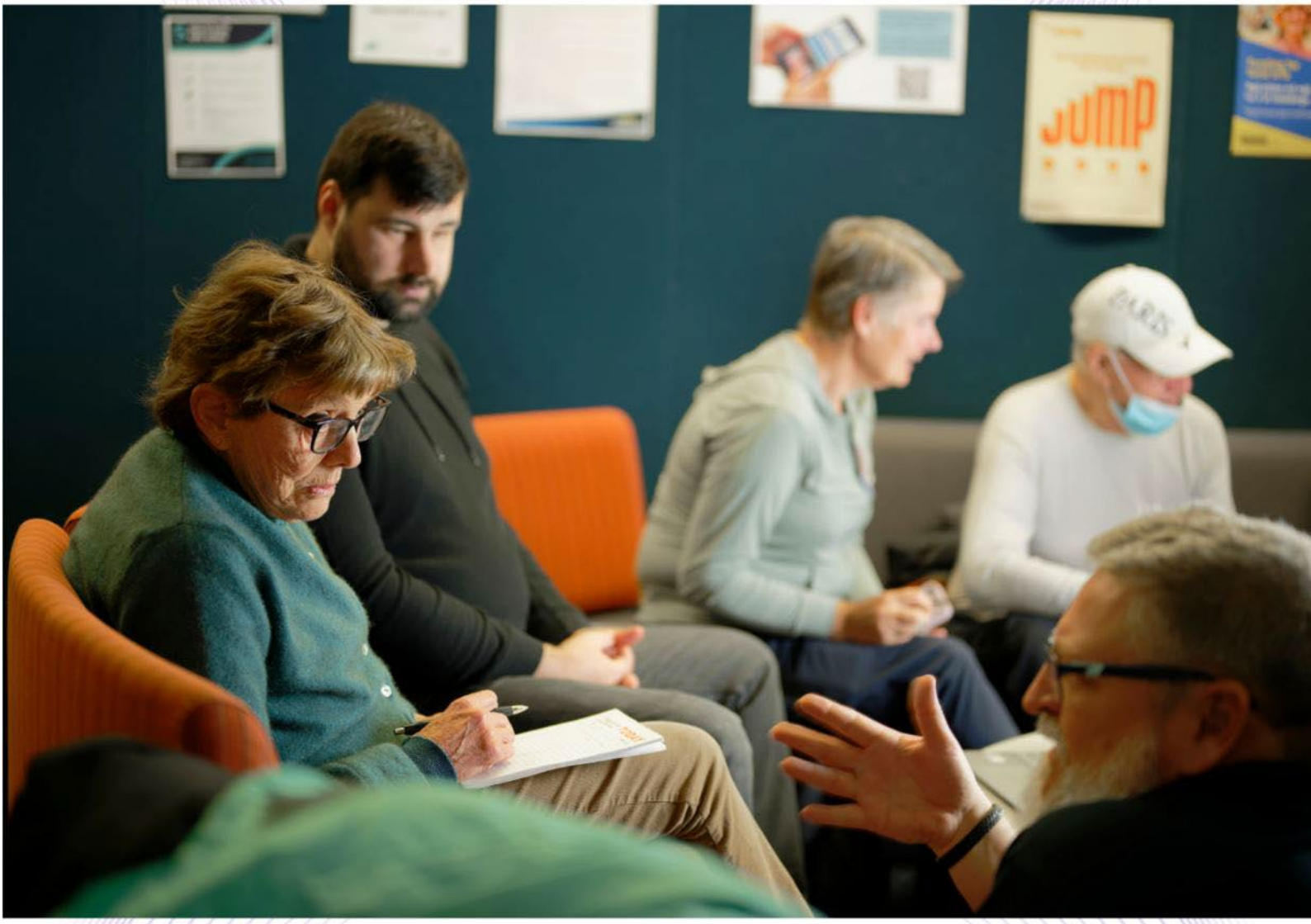
NEW ZEALAND POLICY RESEARCH INSTITUTE
TE KĀHUI RANGAHAU MANA TAURITE

AUT

NATIONAL STUDY OF ABUSE OF OLDER PEOPLE:

Defining thresholds for measuring prevalence of 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



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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 is a supplementary report to the main findings report from the *Prevalence survey on the abuse of older people in Aotearoa New Zealand*, and presents additional research completed as part of the *National Study* to examine the use of thresholds in measuring the prevalence of AOP in Aotearoa New Zealand (NZ).

This document details the rationale and process for selecting the thresholds used for each AOP subtype estimated in the *Prevalence Survey*. It draws on international evidence, expert consultation, and data-driven analysis of the survey responses, to examine how different threshold options impact estimated prevalence rates. This supplementary research ensures the chosen definitions were both conceptually robust and practically appropriate for NZ's context.

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 and Victims Survey (NZCVS).
3. Qualitative interviews – In-depth interviews with older victim-survivors of abuse to explore the contexts in which AOP occurs, and the barriers and enablers to seeking help across four groups: Māori, Pacific, NZ European, and disabled people.
4. Contextual analysis of financial abuse – Mixed methods study exploring how financial abuse is identified, addressed, and prevented within financial institutions, supplemented with insights from the legal sector.
5. Analysis of economic and social costs – Estimates the economic impact of AOP on individuals, whānau, communities, and government systems, and outlines broader social consequences such as reduced wellbeing and lost productivity.

This study includes 10 key reports:

1. Overall synthesis report, summarising the key findings from all parts of the project.
2. Disability synthesis report, summarising key findings about AOP among disabled older people.

3. Survey findings report, presenting results from the *Prevalence Survey*.
4. Survey methodology report.
5. Survey thresholds report, a supplementary report to the main *Prevalence Survey Report* that presents research into the application of AOP thresholds to the survey data **(this report)**.
6. Main Integrated Data Infrastructure (IDI) report, detailing analysis of AOP among those living in the community using administrative and NZCVS data from the IDI.
7. Supplementary IDI report on AOP among those in aged residential care.
8. Qualitative interviews report, presenting findings from qualitative interviews of victim-survivors undertaken across four groups: Māori, Pacific, NZ European and disabled older people.
9. Financial institutions 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 and thresholds in this context. Section 2 then outlines the methods used to establish appropriate thresholds for the *Prevalence Survey* analysis, namely the rapid scoping review (RSR) (see Section 3), expert consultation process (see Section 4), and data-driven analysis (Section 6). Section 5 outlines recommendations for the approach used in the study, with Section 6 exploring the impact of various threshold settings on the *Prevalence Survey* analysis. Section 7 concludes.

1.1 Study aims and definition of AOP

The main aim of the *Prevalence Survey* is to collect population-level data[1] 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.

Prevalence Survey

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

[1] The *National Prevalence Study of Abuse of Older People* was approved by the AUT Ethics Committee (AUTEC Ref. 24/30).

working definition of AOP, which is consistent with the most recent survey of AOP prevalence carried out in Australia:

> *A single or repeated act or failure to act, including threats, that results in harm or distress to an older person. These occur where there is an expectation of trust and/or where there is a power imbalance between the party responsible and the older person.* (Qu et al., 2021, p. 17)

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

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

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

The definition of AOP used in this study does not require intent to harm, although we acknowledge this point to be controversial among experts in the field (see Section 4.2 for a brief discussion, or Dovetail (2024) for broader sector-level findings). 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.

What is a threshold?

A threshold is a rule used to help decide which experiences are included 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.

Establishing appropriate thresholds for the AOP prevalence measures is a critical part of the analysis for data collected in the *Prevalence Survey*. While the research team previously recognised the importance of thresholds in estimating a robust prevalence measure, initial stakeholder engagement on the survey's preliminary findings highlighted the significance of this issue. As a result of this engagement, the Ministry of Social Development (MSD) asked Auckland University of Technology (AUT) to undertake further focused work to support a robust and defensible threshold setting.

To the best of our knowledge, and that of the experts we consulted with (see Sections 2.2 and 4), this work is a significant contribution to the international literature. It represents an important methodological development for AOP prevalence measurement, supporting both transparency and a more standardised approach.

2 METHODOLOGY

This section outlines the methods used to establish appropriate thresholds for the *Prevalence Survey* analysis. As noted in the previous section, during initial research design the team discussed threshold use for the *Prevalence Survey*, alongside a review of international AOP prevalence studies. The research team agreed that thresholds would be used in line with previous studies, although the lack of consensus across international surveys impeded a definitive choice being made. The final decision on threshold use was deferred until after data collection, with researchers planning to choose and/or refine thresholds as relevant during analysis.

Preliminary survey findings were presented to stakeholders at a workshop in early 2025. This consultation process emphasised the importance of having a strong rationale for thresholds and, subsequently, robust prevalence estimates. To facilitate additional focused work on prevalence thresholds to support the *Prevalence Survey* analysis, MSD commissioned AUT to conduct the project described in this report.

This supplementary work comprised of two complementary phases:

1. Conduct an RSR, and
2. Consultation with a range of domestic and international experts.

The recommended approach was then tested using data collected in the *Prevalence Survey* (see Meehan et al., 2026, and Tee et al., 2025, for details of the survey).

2.1 Rapid scoping review (RSR) method

To review the academic and grey[2] literature on AOP thresholds and related issues, we conducted an RSR. The review included AOP definitions, its prevalence, and other types of family harm (e.g. intimate partner violence (IPV), child abuse, and neglect) where relevant. To complement the primary objective of the survey (i.e. estimate the AOP prevalence rate for NZ), this review is instrumental in informing a rigorous approach to data analysis and aiding transparency of the full survey results (see Meehan et al., 2026).

A scoping review maps and summarises existing evidence on a topic. For this project, the scoping review allows consideration of research across both AOP-specific thresholds and that available in the wider

[2] Grey literature refers to research published by non-academic organisations, like government departments or non-government organisations (NGOs), and includes white or technical papers, policy briefs, theses and dissertations, and government reports.

family violence literature. Full scoping reviews typically require 12 months or more and large, multidisciplinary teams. The RSR method used in this project provides focused interrogation of the prevalence estimate for AOP in NZ, based on prior international research, within a shorter timeframe than a full review.

The review is limited to academic and grey literature written in English, including methodology reports from similar prevalence surveys conducted elsewhere, and published between 2000–2024. Written materials were sourced from internet and database searches, complemented with citation snowballing. Citation snowballing adds materials referenced in sources already found (referred to as 'seed articles') to ensure comprehensive coverage of relevant literature (in Table 1 seed articles are those in shaded rows). Figure 1 illustrates the snowball approach used in this review.

Six seed articles and reports were initially sourced from the wider *National Study* and used as a starting point for the RSR. Citation snowballing and reference list checks of these articles identified additional publications that met the inclusion criteria described above (n=21, after duplicates were removed). A second citation check using the sources identified in this first stage yielded a further seven sources. Table 1 provides a summary of the literature included in this review.

As the most recent seed article was dated 2021, a Google Scholar search was conducted to capture more recent prevalence studies. The search term used was 'elder abuse prevalence'[3] and results were refined to only include records since 2021. The first two pages of results were used. After screening for relevance and duplicates, an additional 14 records were added to the review (see Figure 2).

A total of 48 articles and reports were included in the review and are discussed in Section 3.

[3] 'Elder abuse' is traditionally a more common term for AOP in international research and the existing literature, so it was used as the search term here. We note that terminology has shifted over time, and that the wider *National Study* has documented findings on the relevance of language to how AOP is conceptualised. For example, the use of 'harm' or 'mistreatment' is considered more inclusive and appropriate than 'abuse'.

Figure 1: Snowball search approach

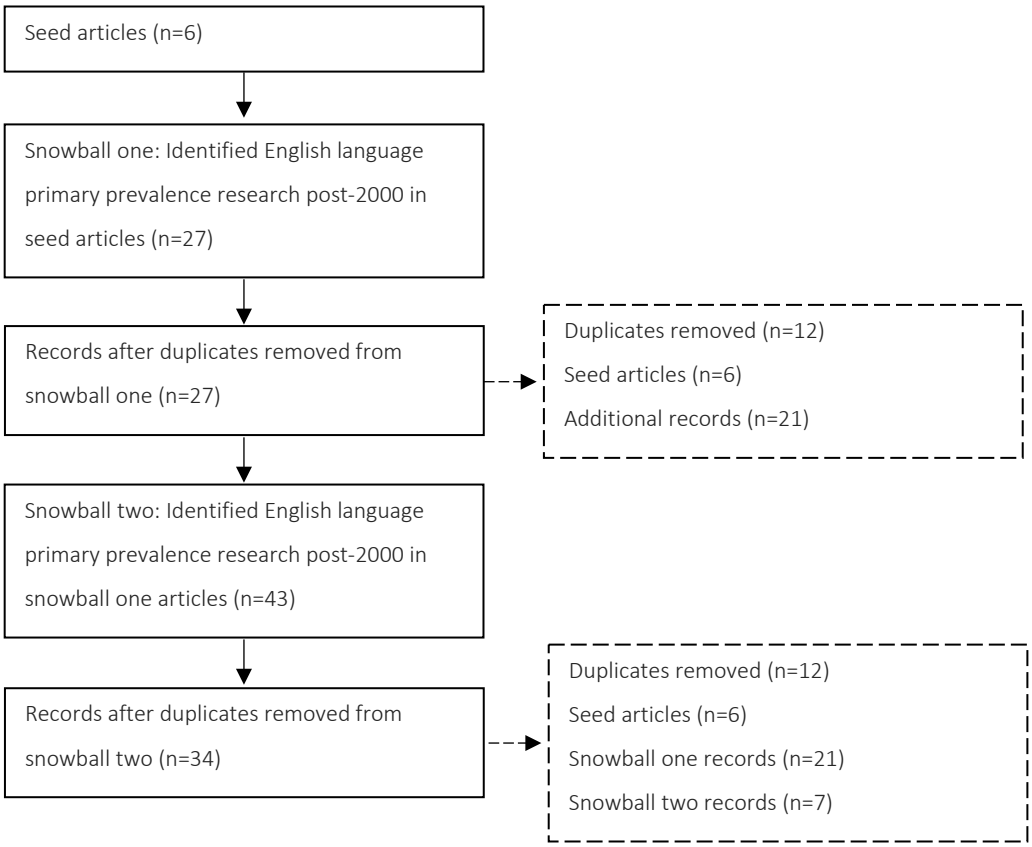
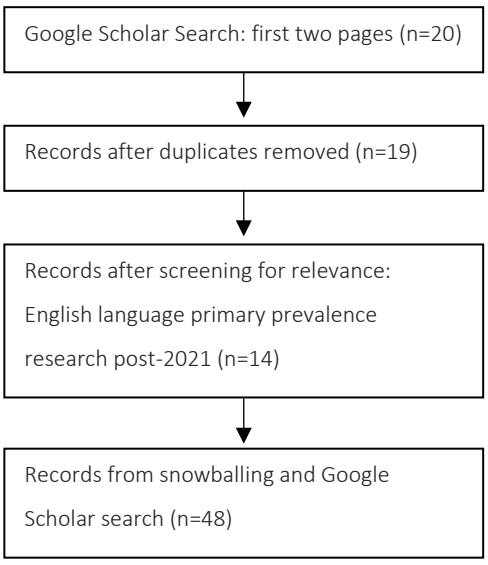


Figure 2: Further database search



2.2 Expert consultation method

In addition to the RSR, we consulted with researchers and clinicians familiar with AOP and other forms of family violence on the topic of applying thresholds when estimating prevalence rates. For the purposes of this project, we refer to those we consulted with as *experts*, in acknowledgement of their insight and expertise in the area.

In the first instance, the research team aimed to connect with relevant experts from our existing professional networks, then use a snowball (referral) approach. In total, eight experts were invited to speak with us, and six were able to schedule time to meet over a three-week period in May and June 2025. Meetings took place virtually and lasted approximately 75–90 minutes; to allow candid and frank discussion, meetings were not audio-recorded, although written notes were taken.

Of those experts we contacted but did not speak with, one is NZ-based and the other international. Both are experienced researchers on the topic of older people's wellbeing and AOP, including AOP screening and risk assessment, and AOP prevalence, respectively. Both experts were invited to provide earlier feedback on the wider *National Study* and our *Prevalence Survey.*

Four of the six experts included in the consultation are NZ-based and the remaining two international. While all have comprehensive research experience, they come from a range of disciplines, including nursing, psychiatry (specifically, psychogeriatric medicine), and social science. Four have conducted research either in NZ or elsewhere on AOP, including its prevalence, and two are specialist IPV researchers with wide-ranging experience on the topic of family violence, including its prevalence in NZ.

All experts were somewhat familiar with the wider research programme, having been consulted with previously as experts in their respective fields. Prior to the thresholds study, they may have provided feedback on the research design, preliminary survey findings, or in some cases been commissioned by MSD to undertake bespoke projects under the broader AOP work programme. However, for the purposes of the current study, we did not assume comprehensive knowledge of the *Prevalence Survey* or its contents.

Each meeting consisted of a brief background to the study, including the other aspects of the wider project (see Section 1), the definition of AOP we adopt, and an overview of the *Prevalence Survey*. Prevalence rates estimated using a range of thresholds were presented to prompt and frame the discussion of AOP thresholds, for overall AOP and each subtype (excluding physical and sexual harm – for further detail on this point, see Section 4.1). The estimates discussed were preliminary figures subject to change, and appropriate caveats were made clear to the experts during the meetings.

The next section contains a description of the thresholds discussed and how they are calculated using the survey data.

2.3 Thresholds for defining and measuring AOP

This section first outlines the Cumulative Harm Index (CHI) approach used to estimate prevalence rates, then describes how each AOP subtype is defined and measured in the survey. For background on how thresholds have been applied in international prevalence studies, see Section 3.

Measuring frequency and severity

Prior to describing how each AOP subtype is captured in the survey, there are key caveats worth highlighting. Specifically, questions on the frequency of behaviours experienced and the self-reported severity of those experiences were asked in a way that prioritised including fewer questions to minimise total interview time. This means that respondents were asked which behaviours they experienced (yes/no) and how often (on a four-point scale), or in the case of neglect, what activities they required help with and how often, and then whether they always received that help when they needed it (if not, how often). For frequency of experience, the data is collected for each behaviour experienced (i.e. behaviour-level data).

However, the perceived seriousness question[4] was asked once per harm subtype and focused on the severity of the behaviour of the one person who affected them the most (if the respondent identified multiple people responsible for the behaviour). Perceived seriousness is therefore subtype-level data, limiting its use in behaviour-level analysis. It also means the survey did not capture cases where multiple individuals may have contributed to a cumulative pattern of neglect or harm – each instance perceived as individually minor or moderate but collectively experienced as very serious.

The Cumulative Harm Index

Along with 'no threshold' (any single occurrence is included), the thresholds presented to the experts were variations of a CHI:

[4] For neglect, "Because this person did not always provide help with some activities when you needed, how serious was this for you?" For other harm subtypes, "How serious for you was their behaviour toward you?"

1. CHI–Core: Respondents were included if they experienced physical or sexual harm (no threshold applied), or scored 3 or more on the CHI for neglect, psychological, or cultural & spiritual harm. Two versions were presented for discussion, based on the treatment of financial harm:
    a) The CHI approach was applied to financial harm in addition to neglect, and psychological, and cultural & spiritual harm (i.e. CHI = 3+).
    b) No threshold on financial harm. In this case, respondents were included in the CHI–Core if they experienced physical, financial, or sexual harm, or scored 3 or more on the CHI for the other harm subtypes.
2. CHI–Very Serious: This extends the CHI–Core to also include respondents who did not meet the CHI threshold but described the harm they experienced as "very serious". Two versions were discussed, depending on the underlying CHI–Core threshold (a or b) described above.
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 threshold.

In the results presented in Section 6.1, we report the distribution of perceived severity by CHI–Core scores responses – this allows us to further explore the interaction between behaviour-level frequency and subtype-level severity.

Physical and sexual harm

As mentioned above, no threshold is applied to physical or sexual AOP; each instance of any behaviour included in the prevalence estimates. The definitions of each and how they are measured in the *Prevalence Survey* are included here for completion.

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. In the survey, physical harm was measured based on whether respondents reported experiencing one or more incidents of physical violence in the past 12 months, perpetrated by someone they knew.

In line with international practice (see Section 3), 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, "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.
- 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.

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. In the survey, sexual harm was measured based on whether respondents experienced one or more specific behaviours in the past 12 months, perpetrated by someone they knew.

Interviewers also prefaced this part of the survey by reminding respondents they did not have to answer if they did not want to, and (re)confirmed the respondent was in a private place before continuing the interview.

As with physical harm, 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 ensures that even single incidents are recognised in prevalence estimates, reflecting the inherently serious nature of sexual harm.

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.

Unlike the other AOP subtypes, which solely measure an older person's exposure to behaviour that may cause harm, neglect requires that they need help with everyday tasks and there is a person, or people, responsible for helping them with these. Measuring neglect is therefore a three-step process:

1. Determine if the respondent requires help with everyday tasks, and how often.
2. Determine who (if anyone) is responsible for helping them with those tasks.
3. Determine if those responsible for helping always provided help when it was needed.

How often did you require help with…?

In the survey, respondents were asked whether they had needed assistance 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

For each activity, respondents were asked how often help was needed with a list of response options (None of the time, Rarely, Some of the time, or All of the time).

Who is mainly responsible for helping you with…?

For each activity a respondent needed help with, they were asked who was mainly responsible for providing it from a pre-defined list of relationships (e.g. partner, child, friend, [paid] professional carer etc).

Those who said they needed help but answered "no-one" when asked who was responsible for helping them are not included in the prevalence rate. This reflects the survey's focus on interpersonal neglect – where someone fails to provide needed help – and is consistent with international practice. It also means that cases of self-neglect, where no helper is involved, are explicitly excluded from the definition of AOP used in this study.

Did you always get the help when you needed it from your…?

For each identified carer, respondents were asked whether they always received the help they needed over the past 12 months. If respondents did not always receive the help they needed, they were asked how often this occurred (Once, A few times, Many times, or Every day or almost every day).

Estimating neglect prevalence

Four prevalence rates were estimated: no threshold, and three variations of a CHI, including the CHI–Core, CHI–Very Serious, and CHI–Expanded Seriousness.

The CHI for neglect is based on how often respondents did not receive the help they needed from the person mainly responsible for providing it across the 10 daily activities.

For each day-to-day activity, a score was assigned based on whether the respondent needed help and how consistently it was received over the past 12 months:

- 0 – Did not require any help
- 0 – Required help and always received it when needed
- 1 – Required help but did not receive it once
- 2 – Required help but did not receive it a few times
- 3 – Required help but did not receive it many times
- 4 – Required help but did not receive it every day or almost every day

These individual item scores are summed together to generate the CHI–Core; respondents with a CHI–Core of 3 or more are defined as experiencing neglect. The index captures repeated instances of unmet need, rather than one-off occurrences.

For example, if a respondent did not receive the help they needed with housework a few times (CHI = 2) but received the help they needed for all other activities (CHI = 0), they would not meet the definition of neglect (CHI–Core = 2). However, if a respondent did not receive the help they needed with housework a few times (CHI = 2), plus did not receive the help they needed with their shopping once (CHI = 1), and had identified someone responsible for providing that help, then they would meet the neglect threshold (CHI–Core = 3).

The CHI–Core threshold captures the number and frequency of activities when help was not provided, but it does not include how serious that experience was for the respondent. Two broader thresholds were also estimated to capture the seriousness of the unmet need for the respondent:

- Respondents with a CHI–Core below 3 who reported their experience as "very serious" were included in the **CHI–Very Serious** definition.
- Respondents with a CHI–Core below 3 who reported their experience as at least "somewhat or moderately serious" were included in the **CHI–Expanded Seriousness** definition.

Financial harm

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 Enduring Power of Attorney (EPOA), or failing to pay agreed expenses.

In the survey, respondents were asked a series of eight yes/no questions about their experiences of financial harm. Specifically, they 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 experienced any of these financial harms, they were also asked how many times in the last 12 months this had happened (Once, A few times, Many times, or Every day or almost every day).

Estimating financial harm prevalence

Like neglect, four prevalence rates were estimated to explore the use of thresholds in this context: no threshold, and three variations of a CHI, including the CHI–Core, CHI–Very Serious, and CHI–Expanded Seriousness.

For each financial harm item, a score was assigned as follows:

- **0** – Did not experience this type of harm
- **1** – Experienced this type of harm once
- **2** – Experienced this type of harm a few times
- **3** – Experienced this type of harm many times

- **4** – Experienced this type of harm every day or almost every day

These individual item scores are summed together to generate the **CHI–Core**; respondents with a CHI–Core of 3 or more are defined as experiencing financial harm. The index captures repeated instances of financial harm or multiple behaviours experienced infrequently, rather than one-off occurrences.

For example, if someone they knew made financial decisions for them without their permission once (CHI = 1), plus pressured the respondent into loaning money once (CHI = 1), the total CHI–Core would be 2 and they would not meet the threshold. However, if the pressure to loan money occurred many times (CHI = 3), the respondent would meet the threshold (CHI–Core = 3) and would be included in the CHI–Core prevalence rate for financial harm.

As stated previously, the CHI–Core threshold approach captures the number and frequency of harmful instances, but it does not include how serious that experience was for the respondent. Two broader thresholds were also estimated to capture the seriousness of the financial harm for the respondent:

- Respondents with a CHI–Core below 3 who reported their experience as "very serious" were included in the **CHI–Very Serious** definition.
- Respondents with a CHI–Core below 3 who reported their experience as at least "somewhat or moderately serious" were included in the **CHI–Expanded Seriousness** definition.

Psychological harm

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.

In the survey, respondents were asked a series of 10 yes/no questions about their experiences of psychological harm. Specifically, they were asked whether in the last 12 months someone they knew had:

- 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.

If they had experienced any of these psychological harms, they were also asked how many times in the last 12 months this had happened (Once, A few times, Many times, or Every day or almost every day).

Estimating psychological harm prevalence

As above, four prevalence rates were estimated: no threshold, and three variations of a CHI, including the CHI–Core, CHI–Very Serious, and CHI–Expanded Seriousness.

For each psychological harm item, a score was assigned as follows:

- 0 – Did not experience this type of harm
- 1 – Experienced this type of harm once
- 2 – Experienced this type of harm a few times
- 3 – Experienced this type of harm many times
- 4 – Experienced this type of harm every day or almost every day

These individual item scores are summed together to generate the CHI–Core; respondents with a CHI–Core of 3 or more are defined as experiencing psychological harm. The index captures repeated instances of psychological harm or multiple behaviours experienced infrequently, rather than one-off occurrences.

For example, if someone they knew threatened to harm others they cared about once (CHI = 1), plus excluded them once (CHI = 1), their total CHI–Core would be 2 and they would not meet the threshold. However, if the threat occurred many times (CHI = 3), they would meet the threshold (CHI–Core = 3) and be included in the prevalence rate for psychological harm.

As stated previously, the CHI–Core threshold approach captures the number and frequency of harmful instances, but it does not include how serious that experience was for the respondent. Two broader thresholds were also estimated to capture the seriousness of the psychological harm for the respondent:

- Respondents with a CHI–Core below 3 who reported their experience as "very serious" were included in the CHI–Very Serious definition.
- Respondents with a CHI–Core below 3 who reported their experience as at least "somewhat or moderately serious" were included in the CHI–Expanded Seriousness definition.

Cultural & spiritual harm

Cultural & spiritual abuse happens 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.

In the *Prevalence Survey,* respondents were asked a series of 13 yes/no questions about their experiences of cultural & spiritual harm. Specifically, they were asked whether in the last 12 months someone they knew had:

- 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.
- Not respected, shamed, made fun of, or ridiculed your spiritual beliefs or practices.
- Prevented you from attending church or practising your religion how you want to (e.g. not allowing you to worship or pray).
- 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 they had experienced any of these harms, they were also asked how many times in the last 12 months this had happened (Once, A few times, Many times, or Every day or almost every day).

Estimating cultural & spiritual harm prevalence

As above, four prevalence rates were estimated: no threshold, and three variations of a CHI, including the CHI–Core, CHI–Very Serious, and CHI–Expanded Seriousness.

For each harm item, a score was assigned as follows:

- 0 – Did not experience this type of harm
- 1 – Experienced this type of harm once
- 2 – Experienced this type of harm a few times
- 3 – Experienced this type of harm many times
- 4 – Experienced this type of harm every day or almost every day

These individual item scores are summed together to generate the CHI–Core; respondents with a CHI–Core of 3 or more are defined as experiencing cultural & spiritual harm. The index captures repeated instances of harm or multiple behaviours experienced infrequently, rather than one-off occurrences.

For example, if someone had limited their access to familiar cultural activities a few times (CHI = 2), plus used cultural beliefs to belittle them once (CHI = 1), they would meet the threshold (CHI–Core = 3) and be included in the prevalence rate of cultural & spiritual harm.

As before, the CHI–Core threshold approach captures the number and frequency of harmful instances, but it does not include how serious that experience was for the respondent. Two broader thresholds were also estimated to capture the seriousness of the cultural & spiritual harm for the respondent:

- Respondents with a CHI–Core below 3 who reported their experience as "very serious" were included in the CHI–Very Serious definition.
- Respondents with a CHI–Core below 3 who reported their experience as at least "somewhat or moderately serious" were included in the CHI–Expanded Seriousness definition.

3 RAPID SCOPING REVIEW

This section summarises the RSR findings and discusses how existing studies define and apply thresholds for measuring AOP prevalence. Related issues are also reviewed where relevant, including conceptual definitions of AOP and insights from research on other types of family harm (e.g. IPV, child abuse, and neglect).

3.1 What is AOP?

Abuse of older people (AOP, also referred to as 'elder abuse') is a significant societal problem with serious consequences for victim-survivors (Yon et al., 2017; World Health Organization, 2024). It is recognised as an important public health issue due to its association with increased mortality and morbidity, negative health outcomes, and poor quality of life (see Garre-Olmo et al., 2009; Yon et al., 2017; Jeon et al., 2019, among others). Understanding the prevalence of AOP, including its various forms (such as neglect, and physical, sexual, psychological, cultural/language/spiritual, and financial abuse) is crucial for developing evidence-based policies, practices, and prevention efforts.

AOP lacks a universally agreed definition, and this inconsistency is widely recognised as a barrier to data collection, generalisable research findings, and the development of effective policy and service responses (Dong, 2015; Blundell et al., 2017). Definitions vary in terms of scope, emphasis (e.g. intention, relationship dynamics) and the types of harm considered. However, several definitions have gained acceptance in the research literature.

The most commonly cited definition is that adopted by the World Health Organization (WHO) from Action on Elder Abuse in the United Kingdom (1995), which defines AOP as, *"a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person"* (WHO, 2008, p. 1). This definition highlights key elements found in earlier frameworks,[5] including harm or distress caused to an older person, action or inaction, and the presence of relationships characterised by trust. For instance, in the *National survey on the mistreatment of older Canadians*, McDonald (2015, p. 6) describes mistreatment of older adults as *"action and/or behaviours, or lack of actions and/or behaviours, that cause harm or risk of harm within the trusting relationship."*

[5] For example, Wolf (2000) defined elder abuse as simply any type of abuse or maltreatment of older adults.

Qu et al. (2021, p. 17) extend this definition for their Australian prevalence study by including threats and acknowledging power imbalances as a critical dimension of AOP: *"a single or repeated act or failure to act, including threats, that results in harm or distress to an older person. This occurs where there is an expectation of trust and/or where there is a power imbalance between the party responsible and the older person".*

The definition has five elements:

1. *A single or repeated act or failure to act*. The measures applied in international studies capture different forms of physical, sexual, financial, and psychological abuse and neglect. The Australian study also examined abuse relating to language and culture.
2. *An older person*. Most studies defined an older person as either 60 years or over or 65 years and over.
3. *A party who is responsible for the act or omission*. Most international prevalence surveys included family members, friends, neighbours, acquaintances, or professionals (such as medical professionals, care workers, financial advisors), but excluded strangers.
4. *The consequence of harm or distress.* In existing studies, this is typically measured by asking the older person how serious the abuse was.
5. A situation where the connection between the older person and the person responsible for the act or omission involves an *expectation of trust and/or a power imbalance.*

For the wider *Prevalence Study*, Qu et al.'s (2021) definition is used as described in Section 1.1. However, alternative approaches to defining AOP are worthy of mention. For example, Iborra (2008) suggest a rights-based lens, framing AOP as a violation of not only care expectations, but of dignity.

> *"Elder abuse is any voluntary – i.e., non-accidental – act that harms or may harm an elderly person, or any omission that deprives an elderly person of the care they need for their wellbeing, as well as any violation of their rights. To be classified as elder abuse, such acts or omission must take place within the framework of interpersonal relationship in which one expects trust, care, convivencia ('living together') or dependency."* (Iborra, 2008, p. 88)

Similarly, Lowenstein et al. (2009) build on Hudson's (1989, p. 16) "critical attributes" of elder abuse by framing AOP as a "violation of human rights" (p. 258) that occurs in "the context of a trusting relationship." Unlike Iborra (2008), dependency of the older person is not mentioned, and the focus is on frequency and severity – harm that "occurs consistently" – implying AOP is a pattern of behaviour and its impact cumulative.

> *"…destructive and offensive behavior inflicted on an elder person within the context of a trusting relationship. This behavior occurs consistently and with such severity and frequency that it produces physical and psychological pain or financial harm, and unnecessary suffering, loss, or violation of human rights and induces harm to the elder person's quality of life."* (Lowenstein et al., 2009, p. 258)

In contrast to earlier conceptualisations of AOP, for example Hudson (1989), current understandings of AOP share a focus on interpersonal relationships. As Wilson et al. (2026) point out, a pre-existing relationship between the older person and the person/people causing them harm is assumed, and risks excluding relevant experiences of older people that impact their wellbeing. We acknowledge this tension as a product of AOP's complexity.[6] It is a multifaceted issue shaped by complex interrelated layers of family, community, and broader system and societal dynamics (Blundell et al., 2017). Applying a human rights lens highlights the role of ageism as a fundamental driver of AOP; this perspective frames AOP as not just a personal or relational issue, but as a broader violation of older people's rights to dignity, respect, and care (Qu et al., 2021). These wider systemic and structural factors influence not only the risk and experience of abuse, but also how AOP is identified, interpreted, and addressed.

Variation in definition is matched by diverse theoretical frameworks to capture the complexity and multifaceted nature of AOP. These frameworks vary in terms of focus, from individual and relational dynamics to broader systemic and societal influences. For example, Bronfenbrenner's (1986) ecological model has been widely applied to the study of older people's wellbeing (see, for example, Tang et al., 2023, among others). The framework provides a lens for understanding AOP as a complex issue arising from the interplay of factors at multiple levels (Ahnlund et al., 2020), an outcome of the interaction of the individual with their interpersonal, community, and societal context (Luoma et al., 2011). An advantage of an ecosystem and sociocultural approach is the emphasis placed on factors at a personal level, such as characteristics of the victim-survivor and person(s) responsible for the harm, in addition to other relationships within the family and whānau, community, and society – it acknowledges intersectionality (Wilson et al., 2026). Further, it is a useful framework for identifying and describing the risk factors associated with AOP (Blundell et al., 2017), allowing operationalisation of the definitions above.

It is operationalisation (i.e. measurement of AOP) that is the focus of this scoping review, providing the necessary background to the more specific topic of thresholds.

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[6] For a more comprehensive discussion of definitional considerations relevant to the NZ context, see the *Qualitative Interviews Report* (Wilson et al.,2026).

Table 1: Summary of selected literature

No	Author/s	Key objectives (focus, geography, and sample description)	Methodology	Prevalence rate (12-month)	Type of abuse
1	Acharya et al. (2021)	To find out the prevalence of different forms of abuse among elderly Nepalese people (60–80 years) in Syangja district, Nepal	Empirical study, simple random sampling, cross-sectional quantitative analytical study	54.50% (period unknown)	Neglect, psychological, physical, financial, and sexual abuse
2	Acierno et al. (2010)	To assess elder abuse among community residing adults (aged 60+) in the US	Empirical study, randomly selected national sample, survey via computer-assisted telephone interviews	11.4%	Emotional, physical, sexual, financial abuse, and neglect
3	Ahnlund et al. (2020)	To examine prevalence of elder abuse (aged 60+) in Sweden	Empirical study, nationally representative sample, survey via online and postal questionnaire	4.2%	Psychological violence, physical violence, and sexual violence
4	Amstadter et al. (2011)	To examine the prevalence of elder mistreatment (aged 60+) in South Carolina, US	Empirical study, randomly selected sample of South Carolinians, survey via computer assisted telephone interviews	10%	Emotional, physical, sexual, financial abuse, and neglect mistreatment
5	Biggs et al. (2009)	To provide prevalence estimates of elder mistreatment (aged 66+) in England	Secondary analysis of nationally representative data (UK Study of the Abuse and Neglect of Older People)	2.6%	Financial abuse, psychological abuse, physical abuse, sexual abuse, and neglect
6	Blundell et al. (2017)	To review current policy, legislative and service responses to elder abuse in Queensland, Australia	Qualitative: key stakeholder interview and focus group of staff from organisations working with elder abuse Quantitative: online survey completed by staff from various organisations. Literature review	The study did not directly gather primary data from victim of elder abuse.	
7	Brijoux et al. (2021)	To estimate the prevalence of elder abuse (aged 80+), identify risk factors, and investigate the effects in North Rhine-Westphalia, Germany	Empirical study, selective subsample of self-report interviews, computer-assisted personal interviews	54.1%	Financial exploitation, physical abuse, neglect, psychological (intimidation, shaming, blaming, paternalism)
8	Burnes et al. (2015)	To estimate elder abuse (aged 60+), and identify the risk and protective factors in New York, US	Empirical study, cross-sectional, population-based study using random-digital sampling method, direct telephone interviews	4.6%	Emotional abuse, physical abuse, neglect
9	Burnes et al. (2022)	To estimate the prevalence of elder abuse (aged 65+) and identify risk factors in Canada	Empirical study, longitudinal, population-based design using Canadian Longitudinal Study on Aging (CLSA), telephone and in-person interviews	10%	Emotional, financial abuse, physical abuse
10	Cevik et al. (2023)	To determine the prevalence of elder abuse (aged 65+) and factors related to the abuse in northwestern Turkey	Empirical study, community-based cross-sectional study, cluster sampling method, interviews	19.5%	Type of abuse not explicitly stated
11	Chandanshive et al. (2022)	To estimate the prevalence and pattern of elder abuse (aged 60+) in urban slums of Bhubaneswar, India	Empirical study, cross-sectional community-based study, simple random sampling, face-to-face interviews	19.4%	Emotional/psychological abuse, verbal, financial abuse, and physical abuse

No	Author/s	Key objectives (focus, geography, and sample description)	Methodology	Prevalence rate (12-month)	Type of abuse
12	Chang & Levy (2021)	To estimate the prevalence of elder abuse (aged 60+) and identify risks associated during Covid-19 pandemic in the US	Empirical study, survey study using online platform Qualtrics platform	21.3% (period unknown)	Financial mistreatment, verbal abuse, and physical abuse
13	Chen & Chan (2022)	To examine the prevalence and chronicity of elder abuse (no age limit) in China	Empirical study, multi-stage stratified probability sampling, large-scale cross-sectional household survey, questionnaire	10%	Psychological aggression, physical assault, neglect
14	Chokkanathan (2018)	To identify the prevalence and risk factors associated with elder (aged 60+) mistreatment in Singapore	Empirical study, cross-sectional design, non-randomly selected, door-to-door surveys/interviews	8.3% (period unknown)	Physical, financial, psychological abuse, and neglect
15	Chokkanathan & Lee (2005)	To examine the extent and correlates of mistreatment among cognitively normal community-dwelling older adults (aged 65+) in Chennai, India	Empirical study, randomly selected elders from electoral list of residential area, survey via face-to-face interviews	14%	Chronic verbal abuse, financial abuse, physical abuse, neglect
16	Dong et al. (2007)	To investigate the prevalence and types of elder abuse and neglect (aged 60+) in Nanjing, China	Empirical study, conveniently selected patients, self-administered survey	35.2%	Physical abuse, sexual abuse, emotional abuse, financial exploitation, neglect, and abandonment
17	Du & Chen (2021)	To estimate the prevalence of elder abuse (aged 65+) in Hunan province, China during the Covid-19 pandemic	Empirical study, cross-sectional study design, randomly selected communities, face-to-face questionnaire survey	15.4%	Physical abuse, emotional abuse, financial abuse, and neglect
18	Eisikovits et al. (2004)	To examine elder abuse and neglect as social problem (men aged 60+ and women aged 65+) in Israel	Empirical study, randomly selected national sample of urban dwellers, survey interviews	18.4%	Physical, sexual abuse, verbal abuse, limitation of freedom, financial exploitation
19	Ergin et al. (2012)	To investigate elder abuse and neglect among elderly (aged 65+) within the family and identify risk factors in Aydin, Western city of Turkey	Empirical study, community-based cross-sectional study, multi-stage sampling methods, face-to-face interviews	14.2%	Physical, psychological, sexual, financial abuse, and neglect
20	Garre-Olmo et al. (2009)	To assess prevalence of suspected elder abuse (aged 75+) subtypes and identify related factors of these subtypes in eight rural villages in Girona, Spain	Empirical study, simple randomised sampling, face-to-face interviews	29.3%	Physical abuse, psychological abuse, financial abuse, and neglect
21	Gil et al. (2015)	To estimate the prevalence of abuse and neglect among older people (aged 60+) in family settings in Portugal	Empirical study, cross-sectional population-based study, nationally representative probability sample, telephone survey	15%	Physical, psychological, financial, sexual abuse, and neglect
22	Jeon et al. (2019)	To examine differences in the prevalence estimates of elder abuse among community-dwelling older people (65+) in Korea	Empirical study, used stratified sampling from nationally representative LPOPS survey data, interviews	9.9%	Physical abuse, verbal abuse, financial exploitation, neglect (caregiving & financial)
23	Koga et al. (2020)	To clarify the prevalence of each type of elder abuse among independent older Japanese (aged	Retrospective observational study design using cross-sectional data (Japan Gerontological Evaluation study),	12.3%	Physical, psychological, financial abuse

No	Author/s	Key objectives (focus, geography, and sample description)	Methodology	Prevalence rate (12-month)	Type of abuse
		65+) adulst and investigate the associations between other risk factors	randomly selected sample, self-reported questionnaire		
24	Kulakçı Altıntas & Korkmaz Aslan (2020)	To determine the prevalence of elder abuse among community-dwelling older adults (aged 60+) in Zonguldak city centre, Turkey	Empirical study, cross-sectional study design, non-probability sampling method, face-to-face interviews	13.6%	Physical, psychological, financial, sexual abuse, and neglect
25	Lai (2011)	To examine the incidence of maltreatment or neglect experienced by ageing Chinese (aged 55+) in Canada	Empirical study, used random sampling method, face-to-face interviews	4.5%	Psychological, verbal, physically, financial abuse, and neglect
26	Lee et al. (2021)	To investigate the factors associated with elder abuse and the effects of social support in community-dwelling elder people (aged 65+) in Korea	Analysing a dataset from pre-existing survey, survey of living conditions and welfare needs of Korean older persons, stratified two-staged cluster sampling design, face-to-face interviews	12.6%	Physical, psychological, financial abuse, and neglect
27	Lifespan of Greater Rochester et al. (2011)	To estimate the prevalence and incidence of elder abuse experienced by older New Yorkers (aged 60+) in US	Empirical study, randomly selected sample, self-reported prevalence study and documented case study	7.6%	Physical, sexual, emotional abuse, neglect (active/passive), and financial exploitation
28	Lindert et al. (2013)	To investigate the prevalence rate of abuse of older persons (aged 60–84) in seven cities from seven countries (Germany, Greece, Italy, Lithuania, Portugal, Spain, and Sweden)	Empirical study, cross-sectional community study design, random sampling methods, interviews	22.1% (for 7 countries)	Physical, psychological, financial, sexual abuse, and neglect
29	Lowenstein et al. (2009)	To examine the prevalence and severity of various forms of abuse and neglect of community urban dwellers (aged 65+) in Israel	Empirical study, cluster sampling from nationally representative sample, face-to-face interviews	18.4% (excludes neglect)	Physical, verbal, financial, sexual, limitation of freedom, and neglect
30	Luoma et al. (2011)	To provide comparable information about abuse and violence against women (aged 60+) who live in private household in five European countries (Austria, Belgium, Finland, Lithuania, and Portugal)	Empirical study, various sampling methods (stratified random sampling, proportional stratified, random sample and random probability stratified sampling methods), telephone, postal and face-to-face survey data collection	28.1%	Neglect, emotional, financial, physical, sexual abuse, and violation of rights
31	Iborra (2008)	To determine the current situation of elder (aged 64+) abuse in Spain	Empirical study, randomly selected nationally representative data, in-person interviews	0.8%	Physical, psychological, financial, sexual abuse, and neglect
32	Maurya et al. (2024)	To examine the prevalence and determinants of elder (aged 60+) abuse in India	Longitudinal ageing study, nationally representative survey, multi-stage stratified area probability cluster sampling	5.22%	Physical, verbal/disrespect, financial abuse, psychological abuse, and neglect
33	McDonald (2015)	To present five forms of mistreatment of community-dwelling older adults (aged 55+) in Canada	Empirical study, population weighted sampling, direct respondent interviews by telephone	8.2%	Physical, sexual, psychological, financial abuse, and neglect
34	Naughton et al. (2010)	To identify prevalence of abuse and types of abuse in community-dwelling older people (aged 65+) in Ireland	Empirical study, multi-stage cluster random sample, nationally representative population, face-to-face interviews	2.2%	Physical, psychological, financial, sexual abuse, and neglect

No	Author/s	Key objectives (focus, geography, and sample description)	Methodology	Prevalence rate (12-month)	Type of abuse
35	Nemati-Vakilabad et al. (2023)	To identify types of elder (aged 60+) abuse and examine associated risk factors in Ardabil, Iran	Empirical study, cross-sectional analytical study, simple random sampling, face-to-face interviews	75.4%	Physical, psychological, financial abuse, and neglect
36	O'Keeffe et al. (2007)	To address the absence of sound data on the prevalence of older people (aged 66+) experiencing mistreatment in the UK	Empirical study, random probability sampling, face-to-face interviews using computer-assisted personal interviews	2.6%	Neglect, financial, psychological, physical, and sexual abuse/mistreatment
37	Oh et al. (2006)	To investigate the state of elder abuse (aged 65+) in Seoul, Korea	Empirical study, population-based survey, using interviews	6.3% (at least one incident in the last month)	Physical, emotional, economic, verbal abuse, and neglect
38	Qu et al. (2021)	To measure the prevalence of elder abuse among community-dwelling people (aged 65+) in Australia	Empirical study, random sampling of nationally representative population, computer-assisted telephone interviews	14.8%	Psychological, neglect, financial, physical, and sexual abuse
39	Sandmoe et al. (2017)	To map the prevalence of violence and abuse against individuals (aged 65+) living in their own homes in Norway	Empirical study, selection of representative sample from Central Population Register, questionnaire	5.2% - 7.2%	Physical violence, psychological abuse, sexual abuse, financial abuse. and neglect experienced
40	Sathya et al., 2022	To assess the prevalence of elder (aged 60+) abuse and associated factors in India	Nationally representative data from the first wave of Longitudinal Aging Study in India, interviews	5.2%	Physical, psychological, financial, sexual abuse, and neglect
41	Seutodan Hagh et al. (2021)	To investigate the prevalence of elder (aged 60+) abuse and its gender differences in Tabriz, Iran	Empirical study, cross-sectional study, two-stage cluster sampling method, questionnaire through interviews	52.6% (period unknown)	Physical, psychological, financial abuse, and neglect
42	Soares et al. (2010)	To examine the prevalence of abuse against elders (aged 60–84) in seven different European countries (Sweden, Germany, Lithuania, Greece, Portugal, Italy, and Spain)	Empirical study, random sampling method, face-to-face interviews	No overall prevalence	Psychological, physical, sexual, financial abuse, and injuries
43	Sooryanarayana et al. (2017)	To determine the prevalence of elder abuse among community-dwelling adults (aged 60+) and to identify its associated factors in the rural district of Kuala Pilah, Malaysia	Empirical study, multi-stage sampling, face-to-face interviews	4.5%	Physical, psychological, sexual, financial abuse. and neglect
44	Wainer et al. (2010)	To explore existing data reflecting the incidence and prevalence of financial elder abuse in Victoria, Australia	Secondary data collection from six organisations and key informants from 22 agencies/government departments were interviewed	No primary assessment	
45	Wiklund et al. (2022)	To estimate the prevalence of elder abuse and life-course victimisation among hospitalised older people (aged 65+) in Sweden	Part of a larger Responding to Elder Abuse in GERiAtric care (REAGERA), face-to-face interviews, self-administered questionnaire and information retrieved from medical records	17.8% (period unknown)	Physical, emotional, sexual, financial abuse, or neglect

No	Author/s	Key objectives (focus, geography, and sample description)	Methodology	Prevalence rate (12-month)	Type of abuse
46	Wu et al. (2012)	To investigate the prevalence of elder mistreatment among older adults (aged 60+) in rural China	Empirical study, two-stage cluster sampling, face-to-face interviews	36.2%	Psychological mistreatment, caregiver neglect, physical and financial mistreatment
47	Yan & Tang (2001)	To examine the association of elder abuse with inter-dependence between elderly people (aged 60+) and their caregivers in Hong Kong	Empirical study, community-based sampling method from 15 community centres, face-to-face interviews	21.4%	Verbal abuse, physical abuse, and social abuse
48	Yan & Tang (2004)	To explore the prevalence rate of abuse elderly people (60+) experience in Hong Kong	Empirical study, community-based sampling method from 15 community centres, face-to-face interviews	27.5%	Verbal abuse, physical abuse, violation of personal rights

3.2 A note on eligibility criteria, timeframe, and thresholds

Before synthesising the literature summarised in Table 1, it is useful to distinguish between eligibility criteria (e.g. age), the timeframe in which the abuse occurred (e.g. lifetime versus previous 12 months), and the concept of a threshold, as defined here. This section briefly describes the non-threshold aspects of prevalence studies, to give context to the later discussion.

As stated in Section 1.1, 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 contrast, eligibility criteria describe the characteristics of the target population. In the *Prevalence Survey*, older people living in the community aged 55 years and above were eligible to take part in the study. While a general question regarding past experiences of harm was asked in the survey, the timeframe of interest was instances of harmful behaviour experienced within the 12 months prior to the survey interview.

Other factors, such as what types of relationships with the older person are included (e.g. family and friends versus paid professionals versus acquaintances), are also important to note when reviewing the prevalence literature. For example, Wu et al. (2012) refer to "caregiver neglect" as opposed to the more common "neglect", and some studies report two prevalence rates – one that includes neighbours and acquaintances, and one that excludes them (see, for example, Naughton et al., 2010). While it is beyond the scope of this report, there is an apparent gap in how AOP studies seek to capture institutional and/or organisational abuse for community-dwelling populations of older people – see the wider *National Study* findings for further discussion.

Of relevance here is that in the *Prevalence Survey*, any person known to the respondent was included – strangers, however, were not.

Age

One of the most fundamental criteria used to define AOP is 'age'. However, the definition of 'older person' varies across studies. Some research defines older adults as those aged 55 and above (McDonald, 2015; Lai, 2011), while others apply cut-offs of 60 (Acierno et al., 2010; Ahnlund et al., 2020; Amstadter et al., 2011), 65 (Chokkanathan & Lee 2005; Jeon et al., 2019; Lowenstein et al., 2009), or even 75 years (Garre-Olmo et al., 2009). Although most studies do not set an upper age limit, some restrict participation to specific age brackets, such as 60–84 or up to 97 years (Luoma et al., 2011; Soares et al., 2010). A few studies

also apply gender-specific thresholds, defining older men as those aged 65 and above, and older women as those aged 60 and above (Eisikovits et al., 2004).

Timeframe

So-called temporal criteria define the period within which an abusive incident must occur to be counted in the prevalence rate. Most research measures the prevalence of AOP within the past 12 months (Iborra, 2008; Naughton et al., 2010; Luoma et al., 2011). However, some studies adopt broader or alternative periods such as abuse experienced in the last month (Oh et al., 2006), or past 3 months (Lowenstein et al., 2009), or since reaching a particular age (Naughton et al., 2010; Sandmoe et al., 2017). The latter can be considered the AOP equivalent of lifetime prevalence, common in the related intimate partner and family violence fields. It is often directly tied to the minimum age of eligibility for the study (e.g. 65 years).

Other factors

While age and temporal criteria are standard considerations for any research design, several additional methodological factors also shape how AOP is understood, measured, and reported. These include the nature of the relationship between the older person and the person causing harm (Blundell et al., 2017; O'Keeffe et al., 2007; Naughton et al., 2010), the characteristics or motivations of the abuser (Ahnlund et al., 2020; Lifespan of Greater Rochester et al., 2011; Oh et al., 2006), and the setting or context in which abuse occurs (McDonald, 2015; O'Keeffe et al., 2007). The cultural norms and broader social and political environment of the target population also influence whether certain behaviours are recognised, measured, and reported as abuse (Garre-Olmo, 2009).

Also, research methods themselves play a critical role in shaping data collection and subsequent findings. The ways in which questions are asked, the sources of information used, and the study design all influence how abuse is defined, identified, and quantified across different contexts (O'Keeffe et al., 2007). While including the full questionnaires for all 48 studies reviewed is not possible, Table 1 includes information about the nature of data collection (e.g. face-to-face versus telephone interview), alongside the geographic location of the research, age of participants, and time period being captured.

3.3 Thresholds used in AOP research

This section brings together the AOP prevalence literature to provide an overview of how researchers have identified and categorised behaviours experienced by older adults, and how thresholds have been applied (if at all). The review is structured by the subtypes measured in the *Prevalence Survey*, beginning

with physical and sexual harm, before turning to neglect, financial, psychological and, finally, cultural & spiritual harm. For each, a brief definition is given before providing the behavioural scales – lists of the actions or inactions that may cause harm – for the three seed articles used as both the foundation of this scoping review and the *Prevalence Survey* questionnaire. Importantly for this report's purpose, we describe the threshold used in determining the prevalence of each AOP subtype for these studies.

A note on subtype ambiguity

Behaviour scales vary significantly across studies, driven by the lack of agreement in the literature on what exactly constitutes abuse of an older person. How many harmful behaviours are experienced by an older person, and how often, before that person's cumulative experience is considered abuse also varies widely. As is evident in Table 1, there is also diversity in the subtypes, or forms, of AOP measured.

For instance, some studies use "social abuse" to describe situations where older individuals are deliberately isolated and prevented from maintaining social contact with family or friends, participating in chosen activities, or they have been experiencing abandonment (Blundell et al., 2017; Yan & Tang, 2001, 2004; Dong et al., 2007). While social isolation is considered a distinct consequence of AOP, social abuse is closely linked to neglect, particularly when isolation results from failure to support an older person's social needs (O'Keeffe et al., 2007). Abandonment can also be included as a form of neglect, measured separately to emotional abuse (see, for example, Dong et al., 2007).

Similarly, the rights-based lens discussed in Section 3.1 is evident in several studies. For example, "limitation of freedom" (Eisikovits et al., 2004; Lowenstein et al., 2009), "violation of rights" (Yan & Tang, 2004; Luoma et al., 2011), or "paternalism" (Brijoux et al., 2021). These constructs are often included alongside psychological abuse as separate subtypes of AOP. A last, relatively common. example of variation in abuse subtypes is "verbal abuse". While many studies include verbal abuse under the umbrella of psychological abuse, some treat it as a distinct category. For example, studies by Chokkanathan and Lee (2005), Jeon et al. (2019), Oh et al. (2006), and Yan and Tang (2001, 2004) distinguish verbal abuse from broader psychological harm. This suggests substantial diversity in how subtypes are defined across research settings before the topic of thresholds is even considered.

Physical harm

Physical abuse typically includes acts that cause bodily harm or pain to an older person. For instance, Yan and Tang (2001, 2004) identify specific behaviour such as kicking, biting, punching, slapping, hitting, choking, slamming, grabbing, pushing, twisting limbs or hair, or burning as indicators of physical abuse. Similarly, Naughton et al. (2010, p. 31) define physical abuse as *"the non-accidental infliction of physical*

force that resulted in a bodily injury, pain or impairment", highlighting the active use of force by the perpetrator. Table 2 outlines how the Ireland, UK, and Australian prevalence studies measure physical abuse of older adults (for full details of the studies, see Articles 34, 36, and 38 of Table 1).

Table 2: Physical abuse measurement

Author/s	Behaviours	Threshold
Naughton et al. (2010)	1. Tried to slap or hit you 2. Pushed, grabbed, shoved or slapped you 3. Kicked, bit or hit you with a fist 4. Hit or tried to hit you with an object 5. Burned or scalded you 6. Given you drugs or too much medicine in order to control you or make you sleepy 7. Restrained you in any way e.g. locked you in your room, tied you in a chair 8. Threatened you with a knife, gun or other weapon 9. Injured you with a knife, gun or other weapon	One or more incidents in the past 12 months Perpetrated by: • Family member • Close friend • Care worker
O'Keeffe et al. (2007)	1. Slapped you 2. Grabbed, pushed or shoved you 3. Kicked, bit or hit you with a fist 4. Burned or scalded you 5. Threatened you with a knife, gun or other weapon 6. Used a knife, gun or other weapon 7. Any other violence 8. Tied you down 9. Locked you in your room 10. Given you drugs or too much medicine in order to control you/ to make you docile 11. Restrained you in any other way	One or more incidents in the past 12 months Perpetrated by: • Family member • Close friend • Care worker
Qu et al. (2021)	1. Tied or held you down, or restrained you in any other way, or locked you up 2. Grabbed, pushed or shoved you 3. Hit, punched, kicked or slapped you 4. Threatened you with a weapon (e.g. knife, gun or any other objects) 5. Injured you with a weapon (e.g. knife, gun or any other objects) 6. Threatened to harm you in any way 7. Given you drugs or too much medicine in order to control you/make you docile 8. Hurt you physically in any other way	One or more incidents in the past 12 months Perpetrated by: • Family member • Carer • Other professional or service provider • Other known person

While the most recent study (Qu et al., 2021) widens the relational scope to any person known to the respondent, the behavioural items captured as indicative of physical AOP are broadly consistent across surveys. Also, no threshold – either for number of behaviours or their frequency – is applied; any instance of physical harm constitutes abuse.

For the *Prevalence Survey*, we use the behaviours used by Qu et al. (2021) with the one variation and two additions; see Table 3 (bold emphasis added for convenience).

Table 3: Physical harm behaviours, Australia versus NZ

Australia (Qu et al., 2021)	Prevalence Survey (NZ; see Meehan et al., 2026)
Given you drugs or too much medicine in order to control you/make you docile	Given you drugs or too much medicine **on purpose**
	Withheld medicine you were prescribed or needed
	Ignored or failed to respect your Advanced Directive *(asked only of respondents with an Advanced Directive)*

Note: Bold emphasis added for convenience.

Sexual harm

Naughton et al. (2010. p. 31) define sexual abuse as *"direct or indirect involvement in sexual activity without consent."* Nonconsensual activity encompasses a range of behaviours such as unwanted intimacy, sexual touching, rape, undressing in front of the victim, sexually suggestive comments or approaches, being forced to undress, molestation, being photographed nude, sexual harassment or humiliation, and being coerced into sexual contact with a third party (Lifespan of Greater Rochester et al., 2011; Ahnlund et al., 2020; Acierno et al., 2010; Luoma et al., 2011). Table 4 outlines how the Ireland, UK, and Australian prevalence studies measure sexual harm (refer to Table 1 for full research details).

Table 4: Sexual abuse measurement

Author/s	Behaviours	Threshold
Naughton et al. (2010)	1. Talked to you in a sexual way that you did not like 2. Touched you or tried to touch you in a sexual way you did not like/against your will 3. Forced you or tried to force you to have sexual intercourse against your will	One or more incidents in the past 12 months Perpetrated by: • Family member • Close friend • Care worker
O'Keeffe et al. (2007)	1. Talked to you in a sexual way that made you feel uncomfortable 2. Touched you in a sexual way against your will 3. Tried to touch you in a sexual way against your will 4. Made you watch pornography against your will 5. Tried to make you watch pornography against your will 6. Had sexual intercourse with you against your will 7. Tried to have sexual intercourse with you against your will	One or more incidents in the past 12 months Perpetrated by: • Family member • Close friend • Care worker
Qu et al. (2021)	1. Touched you in a sexual way against your will 2. Made you watch pornography against your will 3. Forced you to engage in sexual acts against your will	One or more incidents in the past 12 months

Author/s	Behaviours	Threshold
	4. Talked to you in a sexual way when you did not want to 5. Tried to engage you in any other unwanted sexual experience/s	Perpetrated by: • Family member • Carer • Other professional or service provider • Other known person

Like physical abuse, Qu et al. (2021) widens the relational scope to any person known to the respondent. Also, the behavioural items captured as indicative of sexual AOP are broadly consistent across surveys, although the Irish study (Naughton et al., 2010) did not ask about pornography and asked the attempted and actual behaviour items together. As was the case for the physical subtype, no threshold on number of behaviours or their frequency is applied; any instance of sexual harm constitutes abuse.

For the *Prevalence Survey*, we use the behaviours used by Qu et al. (2021). However, we reordered them to place physical violations (touching, forced sexual acts) after the talking and pornography items.

Neglect

Neglect is defined as *"the repeated deprivation of assistance needed by the older person for important activities of daily living"* (Naughton et al., 2010, p. 31). This definition highlights the dependent position of older people who require ongoing care and support. Neglect can involve the refusal or failure by those responsible to provide essential support – such as food, shelter, medical care, protection, hygiene or help with daily tasks like getting out of bed showering (Amstadter et al., 2011; Luoma et al., 2011). Unlike the other AOP subtypes, which require action to cause harm, neglect refers more often to inaction.

Research occasionally distinguishes between "active" and "passive" neglect, for example, the New York study (Lifespan of Greater Rochester et al., 2011 – see Article 27 in Table 1 for details), while the concepts of self-neglect and unmet need also appear in the literature.

Under the definition in Section 1.1, and following the work of Naughton et al. (2010), O'Keeffe et al. (2007), and Qu et al. (2021) in Table 5, neglect requires that an older person:

1. Requires help with everyday tasks.
2. Someone[7] responsible for providing that help (if no-one, it is considered self-neglect).
3. The person (or people) responsible for providing help do not always provide that help.

[7] While the survey was not designed to capture institutional or organisational abuse, some respondents named organisations, or members of organisations, as responsible for causing them harm or in the case of neglect, as responsible for providing help. In these instances, organisations were able to be re-categorised as "professional carer" or another professional (e.g. if a home-care provider was named).

However, how often an older person requires help can vary – as can the impact for the older person of not receiving that help when they need it. Similarly, the complexity or nature of everyday tasks varies. Accordingly, prevalence studies tend to apply thresholds on the frequency of instances where their need for help went unmet (McDonald, 2015; Qu et al., 2021) and/or the seriousness of this for the older person (O'Keeffe et al., 2007; Naughton et al., 2010). Notably, the US study (Acierno et al., 2010) is an exception and sets no threshold; any instance of unmet need is considered neglect.

The CHI for the *Prevalence Survey* (described in Section 2.3) builds on the scoring approach of Qu et al. (2021). The *Prevalence Survey* asks about the same 10 daily activities as Qu et al. (2021).

Table 5: Neglect measurement

Author/s	Behaviours	Threshold
Naughton et al. (2010)	Needing help defined as a being unable to independently perform everyday activities, including: Complex activities • Shopping for food or clothes • Preparing food • Housework • Taking medication • Using public transport or driving Basic activities • Cutting up and eating own food • Moving around the house • Going to the toilet • Dressing • Washing	In past 12 months: • Ten or more instances of refusal to provide help, OR • Less than 10, but reported as "very serious" by respondent Perpetrated by the person responsible for providing help, referred to as the "carer"
O'Keeffe et al. (2007)	Needing help defined as a having difficulty performing the activity by themselves. Activities include: Day-to-day activities • Shopping for groceries or clothes • Preparing meals • Doing routine housework • Travel or transport Personal care activities • Getting in and out of bed • Washing or bathing • Dressing or undressing • Eating, including cutting up food • Getting to and using the toilet Help with medication, including correct dose and timing	In past 12 months: • Ten or more instances of not receiving help, OR • Less than ten, but reported as "very serious" by respondent Perpetrated by the person responsible for providing help: • Family member • Close friend • Care worker
Qu et al. (2021)	Needing help defined as requiring help at least 'rarely' with everyday activities. Activities include: 1. Preparing meals 2. Shopping for groceries or clothes	In past 12 months: • Cumulative score of 3 or more (across the 10 activities)

Author/s	Behaviours	Threshold
	3. Doing routine housework 4. Travel or transport 5. Personal care such as washing or bathing (including getting in and out of the bath or shower), dressing or undressing 6. Getting to and using the toilet 7. Getting in and out of bed 8. Taking the right amount of medicine at the right times 9. Eating, including cutting up food 10. Any other day-to-day activity	For each activity, score is by frequency of unmet need: 0 Never 1 Once 3 Few times 7 Many times 10 Daily or almost daily Perpetrated by the person responsible for providing help: • Family member • Carer • Other professional or service provider • Other known person

Financial harm

Financial abuse, also known as financial exploitation or economic abuse in the AOP literature, is *"the unauthorised and improper use of funds, property or any resources of an older person, and includes theft, coercion, fraud, misuse of power of attorney, and also not contributing to household costs where this was previously agreed"* (Naughton et al., 2010, p. 30). Some studies further expand this definition to include behaviours such as failing to make good financial decisions on behalf of the older person or compelling them to earn income against their will (Acierno et al., 2010; Oh et al., 2006).

Table 6 lists the behaviours associated with experiencing financial harm, as included in the three main reference studies. Most items included in the financial harm scale are similar between studies, although the earlier UK-based research has a narrower focus on misappropriation or attempted misappropriation of financial assets and decision-making via an EPOA (O'Keeffe et al., 2007). Naughton et al. (2010) added not contributing to expenses when it had been agreed and pressure to change the older person's will, items which were also included in the Australian study (Qu et al., 2021), albeit with the wording simplified. As with physical and sexual harm, no threshold on number of behaviours or frequency are used for financial harm; any instance of the behaviours listed constitutes financial AOP.

For the *Prevalence Survey*, we use the behaviours used by Qu et al. (2021) with one variation (addition) to fit the NZ context. The item used, with variation in bold, was: *Misused an **enduring** power of attorney*.

Table 6: Financial abuse measurement

Author/s	Behaviours	Threshold
Naughton et al. (2010)	1. Stolen money or any of your possessions/property/land or documents 2. Deliberately prevented you access to your money/possessions/property/land or documents 3. Forced or misled you into giving them money/possessions/property/land or your pension book against your will 4. Forced or misled you to sign over ownership of your home or property or pension book against your will 5. Forced or misled you to change your will (Last Will/Testament) or any other financial documents against your will 6. Signed your name on cheque/pension book or other financial documents without your knowledge or permission 7. Misused the power of attorney you gave them or have been forced or misled into signing a power of attorney 8. Tried/pressured you (but not succeeded) in doing any of the previous (to steal money, property, change legal documents) 9. Stopped contributing to household expenses such as rent or food where this had been previously agreed	One or more incidents in the past 12 months Perpetrated by: • Family member • Close friend • Care worker
O'Keeffe et al. (2007)	1. Stolen money, possessions or property 2. Attempted to steal money, possessions or property 3. Made you give money, possessions or property 4. Tried to make you give money, possessions or property 5. Used fraud to take money, possessions or property 6. Tried to use fraud to take money, possessions or property 7. Taken or kept power of attorney 8. Tried to take or keep power of attorney	One or more incidents in the past 12 months Perpetrated by: • Family member • Close friend • Care worker
Qu et al. (2021)	1. Taken your money, possessions or property without your permission 2. Deliberately prevented you from accessing or using your money, possessions or property 3. Pressured you into giving or loaning them money, possessions or property 4. Pressured you to make or change your will 5. Made financial decisions for you without your permission 6. Misused a power of attorney 7. Not contributed to household expenses such as rent or food, or aged care/home service fees where this was previously agreed 8. Done anything else to harm you financially	One or more incidents in the past 12 months Perpetrated by: • Family member • Carer • Other professional or service provider • Other known person

Psychological harm

Psychological abuse, often referred to as emotional abuse, involves behaviours that cause distress and/or mental suffering. Naughton et al. (2010, p. 31) define it as *"the persistent use of threats, humiliation, bullying, swearing and other verbal conduct and/or any form of mental cruelty that resulted in mental or physical distress."* This AOP subtype includes behaviour such as scolding, threatening, yelling, ridiculing, shaming, harassment, and general impolite or disrespectful treatment (Blundell et al., 2017; Amstadter et al., 2011; Lai, 2011; Garre-Olmo et al., 2009). As discussed in Section 3.3, there is variation in what researchers term emotional or psychological abuse, versus other types. For the purposes of this report, we follow the prevalence studies conducted in Ireland, the UK, and Australia in defining the psychological harm scale (with one notable exception, see Table 8).

Table 7 lists the behaviours associated with experiencing psychological harm, as included in the three main reference studies (see Table 1). Importantly, the literature places a threshold on the number of incidents experienced, tending to incorporate either frequency of occurrences (McDonald, 2015) and/or their perceived severity (Naughton et al., 2010). A notable exception is the US study (Acierno et al., 2010), which sets no threshold on "emotional" harm; any instance of psychological distress constitutes abuse. For the UK study, O'Keeffe et al. (2007) go further than frequency count and specify the harm be caused by the same individual. A more sophisticated scoring approach is suggested by Qu et al. (2021), inspiring the CHI described in Section 2.3 for the *Prevalence Survey*.

We revisit the controversial issue of psychological harm thresholds in Sections 5 and 6.1.

Table 7: Psychological/emotional abuse measurement

Author/s	Behaviours	Threshold
Naughton et al. (2010)	1. Insulted you, called you names, or swore at you 2. Threatened you verbally 3. Undermined or belittled what you do 4. Excluded you or repeatedly ignored you 5. Threatened to harm others that you care about 6. Prevented you from seeing others that you care about or your doctor or nurse 7. Removed or prevented you access to equipment such as hearing or walking aids	In past 12 months: • Ten or more instances OR • Less than 10, but reported as "very serious" by respondent Perpetrated by: • Family member • Close friend • Care worker
O'Keeffe et al. (2007)	1. Insulted you, called you names or sworn at you 2. Threatened you 3. Undermined or belittled what you do 4. Excluded you or repeatedly ignored you 5. Threatened to harm others that you care about 6. Prevented you from seeing others that you care about	In past 12 months: • Ten or more instances AND • Perpetrated by the same person Perpetrated by: • Family member • Close friend • Care worker
Qu et al. (2021)	1. Insulted you, called you names or swore at you in a way you found offensive or aggressive 2. Excluded you or repeatedly ignored you 3. Undermined or belittled what you do 4. Threatened to harm others that you care about (e.g. pets, children, relatives, friends) 5. Threatened to harm themselves if you don't do what they ask 6. Prevented you from seeing or contacting family members (e.g. grandchildren) or your doctor/nurse 7. Done anything else to cause you emotional distress	In past 12 months: • Cumulative score of 3 or more (across the seven behaviours) For each behaviour, score is by frequency: 0 Never 1 Once 3 Few times 7 Many times 10 Daily or almost daily Perpetrated by: • Family member • Carer • Other professional or service provider • Other known person

For the *Prevalence Survey*, we use the behaviours used by Qu et al. (2021) with the three variations in Table 8 (bold emphasis added for convenience):

Table 8: Psychological harm behaviours, Australia versus NZ

Australia (Qu et al., 2021)	Prevalence Survey (NZ; see Meehan et al., 2026)
Undermined or belittled what you do	Undermined or belittled what you do **in public (i.e. in front of others)**
	Undermined or belittled what you do **in private**
Prevented you from seeing or contacting family members (e.g. grandchildren) or your doctor/nurse	Prevented or restricted you seeing or contacting **family members or friends**
	Prevented or restricted you seeing or contacting **your doctor/nurse or other professional**
Asked under "Cultural & Spiritual Abuse" of CALD respondents only	Made you feel that you are just free labour (e.g. doing most of household work, or providing childcare, etc)

Note: CALD refers to culturally and linguistically diverse individuals.

Distinguishing between public and private spaces for behaviours to occur, and control of social versus professional interactions, may provide better understandings of how harmful behaviour manifests. Also, the impact of these items on older people may differ according to these factors (i.e. location, interaction type). For the NZ context, shifting the 'free labour' item from additional cultural subtype included for the Australian CALD respondents into psychological harm makes sense, if only to acknowledge the support provided by grandparents to their children and grandchildren – intuition later supported by the qualitative component of the wider *National Study*, see Wilson et al. (2026).

Cultural & spiritual

Only one study – Qu et al. (2021) for Australia – provides a scale for the cultural/language/spiritual abuse of older adults. However, it is not included in their estimated prevalence of AOP as the behaviours listed in Table 9 were asked only of those respondents identifying as CALD. Comparison of the Qu et al. (2021) scale with that used in the *Prevalence Survey* is contained in Table 9 (items asked in both questionnaires are highlighted).

Given its novelty as a distinct AOP subtype, the literature has not investigated thresholds for measuring the cultural & spiritual harm of older people. In this report, the topic is examined in detail; the methodological approach is described in Section 3.3, then qualitative and empirical findings reported in Sections 4 and 6, respectively.

Table 9: Cultural (includes language) & spiritual harm behaviours, Australia versus NZ

Australia (Qu et al., 2021)	Prevalence Survey (NZ; see Meehan et al., 2026)
Made you feel that you are just free labour (e.g. doing most of household work, or providing child care, etc)	See Table 8
Not respected you when talking to you because of your culture, race or, ethnicity	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	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	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 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, watching or listening to shows in your preferred language)	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
	Not respected, shamed, made fun of, or ridiculed your spiritual beliefs or practices
	Prevented you from attending church or practising your religion how you want to (e.g. not allowing you to worship or pray)
	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

Note: Qu et al. (2021) asked the behaviours listed of CALD respondents only.

3.4 Rapid scoping review conclusion

This RSR explored how existing studies define and apply thresholds for measuring the AOP prevalence. The review found variation across studies in how abuse of older people (living in the community) is conceptualised and operationalised, with diversity in definitions of both overall AOP and its forms. Ambiguity in what to measure or include is evident across the literature, and there is substantial diversity in non-threshold aspects of prevalence research, including eligibility criteria (e.g. age, timeframe of abuse) and research design. Despite these differences, and the lack of consensus on thresholds for estimating AOP, there are some general conclusions to draw from the existing body of work that can help guide the current project.

First, thresholds used tend to incorporate two dimensions: frequency of incidents of harm and the severity of that harm for the respondent. The former accounts for both the number of behaviours experienced and how often each behaviour occurred (over a defined period such as the previous 12 months). The latter is often measured by asking survey respondents how serious the harm was for them and referred to as perceived or self-reported severity/seriousness.

Second, there is very little support in the literature for any threshold being applied on physical, sexual, or financial harm. In the case of physical and sexual harm, the objectively severe nature of experiencing these behaviours means each instance is considered abuse and included in the prevalence rate. For financial harm, frequency is thought to be an unreliable indicator of severity or significance for the older person. One instance of financial harm could devastate an older person's financial security and have ongoing wellbeing impact, or it may be characterised by many smaller events over a longer period. For these reasons, the literature tends to avoid any threshold for financial harm.

Third, when thresholds are applied it tends to be for neglect, and harms that cause psychological or emotional distress. For neglect and psychological harm, recognising that one-off instances may not be abuse – especially if they are not considered serious by the older person – the literature tends to set a threshold based on frequency and severity. The hurdle applied to how many instances qualifies as abuse, however, differs between studies. A related subtype, cultural & spiritual harm, is novel to the *National Study* and thus thresholds for this subtype are not present in the AOP literature.

Lastly, while theoretical frameworks such as the socio-ecological model are commonly used to contextualise risk factors for AOP, the application of these approaches is not apparent in determining thresholds.

Overall, this review highlights the need for clearer conceptualisation and operationalisation of thresholds to strengthen both research and practical responses to AOP. The current study is therefore timely and likely to contribute to AOP research globally.

4 CONSULTATION WITH EXPERTS

As identified in Section 3, setting thresholds to operationalise AOP's definition remains controversial in the literature. To enable thorough exploration of this issue, we consulted with key NZ and international experts from a range of fields to discuss the topic of AOP thresholds. Specifically, we sought their views on three related questions:

1. The use of any threshold in estimating the overall prevalence rate of AOP and harm subtypes.
2. The use of thresholds for selected harm subtypes (e.g. neglect, and psychological, cultural/language/spiritual and financial harm, but not for physical or sexual harm).
3. If applying a threshold, the suitability of a CHI (see below) to capture the number of behaviours experienced and frequency of experiences. Further, if and/or how to include seriousness for those experiences that may have been infrequent but reported as serious by the respondent.

Conversations were wide-ranging, across several related topics, with insights relevant to the use of thresholds for the purposes of estimating AOP prevalence and other (non-AOP) abuse, the definition of AOP used in this study, potential victim/perpetrator overlap, wellbeing of older people in general (including ageism etc), and unmet need. For the purposes of the current report, we focus on those insights applicable to the use of thresholds in measuring AOP prevalence.

In the interests of confidentiality, the experts' names will not be used. A preliminary draft of this report was shared with them to ensure they were satisfied with the portrayal of their comments and the level of detail given on their role and area of expertise. Following their assent,[8] we finalised this section.

The purpose of this section is to report the insights gained from those conversations, before outlining the threshold approach taken in the current study in Section 6.

4.1 Prior expectations

From the outset of the *National Study*, specifically the prevalence survey design, the research team anticipated the importance of thresholds for measuring AOP prevalence. Notably, variation across international studies pointed to needing a robust theoretical basis for decisions related to thresholds. For

[8] Two of the six experts we consulted with provided written comments via email; the remaining four did not respond and their assent is assumed. All experts were then provided with an additional opportunity to review the full draft report prior to its publication.

NZ, the lower age inclusion criteria (55 years or older) and the expanded culture/spiritual/language[9] abuse scale relative to previous studies presented challenges. First, the inclusion of 55–64-year-olds in the target population may amplify the impact of thresholds as it is reasonable to expect differences in reported experiences of harm by age, across subtypes of harm. For example, the younger age group may differ from older groups, specifically in terms of employment status and living situation, leading to differences in their interpersonal relationships and vulnerability to harm.

Second, prior international research finds that thresholds have a greater impact on the prevalence rate for neglect, and psychological abuse, relative to other subtypes. As cultural & spiritual abuse is similar in nature to psychological abuse, albeit defined by a more specific context, it is reasonable to assume thresholds may also have a significant impact on this subtype's prevalence rate. More generally, it is possible that defining the threshold for one subtype may inform definitions for another subtype.

Third, prior work on abuse scale validation may have been undertaken on specific populations (e.g. victim-survivors of abuse rather than a general population), limiting its direct applicability to the current study. Those interested may refer to the full survey findings report, Meehan et al. (2026), for further discussion of the complexity inherent in measuring AOP.

Taken together, these challenges presented an opportunity to widen the scope of the expert consultations and discuss the underlying premise of thresholds, across all subtypes of abuse and neglect, and threshold methodologies. Prior to undertaking this supplemental research to examine the use of thresholds in measuring the prevalence of AOP in NZ, we did not expect to limit conversations with the expert panel to any one harm subtype or threshold. However, following the RSR of the literature and preliminary data analysis, the research team decided to not set a threshold on physical or sexual harm. This decision meant analysis presented to the experts was partially restricted, in that all prevalence rates discussed included no threshold on physical or sexual harm. Irrespective of this analytical choice made prior to the consultations taking place, the conversations did include comment on the topic of thresholds for physical and sexual harm.

[9] Referred to as 'cultural & spiritual' abuse or harm for simplicity.

4.2 Expert insights

Working definition of AOP

At some point during the meetings, each expert interrogated the working definition of AOP used in the study, highlighting some aspects as challenging to convert into a workable threshold or operational definition of abuse. While mostly beyond the scope of this report, these conversations around the working definition point to the diversity of views within the field about how best to measure AOP.

For example, the 'expectation of trust' in a relationship was noted as being key to interpreting the data by two experts, along with the inherent complexity of interpersonal relationships. Several scenarios were put forward by the experts and discussed, highlighting the large variation in the types of interactions where an older person may have an expectation of trust with an individual or organisation and be vulnerable to harm. It was noted this was likely most relevant to experiences of psychological or cultural & spiritual harms, a point discussed further below.

Measuring prevalence in context

The need for abuse to be placed in context was highlighted as crucial to our understanding and interpretation of the prevalence rate. For example, those caring for children (and young adults) with complex needs, like mental illness or disability, and experiencing harm may be reluctant to disclose their situation and seek support. Experts articulated general appreciation and support for the qualitative components of the *National Study* (Wilson et al., 2026), beyond the prevalence survey, as key to providing the necessary grounding for the quantitative analysis.

The question of "intent" on behalf of the person causing harm was raised, particularly by one expert, who questioned whether an attempt to protect the older person, or keep them safe, should be captured in an abuse measure. In their report on the qualitative component of the *National Study*, Wilson et al. (2026) find that intent to harm is a distinguishing factor to consider in designing tailored responses for those who have been deliberately targeted. More generally, on the question of intent, the international literature remains divided and there is variation based on research aims, methods, and data availability.

On the topic of thresholds

Leading into the topic of thresholds, one (international) expert noted that researchers tread a 'fine line' – an observation echoed by others we spoke to – in broadening societal and academic understandings of what constitutes harm and mistreatment of older people, and what may be better characterised as a poor relationship dynamic. One expert reasoned that previous research had set relatively restrictive

thresholds on the number of behaviours experienced and their frequency in line with a focus on severe neglect, harm, and mistreatment before observing that our collective understanding of AOP had evolved. Both international experts cautioned against becoming too inclusive and setting no threshold, arguing that a robust prevalence rate was one that was defensible to non-experts.

This latter point was echoed by the (NZ-based) clinician, who elaborated that being able to assign scarce resources to those in most need required a practical approach.

Psychological abuse was raised as an example of this tension. Experts we consulted tended to emphasise the importance of not casting too wide a net when operationalising the psychological harm definition, while also considering contemporary understandings of its adverse impacts on older people. Despite the apparent disagreement in the literature (see Section 3.3) on the best threshold to set for this harm subtype relative to other forms of AOP, taken together with the expert opinions we can make two observations:

1. Thresholds set in earlier research, such as O'Keeffe et al. (2007) and Naughton et al. (2010) in Table 7, were (in hindsight, according to one researcher) too restrictive.
2. Applying no threshold at all to psychological harm risks misalignment between community perceptions of what does and does not constitute harm of an older person and study findings.

This tension between reporting the data accurately via robust prevalence estimates and enabling useful inferences to be drawn that will inform future policy responses is at the core of this supplementary work on thresholds.

All experts acknowledged the complexity inherent with the question of thresholds in the study of AOP, and abuse more generally. One observed that as researchers we caveat our findings with the limitation that abuse is underreported, then impose a threshold for inclusion in the prevalence rate (for some subtypes of abuse). These two conflicting ideas are relevant to all studies of people's experiences of harm, and it is widely understood that those most vulnerable to abuse are unlikely to be contacted by researchers. For further discussion on these points, refer to the *National Study* reports by Tee et al. (2025), Meehan et al. (2026), and Wilson et al. (2026).

The lack of consensus demonstrated in the scoping review (Section 3) and the complexity highlighted in the consultation meetings on what thresholds should be used when measuring AOP prevalence led one (international) expert to encourage us to consider transparency in determining what thresholds to apply and when. For the decisions taken in this study to be effectively transparent, simplicity and consistency were highlighted as important. The first implication of this focus is that the same threshold should be applied across all harm subtypes, enabling clear communication of what is counted in the prevalence rate

and what is not. The second, elaborated on in Section 5 below, is that the most appropriate threshold to apply across relevant subtypes should consider the impact of the threshold on the prevalence rate for each subtype and total AOP.

Cumulative Harm Index

As outlined in Section 2.2, experts were presented with alternative prevalence rates for AOP and its subtypes (excluding physical and sexual harm where no threshold is used), corresponding to four thresholds. For the total AOP estimate, two scenarios based on whether a threshold was applied to financial harm or not were also included, and this is discussed separately later. The results were caveated as preliminary, subject to further analysis, and not finalised at the time of the consultations.

As described elsewhere in this report, prevalence rate thresholds tend to be applied to avoid including one-off or infrequent occurrences and/or incidents not considered serious to the older person. A CHI aims to capture patterns of harm (within a given AOP subtype) by allowing for experiences that occurred more frequently or, if only once, across a range of behaviours. The CHI was based on a similar approach used in the Australian survey (Qu et al., 2021), and differences in the methods are discussed further in Section 6.1.

In brief, the CHI–Core threshold presented to the experts restricted neglect, psychological harm, and cultural & spiritual harm to only those respondents who reported at least one harmful behaviour as occurring many times or three behaviours that occurred once each. That is, a CHI–Core of 3+ is required to meet the threshold. As outlined in Section 6.1, the CHI–Core restriction lowers the prevalence rate by between one and two-thirds for the relevant subtypes (e.g. 36.3% decrease for psychological harm versus 65.7% for neglect), although the impact varies by subtype.

While there was broad support for thresholds (albeit with the caveats highlighted above) among the experts, and acknowledgement that for neglect, psychological, and cultural & spiritual harm a threshold is appropriate, the consensus appeared to be that counting frequency and/or number of behaviours experienced risked missing those infrequent instances that had significant adverse consequences for the older person. Self-reported severity was emphasised as key to minimising this risk by the expert panel.

Expanding the Cumulative Harm Index

Two additional thresholds, described in Section 2.3, were presented for discussion. CHI–Very Serious included those respondents with cumulative harm indices of 1 or 2, but who reported their experience (by harm subtype) as “very serious”. Respondents with a CHI equal to 1 or 2 who perceived this

experience as at least “somewhat or moderately serious” were captured in the CHI–Expanded Seriousness measure.

How serious is serious?

The concept of seriousness generated the most discussion across the consultations. Three experts expressed being in favour of the CHI–Expanded Seriousness threshold, with one stating that an experience a respondent identified as serious in any way should be counted. Normalisation of abuse for the older person was highlighted by another expert as common, suggesting that a respondent may not identify their experience as “very serious” as they had learned to live with the harm they were experiencing. All three expressed the sentiment that even remembering an incident that occurred up to 12 months ago to then report in a survey implied some degree of seriousness for the respondent. A further point was raised about the currency of the harm being reported, and that patterns of abuse may not be immediately obvious to those experiencing the harmful behaviours.

In contrast, one of the experts suggested more credit be given to respondents for knowing how serious their experience was and accurately reporting that to the interviewer. The same expert argued for a threshold that would produce a defensible prevalence rate and be widely accepted as theoretically robust. The remaining two experts felt capturing severity in some manner was important if any threshold was being used, and both were in favour of the CHI–Very Serious estimate.

On a threshold for financial harm

On the question of placing a threshold on financial harm, experts generally agreed that (a) frequency was an unreliable measure of seriousness or financial impact of experiencing any of the financially harmful behaviours, (b) financial harm likely co-occurs with other subtypes, and (c) setting a threshold or not for financial harm made little significant difference to the overall AOP prevalence rate. This latter point is discussed in more detail in Section 6.2, while co-occurrence is left for the main *Prevalence Survey Report*, see Meehan et al. (2026).

An international expert suggested the commonly held view that financial harm is highly prevalent for older people and experienced at a higher rate than other types of abuse likely conflates fraud and scams perpetrated by strangers with the behaviours defined as financial AOP in the *National Study*. A similar point was later echoed by an NZ-based expert in a separate consultation. This point is explored further in the mixed-methods study examining financial AOP of older people (see Scott et al., 2026).

Following the discussions, all experts agreed that no threshold be set for financial harm.

Questions for future research

The nature of the consultation meetings – researchers discussing their preliminary results on a large-scale prevalence study with other researchers – led to several ideas for future work. First, the variation of AOP experiences for different groups and perpetration – who experiences/causes what harm differs (see Meehan et al., 2026) – is worthy of more research, specifically in the context of thresholds.

Second, testing the psychometric validity of the harm scales was highlighted as a key area lacking in the current literature. For this, longitudinal surveys and/or administrative data linkage is needed. Third, comparability between studies is key to forming consensus on appropriate threshold use for measuring AOP. Both projects require additional research on AOP itself, and over longer timeframes than is usually possible – the experts noted the importance to society of continuing research as populations age.

Lastly, ongoing research into screening tools and risk assessment may inform future prevalence work and threshold setting as our understanding of how AOP is experienced and how we might respond evolves. Given the routine use of such tools, ongoing evaluation studies and opportunities for research are more numerous than those for measuring prevalence. Ideally, studies such as this one and future prevalence studies will also be used to improve or refine screening and risk assessment processes.

4.3 Summary

The experts we spoke with emphasised the importance of defining and measuring AOP prevalence in a transparent, rigorous, and robust manner. In wide-ranging conversations, several topics were covered. These included the *working definition of AOP*, *measuring prevalence in context*, *thresholds*, the *Cumulative Harm Index* (and its expansion), placing a *threshold on financial AOP*, and *questions for future research*. In the next section, we combine the RSR findings (Section 3) with those contained in this section, to present our suggested approach to setting thresholds when estimating AOP prevalence in NZ.

5 SUGGESTED APPROACH

As outlined in Section 4, the panel of experts agreed that thresholds were important to ensuring that the resulting prevalence rate of AOP included those experiences of harm that (a) align with current academic and practitioner understandings of AOP, and (b) align with societal perceptions of AOP.[10] For example, one incident of not receiving help when it was needed in the previous year, which was not perceived as serious to the respondent, is unlikely to be viewed as neglect. However, multiple incidents of not receiving help across either a range of activities, or one activity multiple times, may amount to neglect. Similarly, being spoken to in a way that was offensive or aggressive once or twice, and was not perceived as serious for the respondent, is unlikely to be viewed as psychological abuse. Experiencing a range of behaviours that may indicate psychological or emotional harm, or one behaviour multiple times in the previous year, suggests a pattern of behaviour aligned with collective understandings of abuse.

For some subtypes of harm, however, one incident reported as occurring once may meet the threshold for inclusion in the prevalence rate. In the case of physical or sexual abuse, irrespective of frequency, number of harms experienced, or severity, one such experience constitutes abuse and is included in the prevalence rate (see Section 2.3). For financial harm, more than one experience more than once may indicate a pattern of behaviour, or one experience occurring one time may be catastrophic for a respondent. Range of harms experienced, 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.

Thresholds are applied inconsistently across existing AOP prevalence studies; the selected international surveys on which the *National Study* is based use varied approaches (Section 3). Frequency and severity are important considerations for some types of abuse, while objectively inappropriate to consider for others. For our prevalence survey, inclusion or expansion of behaviour scales (e.g. cultural & spiritual abuse) adds further complexity.

Considering the range of behaviours experienced, and their frequency described above, leads to two recommendations for threshold use in the *National Study*.

Recommendation 1: *The use of thresholds is important to ensure that the overall prevalence rate includes those experiences that objectively constitute AOP, but does not include those experiences that do not align with current perceptions and understandings of AOP.*

[10] One expert noted they felt research should guide societal understanding, especially in light of persistent ageism.

Recommendation 2: *Thresholds are appropriate to apply to neglect, psychological harm, and cultural & spiritual harm. Thresholds should not be applied to physical, sexual, or financial harm.*

Several observations were made by the expert panel on the importance of thresholds to the robustness of the analysis and its use by policy-makers, and future research. Of note is the need for any threshold(s) and its use to be both transparent and simple to understand. Taken together:

Recommendation 3: *The threshold methodology should be simple to explain and apply, then applied consistently across subtypes when used. Descriptions of the threshold should be accurate, clear and its impact on the prevalence rate(s) stated and discussed.*

In terms of the threshold methodology favoured by the experts, there was general agreement the CHI approach was suitable for the purposes of measuring AOP prevalence in NZ (although some expressed reservations with any threshold). As discussed in Sections 2.3 and 6.1, the CHI–Core was based on a similar approach used in the Australian study (Qu et al., 2021) for psychological abuse. In brief, a score of 0–4 is assigned to each behaviour listed for a given subtype based on its frequency. These item-level scores are then summed across the subtype behaviours to generate a respondent's CHI–Core for a given subtype. A CHI–Core of 3 or more for a given subtype meets the threshold for inclusion in the prevalence rate. Sensitivity analysis of the '3 or more' hurdle is presented for each harm subtype in Section 6.1.

Respondents were also asked how serious their experience was to them on a 3-point scale: "not serious", "somewhat or moderately serious", or "very serious". This subtype-level data enables the expansion of the CHI–Core to include severity, like the approach used in the Irish study (Naughton et al., 2010), and to capture those respondents who may not reach the 3 or more cut-off, but who reported their experience as "somewhat or moderately serious", or "very serious". As outlined in the previous section, however, the expert panel diverged on whether including any degree of seriousness or only those reporting their experience as "very serious" was appropriate.

In deciding on which threshold should be used for the main prevalence rate, the research team considered two factors. First, the intention to report all four prevalence rates (no threshold, CHI–Core, CHI–Very Serious, and CHI–Expanded Seriousness) enables transparent comparison of the impact of thresholds, both on the overall prevalence rate and on each subtype. Second, given the experts came from a range of discipline backgrounds, and their opinions appear to align with their specific field of expertise, we have given more weight to those most familiar with AOP.

Recommendation 4: *The chosen threshold is the Cumulative Harm Index–Very Serious applied to neglect, psychological harm, and cultural & spiritual harm.*

In the next section, we present and discuss the impact of the thresholds on the prevalence rate of AOP and its subtypes.

6 OUR APPROACH TO PREVALENCE THRESHOLDS

Following Section 5's recommendations, this section presents an overview of thresholds applied to the *Prevalence Survey* data collected as part of the *National Study*. As described in Section 2.3, no threshold was used for measuring prevalence of physical or sexual harm; these harm subtypes are included in the overall prevalence rates presented here but not discussed further. Neglect, psychological harm, and cultural & spiritual harm are subject to thresholds in the main AOP prevalence estimate (see Meehan et al., 2026), and details on this decision are provided in this section. While *Recommendation 2* concludes that no threshold should be applied to financial harm, we expand on the impact of this choice and that made for the other subtypes here.

Data limitations: Frequency and severity refresher

Recall the survey design prioritised brevity to reduce the total interview time required (discussed in Section 2.3). While frequency data was collected for each behaviour (for all subtypes), perceived seriousness was assessed only once per AOP subtype and focused on the most impactful individual. This restricts our use of severity in detailed behaviour-level analysis and may overlook cumulative harm from multiple people or acts.

Despite this limitation, the need to capture instances of infrequent, but subjectively severe, experiences justified the inclusion of perceived seriousness in the thresholds examined here.

6.1 Impact of thresholds on AOP subtypes

This section explores the impact of various threshold settings on our analysis, by harm subtype, before presenting the overall 12-month AOP prevalence rate. In each case, the thresholds presented follow the description contained in Section 2.3 and are referred to as CHI–Core, CHI–Very Serious, and CHI–Expanded Seriousness. Results using no threshold are also presented for comparison. For brevity, the survey dataset is not summarised in detail here – refer to the main *Prevalence Survey Report* (Meehan et al., 2026) for details.

Neglect

As described in Section 2.3, neglect first requires that an older person needs help with at least one of 10 daily activities. Approximately one-third (31.6%) of older people surveyed reported needing help.

Respondents who reported requiring help were asked who was mainly responsible for providing that help. See the main *Prevalence Survey Report* (Meehan et al., 2026) for who provides care to older adults living in the community.

For the purposes of this analysis, it is worth recalling the AOP definition used for the *National Study* states that there is another party causing harm or distress to the older person. For neglect to occur there must be a person(s) responsible for providing help to the respondent and who does not always provide that help. For *Prevalence Survey* respondents, 4.6% (of all respondents) reported experiencing an unmet need. Of these:

- Approximately one-third (1.6% for all respondents) reported 'no-one' was responsible for helping them – these respondents are defined as experiencing 'self-neglect' and are not included in the neglect prevalence rate.
- Almost one in 10 (9.1%) of respondents needing help with daily activities reported the person(s) responsible for providing that help did not always do so. For all survey respondents, this results in a 'no threshold' prevalence rate of 3%.

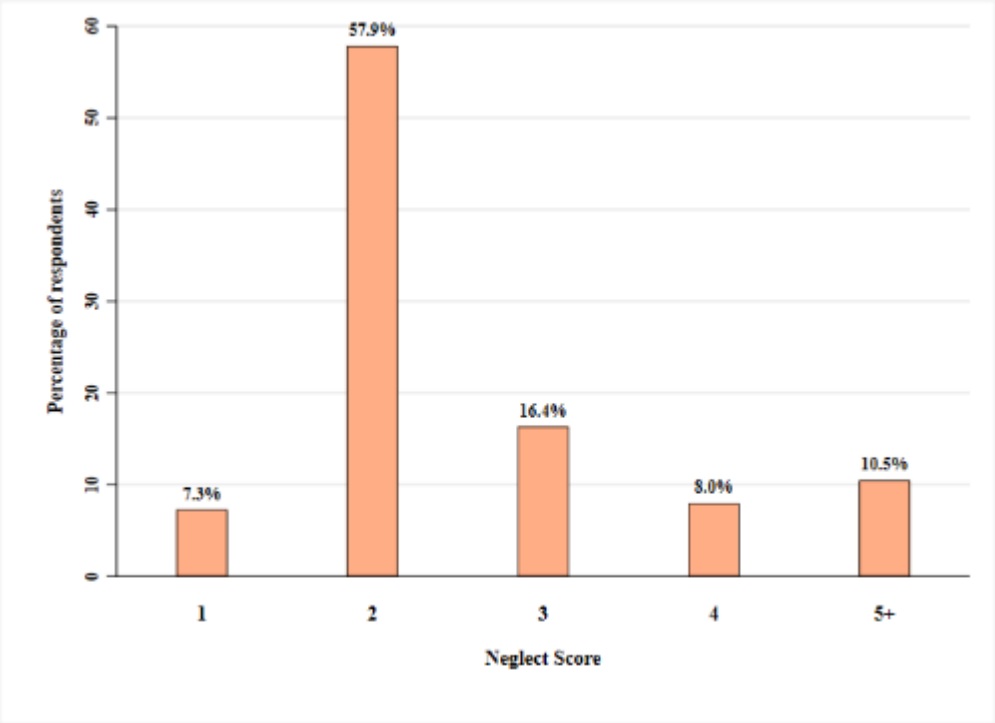
As highlighted in Section 3.3, international studies tend to apply a threshold when measuring neglect prevalence. As noted in Section 4.2, by the experts we spoke to, such thresholds have tended to be more restrictive than those proposed for this study (Section 5).

A threshold means that infrequent or one-off instances of not receiving help when needed are not counted in the prevalence rate as neglect. For instance, if a caregiver does not help with transport once in the 12 months prior to the survey (e.g. because something comes up or, in the case of paid professional care, the organisation is short-staffed), with no additional instances of not receiving needed help, this is unlikely to indicate an older person is experiencing neglect.

For this study, a CHI approach is used (see Sections 2.2 and 2.3) to establish those experiences that were not one-off instances, but that may indicate a pattern of not receiving help when it was needed.

Figure 3 shows the distribution of the CHI for respondents who did not always receive help when they needed it; 7.3% have an index of 1, indicating they did not receive help for one activity once in the 12 months prior to the survey. A further 57.9% of respondents record a CHI of 2, suggesting that they did not receive help for two activities once each, or did not receive help a few times for one activity. An index of 3 or more, referred to as the CHI–Core, is recorded for a little over one-third (34.8%) of respondents who did not always receive help when they needed it (equates to 1% of all respondents).

Figure 3: Distribution of neglect CHI



Note: CHI scores for those respondents who did not always receive help when they needed it, n=163.

To investigate the impact on the neglect prevalence rate of the CHI approach, we estimate neglect prevalence using a range of CHI–Core cut-offs: 2 or more, 3+, 5+, and 7+ (Table 10). Most respondents who did not receive help when needed record a CHI of 1–2, while only 10.5% have 5 or more – the latter is considered too restrictive for the purposes of measuring neglect. For example, to record a CHI of 5, a respondent must report:

- Five separate activities they did not receive help for when needed once (score of 1 multiplied by 5 activities), or
- An activity they didn't receive help for many times (score 3) plus an activity they didn't receive help for a few times (score 2), or
- One daily activity they need help with and didn't receive it almost every day in the 12 months prior to the survey (score 4) plus one other activity they did not receive help for once (score 1).

Table 10: Sensitivity analysis of neglect CHI–Core threshold

Threshold	Prevalence rate % (standard error)	95% confidence Interval (%)	Observations (unweighted/weighted)
No threshold	**3.00 (0.32)**	**2.38–3.62**	**168/45,800**
CHI–Core of 2+	2.75 (0.31)	2.15–3.34	151/41,900
CHI–Core of 3+	**1.03 (0.17)**	**0.69–1.37**	**65/15,700**
CHI–Core of 5+	0.31 (0.09)	0.13–0.49	20/4,700
CHI–Core of 7+	s.	s.	s.

Note: CHI–Core cut-offs, for neglect. Total number of respondents is n=5,584 for CHI–Core and n=5,589 for 'no threshold'. 's.' indicates suppressed values due to small underlying counts.

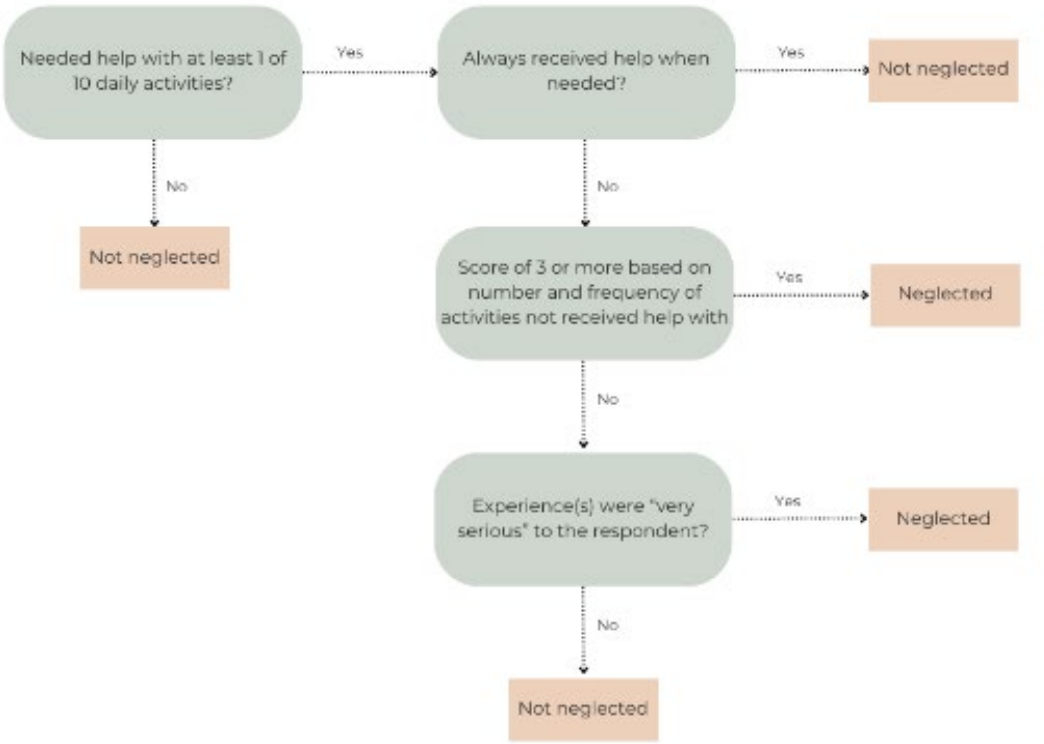
In contrast, for a CHI–Core of 2 a respondent reported:

- They did not receive help for one activity a few times during the 12 months prior to the survey (score 2), or
- They didn't receive help for two activities once each (score of 1 multiplied by 2 activities).

We argue that an appropriate CHI–Core threshold is 3 or more, capturing those respondents who (at a minimum) either did not receive the help they needed across three activities once, or who did not receive help for one activity many times in the 12 months prior to the survey. Using the CHI–Core threshold of 3 or more results in a neglect prevalence rate of 1% (all respondents) and 3.5% of those respondents who require help.

However, the CHI–Core approach only considers frequency. For some respondents, even one instance of unmet need may have caused serious harm or distress. To capture these cases, respondents who recorded a CHI–Core of 1 or 2 but who reported their experience as "very serious" or at least "somewhat or moderately serious" are included in two additional thresholds: CHI–Very Serious and CHI–Expanded Seriousness. The flowchart in Figure 4 illustrates how the CHI–Very Serious threshold defines a respondent's experience.

Figure 4: Measuring neglect using the CHI–Very Serious

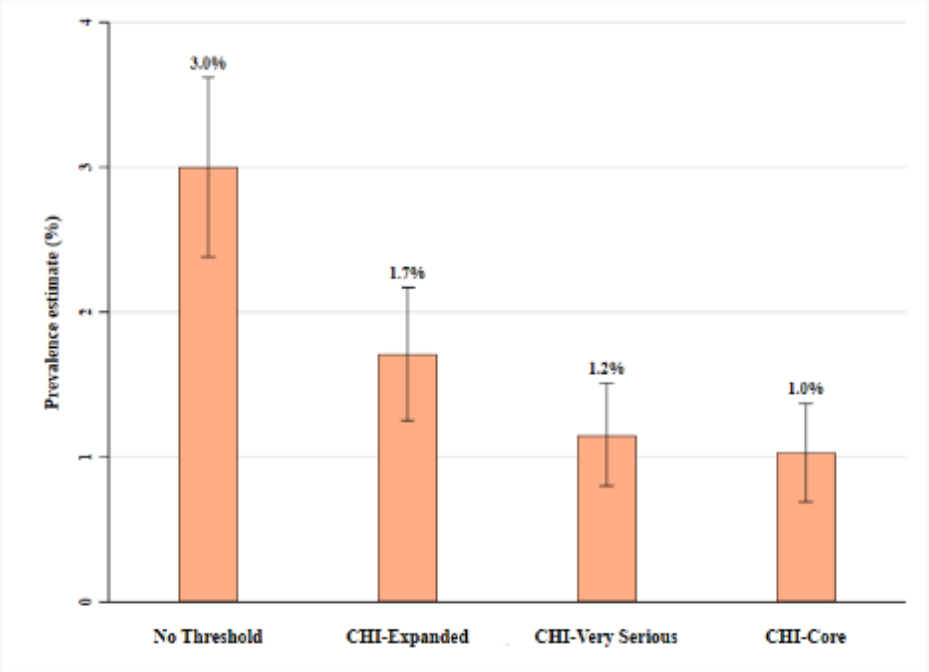


Note: For a full description of how neglect is captured in the survey, see Section 2.3.

Variation in threshold definitions has an impact on the estimated prevalence of neglect (Figure 5). Using no threshold, the prevalence rate is 3% of all respondents; this equates to 9.1% of those who required help in the 12 months prior to the survey. Applying the CHI–Core threshold (3+), which considers only the number and frequency of unmet needs, reduces the prevalence rate to 1.0% (3.5% of those needing help).

When respondents did not meet the CHI–Core threshold (3+) but described their experience as "very serious" are included (CHI–Very Serious), the prevalence rate increases to 1.2% – this equates to 3.9% of those who require help. A further expansion to include those who rated their experience as "somewhat or moderately" or "very" serious (CHI–Expanded Seriousness) results in a prevalence rate of 1.7% (5.6% of those requiring help).

Figure 5: Neglect prevalence rate by CHI



Note: The number of observations differs by threshold due to missing ("don't know" and "refused to answer") responses.

In line with the *Recommendations* outlined in Section 5, the chosen approach for the main estimate of neglect prevalence is CHI–Very Serious.

Financial harm

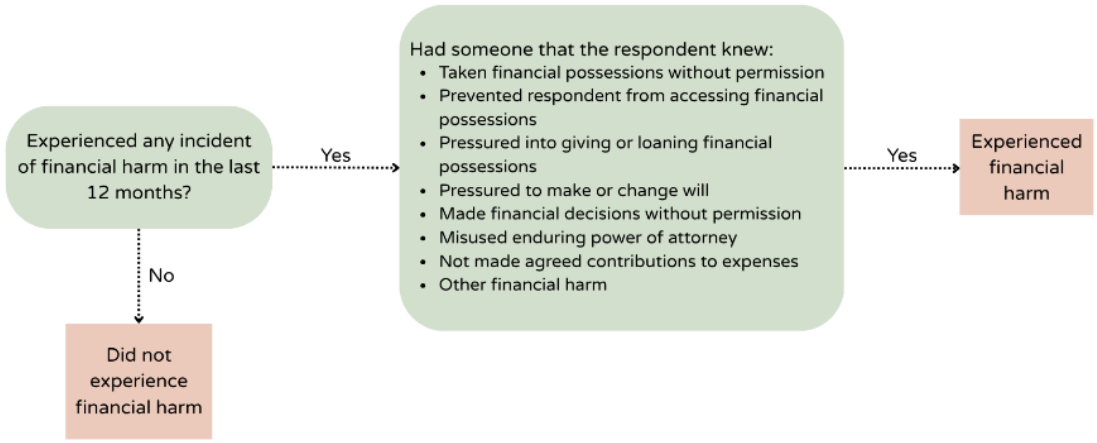
As described in Section 2.3, and shown in Figure 6, the survey asks a respondent if they have experienced one or more of eight behaviours that may cause financial harm. Applying no threshold, any instance that occurred at least once is counted as financial harm.

Approximately 4.0% reported experiencing one or more of the behaviours listed in Figure 6 at least once in the 12 months prior to the survey, equivalent to 61,200 people aged 55 years and above. This is the second-most common AOP subtype reported by respondents, after psychological abuse (discussed next).

In line with *Recommendation 2*, we note that previous international work does not apply thresholds to financial abuse. However, the inclusion of financial abuse items in AOP studies is relatively novel and not used consistently across the literature (see Section 3.3). This supplementary research project allows us to take a closer look at how thresholds may cause variation in the prevalence rate of financial harm and AOP overall.

For brevity, we present analysis of the CHI approach for financial harm in Appendix 1. Further analysis of the impact of threshold use on the overall AOP prevalence rate is discussed in Section 6.2.

Figure 6: Measuring financial harm with no threshold applied



Note: For a full description of how financial harm is captured in the survey, see Section 2.3.

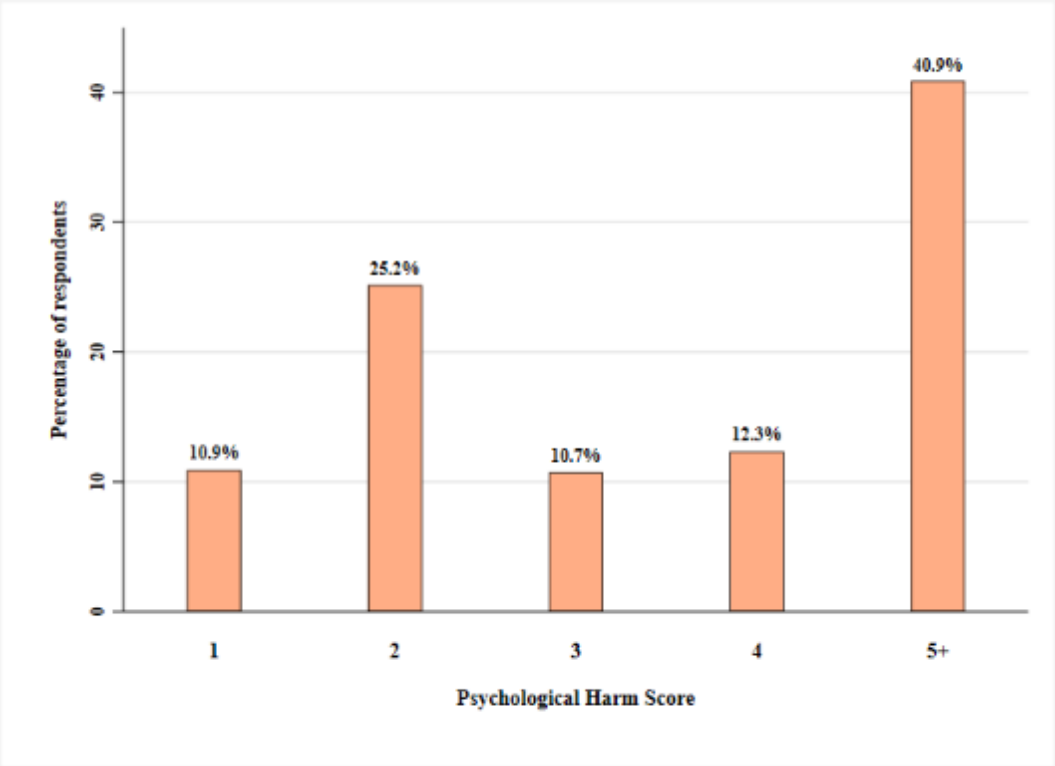
Psychological harm

As described in Section 2.3, the survey asks a respondent if they have experienced one or more of 10 behaviours that may cause psychological harm. Applying no threshold, any instance that occurred at least once is counted as psychological harm.

Approximately 18.5%, equivalent to 282,400 people aged 55 years or above, reported experiencing one or more of the behaviours at least once in the 12 months prior to the survey. As discussed previously, infrequent or one-off instances of the behaviours listed as indicating potential emotional harm or distress may not indicate an older person is experiencing psychological abuse. Prior prevalence studies tend to address this with a threshold on what is counted in the prevalence rate as psychological harm, and what is not. For this study, a CHI approach is used (see Sections 2.2 and 2.3) to establish those experiences that were not one-off instances but that may indicate a pattern of behaviour.

Figure 7 shows the distribution of the psychological harm CHI for respondents surveyed who reported at least one instance of the behaviours indicative of psychological harm listed in Section 2.3; one in 10 (10.9%) have an index of 1, indicating they experienced one behaviour once in the 12 months prior to the survey. A further 25.2%, or one in four, of respondents reporting any of the 10 behaviours record a CHI of 2, suggesting that they either experienced two behaviours once each, or one behaviour a few times. An index of 3 or more, referred to as the CHI–Core, is recorded for 63.9% of respondents reporting any psychologically harmful behaviour (11.8% of all survey respondents).

Figure 7: Distribution of psychological harm CHI



Note: CHI scores for those respondents who reported experiencing psychologically harmful behaviours, n=998.

Note that the CHI approach used in this study is based on that used in the Australian prevalence study (Qu et al., 2021), with some key differences. Qu et al. (2021) ask about seven behaviours (not 10) and assign scores for each behaviour based on frequency using a different scale to that applied here. See Table 11 for a comparison.

Table 11: Comparison of scoring approach, Australian prevalence study, and CHI

Frequency of behaviour	Australian (Qu et al., 2021)	Cumulative Harm Index (CHI)
Not experienced	0	0
Experienced once	1	1
A few times	3	2
Many times	7	3
Every day or almost every day	10	4

Qu et al. (2021) then count scores of 3 or more (i.e. at least one behaviour experienced a few times or at least three behaviours once) as psychological abuse. While the latter case is equivalent between this study and the Australian research, the former would result in a CHI of 2 (one behaviour experienced a few times) and would not count in a prevalence rate using a cut-off of 3 or more. To ensure using the 3 or more cut-off is appropriate for the current data, we conducted sensitivity analysis.

First, we investigated the impact on the prevalence rate of the CHI approach and estimated psychological harm prevalence using a range of CHI–Core cut-offs: 2 or more, 3+, 5+, and 7+ (Table 12). Applying a higher cut-off (e.g. five or more) results in a prevalence rate decrease of approximately one-third relative to that using the 3 or more threshold (decrease of 36.1%; i.e. a prevalence rate of 7.5% versus 11.8%). Lowering the cut-off from 3 to 2, in contrast, results in a prevalence rate 4.6 percentage points higher – an increase of nearly 40%.

Second, we examine the distribution of the CHI for psychological harm (Figure 7) and recall that among respondents who reported any incidents of psychological harm, the majority had a CHI–Core of 3 or more while only one-third (36.1%) record a CHI of 1 or 2. Note that compared to the other harm subtypes, the distribution in Figure 7 is skewed to the right – reflective of the higher frequency and range of behaviours experienced by respondents. The implication is the relative contribution of psychological harm to the total AOP prevalence rate is higher than that of the other subtypes, and applying a threshold to psychological harm will have a larger impact on the AOP prevalence estimate than doing so for the other subtypes.

Taken together with the expert insights discussed in Section 4.2, we argue that an appropriate CHI–Core threshold to test in further analysis is 3 or more, capturing those respondents who (at a minimum) either experienced three harmful behaviours once, or who experienced one behaviour many times in the 12 months prior to the survey. Using the CHI–Core threshold of 3 or more results in a psychological harm prevalence rate of 11.8%, a little over one in 10 older people. Also, the 3 or more cut-off matches that of neglect and therefore meets *Recommendation 3* in Section 5 that the thresholds be consistent between harm subtypes to aid transparency.

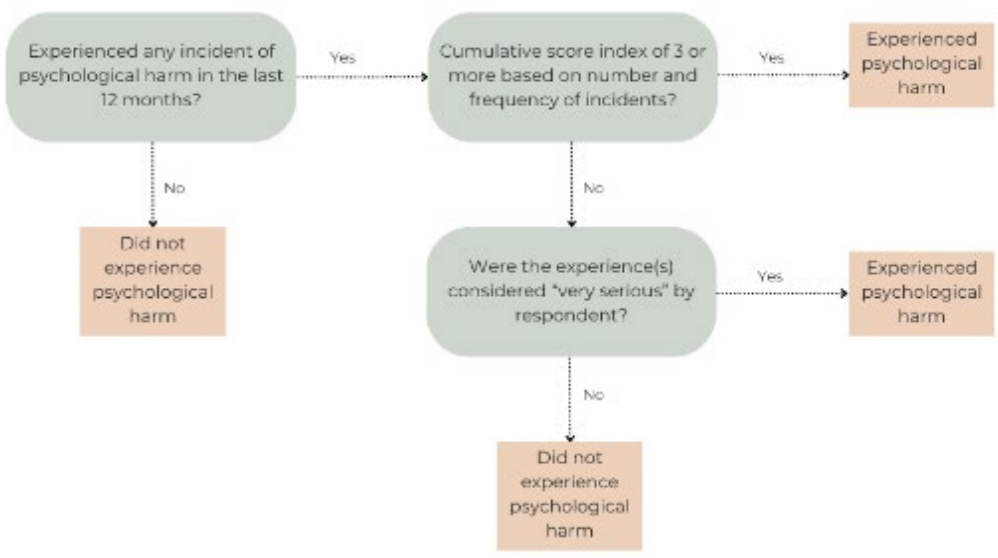
Table 12: Sensitivity analysis of psychological harm CHI–Core threshold

Threshold	Prevalence rate % (standard error)	95% confidence interval (%)	Observations (unweighted/weighted)
No threshold	**18.46 (0.71)**	**17.06–19.86**	**1,004/282,400**
CHI–Core of 2+	16.38 (0.68)	15.04–17.73	873/250,500
CHI–Core of 3+	**11.76 (0.60)**	**10.58–12.94**	**611/179,800**
CHI–Core of 5+	7.52 (0.50)	6.54–8.50	373/114,900
CHI–Core of 7+	4.55 (0.39)	3.78–5.31	225/69,500

Note: CHI–Core cut-offs, for psychological harm. Total number of respondents is n=5,605 for CHI–Core and n=5,611 for 'no threshold'.

As is the case for neglect, for some respondents, even one occurrence of any one behaviour may have caused serious harm or distress. To capture these cases, respondents who recorded a CHI–Core of 1 or 2, but who reported their experience as "very serious" or at least "somewhat or moderately serious", are included in two additional thresholds: CHI–Very Serious and CHI–Expanded Seriousness. The flowchart in Figure 8 illustrates how the CHI–Very Serious threshold defines a respondent's experience.

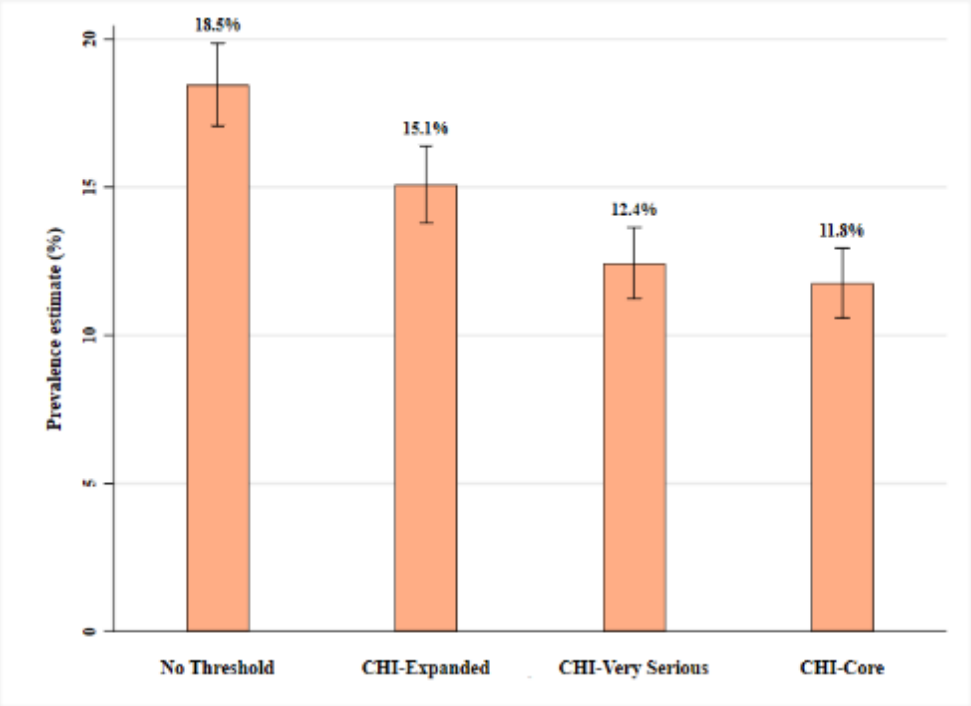
Figure 8: Measuring psychological harm using the CHI–Very Serious



Note: For a full description of how psychological harm is captured in the survey, see Section 2.3.

As expected, variation in threshold definitions has an impact on the estimated prevalence of psychological harm (Figure 9). Using no threshold, the prevalence rate is 18.5%. Applying the CHI–Core threshold, which considers only the number and frequency of experiences, reduces the prevalence rate to 11.8%. When respondents did not meet the CHI–Core threshold (3+), but described their experience as "very serious" are included (CHI–Very Serious), the prevalence rate increases marginally to 12.4%. A further expansion to include those who rated their experience as "somewhat or moderately" or "very" serious (CHI–Expanded Seriousness) results in a prevalence rate of 15.1%.

Figure 9: Psychological harm prevalence rate by CHI



Note: The number of observations differs by threshold due to missing ("don't know" and "refused to answer") responses.

In line with the *Recommendations* outlined in Section 5, the chosen approach for the main estimate of psychological harm prevalence is CHI–Very Serious.

Cultural & spiritual harm

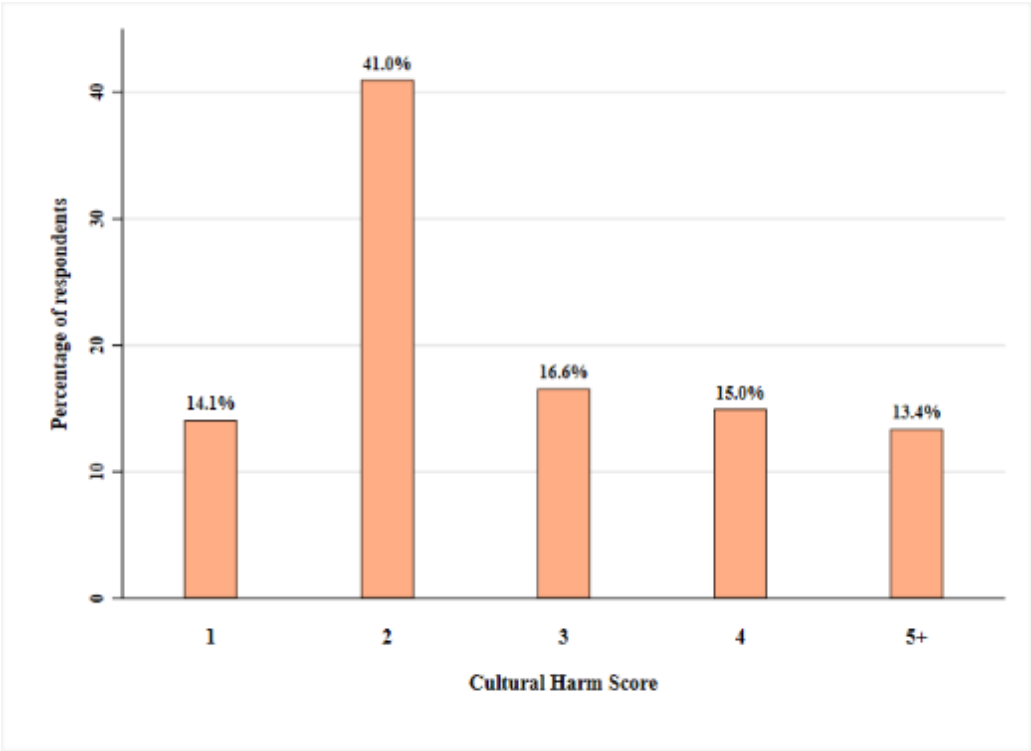
As described in Section 2.3, the survey asks a respondent if they have experienced one or more of 13 behaviours that may cause cultural, language, or spiritual harm. Applying no threshold, any instance that occurred at least once is counted as cultural & spiritual harm.

Approximately 6.3%, equivalent to 97,000 older people aged 55 years and above, reported experiencing one or more of the behaviours at least once in the 12 months prior to the survey. As discussed previously, infrequent or one-off instances of the behaviours listed as indicating potential harm or distress may not indicate an older person is experiencing cultural & spiritual abuse. The first prevalence study to include this harm subtype was the Australian research (Qu et al., 2021), which asked CALD respondents about their experience of six behaviours that may indicate cultural & spiritual abuse. In the current prevalence study, the list of possible behaviours is expanded to 13 and were asked of all respondents (except for the mis-translation item, which was only asked of those who spoke more than one language).

As prior studies do not measure cultural & spiritual harm, or do so in a limited way, we approach this harm subtype using the method applied for psychological harm (and neglect). That is, a CHI is used (see Sections 2.2 and 2.3) to establish those experiences that were not one-off instances, but that may indicate a pattern of behaviour that adds to cultural & spiritual abuse.

Figure 10 shows the distribution of the cultural & spiritual harm CHI for respondents surveyed who reported experiencing at least one behaviour indicating this AOP subtype (listed in Section 2.3); one in seven (14.1%) who have an index of 1 indicated they experienced one behaviour once in the 12 months prior to the survey. A further 41% of these respondents record a CHI of 2, suggesting they either experienced two behaviours once each, or one behaviour a few times. An Index of 3 or more, referred to as the CHI–Core, is recorded for 45% of respondents who reported experiencing behaviour indicative of cultural & spiritual harm.

Figure 10: Distribution of cultural & spiritual CHI



Note: CHI scores for those respondents who reported experiencing culturally & spiritually harmful behaviours, n=354.

Compared to psychological harm, the distribution was more heavily skewed toward fewer and less frequent incidents, suggesting that cultural & spiritual harm was more often experienced as isolated or lower-frequency events – similar to neglect (Figure 3). For completion, we investigate the impact on the prevalence rate of the CHI approach and estimate cultural & spiritual harm prevalence using a range of CHI–Core cut-offs: 2 or more, 3+, 5+, and 7+ (Table 13). In line with the distribution of scores in Figure 10,

applying a higher cut-off to the CHI–Core reduces the prevalence rate markedly. For example, applying a CHI–Core cut-off of 5+ reduces the prevalence rate by about two-thirds compared to using the 3 or more threshold (0.8% versus 2.8%). This implies that a threshold of 3 or more is appropriate and avoids setting a hurdle that is too restrictive relative to respondent experiences.

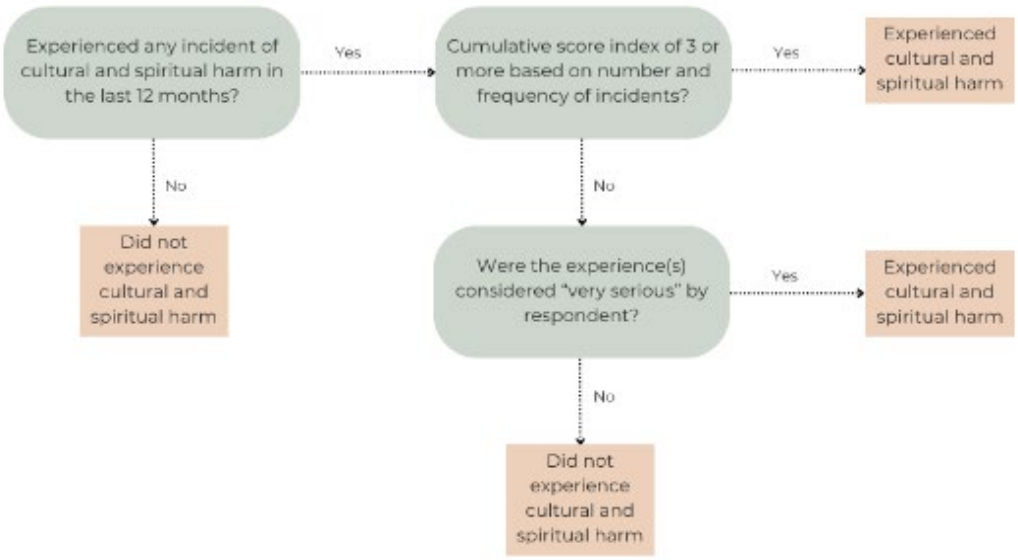
Table 13: Sensitivity analysis of cultural & spiritual harm CHI–Core threshold

Threshold	Prevalence rate % (standard error)	95% confidence Interval (%)	Observations (unweighted / weighted)
No threshold	**6.34 (0.45)**	**5.46–7.22**	**362/97,000**
CHI–Core of 2+	5.37 (0.41)	4.57–6.18	310/82,200
CHI–Core of 3+	**2.81 (0.29)**	**2.24–3.38**	**166/43,000**
CHI–Core of 5+	0.84 (0.16)	0.52–1.16	51/12,800
CHI–Core of 7+	0.29 (0.09)	0.10–0.47	18/4,400

Note: CHI–Core cut-offs, for cultural & spiritual harm. Total number of respondents is n=5,604 for CHI–Core and n=5,612 for 'no threshold'.

As with psychological harm and neglect, the definition of cultural & spiritual harm was extended to include respondents who did not meet the CHI–Core threshold, but described the harm they experienced as "very serious". This forms the CHI–Very Serious measure, which is then used as the main prevalence estimate. Figure 11 presents a flowchart outlining how the CHI–Very Serious estimate was derived from the survey data. A broader measure, CHI–Expanded Seriousness, also includes those who described the harm as at least "somewhat or moderately serious," even if their CHI–Core total was less than 3.

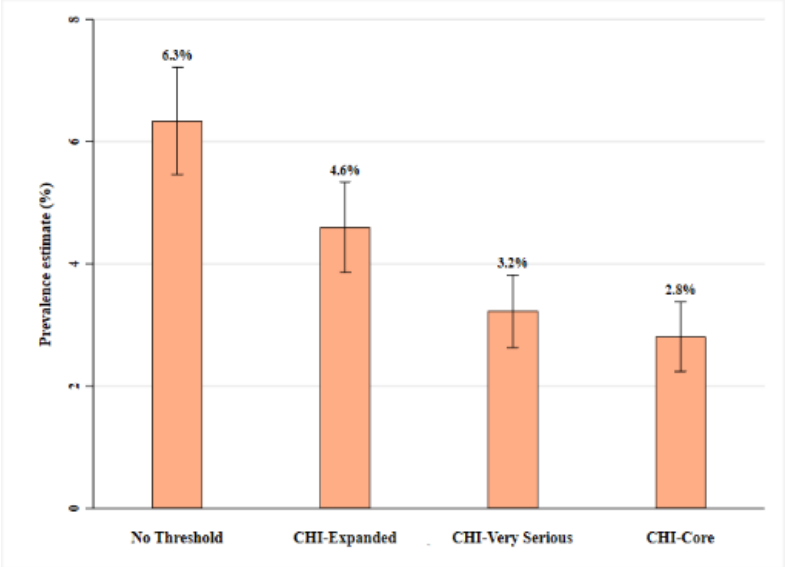
Figure 11: Measuring cultural & spiritual harm using the CHI–Very Serious



Note: For a full description of how cultural & spiritual harm is captured in the survey, see Section 2.3.

As for the previous subtypes, variation in threshold definitions has an impact on the estimated prevalence of cultural & spiritual harm (Figure 12). Using no threshold, the prevalence rate is 6.3%. Applying the CHI–Core threshold, which considers the number and frequency of experiences, reduces the prevalence rate to 2.8%. When respondents did not meet the CHI–Core threshold (3+) but described their experience as "very serious" are included (CHI–Very Serious), the prevalence rate increases to 3.2%. A further expansion to include those who rated their experience as "somewhat or moderately" or "very" serious (CHI–Expanded Seriousness) results in a prevalence rate of 4.6%.

Figure 12: Cultural & spiritual harm prevalence rate by CHI



Note: The number of observations differs by threshold due to missing ("don't know" and "refused to answer") responses.

As per *Recommendation 3* in Section 5, for consistency with neglect and psychological harm, the CHI–Very Serious threshold is used for cultural & spiritual harm. The literature on cultural & spiritual harm, and its prevalence, is in its infancy. However, it is reasonable to consider this subtype of AOP as context-specific psychological abuse: it does not leave physical marks, nor result in financial loss, but may disrespect, isolate, or offend those experiencing it. Therefore, it is appropriate to apply the same threshold approach to cultural & spiritual abuse as we do for psychological harm.

6.2 Impact of thresholds on overall AOP prevalence

Applying thresholds for any AOP subtype will impact the headline prevalence estimate for the *National Study*. In this section, we complete our analysis of the cumulative harm approach for setting thresholds on neglect, psychological, and cultural & spiritual abuse.

This study uses the CHI–Very Serious variant as the main prevalence estimate, as recommended in Section 5, and does not apply a threshold to financial, physical, or sexual harm. Applying the same threshold approach across subtypes (when used) is a cautious approach for more prevalent harm types (like psychological), while incorporating expert views that previous research was likely too restrictive. Further, our approach respects an older person's judgement on how serious their experience was for them, while also quantifying number and frequency of behaviours, ensuring that infrequent but severe experiences are captured in the prevalence rate.

The four thresholds (including no threshold) and the respective prevalence rates are reported in Table 14, with a graphical representation of the prevalence rates, with 95% confidence intervals, in Figure 13.

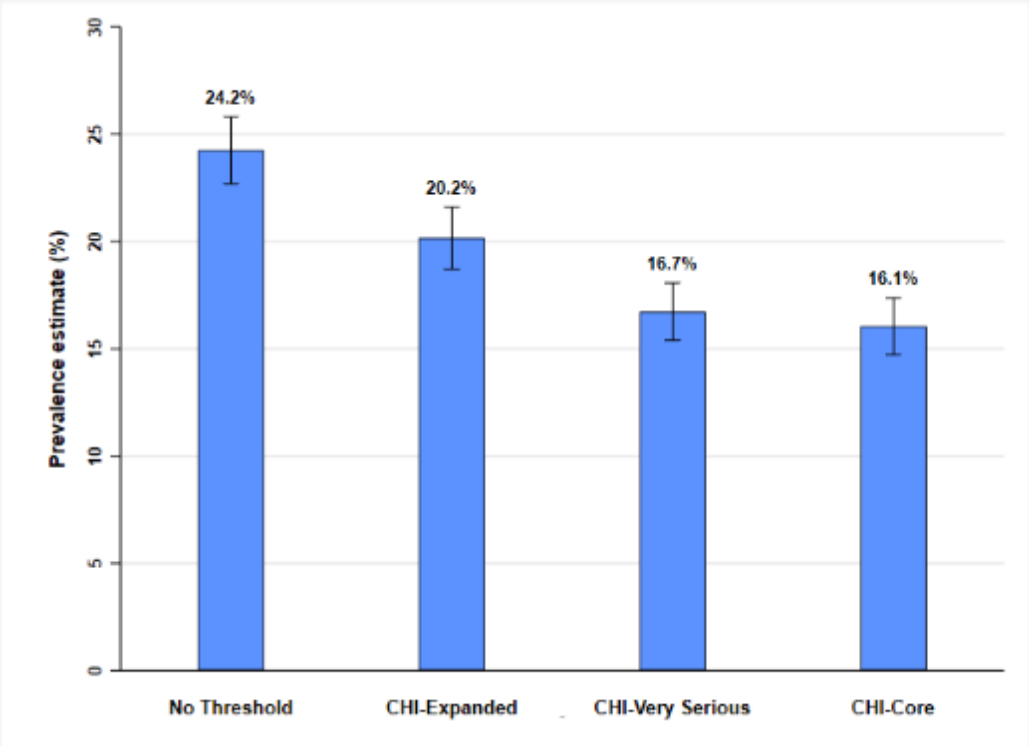
If no threshold is applied, nearly one in four respondents (24.3%) reported experiencing some form of harm – neglect, financial, psychological, physical, sexual, and/or cultural & spiritual – in the previous 12 months. The CHI–Core yields an estimate of 16.1%, when applied to neglect, psychological, and cultural & spiritual harm. Expanding the CHI–Core to include those respondents with an Index less than 3 but who reported their experience of that harm subtype to be "very serious", referred to as CHI–Very Serious, increases this prevalence to one in six (16.7%). Further including those respondents who also reported their experience as "somewhat or moderately serious", the CHI–Expanded Seriousness threshold, increases the prevalence rate to 20.2%, or one in five older people.

Table 14: 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 Cumulative Harm Index	16.05 (0.67)

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

Figure 13: Overall prevalence rates using different definitions and thresholds



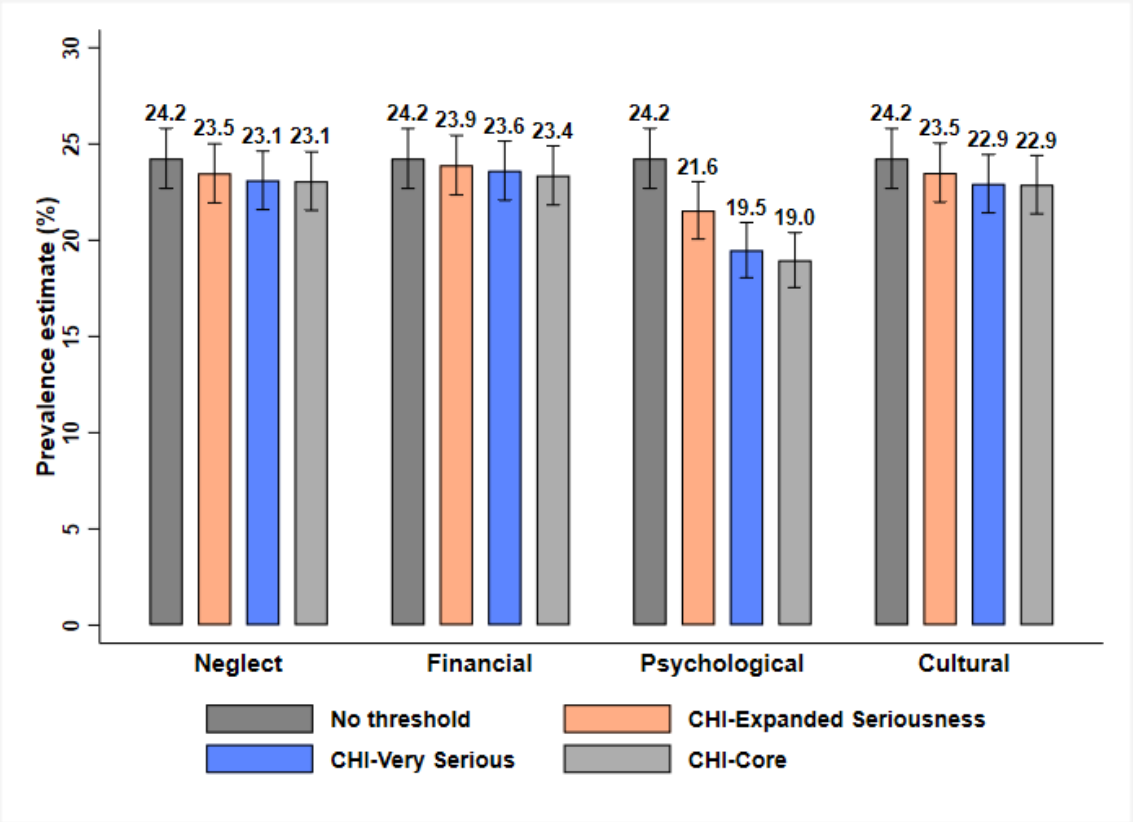
Notes: Based on unweighted/weighted counts of 5,613/1,530,700.

Analysis by subtype

Threshold use impacts the estimated prevalence rate. The previous analysis presented the overall rates when applying the various CHI thresholds for each affected subtype (i.e. neglect, psychological, and cultural & spiritual harm) together.

As discussed in Section 6.1, however, the marginal impact on the total AOP rate likely differs between subtypes. Figure 14 presents the overall prevalence rates, by threshold, if a given threshold is only applied to one abuse subtype.

Figure 14: Overall AOP prevalence with and without each subtype, by threshold definition



As in Table 14, applying no threshold to any subtype results in an estimated prevalence rate of 24.3%. We include results for financial harm, confirming that use of any threshold for financial AOP makes little material difference to total prevalence (reductions of 0.35 to 0.89 percentage points, depending on the threshold).

The marginal impact of applying any threshold to neglect is similarly minor; even applying the most restrictive threshold for this subtype only (CHI–Core) reduces total prevalence by just over one percentage point. Given the target population of older adults in this study – namely, those living in the community – are less likely to require help with daily tasks than those who are not community-dwelling, the relatively low contribution of neglect to total AOP prevalence is in line with expectations. For cultural & spiritual harm, the impact of setting any threshold is slightly larger than that of neglect, although is not statistically significant (evident in Figure 14 as overlapping confidence intervals). This is likely driven by the larger prevalence rate for this subtype versus that of neglect.

In each case, following previous literature and expert opinion to apply a threshold for neglect and not for financial abuse appear appropriate choices. As discussed elsewhere in this report, the novelty of measuring cultural & spiritual harm means we cannot rely on previous studies for guidance. However, we

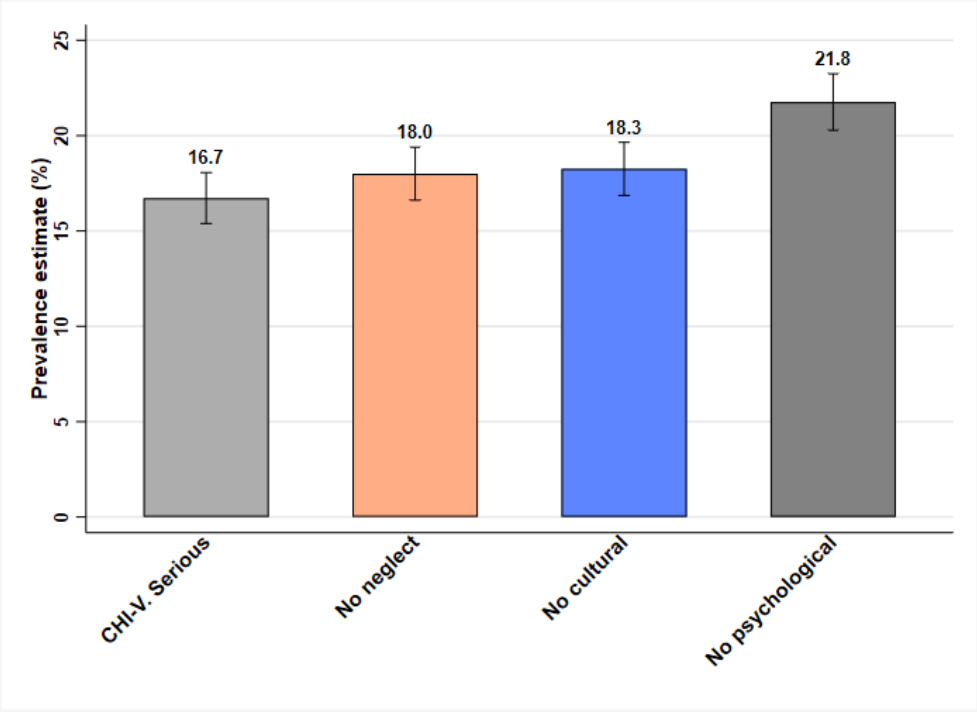
argue that it is reasonable to apply the same approach to it as we do to psychological harm (see Section 6.1 for more on this point).

Psychological abuse does have a significant impact on total prevalence, depending on the threshold used. Most experts we spoke to agreed with prior studies that a threshold is necessary for this subtype; using no threshold at all would include any instance of the psychologically harmful behaviours listed in Section 2.3. For total AOP prevalence, placing a threshold on this subtype alone results in a significant drop of between 2.7 and 5.3 percentage points, or from about one in four older adults to less than one in five.

Relative to the other subtypes, those experiencing psychological harm did so more frequently and/or reported a higher number of behaviours (Figure 7). As the most prevalent type of abuse for the older people surveyed, even using the most restrictive threshold (CHI–Core), choosing an appropriate threshold for psychological harm is a key decision when estimating AOP prevalence.

This point is further illustrated in Figure 15, which shows the total AOP prevalence rate using the CHI–Very Serious threshold for different combinations of subtypes where thresholds are used.

Figure 15: Overall AOP prevalence (CHI–Very Serious), without each subtype separately



Frequency, severity, and subtype ambiguity

As described previously, applying thresholds of any kind restricts what is counted as AOP, but all experiences reported in the survey were of harmful behaviours. A key critique raised in the expert

consultation centres on this point – when excluding any reported instance of harm, researchers risk underestimating the prevalence rate. To minimise the risk that we do not capture severe occurrences if they were infrequent and/or one-off occurrences, we include subtype-level seriousness (as described in Section 2.3).

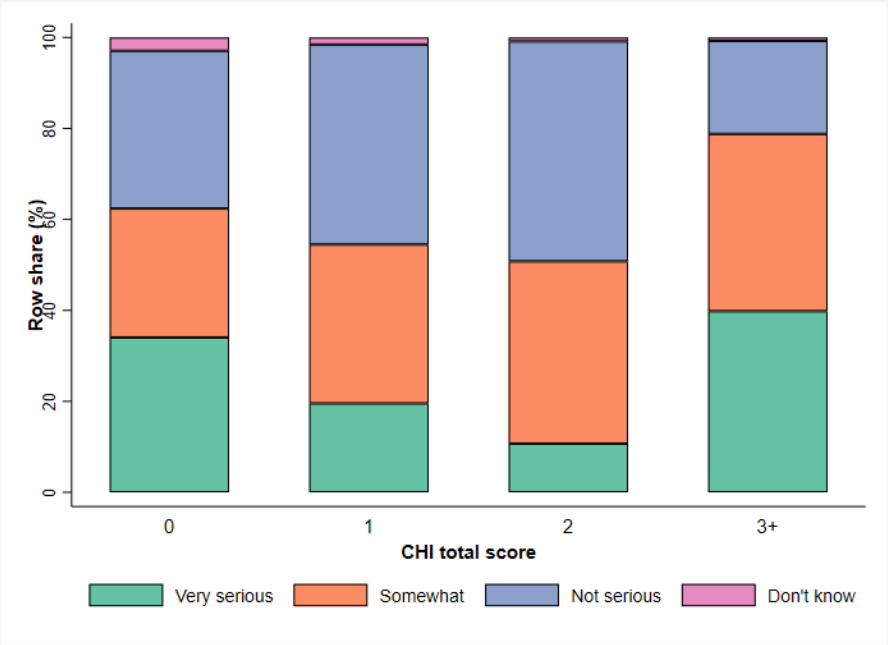
An additional issue arises due to subtype ambiguity, described in Section 3.3, as the potential overlap between AOP subtypes. The CHI scoring approach is applied within each subtype, not across subtypes, and the number and frequency of individual experiences is cumulative for a given subtype only (for neglect, psychological, and cultural & spiritual harm). It is possible that some respondents reported behaviours indicating different subtypes, but record CHI–Core scores less than 3 and did not identify their experience(s) as "very serious". These respondents would not then meet the CHI–Very Serious threshold and not be included in the prevalence rate for these subtypes, or the overall prevalence rate (unless they also experienced financial, physical, or sexual abuse).

For example, if an older person experiences three types of harmful behaviours spread across two or three subtypes subject to thresholds (i.e. one instance of neglect plus two instances of psychological harm; or one instance each of neglect, psychological, and cultural & spiritual abuse; or another combination), their total number of AOP behaviours is three but they would not be included in the CHI–Core threshold.

Figure 16 contains the self-reported severity of respondents' experience of a given AOP subtype, by their total CHI score (across all subtypes). To explore across subtype cumulative harm, we sum the CHI score for each respondent across all subtypes subject to a threshold. We refer to this as the 'total CHI score'. Note that we only calculate CHI scores for neglect, psychological, and cultural & spiritual abuse as these are subject to thresholds, and severity here is based on the most serious experience across all subtypes.

Unsurprisingly, a higher proportion of respondents with CHI scores of 1 or 2 reported their (most serious) experience as "not serious" than those with CHI scores of 3+. Those with a CHI of 0 represent respondents who did not report any instance of neglect, psychological, or cultural & spiritual harm, but who did report experiencing at least one instance of financial, physical, or sexual AOP. Most of these respondents, about three in five older people, stated their most serious experience as "somewhat or moderately" or "very" serious.

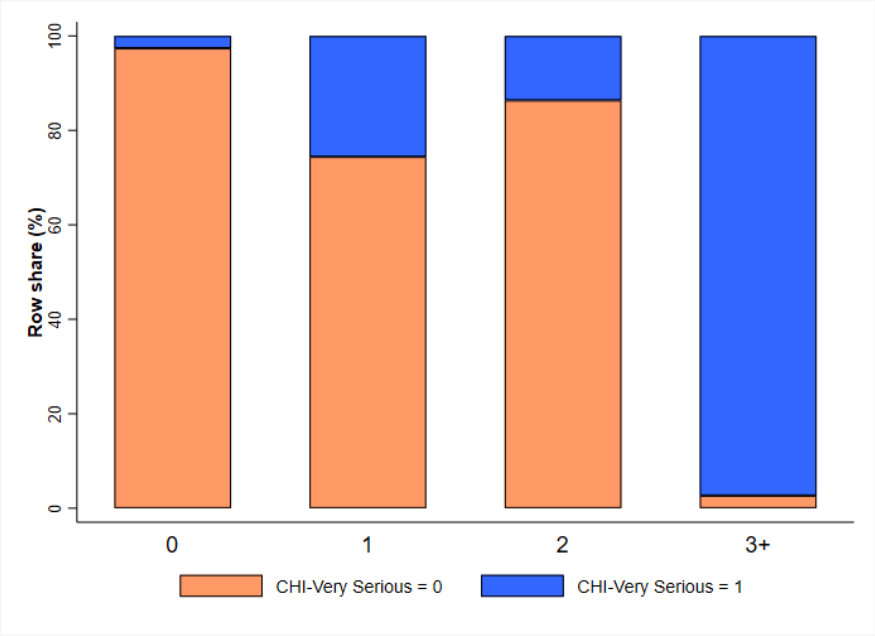
Figure 16: Perceived severity by total CHI score



Notes: Based on unweighted/weighted counts of 5,567/1,522,208 (lower count due to missing responses).

In terms of thresholds, we are most interested in the respondents with total CHI scores of 3+ who did not report any experience as "very serious" – roughly 60% of respondents (Figure 16). To investigate how many are not included in the overall AOP prevalence rate under the CHI–Very Serious threshold, we split all respondents by their CHI–Very Serious status (0 or 1) and total CHI score (Figure 17).

Figure 17: CHI–Very Serious threshold, by total CHI score



Notes: All respondents' CHI–Very Serious status, where 1 means they are included under the threshold and 0 otherwise. Total CHI scores are the sum of CHI scores across relevant subtypes for a given respondent. Based on unweighted/weighted counts of 5,567/1,522,208 (lower count due to missing responses).

Most respondents with a total CHI score less than 3 do not meet the CHI–Very Serious threshold (recall overall AOP prevalence is 16.7%). Those respondents with a CHI total of 0 who are included in the CHI–Very Serious estimate experienced some combination of financial, physical, and/or sexual harm (2.6% of those with a 0 total CHI); the vast majority of those with a total CHI score of 0 are not classified as experiencing AOP (97.4%). One in four of those with a total CHI score of 1 are included in the CHI–Very Serious threshold for the overall prevalence rate (25.6%); a smaller share is included in the headline estimate with a total CHI of 2 (13.6%).

As mentioned above, we are most interested in those with a CHI total of 3+ who are not included in the CHI–Very Serious estimate. In the *Prevalence Survey*, this equated to 2.7% of respondents with a 3+ total CHI score (or 0.6% of all respondents). By definition, none of these respondents reported their most serious experience as "very serious". However, it is useful to consider how many said the behaviours were "somewhat or moderately" serious.

Of those with a total CHI of 3+ who are not included in the CHI–Very Serious estimate, one-third perceived their most serious experience as "somewhat or moderately serious".[11] Inclusion of these respondents in the overall AOP prevalence rate would increase the estimate from 16.7% to 17.2%; this difference is not statistically significant and lies within the 95% confidence interval (CI is 15.4% to 18.1%, see Table 15).

[11] The remaining respondents answered either "not serious" (39.4%) or "don't know/refused" (27.3%); inference is limited due to small counts (unweighted count of those with CHI–Very Serious = 0 *and* total CHI score = 3+ is 33 respondents).

Table 15: Overall AOP prevalence, chosen approach

Harm type	Population prevalence	95% confidence interval (low estimate – high estimate)	Number of people affected (mean estimate)
All harm types	16.72%	15.39%–18.06%	256,000
Neglect	1.15%	0.80%–1.51%	17,600
Financial	4.00%	3.33%–4.67%	61,200
Psychological	12.43%	11.23%–13.64%	189,600
Physical	2.78%	2.21%–3.36%	42,600
Sexual	0.87%	0.57%–1.16%	12,900
Cultural & spiritual	3.23%	2.63%–3.82%	49,300
Total number of older people (weighted count)		**1,530,700**	
Total number of respondents (unweighted count)		**5,613**	

Note: CHI–Very Serious threshold applied to neglect, psychological, and cultural & spiritual abuse. Overall prevalence according to CHI–Very Serious threshold. 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.

Taken together with Figures 16 and 17, the chosen approach of combining number, frequency, and then perceived severity appears to balance the need for thresholds with ensuring seriously harmful (even if infrequent) experiences are captured. Expanding the estimate to include older people who do not meet the CHI–Very Serious threshold but who experienced 3+ occurrences of harm across different subtypes, does not significantly impact the overall prevalence estimate.

The CHI–Very Serious threshold, as per *Recommendation 4* in Section 5, in combination with a no threshold approach for financial, physical, and sexual harm, has a strong rationale for its use in estimating the headline AOP prevalence rate.

6.3 Comparison with previous research

As highlighted in Section 3, there is a lack of consensus across international studies on the topic of thresholds for AOP prevalence. Any direct comparisons should thus be approached with caution, as differences in survey design, abuse definitions, question wording, and target population lead to variation in estimated prevalence rates – before considering diversity in threshold use. Table 16 provides prevalence estimates from a selection of international studies, alongside the current survey's main prevalence estimates.

A systematic review of AOP in community settings estimates that worldwide prevalence rate is one in six older adults (Yon et al., 2017); it is worth noting that the pooled study did not include NZ, as no national prevalence work existed at the time. 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, our survey is most comparable to the Australian *National Elder Abuse Prevalence Study* (Qu et al., 2021). However, the younger age criterion applied in our *Prevalence Survey* compared to the Australian study (55+ versus 65+) appears to contribute to the higher overall prevalence for NZ, at least in part. To illustrate the impact of the inclusion of younger older people, we calculate prevalence estimates for people aged 65 and over only (Table 16); while imperfect, this allows comparison without the different age criterion. The lower overall AOP prevalence rate (12.1% versus 16.7%) reflects harm was most common among those aged 55–64 (see the main *Prevalence Survey Report*, Meehan et al., 2026).

Also, the NZ study is the first to include cultural & spiritual harm in total AOP prevalence. The definition of psychological harm also differs: the NZ survey uses 10 items, compared to seven in the Australian survey.[12] These differences, coupled with (minor) variation in how remaining subtypes are defined and measured, and how thresholds are applied here versus previous studies, limit detailed comparisons. In future work we plan to recalculate the NZ estimates using the Australian threshold parameters, and explore comparisons using the Australian unit record data, although note that methodological differences between the surveys (detailed in Section 3.3) will remain a limitation.

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 the Canadian study 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%, or 3.0% for 65+) 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).

[12] That said, the Australian estimate (11.7%; CI is 10.8%–12.5%) is within the lower bound of the NZ confidence interval for psychological harm (95% CI is 11.2%–13.6%) suggesting the additional items do not make a significant contribution to the higher prevalence rate for this subtype. The younger age demographic for the NZ survey appears to make a larger difference, though: for respondents 65+, psychological harm prevalence lies within a confidence interval of 7.2%–9.7% and this does not overlap with the CI for the Australian estimate. We leave further analysis of these differences for future research.

Table 16: 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
Pooled (28 countries)[0]	15.7	11.6	2.6	0.9	6.8	4.2	N/A
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.
0. Yon et al. (2017), analysis does not include NZ; 1. Qu et al. (2021); 2. NICE (2015); 3. Naughton et al. (2010); 4. Lifespan of Greater Rochester Inc. (2011); 5. Acierno et al. (2010); 6. O'Keeffe et al. (2007).

Despite the limited comparisons possible between prevalence studies, using thresholds to define and measure neglect and psychological abuse is relatively consistent across research. Further applying thresholds to cultural & spiritual harm – a subtype most like psychological harm in nature – is a natural extension of prior work. More comprehensive analysis and comparison of thresholds between studies, such as the Australian and New Zealand surveys, is left for future research.

6.4 Strengths of our approach

To further explore thresholds' impact on the prevalence rates for AOP overall and its subtypes, this section presents a summary of the strengths of the approach chosen for the main estimate of the prevalence rate in NZ.

Theory and data informed

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 enable the estimate presented in the *National Study* to be informed by international work, appropriate theory, and the data collected as part of the *Prevalence Survey*, this research aimed to undertake an RSR of the literature, speak with experts in the field, and conduct sensitivity analysis.

The thresholds discussed in this report (no threshold, CHI–Core, CHI–Very Serious, and CHI–Expanded Seriousness), and the decision to use the CHI–Very Serious threshold for the main estimate, have been informed by theory and data-driven analysis. The result is a robust and rigorous approach to threshold use for measuring the prevalence of AOP in NZ.

Transparency

As noted in the scoping review and by the experts we consulted with, transparency of any thresholds applied and their relative impact on prevalence measurement hinders comparisons and may, by extension, limit global inferences. Part of the challenge with transparency is not in how thresholds are described in published research (although clarity is important), but rather that studies are conducted as one-off snapshot exercises without the ability to revisit respondents (as in longitudinal surveys) or assess their future outcomes. For the latter point, linking the survey to NZ's administrative database (the IDI) for those respondents who gave consent, will enable future work to analyse the impact of abuse definitions and threshold use relative to the outcomes experienced by those older people.

Being able to investigate the psychometric validity of how we measure AOP and its progression over time, both for the general population and individuals, allows informed decision-making for interventions and societal responses. As understandings of AOP evolve globally, and the global population ages, building robust evidence to support policy-makers is increasingly important.

Simplicity

Further to reporting a transparent method for measuring AOP prevalence, ease of replication and comparison for future researchers in this field is important. Thresholds that are simple to calculate, like those presented in this report, are key for robust measures that can be verified and critiqued by others in the field.

6.5 Limitations of our approach

To conclude the discussion of thresholds' impact on total AOP and subtype prevalence rates, this section summarises the key limitations of our approach.

Lifetime versus 12-month prevalence

The *Prevalence Survey,* and therefore the analysis of thresholds contained in this report, aims to measure abuse experienced by older people in the 12 months prior to the *National Study*. The estimated

prevalence rates presented and tested here only capture a snapshot of the behaviours experienced by respondents aged 55 and above living in the community. It is possible that a longer timeframe would capture a higher number or frequency of behaviours and/or higher self-reported severity, corresponding to a higher prevalence estimate.

Minimising their experience

It is also possible that respondents experiencing harm may not immediately recognise the behaviours they are subject to as abuse. Asking about individual behaviours and their frequency avoids requiring respondents to label or define their experience. Also, an older person may minimise the abuse they are subjected to and downplay its severity. Using the CHI–Very Serious approach, these respondents are included in the estimated rate if they report three or more separate behaviours happening once and/or one behaviour happening many times within each subtype (where threshold is relevant).

On balance, the concern is that we exclude severe but infrequent experiences, not that we miss frequent patterns of harm that are not considered serious by the respondent (as this is unlikely given the frequency/seriousness interaction).

However, a limitation of the survey questionnaire meant that severity was captured at the subtype-level for the person that affected the respondent the most (in the case of multiple individuals causing harm). It is therefore possible that the seriousness of some cumulative experiences of harm was not captured. Given the use of frequency in the underlying index, however, it is reasonable to conclude the impact of this limitation on the prevalence rate is likely minor. This is because one-off occurrences of at least three behaviours per harm (even if perpetrated by three different people) would meet the CHI–Core threshold without considering perceived seriousness.

Behavioural versus subtype thresholds

The thresholds applied in this study are determined within each subtype (where thresholds are used), not across subtypes. The limitation of this approach is that cumulative experiences of multiple behaviours across subtypes may be numerous or reasonably frequent, but the threshold not reached for individual subtypes. Including perceived severity partially addresses this concern, but only for those experiences a respondent identifies as “very serious”.

For the *Prevalence Survey*, we examined the impact on the total AOP prevalence rate of including respondents who had total CHI scores, across subtypes subject to thresholds, of 3 or more but who are not included in the CHI–Very Serious estimate. As discussed in Section 6.2, expanding the headline

estimate to include these respondents increases prevalence marginally but this increase is not statistically significant.

The CHI–Very Serious threshold is therefore a robust approach to measuring overall AOP prevalence.

7 CONCLUDING REMARKS

This report has presented an in-depth discussion on setting thresholds for the purpose of estimating prevalence rates using cross-sectional survey data collected as part of the *National Study of Abuse of Older People*. It is a supplementary report to the main *Prevalence Survey Report* (Meehan et al., 2026). The research involved three components: a literature review, consultation with a panel of experts, and analysis to test the impact of thresholds using the survey data.

Prior AOP prevalence studies and expert opinion led to four recommendations regarding the application of thresholds for the *Prevalence Survey* analysis:

1. The use of thresholds is important to ensure that the overall prevalence rate includes those experiences that objectively constitute AOP, but not those experiences that do not align with current perceptions and understandings of AOP.
2. Thresholds are appropriate to apply to neglect, psychological harm, and cultural & spiritual harm. Thresholds should not be applied to physical, sexual, or financial harm.
3. The threshold methodology should be simple to explain and apply, then applied consistently across subtypes when used. Descriptions of the threshold should be accurate, clear, and its impact on the prevalence rate(s) stated and discussed.
4. The chosen threshold is the CHI–Very Serious applied to neglect, psychological harm, and cultural & spiritual harm.

In line with these recommendations, 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 distinguished between those behaviours reported by survey participants as one-off or infrequent occurrences and those indicating a pattern of harmful behaviour experienced over time. 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.

Including seriousness, as reported by respondents, in the prevalence rate is considered important to ensure those infrequent yet serious experiences were counted in the prevalence of AOP in NZ. Doing so minimises the risk of underestimating total prevalence by being too restrictive – a key concern raised by some experts – without including experiences older people reported as infrequent, or one-off, and not serious.

This research presents several opportunities for future work on the topic of thresholds and their use for measuring prevalence of AOP and its subtypes. First, direct comparisons of thresholds used in international studies with comparable survey questionnaires, even if limited to a subset of behaviours and harm subtypes, would allow differences to be investigated and variation in prevalence rates to be analysed. Second, the impact of thresholds in terms of future outcomes for respondents can be investigated following linkage of this survey to the Stats NZ administrative dataset (the IDI). Examining the impact of experience, frequency, and perceived seriousness with outcomes captured in administrative data (i.e. future residential care or hospitalisation data) may provide insights into the usefulness of capturing severity alongside cumulative harm. Likewise, previous respondent information captured in the IDI may allow researchers to better predict or infer AOP risk or potential harm, allowing them to further refine how AOP prevalence is measured.

REFERENCES

Acharya, S. R., Suman, B. K., Pahari, S., Shin, Y. C., & Moon, D. H. (2021). Prevalence of abuse among the elderly population of Syangja, Nepal. *BMC Public Health*, *21*(1). https://doi.org/10.1186/s12889-021-11417-0

Acierno, R., Hernandez, M. A., Amstadter, A. B., Resnick, H. S., Steve, K., Muzzy, W., & Kilpatrick, D. G. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study. *American Journal of Public Health*, *100*(2), 292–297. https://doi.org/10.2105/ajph.2009.163089

Action on Elder Abuse in the United Kingdom. (1995). What is elder abuse? *Action on Elder Abuse Bulletin*, *11*(May-June).

Ahnlund, P., Andersson, T., Snellman, F., Sundström, M., & Heimer, G. (2020). Prevalence and correlates of sexual, physical, and psychological violence against women and men of 60 to 74 years in Sweden. *Journal of Interpersonal Violence*, *35*(5-6), 1539-1561. https://doi.org/10.1177/0886260517696874

Amstadter, A. B., Zajac, K., Strachan, M., Hernandez, M. A., Kilpatrick, D. G., & Acierno, R. (2011). Prevalence and correlates of elder mistreatment in South Carolina: The South Carolina Elder Mistreatment Study. *Journal of Interpersonal Violence*, *26*(15), 2947–2972. https://doi.org/10.1177/0886260510390959

Biggs, S., Erens, B., Doyle, M., Hall, J., & Sanchez, M. (2009). *Abuse and neglect of older people: Secondary analysis of UK prevalence study.* London, UK: King's College London and the National Centre for Social Research.

Blundell, B., Moir, E., Clare, J., Clare, M., & Webb, E. (2017). *Review into the prevalence and characteristics of elder abuse in Queensland*. Perth, WA: Curtin University and Murdoch University. http://hdl.handle.net/10072/388501

Brijoux, T., Neise, M., & Zank, S. (2021). Elder abuse in the oldest old: Prevalence, risk factors and consequences. *Zeitschrift für Gerontologie und Geriatrie*, *54*(S2), 132-137. https://doi.org/10.1007/s00391-021-01945-0

Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology, 22*(6), 723–742. https://doi.org/10.1037/0012-1649.22.6.723

Burnes, D., Pillemer, K., Caccamise, P. L., Mason, A., Henderson Jr, C. R., Berman, J., Cook, A. M., Shukoff, D., Brownell, P., & Powell, M. (2015). Prevalence of and risk factors for elder abuse and neglect

in the community: A population-based study. *Journal of the American Geriatrics Society*, *63*(9), 1906–1912. https://doi.org/10.1111/jgs.13601

Burnes, D., Pillemer, K., Rosen, T., Lachs, M. S., & McDonald, L. (2022). Elder abuse prevalence and risk factors: Findings from the Canadian Longitudinal Study on Aging. *Nature Aging, 2*(9), 784–795. https://doi.org/10.1038/s43587-022-00280-2

Cevik, C., Ozdemir, R., Koran, N., & Agın, A. (2023). Prevalence and risk factors for elder abuse: A community-based cross-sectional study from North West Turkey. *Current Psychology, 42*(1), 726–733. https://doi.org/10.1007/s12144-021-01423-1

Chandanshive, P., Subba, S. H., Parida, S. P., & Mishra, S. (2022). Prevalence patterns and associated factors of elder abuse in an urban slum of eastern India. *BMC Geriatrics, 22*(1). https://doi.org/10.1186/s12877-022-02986-9

Chang, E. S., & Levy, B. R. (2021). High prevalence of elder abuse during the COVID-19 pandemic: risk and resilience factors*. The American Journal of Geriatric Psychiatry, 29*(11), 1152–1159. https://doi.org/https://doi.org/10.1016/j.jagp.2021.01.007

Chen, M., & Chan, K. L. (2022). Elder abuse and neglect in China: Prevalence, co-occurrence, and intergenerational risk factors. *Journal of Interpersonal Violence, 37*(11–12), NP9839-NP9862. https://doi.org/10.1177/0886260520985501

Chokkanathan, S. (2018). Prevalence and correlates of elder mistreatment in Singapore. *Journal of Elder Abuse & Neglect, 30*(4), 271–283. https://doi.org/10.1080/08946566.2018.1471433

Chokkanathan, S., & Lee, A. E. Y. (2005). Elder mistreatment in urban India: A community based study. *Journal of Elder Abuse & Neglect, 17*(2), 45–61. https://doi.org/10.1300/J084v17n02_03

Dong, X. Q. (2015). Elder abuse: Systematic review and implications for practice. *Journal of the American Geriatrics Society*, *63*(6), 1214–1238. https://doi.org/10.1111/jgs.13454

Dong, X., A., S. M., & Gorbien, M. (2007). Elder abuse and neglect in an urban Chinese population. *Journal of Elder Abuse & Neglect, 19*(3–4), 79–96. https://doi.org/10.1300/J084v19n03_05

Dovetail. (2024). *Gathering Insights from the Elder Abuse Prevention Fund: A learning and insights review prepared for the Office for Seniors*. Wellington, NZ: Office for Seniors. https://www.officeforseniors.govt.nz/assets/documents/our-work/Elder-Abuse-Prevention-Fund/Elder-Abuse-Prevention-Fund-Report-Final-v3.pdf

Du, P., & Chen, Y. (2021). Prevalence of elder abuse and victim-related risk factors during the COVID-19 pandemic in China. *BMC Public Health, 21*(1). https://doi.org/10.1186/s12889-021-11175-z

Eisikovits, Z., Winterstein, T., & Lowenstein, A. (2004). *The national survey on elder abuse and neglect in Israel.* Jerusalem, Israel: The Center for Research and Study on Ageing (National Insurance Institute).

Ergin, F., Evci-Kiraz, E., Saruhan, G., Benli, C., Okyay, P., & Beser, E. (2012). Prevalence and risk factors of elder abuse and neglect in western city of Turkey: A community based study. *Bulletin of the Transilvania University of Brasov. Series VI: Medical Sciences*, 33–50.

Garre-Olmo, J., Planas-Pujol, X., López-Pousa, S., Juvinyà, D., Vilà, A., & Vilalta-Franch, J. (2009). Prevalence and risk factors of suspected elder abuse subtypes in people aged 75 and older. *Journal of the American Geriatrics Society*, *57*(5), 815–822. https://doi.org/10.1111/j.1532-5415.2009.02221.x

Gil, A. P. M., Irina, K., João, S. A., Baltazar, N., Rita, N., & and Fernandes, A. A. (2015). Elder abuse in Portugal: Findings from the first National Prevalence Study. *Journal of Elder Abuse & Neglect*, *27*(3), 174–195. https://doi.org/10.1080/08946566.2014.953659

Hudson, M. (1989). Analyses of the concepts of elder mistreatment: Abuse and neglect. *Journal of Elder Abuse & Neglect*, *1*(1), 5–26. https://doi.org/10.1300/J084v01n01_02

Jeon, G.-S., Cho, S.-I., Choi, K., & Jang, K.-S. (2019). Gender differences in the prevalence and correlates of elder abuse in a community-dwelling older population in Korea. *International Journal of Environmental Research and Public Health*, *16*(1), 100. https://doi.org/10.3390/ijerph16010100

Koga, C., Hanazato, M., Tsuji, T., Suzuki, N., & Kondo, K. (2020). Elder abuse and social capital in older adults: The Japan Gerontological Evaluation Study. *Gerontology, 66*(2), 149–159. https://doi.org/10.1159/000502544

Kulakçı Altıntaş¸, H., & Korkmaz Aslan, G. (2020). Prevalence of elder abuse among community-dwelling older adults in Turkey and its associated factors. *Psychogeriatrics, 20*(1), 3–10. https://doi.org/10.1111/psyg.12446

Lai, D. W. L. (2011). Abuse and neglect experienced by aging Chinese in Canada. *Journal of Elder Abuse & Neglect, 23*(4), 326–347. https://doi.org/10.1080/08946566.2011.584047

Lee, Y. J., Kim, Y., & Park, J.-I. (2021). Prevalence and factors associated with elder abuse in community-dwelling elderly in Korea: Mediation effects of social support. *Psychiatry Investigation, 18*(11), 1044–1049. https://doi.org/10.30773/pi.2021.0156

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

Lindert, J., de Luna, J., Torres-Gonzales, F., Barros, H., Ioannidi-Kopolou, E., Melchiorre, M. G., Stankunas, M., Macassa, G., & Soares, J. F. J. (2013). Abuse and neglect of older persons in seven cities in seven countries in Europe: A cross-sectional community study. *International Journal of Public Health, 58*(1), 121–132. https://doi.org/10.1007/s00038-012-0388-3

Lowenstein, A., Eisikovits, Z., Band-Winterstein, T., & and Enosh, G. (2009). Is elder abuse and neglect a social phenomenon? Data from the First National Prevalence Survey in Israel. *Journal of Elder Abuse & Neglect*, *21*(3), 253–277. https://doi.org/10.1080/08946560902997629

Luoma, M.-L., Koivusilta, M., Lang, G., Enzenhofer, E., Donder, L., Verté, D., Reingarde, J., Tamutiene, I., Alves, J. F., & Santos, A. J. (2011). Prevalence study of abuse and violence against older women: Results of a multi-cultural survey conducted in Austria, Belgium, Finland, Lithuania, and Portugal. Helsinki, Finland: National Institute for Health and Welfare. https://repositorium.uminho.pt/bitstream/1822/16541/1/avow%20study%20-%20final%20report.pdf

Iborra, I. (2008). *Elder abuse in the family in Spain*. Valencia, Spain: Queen Sofía Centre. http://www.inpea.net/images/Spain_Report_2008_Elder.pdf

Maurya, P., Chattopadhyay, A., Rao, S., & Sharma, P. (2024). Understanding elder abuse in India: Contributing factors and policy suggestions. *Journal of Population Ageing, 17*(1), 5–32. https://doi.org/10.1007/s12062-022-09399-x

McDonald, L. (2015). *Into the light: National survey on the mistreatment of older Canadians*. Toronto, Canada: National Initiative for the Care of the Elderly. https://cnpea.ca/images/canada-report-june-7-2016-pre-study-lynnmcdonald.pdf

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 New Zealand.* Auckland, NZ: New Zealand Policy Research Institute.

Naughton, C., Drennan, J., Treacy, M. P., Lafferty, A., Lyons, I., Phelan, A., Quin, S., O'loughlin, A., & Delaney, L. (2010). *Abuse and neglect of older people in Ireland: Report on The National Study of Elder Abuse and Neglect. Report Summary*. Dublin, Ireland: National Centre for the Protection of Older People. https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=43921d446a82ad2a310843e9e97944eca3bd97e7

Nemati-Vakilabad, R., Khalili, Z., Ghanbari-Afra, L., & Mirzaei, A. (2023). The prevalence of elder abuse and risk factors: A cross-sectional study of community older adults. *BMC Geriatrics, 23*(1). https://doi.org/10.1186/s12877-023-04307-0

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 elder abuse and neglect of older people: Prevalence survey report.* London, UK: National Centre for Social Research.

Oh, J., Kim, H. S., Martins, D., & Kim, H. (2006). A study of elder abuse in Korea. *International Journal of Nursing Studies, 43*(2), 203–214. https://doi.org/10.1016/j.ijnurstu.2005.03.005

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).* Melbourne, Australia: Australian Institute of Family Studies. https://aifs.gov.au/sites/default/files/publication-documents/2021_national_elder_abuse_prevalence_study_final_report_0.pdf

Sandmoe, A., Wentzel-Larsen, T., & Hjemdal, O. K. (2017). *Violence and abuse against elderly people in Norway*. Gullhaugveien, Norway: Publisher. http://www.inpea.net/resources/NKVTS_report_9_17_violence-against-the-elderly_web.pdf

Sathya, T., Selvamani, Y., & Nagarajan, R. (2022). Elder abuse/mistreatment and associated covariates in India: Results from the Longitudinal Aging Study in India wave 1, 2017–2018. *Epidemiology and Health, 44,* e2022017. https://doi.org/10.4178/epih.e2022017

Scott, A., Nicholson, K., Meehan, L., & Wilson, D. (2026). *National Study of Abuse of Older People: Finance and legal sector perspectives on preventing financial abuse of older people.* Auckland, NZ: New Zealand Policy Research Institute.

Seutodan Hagh, H., Rezaeipandari, H., Mousavi, S., & Allahverdipour, H. (2021). Prevalence and gender differences of elder abuse among community-dwelling older adults in Tabriz, Iran. *Salmand, 15*(4), 458–471. https://doi.org/10.32598/sija.15.4.1124.1

Soares, J., Barros, H., Torres-Gonzales, F., Ioannidi-Kapolou, E., Lamura, G., Lindert, J., de Dios Luna, J., Macassa, G., Melchiorre, M. G., & Stankunas, M. (2010). Abuse and health among elderly in Europe. Kaunas, Lithuania: University of Health Sciences Press. https://www.diva-portal.org/smash/get/diva2:377016/FULLTEXT01.pdf

Sooryanarayana, R., Choo, W. Y., Hairi, N. N., Chinna, K., Hairi, F., Ali, Z. M., Ahmad, S. N., Razak, I. A., Aziz, S. A., & Ramli, R. (2017). The prevalence and correlates of elder abuse and neglect in a rural community of Negeri Sembilan state: Baseline findings from The Malaysian Elder Mistreatment Project (MAESTRO), a population-based survey. *BMJ Open, 7*(8), e017025. https://doi.org/10.1136/bmjopen-2017-017025

Tang, F., Li, K., Rauktis, M. E., Chi, I., & Dong, X. Q. (2023). A social-ecological approach to understanding activity engagement patterns among older Chinese immigrants. *International Journal of Aging and Human Development*, *96*(2), 219–233. https://doi.org/10.1177/00914150221084648

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

Wainer, J., Owada, K., & Darzins, P. (2010). *Prevalence of financial elder abuse in Victoria.* Melbourne, Australia: Monash University. https://www.eapu.com.au/uploads/research_resources/VIC-Prevalence_of_FInancial_Elder_Abuse_MAY_2010-Monash.pdf

Wiklund, N., Ludvigsson, M., Nägga, K., & Simmons, J. (2022). Elder abuse and life-course victimization in hospitalized older adults in Sweden: Prevalence and associations with mental ill-health. *BMC Geriatrics, 22*(1). https://doi.org/10.1186/s12877-022-03638-8

Wilson, D., lusitini, 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*. Auckland, NZ: New Zealand Policy Research Institute.

Wolf, R. S. (2000). Introduction: The nature and scope of elder abuse. *Generations Journal*, *24*(2), 6–12.

World Health Organization (WHO). (2008). *A global response to elder abuse and neglect: Building primary health care capacity to deal with the problem worldwide.* Geneva, Switzerland: WHO.

World Health Organization (WHO). (2024). *Abuse of older people*. Geneva, Switzerland: WHO. https://www.who.int/news-room/fact-sheets/detail/abuse-of-older-people

Wu, L., Chen, H., Hu, Y., Xiang, H., Yu, X., Zhang, T., Cao, Z., & Wang, Y. (2012). Prevalence and associated factors of elder mistreatment in a rural community in People's Republic of China: A cross-sectional study. *PLOS ONE, 7*(3), e33857. https://doi.org/10.1371/journal.pone.0033857

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

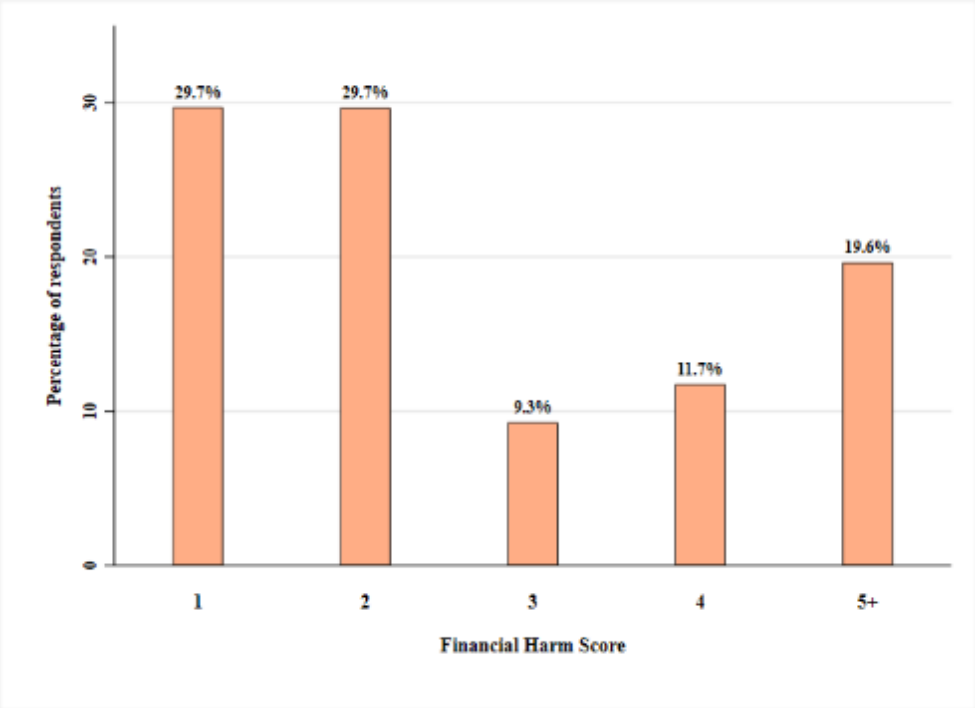
Yan, E. C. W., & Tang, C. S. K. (2004). Elder abuse by caregivers: A study of prevalence and risk factors in Hong Kong Chinese families. *Journal of Family Violence*, *19*(5), 269–277. https://doi.org/10.1023/B:JOFV.0000042077.95692.71

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. https://www.ncbi.nlm.nih.gov/pubmed/28104184

Appendix 1: Thresholds for financial harm (additional analysis)

As for neglect and the other subtypes (not physical or sexual harm), a Cumulative Harm Index (CHI) approach is used (see Sections 2.2 and 2.3) to establish those experiences that were not one-off instances but that may indicate a pattern of financial harm.

Appendix Figure 1: Distribution of financial harm CHI



Note: CHI scores for those respondents who reported experiencing financially harmful behaviours, n=247.

Appendix Figure 1 shows the distribution of the CHI for respondents reporting any financially harmful behaviour; almost one in three (29.7%) have an index of 1, indicating they experienced one behaviour indicating financial harm once in the 12 months prior to the survey. A further 29.7% record a CHI of 2, suggesting that they experienced two behaviours once each, or experienced one behaviour a few times. An index of 3 or more, referred to as the CHI–Core, is recorded for two in five respondents (40.7%) who experienced any of the behaviours listed in Figure 6.

To investigate the impact on the financial harm prevalence rate of the CHI approach, we estimate financial harm prevalence using a range of CHI–Core cut-offs: 2 or more, 3+, 5+, and 7+ (Appendix Table 1). Most respondents' record a CHI of 1-2, while approximately one in five record a CHI of 3–4. The remainder (19.6%) have a CHI of 5 or more, but this is considered too restrictive for the purposes of

measuring financial harm. To record a CHI of 5, a respondent must identify five separate behaviours that occurred once, or rather, one behaviour they experienced almost every day in the 12 months prior to the survey plus one other behaviour once.

We argue that an appropriate CHI–Core threshold to test in further analysis is 3 or more, capturing those respondents who (at a minimum) either experienced three harmful behaviours once, or who experienced one behaviour many times in the 12 months prior to the survey. Using the CHI–Core threshold of 3 or more results in a financial harm prevalence rate of 1.6%.

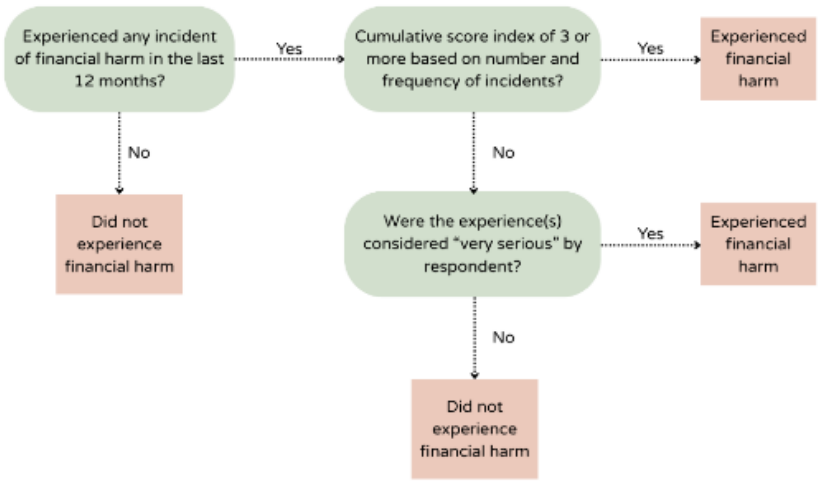
Appendix Table 1: Sensitivity analysis of financial harm CHI–Core threshold

Threshold	Prevalence rate % (standard error)	95% confidence interval (%)	Observations (unweighted/weighted)
No threshold	**4.00 (0.34)**	**3.33–4.67**	**250/61,200**
CHI–Core of 2+	2.75 (0.28)	2.20–3.31	169/42,100
CHI–Core of 3+	**1.59 (0.21)**	**1.19–2.00**	**97/24,300**
CHI–Core of 5+	0.77 (0.15)	0.47–1.07	41/11,800
CHI–Core of 7+	0.40 (0.11)	0.18–0.61	21/6,100

Note: CHI– Core cut-offs, for financial harm. Total number of respondents is n=5,608 for CHI–Core and n=5,611 for 'no threshold'.

However, for some respondents, even one instance of the behaviours listed may have caused serious financial loss or harm or distress. To capture these cases, respondents who recorded a CHI–Core of 1 or 2 but who reported their experience as "very serious" or at least "somewhat or moderately serious" are included in two additional thresholds: CHI–Very Serious and CHI–Expanded Seriousness. The flowchart in Appendix Figure 2 illustrates how the CHI–Very Serious threshold defines a respondent's experience.

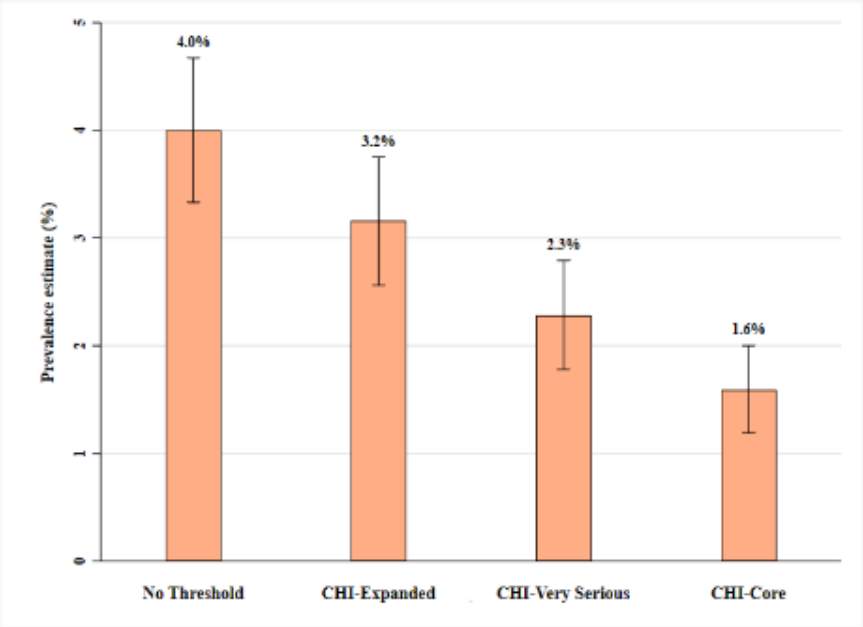
Appendix Figure 2: Measuring financial harm using the CHI–Very Serious



Note: For a full description of how financial harm is captured in the survey, see Section 2.3.

Variation in threshold definitions has an impact on the estimated prevalence of financial harm (Appendix Figure 3). Using no threshold, the prevalence rate is 4% of older people experiencing financial harm in the 12 months prior to the survey. Applying the CHI–Core threshold, which considers only the number and frequency of harmful behaviours, reduces the prevalence rate by almost two-thirds to 1.6%. When respondents did not meet the CHI–Core threshold (3+) but described their experience as "very serious" are included (CHI–Very Serious), the prevalence rate increases to 2.3%. This is equivalent to 34,800 older people (aged 55+). A further expansion to include those who rated their experience of financial harm as "somewhat or moderately" or "very serious" (CHI–Expanded Seriousness) results in a prevalence rate of 3.2%.

Appendix Figure 3: Financial harm prevalence rate by CHI



Note: The number of observations differs by threshold due to missing ("don't know" and "refused to answer") responses.



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