited as key reasons for avoiding intervention. In the *National Study*'s qualitative interviews, reporting the adult child to

authorities was described by some participants as risking a negative impact on their grandchildren (Wilson et al., 2026).

In cases of fatal violence, the Family Violence Death Review Committee (2025) emphasises the role of older people, typically women, in caring for adult children with complex mental health conditions. The *Qualitative Interview Report* also highlights the lack of support for carers of adult children and grandchildren with Foetal Alcohol Spectrum Disorder (FASD) (Wilson et al., 2026). In both cases, inadequate mental health, medical, and social support for the older person's family member directly places the older person in harm's way at a life stage when they themselves may be facing declining health.

Not all children responsible for harm were living with a mental health condition or disability that impacts their ability to interact safely with their older parent; many were described as having no challenging life circumstances at the time the harm occurred (Section 5.3). Facing challenging circumstances, including addiction or financial problems, is not a precursor to committing AOP. However, understanding the situational contexts of those causing harm, including risk factors and potential stressors, can inform prevention and response strategies. Further, such information highlights gaps in current institutional responses to help-seeking. Addressing factors that heighten the risk of AOP – especially those that could be avoided with improved mental health systems and support for children/grandchildren with disabilities including FASD – acknowledges the relationship as important to the older person, and worth preserving.

10.4 Gender

The survey found relatively small differences in overall prevalence rates of harm between men and women. This is consistent with the NZ Crime & Victims Survey (NZCVS), which also shows broadly similar levels of victimisation between genders when looking at overall harm or measures such as controlling behaviour, which do not apply thresholds. However, both the NZFVS and international studies show that women are more likely to experience family violence, sexual assault, and IPV, and that these incidents are often more severe, coercive, and sustained (Fanslow et al., 2023; World Health Organization, 2021). For example, pooled NZCVS data from years 1 to 7 shows women report higher prevalence of IPV (2% compared with 0.6% for men) (Ministry of Justice, 2024). Bows (2019, p. 6) also notes that "research examining violence against older women is primarily located in elder abuse, domestic violence and sexual violence studies", producing definitional variation and at times contradictory findings. Some of these complexities were discussed further in Section 10.3.

In this survey, the prevalence of most abuse subtypes was broadly similar across genders, with the only exception being sexual harm, where the prevalence rate for women was higher (Section 8.1). Men and women reported experiencing harmful behaviours at comparable rates, although their experiences of AOP may differ. While about one-fifth of respondents identified partners or ex-partners as being responsible for the harm across both genders (see Section 10.3), more women identified their child as the person causing them harm. The types of AOP experienced and who caused the harm also differed by gender. For example, women experienced financial and psychological harm caused by their child at a higher rate than men, while men experienced neglect by their child at a higher rate than women.

Where differences may emerge is in the severity, impact and context of harm. Existing research indicates that women are more likely to report fear, repeated harm, and serious emotional or physical consequences – including injuries, psychological trauma, and greater disruption to daily life. This pattern has been observed in the NZFVS, which found that while men and women experience partner violence at similar rates, women are more likely to face sustained abuse with a controlling or coercive dynamic. NZCVS also shows marked gender differences in lifetime experiences: 22% of women compared with 10% of men reported lifetime IPV, and 35% of women compared with 12% of men reported lifetime sexual assault (Ministry of Justice, 2024).

In the *Prevalence Survey*, there do appear to be some differences in perceived severity – women are marginally more likely to report their experience as serious, although these differences were not statistically significant. As mentioned in Section 10.3, Fanslow and Gulliver (2025) find (older) women experience higher lifetime rates of serious physical and sexual IPV, controlling behaviours, and psychological and economic IPV. In contrast, they find (older) men reported higher 12-month rates of any IPV, psychological and moderate physical IPV. As discussed previously, the two genders had a differing list of risk factors in the NZFVS; namely, men who were disabled experienced higher rates of IPV (Fanslow & Gulliver, 2025). While we do not report bivariate sample statistics here, we do note higher AOP prevalence rates for those with high functional limitations than those with no or low functional limitations (Section 8.12).

At the same time, research shows that gendered patterns of help-seeking can influence observed prevalence. For example, Australian-based research finds women are more likely to access helplines (Joosten et al., 2019). Older men are often less likely to disclose certain types of harm, particularly psychological, due to societal expectations around masculinity, a desire to handle problems privately, and a lack of tailored support services (Joosten et al., 2019). In the accompanying qualitative interviews, male participants reported that support systems often felt geared towards women, and that social stigma made it harder for them to identify as victims or access help (Wilson et al., 2026).

Conversely, Fanslow and Gulliver (2025) noted that of the men aged 55 years and above who experienced IPV in the NZFVS data, over two-thirds (71%) stated they were married but not living together. None of the men who experienced serious or moderate physical violence were co-habiting with a partner, perhaps suggesting that men may face fewer barriers to ending relationships with abusive intimate partners (Fanslow & Gulliver, 2025).

These findings suggest that while AOP affects both men and women, gender shapes not only the experience of harm but also how it is recognised, responded to, and reported. To ensure effective prevention and support, future work should continue to explore gender-specific dynamics in both severity and help-seeking, and ensure services are inclusive and accessible to all genders.

10.5 Help-seeking

Patterns of help-seeking among older people who experience harm are complex and shaped by multiple personal, relational and systemic factors. The survey findings indicate that help-seeking behaviours vary by AOP subtype, and these differences should be kept in mind when interpreting service provider data or designing interventions.

As reported in Section 7, financial and physical harm were the subtypes for which help was most often sought, while sexual harm, neglect, and cultural & spiritual harm had the lowest help-seeking rates. Older people most often turned to people they knew personally for support. Psychological abuse – despite being the most prevalent subtype – had a particularly low rate of formal sources of support. This aligns with existing AOP research that psychological and relational harm are often minimised, internalised or kept private.

This variation may help explain why service provider data can give a skewed view of AOP prevalence. Financial abuse, for example, can be more visible to third parties – it may be easier to report or detect through banking systems or legal processes. However, Scott et al. (2026b) highlight that there is significant variation across professional sectors like banking, for both detection and response. Even when financial abuse is identified, there is unlikely to be an accessible, clear, or systematic response available – responses are frequently fragmented, inconsistent, and poorly tailored to older people's circumstances. Psychological harm or neglect, in contrast, may remain entirely invisible unless disclosed directly. This suggests that administrative data sources may under-represent some types of abuse more than others, particularly those that are less tangible or do not result in medical or police interventions (Chen et al., 2026b).

The survey also explored reasons why people did not seek help, see Section 7.2. Beyond apparent self-reliance (a desire to handle it themselves), specific barriers stood out for some subtypes. For example, older adults experiencing:

- neglect were more likely to say they didn't know who to ask or felt no-one would help.
- financial or psychological harm were more likely to cite privacy.
- neglect or physical harm cited embarrassment more often relative to other subtypes.
- sexual harm were more likely to report that they didn't need help.

These findings were echoed in the qualitative interviews – see Wilson et al. (2026). Many older people described reluctance to seek help until the abuse had escalated, often citing shame, fear of being a burden, a desire to maintain family relationships, or the belief that others would not understand or care. For some, the person responsible for the harm had alienated them from their support network or discredited them – often by invoking claims of cognitive decline – making it harder to seek help or be believed.

Help-seeking is also shaped by trust in services. In this report, "formal support services" refers broadly to both government providers (such as MSD-funded Elder Abuse Response Services, police, and health professionals) and community organisations (such as Age Concern, Women's Refuge, and other NGOs). Feelings that these systems are not targeted nor designed for a diverse community of victim-survivors (e.g. men, disabled older people, those from culturally diverse backgrounds) are not uncommon. Existing research also highlights age as a barrier to accessing safety from violence, especially when the person responsible is an adult child (Joosten et al., 2019). In the *Qualitative Interviews Report*, participants described poor past experiences with services (e.g. dismissive response from police or medical professionals), which reduced the likelihood they would seek help again (Wilson et al., 2026). GravitasOPG and Wai Rangahau (2025) echo these themes. Pacific and Māori participants often described a lack of cultural safety and mistrust in mainstream services, particularly where staff lacked understanding of cultural values or did not recognise culturally-specific forms of harm (Wilson et al., 2026).

International research reinforces these findings. A systematic review by Fraga Dominguez et al. (2019) highlights that barriers to help-seeking include shame, fear of retaliation, dependency on the person responsible for the harm and not recognising the situation as abuse. Further, older people may only seek help once the harm becomes "unbearable" or they "fear for their safety" (Fraga Dominguez et al., 2019, p. 466). Victims are often silenced by family dynamics (including not wanting to get a loved one in trouble), stigma, or diminished self-confidence resulting from the abuse itself (Wilson et al., 2026).

Potential implications of these findings include:

- Service statistics alone should not be used as a proxy for prevalence. They likely reflect the most visible and reportable forms of harm rather than providing a full picture of AOP.
- Help-seeking behaviours are not evenly distributed across all subtypes or demographic groups. Culturally appropriate, trauma-informed, and accessible services are critical to improving disclosure and response. While the survey did not assess service quality, particularly not that of individual providers, these themes were consistently raised in qualitative interviews and in wider research (e.g. Wilson et al., 2026; GravitasOPG & Wai Rangahau, 2025).
- Public awareness campaigns can usefully address normalisation, privacy concerns, and stigma, particularly for psychological and cultural & spiritual abuse, which are under-reported. Survey findings show these forms of harm are often not recognised or disclosed, while qualitative interviews highlighted shame, normalisation, and poor past experiences with services as barriers to seeking help. This suggests campaigns could place greater emphasis on raising awareness of less visible forms of harm, tailoring messages for groups under-represented in help-seeking (e.g. men, Asian and Pacific respondents, and those aged 55–64), and ensuring cultural relevance.

11 CONCLUSION AND RECOMMENDATIONS

This report presents findings from NZ's first *National Prevalence Survey on the Abuse of Older People*. The survey provides crucial insights into the extent and nature of abuse experienced by older people in NZ, highlighting both overall prevalence and differences by demographic characteristics.

The results indicate that approximately one in six respondents (16.7%) reported experiencing some form of harm in the past 12 months. This figure reflects the scope of the survey, which focused on harm caused by people known to the respondent. It does not include harm by strangers (such as scams) or in institutional settings, so the actual prevalence of harm affecting older people is likely to be higher. Psychological abuse was the most reported subtype, followed by financial, cultural & spiritual, physical abuse, neglect, and sexual abuse. We report estimates using thresholds for neglect, and psychological and cultural & spiritual abuse, that capture both the frequency and perceived severity of behaviours that cause harm.

International comparisons should be treated with caution. This study was designed specifically for the NZ context, and differences in survey scope, design, and reference populations mean results cannot be directly compared across countries. While an international review suggests NZ's prevalence rate of one in six older people is similar to global estimates (Yon et al., 2019), such comparisons should be interpreted carefully. The NZ rate also appears higher than Australia across most harm types, but this may reflect differences in survey design rather than true differences in prevalence. The *National Study* expanded on previous research in two key ways:

1. The broader age range (55+ versus 60+ or 65+ in most international studies).
2. The expansion of behavioural items considered to cause harm, including a novel behavioural scale measuring cultural & spiritual harm.

In this section, we outline recommendations informed by the report's findings and suggest opportunities for future research.

Recommendations

The survey provides important insights into the prevalence and nature of AOP experienced by older people in NZ. Our report highlights clear areas for policy attention and further investment.

Prioritise communities at greatest risk

Older people who are disabled and/or socially isolated face significantly heightened risks of abuse. These communities should be prioritised in prevention and response strategies, including the development of

tailored services, outreach models, and safeguarding mechanisms. Survey findings in this report, as well as other recent work in NZ, reinforce the urgent need for targeted, community-informed interventions. Community-led supports already exist for some groups, such as Rainbow older people and those from migrant or refugee backgrounds, providing useful foundations to build on. However, these initiatives are often small in scale and may lack the reach, resourcing, or specialist training needed to consistently meet demand across all high-need groups.

Direct support to high-need groups

The same groups – older people with disabilities and those experiencing isolation – should be considered priority populations for support, funding allocation, and service development. Additional investment in carer training and support, particularly for those supporting family members with high and complex needs, would also strengthen the response system. Further, older people who are caring for family members with complex needs, including mental health challenges, need dedicated supports to ensure they can navigate complex family dynamics. Streamlining help-seeking and ensuring services are accessible and culturally appropriate, alongside the recommendations made in other components of the *National Study*, will help ensure that older people experiencing harm have someone to turn to when they need support.

Address gaps in knowledge of AOP

The survey identifies several groups whose experiences remain under-researched, including older people in the Takatāpui and Rainbow communities, younger older adults (aged 55–64), and older people in employment. These groups may face distinct forms of abuse and barriers to support. Further work is needed to understand their experiences, through both expanded data collection and/or dedicated qualitative research.

A major and obvious gap is the lack of data on AOP among residents of aged residential care (ARC). This group was intentionally excluded from the survey due to the different nature of institutional settings, but there is currently little reliable data in NZ about the prevalence, types, or drivers of harm in ARC. Importantly, this group is even less visible in administrative data than older people living in the community (Chen et al., 2026a). Given the heightened risk of some people in care and known international and national concerns about institutional abuse, this represents a critical evidence gap that warrants urgent attention. Findings from the Royal Commission of Inquiry into Abuse in Care also reinforce concerns about institutional abuse, and some of its recommendations may be relevant when considering protections for older people.

In addition to topics mentioned previously, and above, future research should also include:

- More detailed analysis of who causes harm for older people, including those in professional caring roles (especially for neglect and sexual harm), work-related relationships, and traditional familial or 'close' social ties. Appropriate interventions are likely to be different for each group.
- Further to needing better data on ARC, other environments relevant to older people require closer investigation. For example, retirement village residents were included in the *National Study*, yet may present different risks and intervention opportunities compared to general community living.

Strengthen data and reporting infrastructure

Prevalence surveys such as this one tend to be one-off snapshots in time, limiting their ongoing value to inform policies centred on older people's wellbeing. To ensure effective, evidence-based policy and interventions, improvements in data infrastructure, including addressing the limitations of available administrative datasets (see Chen et al., 2026a, 2026b), is necessary to enable prevention and response efforts to be monitored and resourced.

Future work

While these findings provide a comprehensive national estimate, they also highlight key areas for further analysis. This research found variations in AOP experiences, including who was responsible for harm, help-seeking behaviours, and co-occurring types of harm. We leave more in-depth investigation of the behaviour scales used to measure the various AOP subtypes and further comparisons with the Australian survey data for future research.

Understanding the prevalence and nature of AOP is essential for informing policy and intervention efforts. The findings underscore the need for targeted support services, public awareness initiatives, and continued monitoring to ensure the safety and wellbeing of older people in NZ. The *Prevalence Survey*, as part of the *National Study*, contributes detailed insights to a more robust evidence base for addressing abuse in later life.

REFERENCES

Acierno, R., Hernandez-Tejada, M., & Steve, K. (2009). *National elder mistreatment study: Final report*. National Institute of Justice, Washington, USA. https://www.ojp.gov/pdffiles1/nij/grants/226456.pdf

Almack, K. & King, A. (2019). Lesbian, gay, bisexual, and trans aging in a UK context: Critical observations of recent research literature. *International Journal of Aging & Human Development, 89*(1), 93–107.

Alpass, F., Towers, A., Stephens, C., Stevenson, B., Davey, J., & Dixon, R. (2020). Aging in New Zealand: Ka haere ki te ao pakeketanga. *International Journal of Environmental Research and Public Health*, 17(24), 9367. https://doi.org/10.3390/ijerph17249367

Alpass, F., Keeling, S., Allen, J., Stephens, C., Towers, A., & Stevenson, B. (2017). Reconciling work and caregiving responsibilities among older workers in New Zealand. *Journal of Cross-Cultural Gerontology, 32*(3), 323–337. https://doi.org/10.1007/s10823-017-9327-3

Australian Institute of Family Studies. (2022). *Elder abuse in Australia: Wills, powers of attorney and family agreements.* Australian Institute of Family Studies, Melbourne, Australia. https://aifs.gov.au/research/research-snapshots/elder-abuse-australia-wills-powers-attorney-and-family-agreements

Australian Law Reform Commission. (2016). *Elder abuse—Discussion paper 83: Pressure to change wills and financial abuse.* Australian Law Reform Commission, Melbourne, Australia. https://www.alrc.gov.au/publication/elder-abuse-dp-83/9-wills/pressure-to-change-wills-and-financial-abuse

BERL. (2024). *Home ownership and unequal ageing*. *Economic Insights.* BERL, Wellington, NZ. https://berl.co.nz/economic-insights/home-ownership-and-unequal-ageing

Blundell, B., Moir, E., Clare, J., Clare, M., & Webb, E. (2017). *Review into the Prevalence and Characteristics of Elder Abuse in Queensland*. Curtin University and Murdoch University, Perth, WA, Australia. http://hdl.handle.net/10072/388501

Bows, H. (2019). Introduction. In H. Bows (Ed.), *Violence against older women* (Vol. I, pp. 1–9). Palgrave Macmillan, London, UK. https://doi.org/10.1007/978-3-030-16601-4_1

Chen, W.-L., Benson, R., Meehan, L., Scott, A., & Wilson, D. (2026a). *National Study of Abuse of Older People: Aged Residential Care – Evidence from the Integrated Data Infrastructure.* New Zealand Policy Research Institute, Auckland, NZ.

Chen, W.-L., Benson, R., Meehan, L., Scott, A., & Wilson, D. (2026b). *National Study of Abuse of Older People: Evidence from the Integrated Data Infrastructure*. New Zealand Policy Research Institute, Auckland, NZ.

Davey, J. A., & McKendry, J. (2011). *Financial abuse of older people in New Zealand*. Institute of Policy Studies, Wellington, NZ. https://ir.wgtn.ac.nz/server/api/core/bitstreams/ba700655-97e7-4502-be1c-d24b667830d5/content

Dong, X. Q. (2015). Elder abuse: Systematic review and implications for practice. *Journal of the American Geriatrics Society*, 63(6), 1214–1238.

Dong, X., & Simon, M. (2013). Elder self-neglect: Implications for health care professionals. *CGS Journal of CME, 3*(1), 25–27.

Dong, X., Mendes de Leon, C. F., & Evans, D. A. (2009). Is greater self-neglect severity associated with lower levels of physical function? *Journal of Aging and Health, 21*(4), 596–610.

Dong, X., Simon, M. A., & Gorbien, M. (2007). Elder abuse and neglect in an urban Chinese population. *Journal of Elder Abuse & Neglect, 19*(3–4), 79–96.

Dong, X., Simon, M., Beck, T., & Evans, D. (2010). A cross-sectional population-based study of elder self-neglect and psychological, health, and social factors in a biracial community. *Aging and Mental Health, 14*(1), 74–84.

Dong, X., Wilson, R. S., Mendes de Leon, C. F., & Evans, D. A. (2010). Self-neglect and cognitive function among community-dwelling older persons. *International Journal of Geriatric Psychiatry, 25*(8), 798–806.

Fanslow J., & Gulliver P. (2025). *Exploratory analysis of violence against older people as recorded in He Koiora Matapopore | the 2019 New Zealand Family Violence Study* [Final Report]. University of Auckland, Auckland, NZ. https://hdl.handle.net/2292/73826

Fanslow, J. L., Mellar, B. M., Gulliver, P. J., & McIntosh, T. K. D. (2023). Evidence of gender asymmetry in intimate partner violence experience at the population-level. *Journal of Interpersonal Violence*, *38*(15–16), 9159–9188. https://doi.org/10.1177/08862605231163646

Fraga Dominguez, S., Storey, J. E., & Glorney, E. (2019). Help-seeking behavior in victims of elder abuse: A systematic review. *Trauma Violence Abuse*, *22*, 466–480. https://doi.org/10.1177/1524838019860616

Fredriksen-Goldsen, K. I. (2011). Resilience and disparities among lesbian, gay, bisexual, and transgender older adults. *The Public Policy Aging Report, 21*(3): 3–7. doi:10.1093/ppar/21.3.3.

Goergen, T., & Beaulieu, M. (2013). Critical concepts in elder abuse research. *International Psychogeriatrics, 25*(8), 1217–1228. https://www.cambridge.org/core/journals/international-

psychogeriatrics/article/abs/critical-concepts-in-elder-abuse-research/089A475FC422F2E6BCFD3D118B934912

GravitasOPG and Wai Rangahau (2025). *Cultural Perspectives on Abuse of Older People*. Ministry of Social Development, Wellington, NZ.

Joosten, M., Dow, B., & Gaffy, E. (2019). Violence against older women: Intergenerational family violence. In *Violence Against Older Women*, (Vol. I, Nature and Extent (pp. 97–111). Springer International Publishing, Cham, Switzerland.

Katz, S., Ford, A. B., Moskowitz, R. W., Jackson, B. A., & Jaffe, M. W. (1963). Studies of illness in the aged: The index of ADL, a standardized measure of biological and psychosocial function. J*ournal of the American Medical Association*, 185(12), 914–919.

Knochel K. A., Croghan, C.F, Moone, R.P., Quam, J.K. (n.d.). Ready to serve? The aging network and LGB and T older adults. National Association of Area Agencies on Aging, Washnigton, USA. https://www.usaging.org/files/ReadyToServe1.pdf

Law Council of Australia. (2023). Best practice guide for legal practitioners in relation to elder financial abuse. Law Council of Australia, Canberra, Australia. https://lawcouncil.au/publicassets/95ac343a-6a0a-ee11-9482-005056be13b5/Best%20practice%20guide%20for%20legal%20practitioners%20in%20relation%20to%20elder%20financial%20abuse%20June%202023.pdf

Lawton, M. P., & Brody, E. M. (1969). Assessment of older people: Self-maintaining and instrumental activities of daily living. *The Gerontologist, 9*(3), 179–186.

Leiding, D., Lischetzke, T., & Rehbein, F. (2022). Lifetime prevalence of victimization and causing harm as a consequence of aggressive behaviour: A large representative study. *Frontiers in Psychology, 13,* 762079. https://doi.org/10.3389/fpsyg.2022.762079

Lifespan of Greater Rochester Inc. (2011). *Under the radar: New York State elder abuse prevalence study: Self-reported prevalence and documented case surveys: Final report*. Lifespan of Greater Rochester, Inc., NY, USA. https://ocfs.ny.gov/reports/aps/Under-the-Radar-2011May12.pdf

McGarry, J., Simpson, C., & Hinsliff-Smith, K. (2014). An exploration of service responses to domestic abuse among older people: Findings from one region of the UK. *Journal of Adult Protection, 16*(4), 202–212. https://doi.org/10.1108/JAP-08-2013-0036

McGarry, J., Simpson, C., & Hinchliff-Smith, K. (2011). The impact of domestic abuse for older women: A review of the literature. *Health & Social Care in the Community, 19*(1), 3–14. https://doi.org/10.1111/j.1365-2524.2010.00964.x

McGarry, J., & Ali, P. (2019). The invisibility of older women as survivors of intimate partner violence. In H. Bows (Ed.), *Violence against older women* (Vol. I, pp. 41–55). Palgrave Macmillan, London, UK. https://doi.org/10.1007/978-3-030-16601-4_3

Mikulionienė, S., & Tamutienė, I. (2019). Perceptions of domestic violence against older women: When sexism is compounded by ageism. In H. Bows (Ed.), *Violence against older women* (Vol. I, pp. 15–39). Palgrave Macmillan, London, UK. https://doi.org/10.1007/978-3-030-16601-4_2

Ministry of Justice. (2024). *New Zealand Crime and Victims Survey: Cycle 7 sexual violence and family offences, and pooled data years 1–7 tables*. Ministry of Justice, Wellington, NZ. https://www.justice.govt.nz/assets/Documents/Publications/NZCVS-2024-Cycle-7-Sexual-violence-and-family-offences.xlsx and https://www.justice.govt.nz/assets/Documents-Other/tb01_crimerate.zip and https://www.justice.govt.nz/assets/Documents-Other/tb01_crimerate.zip

Ministry of Justice. (2022). *New Zealand Crime and Victims Survey: Cycle 4 core report*. Ministry of Justice, Wellington, NZ. https://www.justice.govt.nz/assets/Documents/Publications/NZCVS-Cycle-4-Core-Report-2022.pdf

Ministry of Social Development (MSD). (2023). *Older people experiencing vulnerability and multiple disadvantage in New Zealand*. MSD, Wellington, NZ. Retrieved from https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/research/older-people-experiencing-vulnerability-and-multiple-disadvantage-in-new-zealand/older-people-vulnerability-and-multiple-disadvantage-june.pdf

Naughton, C., Drennan, J., Treacy, M. P., Lafferty, A., Lyons, I., Phelan, S., Quin, A., O'Loughlin, A., & Delaney, L. (2010). *Abuse and neglect of older people in Ireland: Report on the national study of elder abuse and neglect*. National Centre for the Protection of Older People, Dublin, Ireland. https://safeguardingireland.org/wp-content/uploads/2020/02/National-Prevalence-Study-_FullReport2010.pdf

National Initiative for the Care of the Elderly (NICE). (2015). *Into the light: National survey on the mistreatment of older Canadians*., Toronto, Canada. https://cnpea.ca/en/resources/studies/68-the-national-survey-on-the-mistreatment-of-older-canadians-a-prevalence-study

O'Keeffe, M., Hills, A., Doyle, M., McCreadie, C., Scholes, S., Constantine, R., Tinker, A., Manthorpe, J., Biggs, S., & Erens, B. (2007). *UK study of abuse and neglect of older people: Prevalence survey report*. National Centre for Social Research, London, UK. https://www.researchgate.net/publication/242099186_UK_Study_of_Abuse_and_Neglect_of_Older_People_Prevalence_Survey_Report

Plum, A. & Zhuge, L. (2024). *New Zealand Crime and Victims Research: The burden of crime victimisation among the LGBTQ+ population in Aotearoa.* New Zealand Policy Research Institute, Auckland, NZ.

Previtali, F., Keskinen, K., Niska, M., & Nikander, P. (2022). Ageism in working life: A scoping review on discursive approaches. *The Gerontologist*, *62*(2), e97–e111. https://doi.org/10.1093/geront/gnaa119

Qu, L., Kaspiew, R., Carson, R., Roopani, D., De Maio, J., Harvey, J., Horsfall, B. (2021). *National Elder Abuse Prevalence Study: Final Report*. (Research Report). Australian Institute of Family Studies, Melbourne, Australia. https://aifs.gov.au/research/research-reports/national-elder-abuse-prevalence-study-final-report

Radford, L., Corral, S., Bradley, C., & Fisher, H. L. (2013). The prevalence and impact of child maltreatment and other types of victimization in the UK: Findings from a population survey of caregivers, children and young people and young adults. *Child Abuse & Neglect, 37*(10), 801–813. https://doi.org/10.1016/j.chiabu.2013.02.004

Reisig, M. D., & Holtfreter, K. (2018). The victim–offender overlap in late adulthood. *Journal of Elder Abuse & Neglect, 30*(1), 64–81. https://doi.org/10.1080/08946566.2018.1426512

Saville-Smith, K. (2019). *Housing, New Zealand's tenure revolution and implications for retirement: A paper for the 2019 Review of Retirement Income Policies*. Centre for Research, Evaluation and Social Assessment, Wellington, NZ. https://assets.retirement.govt.nz/public/Uploads/Retirement-Income-Policy-Review/2019-RRIP/Research-docs/Home-ownership/CRESA-Housing-NZs-Tenure-Revolution-and-Implications-for-Retirement.pdf

Scott, A., Mung, Z. S., Nicholson, K., Meehan, L., & Wilson, D. (2026a). *Defining thresholds for measuring prevalence of abuse of older people in Aotearoa New Zealand.* New Zealand Policy Research Institute, Auckland, NZ.

Scott, A., Nicholson, K., Meehan, L., & Wilson, D. (2026b). *Financel and legal perspectives on financial abuse of older people in Aotearoa New Zealand*. New Zealand Policy Research Institute, Auckland, NZ.

Sinclair, C., Joffe, T., Ginnivan, N., Parker, S. K., & Anstey, K. J. (2024). A scoping review of workplace interventions to promote positive attitudes toward older workers and reduce age-based discrimination. *Work, Aging and Retirement, 10*(2), 61–76.

Social Investment Agency. (n.d.). *Functional disability SQL script* [Computer software]. Social Investment Agency. https://github.com/nz-social-investment-agency/definitions_library/tree/415942793ce404509a6473c753b4d9251cea71c8/people

Song, J., Kim, H., & Herrenkohl, T. I. (2022). The association between polyvictimization in childhood and intimate partner violence and child abuse in adulthood. *Journal of Interpersonal Violence, 37*(13–14), NP11336–NP11361. https://doi.org/10.1177/08862605211073088

Stats NZ. (2023, August 1). *Grandparents lend a hand for childcare*. Stats NZ, Wellington, NZ. https://www.stats.govt.nz/news/grandparents-lend-a-hand-for-childcare/

Te Tāhū Hauora Health Quality & Safety Commission. (2025). *Femicide: Deaths resulting from gender-based violence in Aotearoa New Zealand – Kōhuru Wahine: nā te ririhau ā-ira i te whenua o Aotearoa*. Te Tāhū Hauora Health Quality & Safety Commission, Wellington, NZ. https://www.hqsc.govt.nz/assets/Our-work/Mortality-review-committee/FVDRC/Publications-resources/Femicide-Deaths-resulting-from-gender-based-violence-in-Aotearoa-New-Zealand.pdf

Tee, N., Gates, S., Briggs, E., & Hinton, A. (2025). *Prevalence survey of abuse of older people: Methodology report*. Ipsos New Zealand, Auckland, NZ.

Waldegrave, C. (2015a). *Elder abuse and neglect in New Zealand: Summary report.* Office for Seniors, Ministry of Social Development, Wellington, NZ. https://www.officeforseniors.govt.nz/assets/documents/our-work/elder-abuse/Elder-abuse-and-neglect-in-New-Zealand-summary-report.pdf

Waldegrave, C. (2015b). *Measuring elder abuse in New Zealander: Findings from the New Zealand Longitudinal Study of Ageing (NZLSA)*. Family Centre Social Policy Research Unit, Wellington, NZ. https://www.officeforseniors.govt.nz/assets/documents/our-work/elder-abuse/Elder-abuse-technical-report.pdf

World Health Organization (WHO). (2008). *A global response to elder abuse and neglect: Building primary health care capacity to deal with the problem worldwide*. WHO, Geneva, Switzerland.

World Health Organization. (2021). *Violence against women prevalence estimates, 2018: Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence.* WHO, Geneva, Switzerland. https://www.who.int/publications/i/item/9789240022256

Wilson, D., Iusitini, L., Tautolo, E-S., Ravenswood, K., Roguski, M., Mikahere-Hall, A., Muru-Lanning, M., Scott, A., & Meehan, L. (2026). *National Study of Abuse of Older People: Findings from qualitative interviews with NZ European, Māori, Pacific, and disabled older people who have experienced abuse.* New Zealand Policy Research Institute, Auckland, NZ.

Yan, E., & Tang, C. S.-K. (2001). Prevalence and psychological impact of Chinese elder abuse. *Journal of Interpersonal Violence, 16*(11), 1158–1174. https://doi.org/10.1177/088626001016011004

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

Yon, Y., Ramiro-Gonzalez, M., Mikton, C. R., Huber, M., & Sethi, D. (2019). The prevalence of elder abuse in institutional settings: A systematic review and meta-analysis. *European Journal of Public Health, 29*(1), 58–67. https://doi.org/10.1093/eurpub/cky093

Appendix 1: Characteristics of the sample

Appendix Table 1: Characteristics of the sample

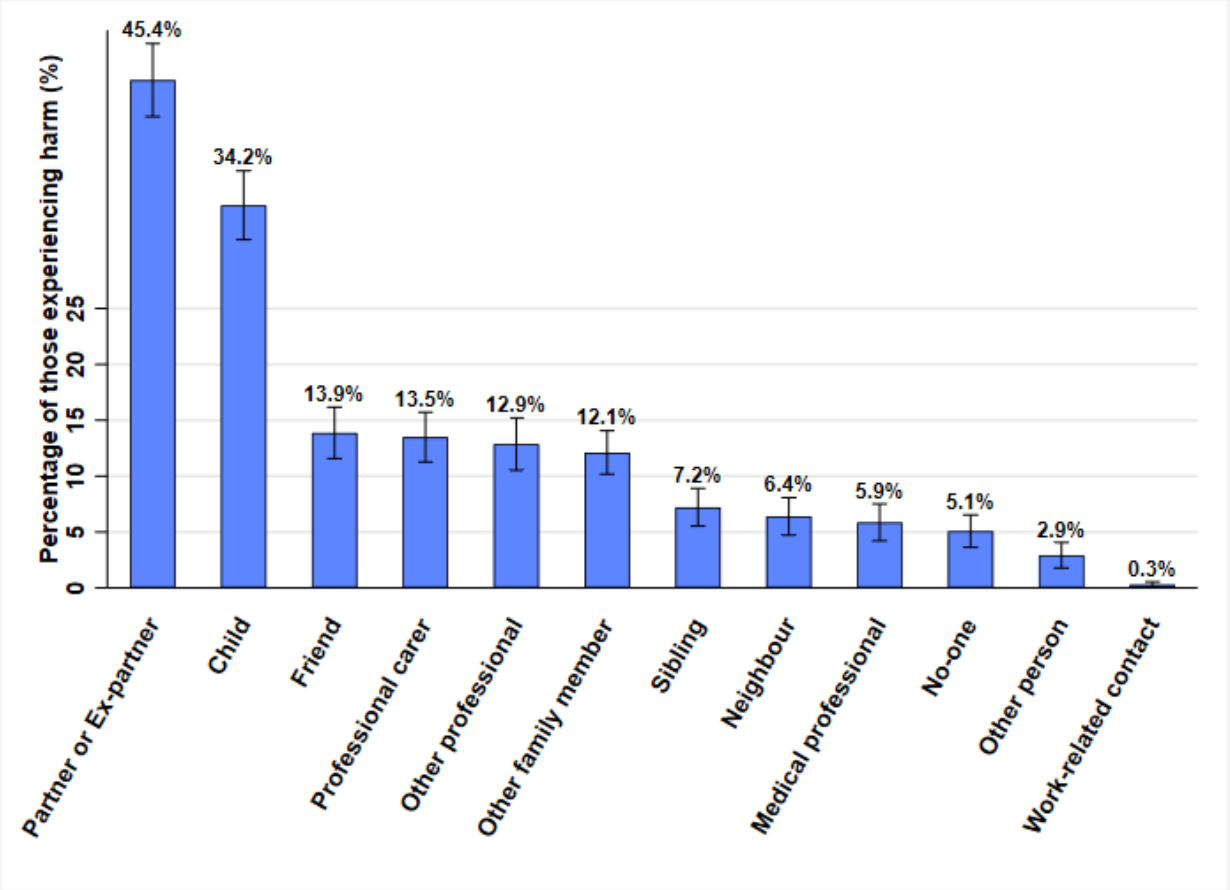
		% weighted sample (standard error)	% unweighted sample (standard error)
Age group	55 to 64 years	41.42 (0.93)	30.04 (0.61)
	65 to 74 years	32.58 (0.87)	38.04 (0.65)
	75+ years	26.00 (0.84)	31.93 (0.62)
	Average age (years)	68.52 (0.18)	70.21 (0.12)
Ethnicity	NZ European	74.04 (0.78)	66.54 (0.63)
	Māori	10.02 (0.49)	12.49 (0.44)
	Pacific	4.05 (0.27)	8.87 (0.38)
	Asian	9.01 (0.54)	9.64 (0.39)
	MELAA and Other	2.88 (0.32)	2.46 (0.21)
Gender	Male	47.52 (0.94)	52.63 (0.67)
	Female	52.42 (0.94)	47.30 (0.67)
	Another gender/Don't know/Refuse	s.	s.
Partnership status	Not partnered	32.74 (0.86)	38.21 (0.65)
	Partnered	66.87 (0.87)	61.46 (0.65)
	Don't know/Refuse	0.40 (0.13)	0.32 (0.08)
Rainbow community	Non-Rainbow	98.02 (0.24)	97.83 (0.19)
	Rainbow	1.98 (0.24)	2.17 (0.19)
Region	Auckland	42.84 (0.92)	51.35 (0.67)
	Waikato	6.04 (0.44)	6.06 (0.32)
	Wellington	11.99 (0.6)	12.58 (0.44)
	Canterbury	9.42 (0.59)	6.84 (0.34)
	Rest of North Island	16.01 (0.68)	14.48 (0.47)
	Rest of South Island	7.15 (0.5)	5.33 (0.3)
	Unknown/Don't know/Refuse	6.55 (0.56)	3.37 (0.24)
Children	Doesn't have children	12.05 (0.61)	12.24 (0.44)
	Has children	87.81 (0.61)	87.51 (0.44)
	Don't know/Refuse	0.14 (0.05)	0.25 (0.07)
Birthplace	NZ born	73.35 (0.82)	69.78 (0.61)
	Born overseas	26.48 (0.82)	30.06 (0.61)
	Don't know/Refuse	0.17 (0.08)	0.16 (0.05)
Household size	One	22.49 (0.76)	27.38 (0.6)
	Two	51.11 (0.94)	46.96 (0.67)
	Three or more	26.28 (0.83)	25.49 (0.58)
	Don't know/Refuse	0.11 (0.04)	0.16 (0.05)
Professional carer at home	No	94.63 (0.43)	93.84 (0.32)
	Yes	5.34 (0.42)	6.13 (0.32)
	Don't know/Refuse	s.	s.
Own home	Not owned	16.16 (0.65)	19.06 (0.52)
	Owned	83.14 (0.66)	80.21 (0.53)
	Don't know/Refuse	0.69 (0.14)	0.73 (0.11)
Employment status	Employed	46.38 (0.94)	39.85 (0.65)
	Not employed	10.95 (0.56)	9.42 (0.39)
	Retired	42.34 (0.93)	50.38 (0.67)
	Don't know/Refuse	0.33 (0.1)	0.34 (0.08)
Household income	<$50k	22.92 (0.77)	27.94 (0.6)
	$50-$100k	21.76 (0.78)	20.79 (0.54)
	$100k+	24.1 (0.82)	19.08 (0.52)

		% weighted sample (standard error)	% unweighted sample (standard error)
	Don't know/Refuse	31.21 (0.88)	32.19 (0.62)
Highest qualification	Secondary or below	38.56 (0.91)	41.21 (0.66)
	Post-secondary	33.93 (0.9)	33.33 (0.63)
	Bachelor's or higher	26.74 (0.84)	24.5 (0.57)
	Don't know/Refuse	0.77 (0.16)	0.96 (0.13)
Self-rated physical health	Excellent/Very good	55.06 (0.94)	53.75 (0.67)
	Moderate	36.82 (0.91)	37.75 (0.65)
	Poor/Very poor	8.07 (0.49)	8.37 (0.37)
	Don't know/Refuse	0.06 (0.03)	0.12 (0.04)
No. of people can rely on for help	Less than 3	18.14 (0.71)	20.63 (0.54)
	3-5	35.84 (0.90)	35.33 (0.64)
	More than 5	45.79 (0.94)	43.76 (0.66)
	Don't know/Refuse	0.23 (0.09)	0.29 (0.07)
Ease of getting practical help	Very easy/Easy	85.08 (0.66)	84.23 (0.49)
	Possible/Difficult/Very difficult	13.97 (0.63)	14.77 (0.47)
	Don't know/Refuse	0.95 (0.19)	1 (0.13)
Disability status	No functional limitation	31.57 (0.88)	30.22 (0.61)
	Low functional limitation	54.36 (0.94)	54.59 (0.66)
	High functional limitation	14.07 (0.64)	15.2 (0.48)
Experienced past harm by known person	No	77.74 (0.78)	79.62 (0.54)
	Yes	20.94 (0.77)	18.96 (0.52)
	Don't know/Refuse	1.32 (0.19)	1.43 (0.16)
Kessler psychological distress	Likely to be well	81.61 (0.72)	81.88 (0.51)
	Moderate or High psychological distress	18.39 (0.72)	18.1 (0.51)
	Don't know/Refuse	s.	s.
Mental health status	No condition	81.11 (0.73)	82.86 (0.5)
	Yes: diagnosed or think so	18.39 (0.73)	16.62 (0.5)
	Don't know/Refuse	0.5 (0.13)	0.52 (0.1)
Neurodivergent status	No condition	89.81 (0.57)	90.65 (0.39)
	Yes: diagnosed or think so	9.38 (0.55)	8.55 (0.37)
	Don't know/Refuse	0.81 (0.17)	0.80 (0.12)
Lives with partner/ex-partner	No	33.52 (0.87)	38.71 (0.65)
	Yes	66.21 (0.87)	60.98 (0.65)
	Don't know/Refuse	0.27 (0.07)	0.3 (0.07)
Live with child/stepchild/child-in-law	No	74.31 (0.82)	75.11 (0.58)
	Yes	25.43 (0.82)	24.59 (0.57)
	Don't know/Refuse	0.27 (0.07)	0.3 (0.07)
Observations		**1,530,700**	**5,613**

Notes: Prioritised ethnicity where the order of prioritisation is Māori, Pacific, Asian, MELAA and Other, NZ European. 'MELAA and Other' ethnicity includes Middle Eastern, Latin American & African and Other ethnicity. 's.' indicates cell was suppressed due to small underlying count.

Appendix 2: Contextual information on care arrangements

Appendix Figure 1: Who is mainly responsible for helping you with day-to-day activities?



Notes: Those who responded “No-one” are not included in the definition of neglect, which excludes self-neglect. “An organisation" was re-categorised as professional carer or medical professional where appropriate (e.g. where a home-help organisation was identified). Percentage of those who needed help with day-to-day activities (unweighted/weighted observation count: 1,854/483,000). Bars may sum to more than 100% because people could name more than one helper.

Appendix 3: Sources of harm by relationship

This appendix compares the main person responsible for any form of harm (according to the CHI–Very Serious threshold) with all people responsible (Appendix Table 2). The overall pattern of relationships is consistent. Partners and children were most often reported across all definitions, with other family members, work-related contacts, friends, and siblings also regularly appearing. As expected, the shares are higher in the "All people responsible" columns than in the "Main person responsible" columns, because respondents could report more than one person causing harm for each harm subtype.

Appendix Table 2: Relationship to respondent of main person versus all people responsible for harm

	Main person responsible	All people responsible
Partner or ex-partner	21.90 (1.92)	26.24 (2.03)
Child	20.59 (1.77)	26.18 (1.95)
Other family member	16.03 (1.62)	23.20 (1.89)
Work-related contact	16.02 (1.59)	20.32 (1.78)
Friend	14.43 (1.51)	20.38 (1.78)
Sibling	10.31 (1.37)	14.21 (1.58)
Other person	9.97 (1.3)	13.99 (1.56)
Neighbour	6.82 (1.08)	8.32 (1.14)
Professional	6.35 (1.01)	8.03 (1.17)
Don't know/Refuse	6.08 (1.13)	3.83 (0.81)

Notes: Based on those experiencing harm according to the CHI–Very Serious definition. "Main person responsible" can add to more than 100% due to different main person responsible being identified for different harm subtypes. "All people responsible" can add to more than 100% due to respondents identifying multiple people responsible. 's.' indicates suppressed due to small counts.

Appendix 4: Additional regression results

Appendix Table 3: Marginal effects from logistic regressions: Overall AOP and by subtype

Marginal effect (standard error)							
	All harm	Neglect	Financial	Psychological	Physical	Sexual	Cultural
Gender (base: Male)							
Female	0.27 (1.3)	0.92* (0.48)	-1.16 (0.76)	0.71 (1.19)	-0.84 (0.63)	0.79*** (0.3)	-0.40 (0.66)
Age	0.60 (1.36)	-0.16 (0.27)	1.28* (0.69)	0.31 (1.37)	0.73 (0.54)	0.24 (0.34)	-0.35 (0.51)
Age squared	-0.01 (0.01)	0.00 (0)	-0.01** (0)	0.00 (0.01)	-0.01 (0)	0.00 (0)	0.00 (0)
Ethnicity (base: NZ European)							
Māori	3.98** (1.94)	-0.24 (0.53)	2.06 (1.34)	3.80** (1.76)	1.09 (0.98)	-0.55 (0.42)	2.93** (1.29)
Pacific peoples	2.77 (2.75)	-0.54 (0.4)	-0.27 (1.08)	2.31 (2.69)	-0.53 (0.98)	-0.37 (0.44)	0.71 (1.13)
Asian	-4.61* (2.52)	0.03 (0.86)	-1.95 (1.29)	-1.65 (2.65)	-1.92*** (0.7)	-0.62** (0.25)	0.03 (1.12)
MELAA & Other	0.48 (3.43)	-0.50 (0.36)	-2.28* (1.25)	2.10 (3.26)	-1.55*** (0.5)	0.56 (0.62)	3.88 (2.95)
Partnership status							
Partnered	-1.17 (1.79)	0.04 (0.64)	-1.82* (0.95)	-1.19 (1.7)	0.03 (0.95)	-0.26 (0.52)	0.08 (0.98)
Region (base: Auckland)							
Waikato	-0.31 (2.86)	1.27 (1.42)	1.32 (1.91)	-2.41 (2.45)	0.21 (1.32)	-0.07 (0.72)	-0.72 (1.36)
Wellington	-0.60 (1.91)	1.00 (0.84)	0.78 (1.13)	-1.74 (1.73)	-0.37 (0.91)	-0.25 (0.49)	0.25 (1.06)
Canterbury	0.90 (2.16)	-0.24 (0.58)	1.05 (1.41)	1.86 (2.03)	-1.27 (0.93)	0.24 (0.93)	-0.20 (1.29)
Rest of North Island	-1.15 (1.67)	-0.74 (0.47)	-0.31 (1.05)	-0.80 (1.55)	-0.04 (0.82)	-0.67* (0.35)	-1.33* (0.8)
Rest of South Island	0.03 (2.86)	0.08 (0.77)	-0.81 (1.57)	-1.59 (2.58)	-0.63 (1.24)	-0.05 (0.73)	-1.05 (1.26)
Unknown/Don't know/Refuse	0.95 (3.88)	-0.64 (0.67)	-3.30*** (0.97)	1.70 (3.54)	2.63 (2.59)	-0.14 (0.48)	0.03 (2.6)
Has biological/adoptive/step children (base: None)							
Has children	3.25* (1.78)	0.31 (0.5)	1.24 (0.77)	3.10** (1.54)	0.27 (0.93)	-0.50 (0.67)	-0.46 (0.99)
Birthplace (base: Born in NZ)							
Born overseas	-3.38* (1.76)	0.32 (0.44)	0.65 (1.14)	-3.58** (1.58)	0.08 (0.91)	0.00 (0.32)	-0.75 (0.84)
Household size (base: 1 person)							
2 people	-2.23 (2.18)	0.20 (0.51)	0.86 (0.89)	-0.35 (1.95)	-2.91** (1.48)	0.23 (0.7)	-0.83 (1.03)
3+ people	-0.42 (2.4)	1.10 (0.92)	1.50 (1.11)	0.64 (2.19)	-1.60 (1.57)	-0.65 (0.51)	0.34 (1.23)
Professional carer at home (base: No)							
Professional carer	3.58 (3.16)	1.44 (0.9)	-1.55 (1.14)	3.20 (2.99)	1.92 (2.51)	3.46* (1.96)	-0.02 (1.34)
Owner-occupied housing (base: No)							
Owns home	-2.68 (1.64)	-0.59 (0.51)	-1.18 (0.91)	-0.56 (1.47)	-1.61* (0.88)	-0.51 (0.54)	-2.16* (1.12)
Employment status (base: Employed)							
Not employed	-2.55 (1.98)	0.10 (0.64)	-0.18 (1.11)	-0.49 (1.89)	0.01 (0.89)	0.18 (0.44)	-1.59* (0.89)

Marginal effect (standard error)							
	All harm	Neglect	Financial	Psychological	Physical	Sexual	Cultural
Retired	-3.15* (1.9)	-0.35 (0.87)	-0.33 (1.28)	-2.60 (1.73)	0.30 (1.14)	-0.16 (0.34)	-0.94 (0.99)
Household income (base: 0-50k)							
50k-100k	-0.56 (2.12)	0.60 (1.2)	-1.25 (1.14)	-0.71 (1.94)	-0.23 (0.81)	0.13 (0.64)	0.20 (1.13)
100k+	-2.17 (2.29)	-0.72 (1.15)	-1.70 (1.37)	-1.03 (2.25)	-0.22 (1.04)	0.25 (0.69)	-1.01 (1.24)
Don't know/Refuse	-0.06 (2.03)	-0.86 (0.87)	0.19 (1.18)	-1.87 (1.8)	0.54 (0.98)	0.26 (0.47)	-0.16 (1.12)
Highest qualification (base: Secondary school or below)							
Post-school	3.37** (1.43)	0.74 (0.52)	1.23 (0.81)	1.97 (1.34)	0.30 (0.73)	-0.02 (0.33)	0.33 (0.76)
Bachelor's or higher	3.88** (1.72)	0.00 (0.45)	1.15 (0.96)	2.03 (1.52)	0.51 (0.86)	0.88* (0.47)	0.34 (0.93)
Physical health status (base: Moderate/Very good/Excellent health)							
Poor/Very poor health	4.62* (2.54)	0.79 (0.71)	3.33** (1.43)	0.99 (2.15)	1.04 (1.33)	2.33 (1.54)	1.48 (1.39)
No. of people can rely on for help (base: Less than 3)							
3-5	1.19 (1.78)	-0.52 (0.55)	-0.55 (0.84)	1.76 (1.62)	0.19 (0.64)	-0.39 (0.44)	0.45 (0.81)
5+	-0.01 (1.8)	-0.39 (0.54)	-0.43 (0.98)	1.57 (1.67)	0.89 (0.74)	-0.15 (0.54)	1.05 (0.83)
How difficult to get practical help (base: Very easy/Easy)							
Possible/Difficult/Very difficult	11.27*** (2.4)	1.20** (0.6)	2.43** (1.14)	11.39*** (2.43)	1.91** (0.95)	-0.05 (0.38)	2.45** (1.09)
Disability status (base: No/Low functional limitations)							
High functional limitations	1.99 (2.06)	1.20** (0.58)	-0.40 (0.78)	0.40 (1.8)	-0.58 (0.95)	-0.55 (0.47)	-0.78 (0.86)
Experienced harm in past by someone they knew (base: No)							
Experienced harm	9.59*** (1.68)	0.59 (0.49)	1.34* (0.81)	8.23*** (1.52)	1.52* (0.83)	1.21** (0.52)	3.38*** (0.94)
Kessler index (base: Likely to be well)							
Moderate or High psychological distress	9.52*** (1.92)	0.70 (0.51)	1.86** (0.86)	7.94*** (1.79)	0.60 (0.75)	-0.32 (0.42)	1.12 (0.93)
Mental health status (base: No)							
Yes - diagnosed or think so	11.75*** (2.02)	0.41 (0.56)	3.08*** (1.01)	8.89*** (1.87)	1.85** (0.8)	0.39 (0.41)	2.89*** (1.11)
Observations (unweighted)	**5,322**	**5,294**	**5,320**	**5,298**	**5,322**	**5,196**	**5,322**

Note: Marginal effects represent the estimated change in the probability of experiencing each type of harm (in percentage points) associated with each characteristic, holding all other factors constant. *** represents statistical significance at the 1% level, ** 5% level and * 10% level.

Appendix Table 4: Marginal effects from logistic regressions: Co-occurrence, main person responsible & help-seeking

Marginal effect (standard error)					
	Co-occurrence	Main person: Partner	Main person: Child	Help-seeking: Asked for help	Help-seeking: Wanted help
Gender (base: Male)					
Female	-3.02 (4.56)	-2.75 (4.06)	6.54* (3.95)	10.45** (4.94)	10.45** (4.94)
Age	3.00 (4.32)	8.21* (4.46)	-4.27 (4.07)	-1.55 (4.63)	-1.55 (4.63)
Age squared	-0.02 (0.03)	-0.06* (0.03)	0.03 (0.03)	0.01 (0.03)	0.01 (0.03)
Ethnicity (base: NZ European)					
Māori	5.13 (6.22)	2.75 (6.59)	6.21 (6.19)	8.17 (6.64)	8.17 (6.64)
Pacific peoples	-5.17 (7.44)	-12.59** (4.95)	-2.35 (6.13)	-14.44 (9.51)	-14.44 (9.51)
Asian	17.59 (13.49)	-10.6 (8.44)	12.52 (14.65)	-21.11* (11.07)	-21.11* (11.07)
MELAA & Other	0.87 (14.81)	-2.07 (11.07)	-0.4 (11.11)	-38.49*** (12.35)	-38.49*** (12.35)
Partnership status					
Partnered	-1.91 (6.31)	9.52* (4.99)	-8.62 (5.61)	-0.14 (6.97)	-0.14 (6.97)
Rainbow community (base: non-Rainbow)					
Rainbow	16.61 (12.75)	13.04 (16.09)	-1.38 (9.04)	-5.33 (14.54)	-5.33 (14.54)
Region (base: Auckland)					
Waikato	7.75 (10.22)	-5.48 (12.27)	-17.86*** (4.2)	3.69 (10.09)	3.69 (10.09)
Wellington	6.13 (7.33)	-1.47 (6.02)	-5.02 (5.75)	-14.04* (7.29)	-14.04* (7.29)
Canterbury	3.93 (8.55)	8.62 (9.18)	-6.05 (7.21)	-0.56 (8.83)	-0.56 (8.83)
Rest of North Island	-0.55 (6.8)	-11.82** (4.8)	-1.54 (5.6)	-7.17 (7.22)	-7.17 (7.22)
Rest of South Island	-14.85* (8.11)	-6.97 (7.86)	-2.37 (8.69)	-0.25 (10.99)	-0.25 (10.99)
Unknown/Don't know/Refuse	2.60 (14.59)	-7.35 (10.87)	17.74 (15.64)	-11.02 (15.09)	-11.02 (15.09)
Has biological/adoptive/stepchildren (base: None)					
Has children	-0.73 (7.57)	10.14* (5.59)		-2.67 (7.52)	-2.67 (7.52)
Birthplace (base: Born in NZ)					
Born overseas	1.88 (6.58)	9.19 (5.69)	-4.62 (5.48)	6.09 (6.93)	6.09 (6.93)
Household size (base: 1 person)					
2 people	4.88 (6.75)	3.64 (6.44)	3.41 (5.74)	-7.92 (7.68)	-7.92 (7.68)
3+ people	6.84 (7.77)	3.46 (7.51)	11.82* (6.38)	-10.51 (8.43)	-10.51 (8.43)
Professional carer at home (base: No)					
Professional carer	7.14 (11.08)	-1.23 (9.05)	-9.39* (5.56)	-5.6 (10.56)	-5.6 (10.56)
Owner-occupied housing (base: No)					

Marginal effect (standard error)					
	Co-occurrence	Main person: Partner	Main person: Child	Help-seeking: Asked for help	Help-seeking: Wanted help
Owns home	-8.29 (5.91)	-1.19 (5.24)	6.53* (3.69)	-6.06 (5.88)	-6.06 (5.88)
Employment status (base: Employed)					
Not employed	2.57 (6.91)	5.21 (5.94)	4.2 (5.34)	8.3 (6.87)	8.3 (6.87)
Retired	-4.72 (7.23)	-1.34 (5.56)	7.03 (5.45)	0.06 (7.06)	0.06 (7.06)
Household income (base: 0-50k)					
50k-100k	-6.51 (7.46)	4.43 (7.12)	-0.65 (6.29)	4.41 (7.9)	4.41 (7.9)
100k+	-3.59 (9.13)	-0.59 (7.24)	1.56 (7.97)	12.08 (9.28)	12.08 (9.28)
Don't know/Refuse	-8.23 (7.22)	-0.43 (6.26)	0.09 (6.06)	5.64 (7.68)	5.64 (7.68)
Highest qualification (base: Secondary school or below)					
Post-school	-3.78 (5.33)	2.64 (4.69)	-3.95 (4.52)	1.19 (5.56)	1.19 (5.56)
Bachelor's or higher	-3.94 (6.25)	6 (4.92)	-9.73* (5.29)	12.44* (6.44)	12.44* (6.44)
Physical health status (base: Moderate/Very good/Excellent health)					
Poor/Very poor health	10.91 (6.84)	9.9 (7.01)	-3.87 (4.39)	-1.81 (7.11)	-1.81 (7.11)
Number of people can rely on for help (base: Less than 3)					
3-5	-3.98 (5.55)	-5.6 (5.98)	0.06 (5.19)	2.26 (6.43)	2.26 (6.43)
5+	9.34 (6.2)	-5.1 (6.38)	2.57 (5.64)	1.64 (6.93)	1.64 (6.93)
How difficult to get practical help (base: Very easy/Easy)					
Possible/Difficult/Very difficult	12.02** (5.5)	3.2 (5.35)	9.49* (5.66)	-5.57 (5.99)	-5.57 (5.99)
Disability status (base: No functional limitations)					
Low functional limitations	3.85 (6.56)	0.3 (5.4)	3.15 (5.29)	-1.25 (6.58)	-1.25 (6.58)
High functional limitations	-2.43 (7.64)	-6.88 (5.93)	8.09 (6.81)	3.45 (7.99)	3.45 (7.99)
Experienced harm in past by someone they knew (base: No)					
Experienced harm	7.80 (4.78)	6 (4.71)	1.24 (3.93)	-4.75 (5.16)	-4.75 (5.16)
Kessler index (base: Likely to be well)					
Moderate or High psychological distress	-4.89 (4.97)	0.36 (4.78)	-3.88 (3.78)	-9.61* (5.7)	-9.61* (5.7)
Mental health status (base: No)					
Yes - diagnosed or think so	6.82 (5.25)	-0.33 (4.5)	4.04 (4.34)	8.4 (5.43)	8.4 (5.43)
Observations (unweighted)	**884**	**884**	**886**	**880**	**837**

Note: Marginal effects represent the estimated change in the probability of the outcome variable (in percentage points) associated with each characteristic, holding all other factors constant. *** represents statistical significance at the 1% level, ** 5% level and * 10% level.

Appendix Table 5: Predicted probabilities from logit regression by gender (All harm, men)

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
Age group	55-64	17.56	14.17	20.95
	65-74	9.93*	7.44	12.42
	75+	7.65*	3.66	11.65
Ethnicity	NZ European	16.86	14.22	19.49
	Māori	19.06	14.17	23.96
	Pacific peoples	21.59	13.59	29.60
	Asian	10.09	5.10	15.08
	MELAA & Other	15.58	6.26	24.89
Partnership status	Not partnered	19.46	15.30	23.62
	Partnered	15.15	12.35	17.96
Region	Auckland	17.58	14.58	20.59
	Waikato	15.52	7.22	23.83
	Wellington	15.72	10.96	20.47
	Canterbury	18.94	13.46	24.43
	Rest of North Island	16.36	11.97	20.74
	Rest of South Island	13.07	4.78	21.36
	Unknown/Don't know/Refuse	16.44	3.16	29.73
Children (biological, adopted, or step)	None	12.77	8.31	17.23
	Has child/ren	17.43	15.13	19.72
Birthplace	Born in NZ	17.49	14.95	20.03
	Born overseas	14.61	10.05	19.17
Household size	1 person	18.07	12.15	23.98
	2 people	15.22	12.27	18.17
	3 or more people	18.09	14.35	21.84
Professional carer at home	No professional carer	16.66	14.47	18.86
	Professional carer	18.40	8.03	28.78
Home ownership	Doesn't own home	20.14	15.81	24.47
	Owns home	15.90	13.53	18.27
Employment status	Employed	15.96	12.80	19.12
	Not employed	17.99	12.57	23.42
	Retired	17.36	13.13	21.60
Household income	0-50k	15.44	10.84	20.04
	50k-100k	17.16	13.59	20.73
	100k+	15.70	11.41	20.00
	Don't know/Refuse	18.40	13.63	23.18
Highest qualification	Secondary school or below	16.11	13.03	19.19
	Post-school	17.76	14.63	20.88
	Bachelor's or higher	16.48	12.15	20.81
Self-rated physical health status	Moderate/Very good/Excellent	16.87	14.55	19.19
	Poor/Very poor	16.03	10.64	21.43
How many people can rely on?	Less than 3	15.84	11.58	20.10
	3-5	19.17	15.80	22.53
	5+	15.22	12.28	18.15
How difficult to get practical help?	Very easy/Easy	15.21	12.89	17.53
	Possible/Difficult/Very difficult	24.12*	18.15	30.09
Disability status	No/Low functional limitations	16.07	13.94	18.21
	High functional limitations	20.08	13.82	26.34
Past harm by known person	No	13.87	11.70	16.04
	Yes	25.18*	19.99	30.37
Kessler psychological distress	Likely to be well	14.49	12.01	16.97
	Moderate or High distress	23.96*	19.17	28.75
Mental health condition	No	13.15	10.90	15.40

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
	Yes (diagnosed) or Think so (not)	28.68*	22.16	35.19
Observations (unweighted)		**2,798**		

Note: Predicted probabilities from logistic regression of any harm according to the CHI–Very Serious threshold. Excludes those with missing information for any of the relevant variables (approximately 5% of the sample). Predicted probabilities show the expected likelihood of experiencing harm for each group, holding all other characteristics (such as age, gender, ethnicity, income, and health) constant at their average values. These probabilities represent model-adjusted estimates rather than raw percentages. In each category, the first group listed is the reference group (base category) that all other relevant groups are compared to. For age, the model included both age and age squared to reflect non-linear patterns. Predicted probabilities for the three age groups (55–64, 65–74, and 75+) were then estimated by holding other characteristics at their average levels across the sample. All other variables are categorical. Shaded rows and * indicate statistical significance where the confidence intervals do not overlap with the base category.

Appendix Table 6: Predicted probabilities from logit regression by gender (All harm, women)

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
Age group	55-64	19.97	16.55	23.38
	65-74	12.07*	9.62	14.51
	75+	4.98*	3.11	6.84
Ethnicity	NZ European	16.28	14.12	18.44
	Māori	21.42	15.85	27.00
	Pacific peoples	14.40	8.74	20.06
	Asian	13.52	6.10	20.95
	MELAA & Other	18.21	7.32	29.09
Partnership status	Not partnered	16.34	12.72	19.96
	Partnered	16.82	14.27	19.38
Region	Auckland	16.61	14.06	19.16
	Waikato	17.78	10.27	25.29
	Wellington	16.83	11.96	21.70
	Canterbury	15.58	9.79	21.37
	Rest of North Island	15.02	11.41	18.64
	Rest of South Island	19.82	12.00	27.63
	Unknown/Don't know/Refuse	18.24	7.91	28.58
Children (biological, adopted, or step)	None	13.25	8.41	18.09
	Has child/ren	17.20	15.27	19.13
Birthplace	Born in NZ	17.72	15.35	20.09
	Born overseas	13.65	9.91	17.38
Household size	1 person	17.87	13.12	22.61
	2 people	15.54	12.87	18.22
	3 or more people	17.53	13.55	21.50
Professional carer at home	No professional carer	16.35	14.51	18.19
	Professional carer	22.76	14.44	31.09
Home ownership	Doesn't own home	18.47	14.01	22.93
	Owns home	16.21	14.29	18.14
Employment status	Employed	19.75	16.45	23.06
	Not employed	13.22	8.81	17.62
	Retired	13.73	10.66	16.81
Household income	0-50k	19.33	14.52	24.14
	50k-100k	16.07	12.21	19.92
	100k+	15.37	11.42	19.31
	Don't know/Refuse	16.54	13.31	19.78
Highest qualification	Secondary school or below	13.36	10.86	15.86
	Post-school	18.08	14.72	21.44
	Bachelor's or higher	19.67	15.82	23.52

Variable		Predicted probability (%)	Lower 95% CI	Upper 95% CI
Self-rated physical health status	Moderate/Very good/Excellent	15.55	13.62	17.47
	Poor/Very poor	26.60*	18.32	34.87
How many people can rely on?	Less than 3	16.67	12.36	20.97
	3-5	16.10	13.14	19.06
	5+	17.07	14.37	19.77
How difficult to get practical help?	Very easy/Easy	14.37	12.33	16.40
	Possible/Difficult/Very difficult	28.28*	21.70	34.86
Disability status	No/Low functional limitations	16.66	14.69	18.62
	High functional limitations	16.62	11.66	21.58
Past harm by known person	No	14.34	12.24	16.43
	Yes	23.15*	19.29	27.01
Kessler psychological distress	Likely to be well	14.56	12.51	16.60
	Moderate or High distress	23.38*	18.38	28.38
Mental health condition	No	14.28	12.18	16.37
	Yes (diagnosed) or Think so (not)	24.17*	19.49	28.86
Observations (unweighted)		**2,524**		

Note: Predicted probabilities from logistic regression of any harm according to the CHI–Very Serious threshold. Excludes those with missing information for any of the relevant variables (approximately 5% of the sample). Predicted probabilities show the expected likelihood of experiencing harm for each group, holding all other characteristics (such as age, gender, ethnicity, income, and health) constant at their average values. These probabilities represent model-adjusted estimates rather than raw percentages. In each category, the first group listed is the reference group (base category) that all other relevant groups are compared to. For age, the model included both age and age squared to reflect non-linear patterns. Predicted probabilities for the three age groups (55–64, 65–74, and 75+) were then estimated by holding other characteristics at their average levels across the sample. All other variables are categorical. Shaded rows and * indicate statistical significance where the confidence intervals do not overlap with the base category.



NEW ZEALAND POLICY RESEARCH INSTITUTE

TE KĀHUI RANGAHAU MANA TAURITE

Auckland University of Technology, Auckland, New Zealand
policy.research@aut.ac.nz | www.nzpri.aut.ac.nz

AUT UNIVERSITY
NEW ZEALAND