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AUT

NATIONAL STUDY OF ABUSE OF OLDER PEOPLE:

Findings from qualitative interviews with NZ European, Māori, Pacific and disabled older people who have experienced abuse

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Glossary

Aotearoa	Land of the long white cloud, commonly known as New Zealand
Aroha	Love, always acting with compassion and empathy
Fa'alevaleve	Financial contributions, donations
Hapori	Community
Hapū	Constellation of whānau with a common tupuna or ancestor
Hauora	Be fit, well, healthy, vigorous, in good spirits
Kai	Food, to eat, consume
Kaikaranga	Women who make the ceremonial call to visitors
Kaimoana	Food sourced from the sea (ocean)
Kanohi ki te kanohi	Face-to-face, in person, in the flesh
Karakia	To recite ritual chants, say grace, pray, recite a prayer, chant
Kauheke	Elder
Kaumātua	Older person, often male, with status
Kaupapa Māori	Māori/Indigenous approach
Kawa	Customs protocols
Koha	Gift exchange, present, offering, donation, contribution
Kōrero	Tell, say, speak, read, talk, address
Kōreroreo	Conversations
Kōrero tuku iho	Imparting mātauranga and mōhio (wisdom)
Kōrero mai	Speak to me, storytelling
Kuia	Older woman
Māori	Indigenous peoples of Aotearoa New Zealand
Mana	Authoritative, valid, prestige, esteem, spiritual power
Mana motuhake	Autonomy, self-government, self-determination, independence, sovereignty, authority
Mana whenua	Authoritative guardians, territorial rights, power from the land, jurisdiction over land or territory
Manaaki	To support, take care of, give hospitality to, protect, look out for
Manaakitanga	Hospitality, kindness, generosity, support, being culturally and socially responsible
Marae	A gathering place, usually connected to whānau and hapū, although there are urban marae for Māori who are disconnected or some distance from their marae
Mātauranga	Māori knowledge systems, knowledge
Mihi	To greet, pay tribute, acknowledge, thank
Mokopuna	Grandchild, and/or descendants/future generations
Ritenga	Customary cultural practices and tikanga
Tangata whenua	People of the land

Te ao Pākehā	The Pākehā or white NZ European world
Te ao Māori	The Māori world
Te Tiriti o Waitangi	Māori language of the Treaty of Waitangi
Tika	To be correct, true, upright, right, just, fair
Tikanga	The customary system of values and practices embedded in the social context, cultural processes, and protocols
Tupuna or Tūpuna	Ancestor or ancestors, respectively
Tūrangawaewae	A place to stand
Wairua	Spirituality
Wānanga	Learning through discussion, deliberation, and consideration
Whaikōrero	To make a formal speech
Whakamā	Embarrassment, shame
Whakapapa	Genealogy, genealogical table, lineage, descent, ancestral connections
Whakawhānaungatanga	Process of establishing and developing relationships, necessary for engagement and connectedness
Whānau	Extended family, family group, a familiar term of address to several people, the primary economic unit of traditional Māori society
Whenua	Land, often used in the plural

EXECUTIVE SUMMARY

This executive summary presents the key findings from the *Findings from qualitative interviews with NZ European, Māori, Pacific, and disabled older people who have experienced abuse* report, which forms part of the *National Study of Abuse of Older People in Aotearoa New Zealand* (NZ), commissioned by the Ministry of Social Development (MSD) as part of its Prevention of Abuse of Older People (AOP) work programme.

The qualitative study (reported here) focused on understanding the experiences, contexts, and impacts of abuse among older individuals across four specific cohorts: Māori, Pacific, NZ European, and disabled people aged 55+ years.

The *National Study* was undertaken in 2024 and 2025, with the broader project including five main components:

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

Background

AOP is a critical issue globally and nationally. It can be considered a social justice, human rights, and public health issue. According to the World Health Organization (WHO), one in six people over the age of 60 has experienced some form of abuse. For those in aged residential care (ARC) facilities, two in three staff declared they had abused an older person in their care in the previous year (World Health Organization, 2024). However, the systematic review and meta-analyses on which the WHO prevalence rate is based did not include NZ (Yon et al., 2017).

Experiencing abuse as an older person is a significant issue at a life stage when someone is likely to become more dependent, or needs to rely on others to meet their daily and longer-term needs, depending on their situation. Abuse across someone's lifetime and abuse as an older person affects older people's health and wellbeing. Fraga et al. (2017) found that lifetime abuse negatively impacts older people's autonomy, social participation, intimacy, and quality of life. Yet, little is known about the experiences of older people in NZ.

AOP is defined in the *National Study* as:

> *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)

As with other forms of family violence, it is generally accepted that AOP is rarely a single or isolated event. Instead, abuse and violence within the context of families are intentional, and form cumulative patterns of harm from abuse over time (NZ Family Violence Death Review Committee, 2016). AOP encompasses diverse forms and varying combinations of harm, such as neglect, physical, sexual, emotional, psychological, financial, and cultural & spiritual harm.

This report presents findings from qualitative interviews conducted with older people aged 55 and above[1] who identified as NZ European, Māori, Pasifika, or disabled.[2] It also identifies the differences that emerged between the cohorts.

Research aims and questions

The qualitative interviews aimed to understand the contextual factors of older people's harm or mistreatment (abuse) by a trusted person or close acquaintance. These interviews explored the nuances and contextual aspects of abuse affecting older people aged 55+, and their health and wellbeing within and across the four cohorts.

We asked the following questions:

1. Can you tell us about your story of keeping safe and well?
2. Can you share how you have been harmed and mistreated as an older person?
3. How has this harm and mistreatment influenced your health and wellbeing?

Participants

A total of 71 older people, aged 55+[3], consented to participate in the following priority populations:

- NZ European (sometimes referred to as Pākehā) (n=18)

[1] Rationale for including older people aged 55+: The research team recognised that Māori and Pacific, as population groups, have a shorter life expectancy (75.8 and 76.9 years, respectively) compared to NZ European/Other (82.8 years) by 7 and 5.9 years, respectively, and the NZ population (81.8 years) by 6 and 4.9 years, respectively (StatsNZ, 2025, https://www.stats.govt.nz/news/maori-have-highest-increases-in-life-expectancy/).

[2] Rationale for the four cohorts: The four cohorts were identified as priority groups to focus the qualitative component of the research.

[3] The National Prevalence of AOP study included people aged 55+, who are in population groups like Māori, Pacific, and disabled people, and who have lower life expectancies than NZ European people.

- Māori (n=15)
- Pasifika (n=21)
- disabled people (n=17).

In line with the broader *National Study*, we excluded people unable to provide informed consent, those at increased risk of harm by participating, and those in ARC. The exclusion of these groups is in line with most international AOP studies of community-dwelling older people, and recognises the distinct nature of abuse in institutional settings and the need for separate investigative approaches.

Methods

We conducted qualitative interviews with older people in each cohort and one group interview with older Māori, which were audio-recorded and transcribed. Transcripts were thematically analysed.

Key findings

This report offers insights into the distinct challenges faced by various groups. The findings highlight the complexity and multifaceted nature of AOP among the four population groups included in this study, underscoring the need for tailored interventions that consider their unique contexts and challenges.

Nature and onset of abuse

Abuse does not necessarily begin in older age. In many cases, AOP has its roots earlier in life, evolving as individuals age. The continuation and manifestation of abuse vary across cohorts, with both cultural and systemic factors influencing its prevalence. For some older people, abuse began at earlier points in their lives. As they entered older age, the nature of harm and mistreatment appeared to change.

Risk and protective factors

Several risk factors heightened older people's susceptibility to abuse, including:

- Poverty and economic constraints reported by participants caused experiences of financial instability and economic pressures that raised their risk of abuse. Many worked all their lives and paid taxes, believing they would be cared for in their retirement. However, participants reported experiencing financial stress due to changes in their circumstances and the associated costs of

food, rent, and healthcare. They also shared their vulnerabilities to abuse by family or whānau members related to their finances and assets.

- Familial and social isolation were sources of risk primarily linked to having a lack of social connections and support networks. Like other forms of family violence, AOP in this study involved the person causing them harm isolating an older person from supportive family or whānau members and support networks. Isolation was identified as a risk factor enabling various forms of abuse, primarily financial and psychological abuse. We found that a threat to remove access to grandchildren and mokopuna was a significant risk factor in social, psychological, and cultural AOP. These threats were effective in silencing an older person and securing their compliance with the person-responsible's wishes. Furthermore, participants reported that professionals working with health, legal, and banking services often inadvertently colluded with the person causing them harm, by believing their narratives over that of the older person, and did not act in their best interests.
- Family or whānau trauma and unresolved issues, especially historical events (like sexual and physical violence in childhood) and intergenerational trauma and unresolved conflicts, can contribute to ongoing abuse into a person's older age. Importantly, participants reported that not all experienced AOP starting at an older age, but had been abused throughout their life course.
- Adult child-to-parent violence (ACPV). Several participants reported ACPV. Violence from their adult children and grandchildren was a significant risk factor found in this research and had implications for help-seeking. For example, where an older person disclosed being abusive to their children earlier in their life, this made them reticent to talk about it when their adult children and grandchildren were being abusive to them.
- Natural disasters and pandemics, like cyclones, earthquakes, and the COVID-19 pandemic exacerbated existing vulnerabilities, increasing the risk of AOP for participants in this research. In this report, several protective factors served to buffer the effects of AOP. These protective factors could mitigate abuse, harm, and mistreatment, which included social isolation, neglect, emotional, and economic abuse.
- Supportive social networks were viewed by participants as necessary when they experienced AOP. Social networks served as a source of respite and support. Importantly, these networks often had people who participants indicated they trusted to provide appropriate support and information.
- Employment and financial security ensured that participants had economic independence and stability, enabling them to make choices in their daily lives and lessening the impacts of financial

and other forms of abuse. Furthermore, employment also provided relief from abuse and provided income to supplement their superannuation.

- Culturally based services enabled participants to access services that they reported were safe and appropriate and could help mitigate the risk of abuse. This was particularly so for Māori participants, who talked about encountering people who knew and understood their realities.

Help-seeking behaviours

Participants, as older people living with AOP, discussed barriers and enablers to seeking help.

Barriers to help-seeking included the following:

- Shame and embarrassment that arose from having to disclose that they were being abused by a family or whānau member(s) was a significant barrier to help-seeking. Shame and embarrassment were compounded by a fear of being judged by those people they needed to ask for help.
- Fear of not being believed was driven by psychological abuse and manipulation that created doubt for participants as to whether anyone would believe their claims of abuse. Such fears were reinforced, for instance, when the person responsible was able to spin a narrative about an older person's cognitive capacity, especially as participants got older, and claims of dementia. Many participants reported that health and legal professionals believed others' lies and inadvertently colluded with the person perpetrating abuse.
- Systemic barriers were reported by participants, such as inadequate support from services available for victims of AOP. For instance, participants reported being unable to access services like women's refuge for AOP because they were often single and did not meet their criteria. Men also reported having no options to seek respite from AOP.

Several factors enabled help-seeking among older people:

- Having trusted individuals or networks to turn to was critical to help-seeking, according to participants.
- Awareness of available services – many participants were unaware of where to begin seeking help. This information is critical for older people to exit abusive situations if they want to. We also found that participants lacked an understanding of the range of services that could assist them when seeking help for AOP, such as lawyers and health professionals.
- Culturally appropriate support mechanisms were essential for those seeking help for AOP. Participants reported that culturally aligned services, and the people within them, would better understand their realities and what support they needed.

Specific population group observations

This report offers insights into the distinct challenges faced by the various cohorts. Participants spoke about being silenced, invisible, and/or isolated, which marginalised them within their families, whānau, and support networks. Many participants discussed how the person responsible for harming them colluded with professionals, such as those working in government agencies, health, and lawyers, who inadvertently believed the narrative that older people lack the capacity to care for and make decisions themselves. Participants discussed how they felt that no-one gave them a voice, even in situations where they were deemed capable of making decisions and caring for themselves.

The continuation of AOP involves differing factors for each cohort:

- NZ European: Abuse was facilitated by systemic enablers that the person causing harm leveraged, especially common for emotional and financial abuse.
- Māori: Systemic and structural abuse were prominent, reflective of the broader social inequities they face. Māori older people also experienced cultural & spiritual abuse.
- Pacific peoples: Older Pacific participants experienced tension between customary cultural practices and expectations, and their acculturation to NZ. Cultural norms related to upholding family status inhibited participants from having open discussions about abuse. This creates barriers to addressing it. The cultural practice of older people living with families[4] meant that for those participants in families who worked, they reported taking care of their homes and children and risked being exploited.
- Disabled people: Systemic factors enabled and perpetuated abuse within this population group. Those interviewed who required others' support and care were at a heightened risk of abuse, especially emotional and financial abuse. Disabled participants reported that infantilisation was often used as a mechanism in their abuse.

Forms of abuse

- Social isolation, neglect, emotional abuse, and financial exploitation were common across all cohorts. Also observed were familial isolation, filial piety, and the weaponisation of grandchildren and mokopuna. Of particular concern was the intentional use of

[4] Note – this statement relates to those Pacific peoples participating in this study. Further research is required to ascertain the extent of the type of abuse older Pacific people's experience.

grandchildren and mokopuna to manipulate, harm, or abuse their grandparents. This form of abuse is evident across all the cohorts.

Critical contextual insights

The qualitative interviews provided critical insights into how cultural, systemic, and interpersonal dynamics shape the experiences of AOP. These findings are crucial to inform government agencies, non-government agencies (NGOs), service providers, and communities when developing targeted interventions that address the distinct needs and challenges faced by diverse groups within NZ.

Recommendations

The recommendations were sourced from the analysis of the participant interviews across the four cohorts. For each recommendation, we identify focus organisations and link to Te Aorerekura Action Plan 2.

Addressing structural and systemic barriers

1. **Incorporate Te Tiriti o Waitangi principles into policy development to ensure equitable outcomes for all older people living in NZ while respecting Māori rights and interests.**
   Equitable outcomes are needed for all those older people living in NZ. However, this study revealed differences in how older people experience AOP between the four cohorts. It is unlikely that adopting a universal approach to addressing AOP will address these differences. Thus, the principles of Te Tiriti o Waitangi should guide policy development, ensuring that decisions are led by the respective service providers, with policy-makers, to ensure that prevention and intervention strategies meet older people's needs. For instance, financial abuse presents differently for NZ European and Māori – older NZ European mostly referred to financial and asset abuse involving family members. In contrast, older Māori mostly struggled without sufficient financial resources and worried that they had nothing to give their grandchildren and mokopuna. This points to the need to commission and resource Māori with Kaupapa Māori or Māori-centred services for addressing AOP. NZ European, on the other hand, need a different approach that likely involves reviews of the legislative mechanisms and unintentional collusion between legal and health professionals and the individuals responsible for AOP. Pacific peoples need to lead the resolution of the findings relating to older Pacific people

participating in this research. Finally, disabled people have not just age and disability to consider, but also other intersecting issues, including access to appropriate services.

Focus organisations: *Centre for Family Violence and Sexual Violence Prevention, Office for Seniors, MSD*

Te Aorerekura Action Plan 2: *Investing and commissioning well, Keeping people safe*

2. Inclusion of AOP in cross-sector and cross-government strategies, informed by intersectionality related to older people, that aim to raise awareness of the subtleties and complexities of AOP to aid in its detection and the development of interventions.

   This study highlighted the complexities that are associated with AOP. These complexities include poverty, housing, unemployment, past histories of violence and trauma, and intergenerational trauma, to name a few. Such strategies need to be informed by intersectionality and the compounding forms of oppression that older people can experience. Importantly, a national dialogue needs to be held, inclusive of cross-government and cross-sector agreement, to address AOP.

   Focus organisations: *Centre for Family Violence and Sexual Violence Prevention, Office for Seniors, MSD*

   Te Aorerekura Action Plan 2: *Keeping people safe*

3. Prioritise the development of national, targeted awareness and intervention strategies aimed at identifying and reducing economic AOP.

   Central to reducing financial AOP is understanding the various ways in which perpetrators manipulate and control older people and their finances. Economic abuse, accompanied by emotional and psychological abuse, was pervasive across the population groups in this study, although it manifests in different ways. Strategies need to reflect the complexity because perpetrators use subtle and subversive ways of manipulating and controlling older people, often accompanied by threats to withhold access to their grandchildren and mokopuna or isolation from their family. These are strong enablers for the occurrence of financial abuse for older people. Economic abuse involves unintended collusion through the coercion of health or legal professionals who do not question claims of diminished capacity of an older person – raising awareness among these professions is critical. Therefore, national and targeted cross-sector strategies are required. Importantly, targeted awareness and intervention strategies need to acknowledge the structural and systemic barriers that exist.

   Focus organisations: *Office for Seniors, Centre for Family Violence and Sexual Violence Prevention, Law Commission, Banking and legal professions, Te Whatu Ora*

   Te Aorerekura Action Plan 2: *Keeping people safe, Stopping violence*

4. **Consideration should be given to including the weaponisation of grandchildren and mokopuna, familial isolation, infantilisation, breaches of filial piety, and cultural & spiritual abuse in the definition of AOP and any screening tools used to detect the harm and mistreatment of older people.**

The research confirmed that AOP exists in a myriad of forms and combinations. Infantilisation and the weaponising of grandchildren and mokopuna are forms of AOP that silence an older person and ensure their invisibility, enabling the continuation of abuse. These forms of abuse harm and diminish the dignity and mana of an older person, who is frequently unable to stop it.

The definition of AOP used in the *National Study* needs to be broadened to better capture tactics that enable and hide AOP. This study found that weaponising grandchildren and mokopuna, familial isolation, infantilisation, and breaches of filial piety are all significant tactics used by individuals to abuse, to manipulate, and to control older people. Drawing from this research and expanding on Qu et al.'s (2021) definition, the following revised definition is recommended:

AOP refers to the intentional action or treatment of an older person in a single or repeated act or failure to act, including threats, weaponisation of grandchildren and mokopuna, familial isolation, infantilisation, breaches of filial piety, and cultural & spiritual abuse. Such actions, singularly or in combination, are considered abuse resulting in the harm or distress of an older person. The harm or distress experienced by an older person includes physical, emotional, or psychological pain that occurs where an expectation of trust and/or a power imbalance exists between the party perpetrating the abuse and the older person.

These tactics ensure an older person's silence, with harm and mistreatment remaining invisible and not disclosed. The consequences of not detecting weaponisation of grandchildren and mokopuna, familial isolation, infantilisation, breaches of filial piety, and cultural & spiritual abuse as AOP are:

- AOP continues, causing relentless harm without redress
- there are ongoing, and often traumatic, cultural & spiritual, psychological, emotional, financial, and social harms (such as suffering, distress, loss, and/or decreased quality of life) arising from their abuse and neglect
- critical social, religious, and health needs are likely to remain unmet.

Participants also discussed that overlaps between the person causing harm and victim were evident. This is where intergenerational trauma and violence meant that an older person may have been abusive in their earlier life, but then as an older person they are the victim of AOP. The presence of unresolved trauma and extreme shame contributes to these older people avoiding seeking help.

Focus organisations: *Office for Seniors, Centre for Family Violence and Sexual Violence Prevention*

Te Aorerekura Action Plan 2: *Keeping people safe, Stopping violence*

5. **Address the systemic and structural barriers that make it difficult for an older person to disclose AOP, impacting their quality of life and obtaining the timely support required to meet their needs.**

   The *National Study* found systemic failures exacerbate abusive relationships, leaving older people with limited means to escape or seek intervention for AOP. While the experiences of systemic and structural violence varied across the four population groups, addressing some aspects would benefit all older people. For instance, promoting respectful and mana-enhancing engagement practices is key to building older people's trust in those who work within the services.

   Focus organisations: *MSD, Ministry of Health, Te Whatu Ora, Office for Seniors, Centre for Family Violence and Sexual Violence Prevention*

   Te Aorerekura Action Plan 2: *Keeping people safe*

6. **Review the Protection of Personal and Property Rights (PPPR) Act 1988 to define "best interests" and include supported decision-making.**

   The PPPR Act 1988 and the Property (Relationships) Act 1976 are utilised by individuals perpetrating AOP for financial and asset gain. An urgent review is required of legislation that enables economic and asset AOP. Primarily, legislation lacks adequate clarity in its definition of "best interests" and its focus on substituted decision-making excludes the older person. The Law Commission is currently reviewing the PPPR Act regarding adult decision-making capacity.[5] Any review of the legislation must consider the unintended consequences that negatively impact the person whose interests are being protected. Thus, a balance needs to be struck between risk and protective factors. There is always an opportunity for older persons to be included in any decision, in accordance with their capacity, referred to as supported decision-making. Participants' recounting of financial and asset abuse signals inadequate monitoring and protection related to this legislation.

   When an older person is perceived to have diminished capacity to make decisions about their welfare, the legislation enables someone (an Enduring Power of Attorney or EPOA) to be authorised to make decisions on their behalf and in their best interests. This is substituted decision-making. However, the notion of "best interests" outlined in the current PPPR Act is not clearly defined and is therefore open to interpretation. Supported decision-making, which involves the older person in decisions about their welfare, is not included in the PPPR Act. Excluding older people, especially

[5] See the Law Commission for details about this review (https://www.lawcom.govt.nz/our-work/review-of-adult-decision-making-capacity-law/tab/overview), which has a slightly different focus.

those who are disabled, from decision-making about their welfare increases the potential for AOP to occur.

Focus organisations: *Law Commission, Office for Seniors, Centre for Family Violence and Sexual Violence Prevention*

Te Aorerekura Action Plan 2: *Keeping people safe, Stopping violence*

Improving responses to AOP

7. **Commissioning of services with Non-Government Organisations should ensure tailored and nuanced approaches to the prevention and interventions for the abuse of older people living in NZ.**

   A key finding from this study is that while similarities exist across the four cohorts, significant differences in the manifestations and experiences of abuse can substantially influence the effectiveness of prevention and intervention activities. Context is an important consideration, not only between differing population groups, but also between geographic locations (rural, provincial, and urban), which means approaches also need to consider the place where interventions are to be delivered. Tailored place-based approaches enable the critical differences between groups of older people to be included in prevention and intervention activities.

   Focus organisations: *Centre for Family Violence and Sexual Violence Prevention, MSD, NGOs*

   Te Aorerekura Action Plan 2: *Investing and commissioning well, Keeping people safe, Stopping violence*

8. **Provide older people with dedicated counselling and support to manage and heal from the abuse and trauma they have experienced across their lifetime or as older people.**

   Well and healthy older people are needed to optimise opportunities for enhanced quality of life. Many participants in this research had histories of abuse in their earlier lives – Māori participants talked about intergenerational trauma and violence they carried into their older age. Similarly, older disabled people had experienced multiple forms of abuse in childhood or early adulthood. Yet, many were unable to access counselling and support to manage their trauma and abuse, and therefore the opportunity to heal.

   Focus organisations: *Te Whatu Ora, ACC, Office for Seniors, Centre for Family Violence and Sexual Violence Prevention*

   Te Aorerekura Action Plan 2: *Keeping people safe*

9. **Use both Tempest's (2024) and Townsend's (2024) reports to develop policy and interventions for preventing and responding to child and adolescent to parent violence and abuse (CAPVA).**

This research found that CAPVA is an issue detrimentally affecting older people, especially those in the disabled cohort. Research shows it is an invisible form of family violence that victim-survivors are often reticent to disclose or talk about, particularly if such activities risk the older person's (adult) child and adolescent being charged for assault, and similar charges. We recommend that CAPVA be recognised and treated as an under-reported form of family violence that requires clear policies focused on prevention and response strategies aimed at enhancing family and whānau wellbeing. Contingent on a successful approach would be funding to raise people's awareness throughout NZ, and to develop a trauma and violence-informed and whānau-focused response plan for intervention and healing.

Focus organisations: *Centre for Family Violence and Sexual Violence Prevention Te Whatu Ora, MSD, ACC, Office for Seniors*

Te Aorerekura Action Plan 2: *Keeping people safe*

10. Develop policy that focuses on responding to the needs of older men who are victim-survivors of AOP and their need to be able to access timely gender-appropriate services.

    In this study, men reported difficulty in accessing support and assistance for the AOP they were experiencing because the services available were designed to meet the needs of women. However, older women also reported challenges in accessing services. With increasing age, people become increasingly vulnerable and need to rely on others for support. This vulnerability and their need for help from other people means older men, too, are susceptible to AOP. The absence of services available for older men to access, especially when wanting to leave an abusive situation, is also a structural and systemic issue that prevents their needs from being met.

    Focus organisations: *Office for Seniors, Centre for Family Violence and Sexual Violence Prevention, MSD, NGOs*

    Te Aorerekura Action Plan 2: *Keeping people safe, Stopping violence*

11. Explore third-party mechanisms to protect older disabled people who have had their agency removed and are isolated from other people and sources of help.

    In this research, the 'othering' of older disabled people was enabled through tactics like familial isolation. We found that with age and disability, disabled people lost their voice, aided by a range of coercive control and manipulative strategies used by the person(s) responsible for their abuse. Notably, the intersection of age, disability, and AOP has a compounding and cumulative effect that makes it increasingly difficult to get their need for help and support heard. When disabled people are non-verbal, this makes it more difficult to express their safety and security needs. Disabled people

living with AOP are often without advocates and need a third-party mechanism that aims to protect them when their agency has been removed.

Focus organisations: *Office for Seniors, Whaikaha – Ministry for Disabled People, Centre for Family Violence and Sexual Violence Prevention, MSD, NGOs*

Te Aorerekura Action Plan 2: *Keeping people safe, Stopping violence*

Keeping older people safe

12. **Establish alternative housing for older people who are being harmed and unable to extricate themselves from the people responsible and unsafe homes.**

    Due to the nature of AOP, older people may find themselves with few options for securing a safe place to live, either because they lack the financial means or because they have lost their homes. Some participants reported being unable to access women's refuges and having no other options. Men also reported being unable to access services and alternative housing. Safe housing is needed for older people who have been abused, especially in circumstances where they have been 'evicted' from what was their home. Special consideration should be given to older adults at risk of further harm.

    Focus organisations: *Office for Seniors, MSD, Kāinga Ora, Centre for Family Violence and Sexual Violence Prevention*

    Te Aorerekura Action Plan 2: *Keeping people safe*

13. **Establish effective responses to older men who were experiencing AOP, including alternative housing or a refuge to separate them from the person responsible and be safe.**

    While small in number in this research, older men experiencing AOP reported few options for support to address their situations. The services they encountered for the provision of family violence were gendered and were not appropriate for men to access.

    Focus organisations: *Office for Seniors, MSD, Kāinga Ora, Centre for Family Violence and Sexual Violence Prevention*

    Te Aorerekura Action Plan 2: *Keeping people safe*

14. **Provide support and respite care for older people caring for adult children or grandchildren and mokopuna with neurodiversity and mental health issues and high support needs, who can be violent.**

    Not all older people have access to support and respite (through Disability Support Services) when they care for an adult child or grandchild with neurodiversity and mental health issues. Some older

people are exposed daily to violence and violent rages. They reported the difficulties in caring for their adult children and grandchildren, with no relief or options to get support. These older people are coping with the disabilities or conditions that often accompany ageing.

Focus organisations: *Office for Seniors, MSD, Te Whatu Ora, Centre for Family Violence and Sexual Violence Prevention, Whaikaha – Ministry of Disabled People*

Te Aorerekura Action Plan 2: *Keeping people safe, Stopping violence*

Workforce development

15. **Raise awareness of AOP among the health, legal, police, disability, and social sector workforces.**

    Building on the second action plan for Te Aorerekura, workforce development should include training on AOP, particularly for the health, legal, police, disability, and social sectors. Specifically, there is a need to raise awareness of: ageism; AOP and its myriad of forms (including those found in this study); perpetrator tactics (such as inadvertent collusion, manipulation, and coercive control), and how these manifest differently from other forms of family violence and intimate partner violence (IPV); and social, systemic, and perpetrator entrapment in relationships with the person responsible for their abuse.

    Focus Organisations*: Centre for the Prevention of Family and Sexual Violence, Office for Seniors*

    Te Aorerekura Second Action Plan*: Keeping people safe, Stopping violence*

16. **Specialist training on AOP is needed for police, health professionals, and lawyers. Specifically, this training should include ageism, AOP and its forms, perpetrator use of coercive control, manipulation, and entrapment, its different manifestations compared to other forms of family violence and IPV, and social and systemic entrapment of older people in relationships with the person(s) responsible for their abuse.**

    AOP has similarities with family violence, but importantly, it also has differences. Across the four cohorts, older people talked about seeking help from police, health, legal, and women's refuge services about stopping the abuse they were living with. However, they were also likely experiencing financial and emotional abuse, which was not seen to warrant attention. Furthermore, the person(s) responsible for their abuse often colluded with police, health professionals, or lawyers, setting a narrative highlighting older people's alleged cognitive impairment or dementia for their financial gain. Specialist training focused on AOP is essential for responding more effectively to AOP. This research found that people often acted inadvertently on ageist assumptions and beliefs that enabled

the perpetration of abuse, while minimising the older people's perspectives and experiences. This training should also be linked to AOP screening and risk assessment tools.

Focus organisations: Office for Seniors, Education providers of health, legal, and police workforces, Te Whatu Ora, Centre for Family Violence and Sexual Violence Prevention

Te Aorerekura Action Plan 2: Strengthening our workforce

17. Training about AOP should include the role of inadvertent collusion with people responsible for AOP in the systemic and structural violence older people encounter.

Key to addressing systemic and structural violence is understanding the role of staff, especially those in government agencies, the police, health and the legal profession, in the inadvertent collusion with the people perpetrating AOP. This research found that people causing harm provide narratives about older people to those working in government agencies, health, and the legal sector that draw on ageist stereotypes that older people lack the necessary cognitive competency to make decisions for themselves. This is part of their suite of coercive control and manipulation tactics. Those responsible for AOP use professionals in subtle and sophisticated ways to acquire an older person's money and/or assets. When older people seek help, they are not believed.

Focus organisations: Office for Seniors, Centre for Family Violence and Sexual Violence Prevention, MSD, Ministry of Health, Ministry of Justice, Police, Lawyers, Education providers

Te Aorerekura Action Plan 2: Keeping people safe, Stopping violence

18. Work with Pacific community leaders focused on the care of older people on strategies to detect the abuse of older Pacific people and develop culturally appropriate interventions, especially related to exploitation, neglect, and breaches of filial piety.

Speaking about abuse is discouraged within and outside of Pacific families because of the shame it creates for the family. Thus, it is a cultural transgression to talk about AOP. In this way, silence keeps AOP hidden. Older Pacific people coming to NZ to assist in the care of family members and their children are at risk of exploitation and isolation, which is accompanied by a sense of loneliness. Neglect occurs when older Pacific people are reliant on family members to meet their needs, such as transportation to access health clinics, shops, and the church. Furthermore, the cultural concept of gift-giving within the contexts of family events in NZ, their island nation, and the church, exerted considerable financial stress for Pacific participants in this research.

Respect underpins the revered status of older Pacific people, something expected as they attain older age. Yet, participants reported that younger family members lacked respect and instead belittled older people, avoiding conversations with older Pacific people living in the same home.

Focus organisations: *Pacific community leaders, Office for Seniors, Centre for Family Violence and Sexual Violence Prevention*

Te Aorerekura Action Plan 2: *Keeping people safe*

Raising awareness

19. **Institute a national campaign that is aimed at raising public awareness of AOP.**

    This study finds that families and whānau play a significant role in AOP. Older people across the cohorts discussed how they were manipulated and controlled financially, emotionally, and spiritually, which caused them harm and mistreatment. This resulted in them feeling abused, isolated, and unsupported. For the Māori and Pacific cohorts, cultural & spiritual abuse was evident, which prevented them from engaging in cultural events and activities and in realising their aspirations for their older age. Furthermore, disabled older people may also require others to support them in their daily lives.

    Focus organisations: *Centre for Family Violence and Sexual Violence Prevention, MSD, Ministry of Health, Ministry of Justice, Police, Lawyers*

    Te Aorerekura Action Plan 2: *Keeping people safe*

20. **Raise awareness about the intentional use of grandchildren and mokopuna to exploit older people and obtain their assets and/or money.**

    The use of grandchildren and mokopuna as an AOP strategy is a powerful lever that results in an older person's silence about, and compliance with, the person causing them harm and their demands. The threat to remove access to grandchildren and mokopuna is potent, and participants discussed the psychological and emotional harm this caused them. Older people in this study went to great lengths to avoid losing access and contact with their grandchildren and mokopuna. Such threats and actions were intentional and can be categorised as coercive control strategies by persons responsible for abuse. There needs to be greater awareness that using grandchildren and mokopuna in the commission of AOP is unacceptable.

    Focus organisations: *Office for Seniors, MSD, Centre for Family Violence and Sexual Violence Prevention, Iwi Leaders Forum, Education providers*

    Te Aorerekura Action Plan 2: *Keeping people safe*

21. **Provide education about online abuse targeting older people, which also includes guidance on protection regarding mobile devices and social media through cross-sector collaboration, such as Office for Seniors (Digital Literacy) and NetSafe.**

Online and digital platforms are a growing and evolving form of psychological and financial abuse. Participants reported online abuse targeting older people by family and non-family members was a source of significant psychological abuse that they were unable to respond to. The impacts were greater when the person responsible for the abuse was a family member, including adult children. Furthermore, older people often do not understand how to protect themselves or their mobile devices, such as phones, exposing them to unauthorised access to their personal information and data. This specific area requires targeted education of older people about these risks and equipping them with practical strategies to protect their information and data.

Focus organisations: *Office for Seniors (Digital Literacy), Centre for Family Violence and Sexual Violence Prevention, NetSafe, Iwi Leaders Group – Pou Tangata*

Te Aorerekura Action Plan 2: *Keeping people safe*

22. **Raise awareness among older people about wills and the requirements for a will to be legally and validly executed.**

    We noted a lack of knowledge among participants about wills that was then exploited by the person(s) responsible for (financial) abuse. Not all older people understand the requirements for creating a legally valid will, and the inability to execute a 'will' was a source of stress and distress.

    Focus organisations: *Office for Seniors, Law Commission, Lawyers*

    Te Aorerekura: *Keeping people safe*

23. **Liaise with the National Iwi Leaders Group – Pou Tangata to raise awareness among whānau Māori about how to transfer land from one generation to the next legally.**

    An area of financial and asset abuse was the loss of whenua (land) for the older people's whānau. Participants were unaware of the consequences of not going through required legal processes upon the passing of their tūpuna. Being unaware of the need to register a claim with the Māori Land Court left older people exposed to someone in their wider whānau claiming their whenua, and in some cases their home. This left them homeless and without any "asset" (i.e. whenua) to start again.

    Focus organisations: *Iwi Leaders Group – Pou Tangata, Office for Seniors, Law Commission, Lawyers*

    Te Aorerekura: *Keeping people safe*

Further research

24. **Undertake more in-depth qualitative research with each of the population groups, especially men, to garner a deeper understanding of the context and experiences of AOP from older people's perspective.**

While this research provides valuable insights into the experiences of AOP for older people, it is limited by the sample size of each cohort and its gender bias towards women (75% of the sample). While similarities existed between all four cohorts, each cohort experienced AOP in unique ways. In building a knowledge base around AOP in NZ, further qualitative research aimed at understanding the context and experiences of AOP is warranted. For disabled people, research needs to explore in-depth the differing experiences of those who have lived with their disability over their lifetime, and those who have acquired a disability as an older person.

Focus organisations: *Centre for Family Violence and Sexual Violence Prevention, Office for Seniors, MSD, Ministry of Health, Te Whatu Ora*

Te Aorerekura Action Plan 2: *Keeping people safe, Preventing violence*

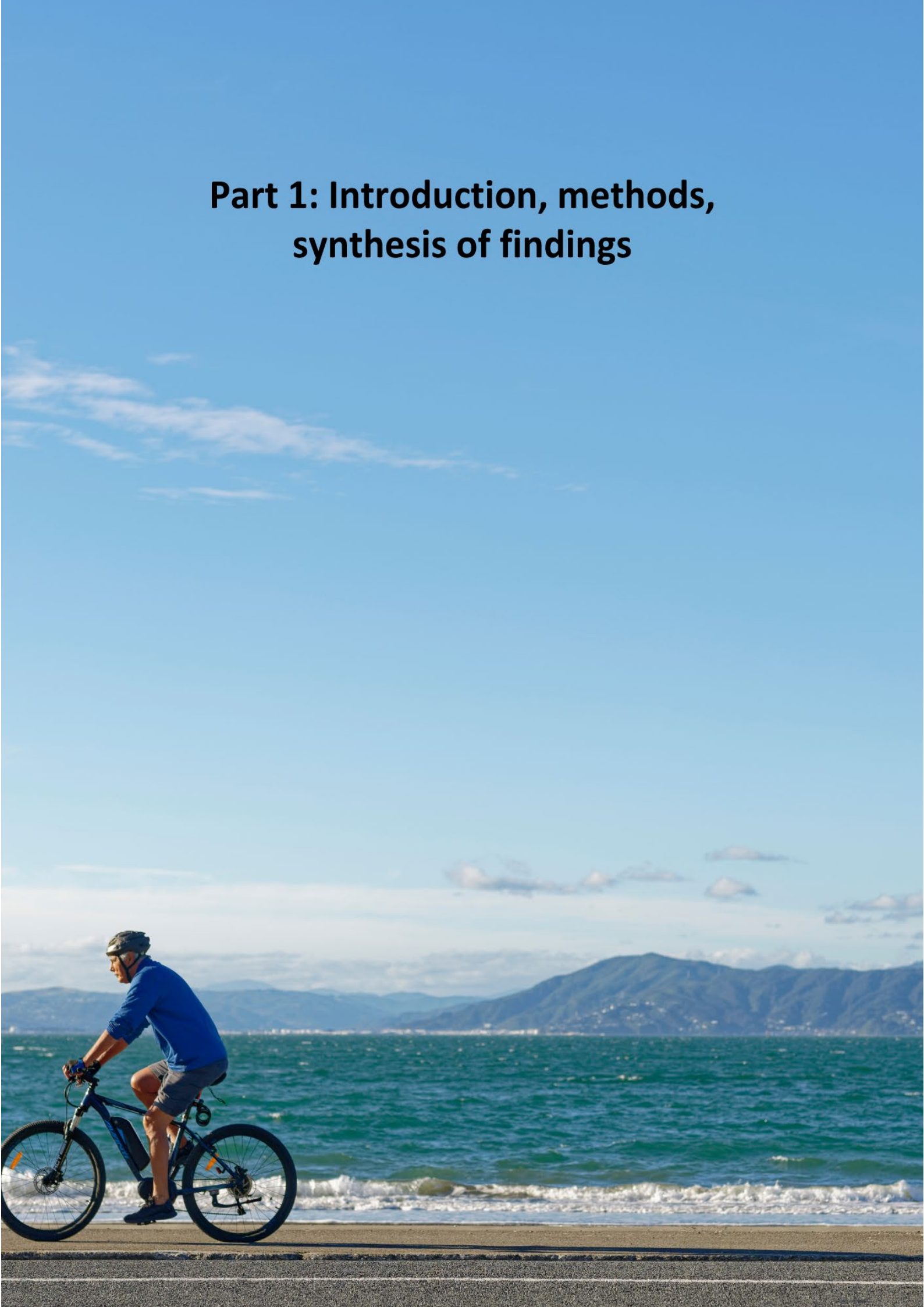
25. **Undertake research that focuses on AOP occurring within aged care residential (ARC) settings and provide space for older people residing in these care facilities and their whānau to have a voice about their care.**

Several older people in this study expressed concerns about the abuse of their partners or older persons in ARC. Older people residing in residential care were out of scope for the *National Study*. Many Māori participants expressed concerns about making decisions about their older people needing to be placed in ARC. The prevalence of abuse in ARC settings and other institutions, such as hospitals, is not captured in this research, and the extent of AOP in these settings is anecdotal and unknown. Seeing signs that an older person in aged care is being abused is distressing for older people and their whānau, yet they talked about being powerless to do anything. This is an area requiring further research.

Focus organisations: *Office for Seniors, MSD, Ministry of Health, Te Whatu Ora*

Te Aorerekura Action Plan 2: *Keeping people safe*

Part 1: Introduction, methods, synthesis of findings



1 INTRODUCTION

This report is part of the *National Study of Abuse of Older People in Aotearoa New Zealand* (NZ) commissioned by the Ministry of Social Development (MSD) as part of its Prevention of Abuse of Older People (AOP) work programme. It presents findings from qualitative interviews with 71 older people aged 55+ across four groups: Māori, Pacific, NZ European, and disabled people. The report provides in-depth insights into the lived experiences of abuse, the contexts in which it occurs, and the barriers and enablers to seeking help. As part of the *National Study*, this report adds essential context to the quantitative *Prevalence survey on the abuse of older people in Aotearoa New Zealand* findings by highlighting the complexity and diversity of AOP experiences.

The *National Study* was undertaken in 2024 and 2025, with the wider project including five main components:

1. Prevalence Survey – A nationally representative survey capturing older people's self-reported experiences of abuse.
2. Integrated Data Infrastructure (IDI) analysis – Examination of AOP through linked administrative datasets, including police, ACC, hospital admissions, InterRAI, and the 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 – Estimate of 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.
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 ARC.
8. *Qualitative Interviews Report*, presenting findings from qualitative interviews of victim-survivors undertaken across four groups: Māori, Pacific, NZ European and disabled older people **(this report)**.
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 is structured in three parts. Part 1 introduces the research by outlining the study's aims and defining AOP in this context (Section 1), followed by a description of the methods used (Section 2). Section 3 presents a synthesis of findings across the four cohorts, highlighting both shared and distinct protective and risk factors – elements that either buffered participants from or contributed to experiences of abuse, harm, and mistreatment. Part 2 (Sections 4 to 7) provides a detailed account of each cohort's specific experiences of AOP. Finally, Part 3 discusses the key implications of the findings within the broader literature (Section 8), including how AOP is conceptualised and its positioning within the family and sexual violence landscape. The report concludes with recommendations and future research directions (Section 9), organised by relevant stakeholder groups and aligned with the Second Action Plan of Te Aorerekura.

1.1 Study aims and background

AOP includes physical, sexual, financial, psychological, cultural & spiritual abuse, and neglect, often occurring cumulatively. Limited prevalence and population-level data are available about AOP among older people living in NZ; see the *Prevalence Survey Report* for estimated prevalence rates (Meehan et al., 2026). We know that abuse harms older people, their families, whānau (extended family networks), and the communities they live in. Nonetheless, it is a highly complex issue with multiple intersecting factors.

As a result, there is a lack of clear evidence to guide decisions about how best to invest in, prevent, and respond to AOP, as well as how to design effective community initiatives and awareness campaigns.

The qualitative interviews conducted as part of the *National Study* aimed to understand the experiences of older people who had been physically, psychologically, sexually, and financially abused. The project aimed to gain a deeper understanding of the contextual factors and experiences of older people aged 55 years and above living in NZ to inform prevention strategies, interventions, and support mechanisms.

Definition of AOP

Although there is some variation in the exact definition used across international research, the working conceptual definition of AOP is broadly similar. The *National Study* uses the following working definition of AOP, which is consistent with the most recent AOP prevalence survey done in Australia:

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

In this report, reference to abuse refers to the intentional action or treatment of someone that causes harm or distress. It can range from disrespect to physical, emotional, or psychological pain. Therefore, abuse is the action and harm or distress are the outcomes.

1.2 Background

Sometimes referred to as elder abuse, AOP is a critical issue globally and nationally. It can be considered a social justice, human rights, and public health issue. According to the WHO, one in six people over the age of 60 has experienced some form of abuse. For those in ARC facilities, a systematic review and meta-analysis found that two in three staff declared they had abused an older person in their care in the previous year (Yon et al., 2019).

AOP can have long-term physical and psychological consequences (Yon et al., 2017; WHO, 2025). The WHO (2025) stated:

> *This type of violence constitutes a violation of human rights and includes physical, sexual, psychological and emotional abuse; financial and material abuse; abandonment; neglect; and serious loss of dignity and respect.* (para. 3)

AOP is a significant issue at a time in people's lives when they are likely to require or need the support of other people to meet some or all of their daily and longer-term needs, depending on their situation.

Alias et al. (2023) highlighted the risks associated with the ageing process.

> *As a result of the natural aging process, physical and mental capacity gradually deteriorates, disease risk increases, and mortality eventually occurs. The diversity observed as people age is not random; these changes are neither linear nor consistent.* (p. 312)

With the population of older people predicted to rise rapidly in NZ and around the world, understanding the complexities and nuances of abuse inflicted on older people is crucial. The WHO (2022) identified the need to produce more information about the risk and protective factors to fill long-standing gaps in the evidence about AOP. Burnes et al. (2021) undertook a scoping review of the literature on the outcome of interventions designed for AOP. Among other things, they identified the need for qualitative research with older people living with abuse.

Abuse across someone's lifetime and abuse as an older person affects older people's health and wellbeing. Fraga et al. (2017) found that lifetime abuse negatively impacts older people's autonomy, social participation, intimacy, and quality of life. Yet, little is known about the experiences of older people living in NZ.

In the NZ family violence literature, it is generally accepted that abuse is rarely a single or isolated event. Instead, abuse and violence are cumulative patterns of harm over time (NZ Family Violence Death Review Committee, 2016). This is a key consideration for people working with older people – much of the harm and mistreatment they suffer goes unseen and unrecognised. Nevertheless, AOP encompasses diverse forms of harm, such as neglect, and physical, sexual, emotional, psychological, financial, and cultural & spiritual harm, in varying combinations.

2 METHODS

This section outlines the methods used for participant recruitment, data collection, and analysis. It begins with the research questions and aims that guided the interviews and data collection, before describing the participant groups and data analysis approach.

2.1 Aim

The qualitative interviews aimed to understand the contextual factors of older people's harm or mistreatment (abuse) by a trusted person or close acquaintance. These interviews explored the nuances and contextual aspects of abuse affecting older people aged 55+, and their health and wellbeing within and across the four cohorts.

We asked the following questions:

1. Can you tell us about your story of keeping safe and well?
2. Can you share how you have been harmed and mistreated as an older person?
3. How has this harm and mistreatment influenced your health and wellbeing?

We also used follow-up questions during the interview for clarification and to prompt further discussion:

1. To help us understand your situation, please tell me what happened and your relationship to the person harming or mistreating you.
2. How did you feel unsafe?
3. How do you keep yourself safe in the good times (if there were any)?
4. What did you do to keep yourself safe when you were being abused or mistreated?
5. What did you do to keep others like whānau members or mokopuna safe? (if appropriate)
6. Who, if anyone, helped you to be safe?
7. Can you tell me about your support networks? How did they contribute to your being safe and well?
8. What were your experiences of getting support from agencies to be safe?
9. Is there anything that I have not asked that you feel we should know about?
10. Do you have any questions?

Letter writing

We also invited older people who have experienced harm or mistreatment to share their stories through a written 'letter'. The letter-writing component of the qualitative interviews was included to allow older people to share their stories in a way that maintains their anonymity. Other studies have found that letter writing affords older people greater confidentiality and enables them to share their stories in a way that maintains privacy (Letherby & Zdrodowski, 1995; Gott et al., 2024).

However, the letter-writing component of this qualitative study had a poor response. As we proceeded with the qualitative interviews, it became apparent that older people held considerable shame (whakamā), and embarrassment about the harm and mistreatment to which they were subjected, and were reticent about sharing their experiences, especially in written form. Compared to studies by Letherby and Zdrodowski (1995), and Gott et al. (2024), the topic of abuse in their later years may not be easily written about by older people, especially given the perceived risk of consequences for them.

2.2 Ethical approval

The Auckland University of Technology Ethics Committee approved the qualitative interviews (24/49) for the 'National prevalence study of abuse of older people: Health and wellbeing of older New Zealanders' ('*National Study of Abuse of Older People*') on 31 May 2024.

Ethical considerations

Participation in this research was voluntary, and we ensured that participants understood the information they received about the research. We provided information sheets in 14-point font then reviewed and discussed the information with participants before they gave their written consent to participate. The information also provided details on how their stories would be managed and stored.

We recognised that keeping participants' privacy intact was essential to their safety. To ensure their confidentiality, we removed all identifying features from their transcripts and replaced them with more general descriptors (e.g. [son] or [small provincial town]). We also sought to ensure that participation in the research would not compromise their safety. For instance, interviews were held in a place that reduced the possibility of their abuser arriving unexpectedly.

All participants were given a choice about how they wanted to participate – in an individual interview or in a small group. Six Māori participants requested and agreed to participate in a group interview, of which two then asked to discuss their more personal experiences of abuse in an individual interview. The

research team recognised that sharing experiences could be distressing for participants. The interviews could be stopped, and participants could withdraw at any time if they wished to do so. We ensured that follow-up support was available, which included the 24-hour daily Elder Abuse Response Service offered by the Office for Seniors. Moreover, if they or the researchers felt they were in immediate danger, the option of contacting the police was provided.

We recognised that participants sharing their stories could be distressing and cause them embarrassment and discomfort. While this was the case for many, none wanted to withdraw from the research. Their motivation in sharing their experiences of AOP was to contribute to making a difference for others. Participants indicated that they appreciated being able to tell their stories to someone who listened and believed them. For many, it was healing.

2.3 Recruitment

Inclusion criteria

We aimed to recruit 60–80 older adults aged 55[6] and over, who were willing to talk about their experiences of AOP and who identified with one of the following population groups (cohorts):

- NZ European (also known as Pākehā)
- Māori
- Pacific peoples
- disabled people

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

[6] The *National Study* decided on using age 55+ in recognition that some population groups (such as Māori, Pacific, and disabled people) have a life expectancy that is lower than NZ European people, and live with chronic non-communicable illnesses that are usually associated with older age.

The research team pragmatically determined the number of participants we aimed to recruit (n=60–80 in total; n=15–20 in each cohort) based on past qualitative research experiences and the parameters and scope of the study.

Older disabled people

For this study, the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (2006) defines people with disabilities as:

> *Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.*

According to the UNCRPD, understandings of disability are evolving, as interpersonal, attitudinal, and environmental barriers hinder disabled people from fully and effectively participating in society equally with others. A further consideration was the alignment of the UNCRPD with the social model of disability, as adopted by the New Zealand Disability Strategy 2016–2026 (Office for Disability Issues, 2016). Consideration was given to the NZ Human Rights Act 1993 definition of disability, but its restrictive focus is on illness and medical-type impairments. We recognised that disability occurs for people with impairments in response to the barriers in society – something shared by all disabled people.

In line with the broader *National Study*, we excluded people unable to provide informed consent, those at increased risk of harm by participating, or those in ARC from this research. This study required the participants to provide informed consent freely based on their understanding of the information provided (Sacco et al., 2021). Therefore, participants needed to be able to communicate coherently and possess the capacity to comprehend the study and what was expected of them.

Exclusion criteria

Older people with moderate-to-severe cognitive impairment, confusion, or a form of dementia were unlikely to be able to participate safely and fully in the qualitative interviews. For those living in ARC, we recognised the distinct nature of abuse in institutional settings and the need for separate investigative approaches. For example, AOP in aged care facilities may involve interactions between residents and staff or organisational shortcomings, which may be influenced by institutional policies and staffing practices (see Yon et al., 2019 for an international review).

Recruitment

We recruited older people aged 55 and above from across NZ who met the study's inclusion criteria and who consented to participate in the *National Study*. Participant recruitment initially involved a two-pronged approach: a social media advertising campaign (Facebook, Google Display Network) alongside the electronic and physical distribution of study flyers. This approach failed to yield Pacific and Māori participants, so the team switched to recruiting via the research team's own personal, professional, and community relationships and networks, and subsequently employed snowball sampling.

2.4 Participants

A total of 71 older people consented to participate in the qualitative interviews. The interviews were conducted between July 2024 and June 2025. Participants in the NZ European, Pacific, and disabled people cohorts ranged in age from 55–59 to 85–89 years. The Māori cohort was slightly younger, with participants aged between 55–59 and 75–79 years (see Appendix Table 1 in Appendix A).

Most participants were women (74.6%), with men comprising 25.3% – none of the participants identified as gender diverse. While the NZ European and Pacific cohorts closely resembled the overall study group, differences were noted in the Māori (33.3% men; 66.7% women) and disabled people (17.6% men; 82.4% women) cohorts (see Table 1).

Table 1: Gender distribution by gender (%(n))

Gender	Male	Female	Gender diverse
NZ European (n=18)	27.8% (5)	72.2% (13)	-
Māori (n=15)	33.3% (5)	66.7% (10)	-
Pacific peoples (n=21)	23.8% (5)	76.2% (16)	-
Disabled people (n=17)	17.6% (3)	82.4% (14)	-
Total	25.3% (18)	74.6% (53)	-

Participants were also asked about their ethnic identity. Almost half (47.9%) of the participants identified ethnically as NZ European. Māori comprised 26.8% of the total participant group, Pacific comprised 38.1%, and those identifying as another ethnicity made up 5.6%. Participants in the NZ European and disabled cohorts identified with a single ethnic group. Some Māori (n=4) and Pacific (n=6) participants

identified with two ethnic groups, with four participants identifying both Māori and Pacific ethnicities (see Table 2).

Table 2: Ethnicity* distribution by cohort - % (n)

Ethnicity	NZ European	Māori	Samoan	Cook Island Māori	Tongan	Niuean	Fijian	Other
NZ European (n=18)	100% (18)	-	-	-	-	-	-	11.1% (2)
Māori (n=15)	20% (3)	100% (15)	-	13.3% (2)	-	-	-	-
Pacific peoples (n=21)	-	9.5% (2)	47.6% (10)	23.8% (5)	33.3% (7)	4.8% (1)	9.5% (2)	-
Disabled people (n=17)	76.5% (13)	11.8% (2)	-	-	-	-	-	11.8% (2)
Total	47.9% (34)	26.8% (19)	14.1% (10)	9.9% (7)	9.9% (7)	1.4% (1)	2.8% (2)	5.6% (4)

Notes: *Some participants identified with more than one ethnicity. Those indicating dual ethnicity: Māori = 4; Pacific peoples = 6. Other referred to participants identifying as having dual or multiple ethnic identities (i.e. South East Asian, European/South African, German/Polish/Hungarian).

Interviews

We conducted one-on-one interviews in each of the cohorts, except for the Māori cohort. Eleven participants (two of whom were included in the wānanga)[7] in the Māori cohort underwent individual interviews, while six participants requested a wānanga with other Māori participants. Of these, two older Māori requested one-on-one interviews following the wānanga.

All participants received a participant information sheet (details about the study, benefits, and potential risks) to review before providing consent. They all had the opportunity to discuss this information further and ask questions. The interviewers for each cohort were experienced qualitative researchers within their relevant cohort:

- A female NZ European interviewer conducted the interviews for the NZ European cohort.
- Two female interviewers experienced in undertaking Kaupapa Māori research, including violence within whānau, conducted the interviews in the Māori cohort.

[7] These two participants who participated in the wānanga and the individual interview were only counted as two participants.

- Two female Pacific interviewers skilled in talanoa (one Samoan and one Cook Islands Māori) conducted the Pacific interviews, providing a culturally comfortable environment for participants to share their stories.
- A male interviewer with expertise in interviewing and conducting research with deaf and disabled people conducted the disabled people's cohort.

Interviews were loosely structured so that participants were enabled to 'tell their story' in whatever way they felt comfortable. Participants recounted their experiences of being harmed or mistreated as an older person (including the type of abuse, the perpetrator(s), and the circumstances or context in which it occurred), how it affected their health and wellbeing, and what (if any) help or support they sought. We also collected basic sociodemographic information from each participant.

The interviews employed culturally relevant methods for collecting information. Participants identifying as Māori were offered wānanga (Smith et al., 2019). At the same time, Pacific interviewers used the talanoa method, which is a pan-Pacific narrative inquiry methodology of face-to-face interaction in which the researcher and participant first build a personal relationship characterised by trust, empathy, respect, humility, and reciprocity. This approach creates a climate conducive to the sharing of knowledge and authentic understanding (Naepi, 2019; Vaioleti, 2006).

Each older person was assigned a study number to protect their privacy, and the sociodemographic information collected was de-identified and aggregated. The data was stored securely and was accessible only by the research team.

The interviews were audio-recorded and transcribed. Transcriptions were checked for accuracy and quality. Five interviews in the Pacific cohort were conducted in the Samoan language, which were transcribed by the Samoan interviewer into Samoan and then translated into English. Otherwise, all other interviews were conducted in English. In appreciation of their time, and for sharing their stories, each participant received a voucher (i.e. koha for Māori and mea'alofa for Pacific participants), which refer to gifts based on reciprocity.

Data analysis

The researchers each analysed the data in their respective cohorts using reflexive thematic analysis (Braun & Clarke, 2021; 2023). They completed this by independently reading and reviewing the transcripts, subjecting them to a systematic inductive coding at both the semantic and latent levels. A clustering process was used to group the codes into initial categories and then regroup them into themes. The researchers jointly discussed emerging insights and initial categories prior to and following

the development to refine candidate themes. Furthermore, the researchers privileged Māori, Pacific, and disabled cultural worldviews and knowledge systems, while constantly reflecting on how their own positionality (their backgrounds and values) might influence their understanding and interpretation of the data.

3 SYNTHESIS OF FINDINGS

3.1 Summary

- Framing of abuse must be considered, as the older people's stories did not just focus on the types of abuse and the context within which it occurred. Participants also spoke about their silence, invisibility, and/or isolation, which marginalised them as their perpetrator(s) colluded with people in services.
- AOP manifests in various forms, including psychological, financial, cultural, and neglect, driven by systemic failures and social norms about older people.
- Each cohort – NZ European, Māori, Pacific peoples, and disabled people – faced unique challenges influenced by cultural, historical, and systemic factors in addition to sharing similarities in AOP.
- Emerging forms of abuse include systemic and structural issues, cultural & spiritual abuse, weaponisation of grandchildren and mokopuna, familial isolation, and breaches of filial piety (respect for older people's status).
- Risk factors include social isolation, economic constraints, and unresolved intergenerational trauma that increase older people's susceptibility to abuse, particularly for Māori.
- Acculturation poses challenges for older Pacific peoples, which can lead to their social isolation and increased work caring for their family members.
- Ageism intersecting with disability compounds and increases older people's risks for abuse.
- Financial stability, social connectedness, and cultural engagement provide buffers against abuse.
- Disabled people benefit from protective intimate partners and employment opportunities.
- Manipulation and coercion involving grandchildren and mokopuna is a common form of abuse across cohorts, impacting participants' psychological and emotional wellbeing, and for Māori and older Pacific people, compromising their cultural & spiritual wellbeing.
- Systemic failures, including inadequate support systems and societal stereotypes, exacerbate abuse and entrapment in harmful and abusive relationships.

- Legal frameworks often enable the manipulation and control by abusers, especially for older disabled individuals.

3.2 Introduction

This section brings together the overall findings from the four cohorts — NZ European, Māori, Pacific, and disabled people — and discusses the similarities and differences between these population groups. This synthesis highlights the complexity and multifaceted forms of abuse experienced by older populations in NZ. Key findings, particularly about how the harm and mistreatment of older people are conceptualised, highlight the unique challenges grounded in cultural, societal, and economic factors. Sections 5 to 8 present more detailed findings for each cohort using participants' voices.

While similarities exist across the groups, the nuances in the manifestations and impacts of abuse warrant focused attention to develop effective and tailored responses and interventions. The findings are organised under the headings: Manifestations of abuse; Intergenerational and lifetime violence and trauma; Contributing factors to the continuation of abuse; Protective and risk factors; Weaponisation (manipulation) of grandchildren and mokopuna; and Systemic and structural issues. Each cohort is then discussed under each.

3.3 Findings

We found that AOP across the cohorts was a multidimensional phenomenon. It manifests in many ways, such as neglect, and social, psychological (in-person and via mediums such as social media), cultural & spiritual, and financial abuse. Key issues for each cohort are presented, followed by a section that highlights the similarities and differences between the cohorts.

3.4 Manifestations of abuse

Recognising the unique forms of abuse and their impacts is essential for fostering safe and empowering environments for all older adults in NZ. Abuse across the NZ European, Māori, Pacific, and disabled populations reveals a range of challenges influenced by cultural norms, historical trauma, economic constraints, and systemic failures, some of which sit outside of the standard definitions of abuse. Addressing these issues requires culturally tailored approaches (because of nuanced cohort differences) that respect both individual and collective needs.

Physical harm and observing the abuse of others (such as harm to tamariki and children) were evident across the older people's accounts, to a greater extent than other forms of abuse. Sexual abuse among participants was uncommon. Given the sensitivity of AOP for many older people, sexual abuse and the social norms they grew up in likely transgress such norms and create considerable discomfort for them to talk freely about sexual encounters. In some cases, AOP was a continuation of IPV they experienced in earlier years.

We noted differences between the cohorts, such as the different manifestations of financial abuse. Also evident for the Māori and Pacific cohorts were cultural differences, such as the expectations of older people. For instance, older Pacific people referred to their autonomy and agency being removed while living with other adults. For Māori, their expectations associated with their status as kaumātua (elderly person with status), kuia (elderly woman), and kauheke (elder) with their mokopuna (grandchildren) were unrealised.

NZ European

AOP for older NZ European people is complex and occurs across multiple 'categories' of abuse. While many of the older NZ European participants' experiences of abuse arose from past family and partner relationships, it often re-started in their older years as family relationships changed and different family members returned from other locations. Stereotyped ideas of older NZ European people as being frail, or in mental decline, could be used against them to explain or justify the abuse. In some instances, these were used to discredit an older person and/or activate an Enduring Power of Attorney (EPOA). However, some participants were abused by their older relatives. In these instances, it was difficult to gain support and help because it was unbelievable that an older person could be abusive.

For this cohort of participants, AOP was mostly gendered in nature, with most of the perpetrators being family members. For instance, there was an expectation that older NZ European women would care for their ageing parents. Older NZ European people belonging to this cohort mainly reported experiencing psychological, emotional, and financial abuse, followed by physical and verbal abuse, and then coercive control. Family trusts, businesses, and inheritance disputes created avenues for financial abuse by family members, including their children and grandchildren. Often, emotional and economic abuse were interconnected, marginalising older NZ European participants, restricting their career and employment opportunities, and perpetuating their isolation.

Nonetheless, many NZ European older people interviewed had histories of abuse and violence. Past abuse, broken relationships, and absent parents (sometimes through death) in their childhood impacted their family and partner relationships. Partner abuse was a less common form of abuse for NZ European

older people (than younger age groups and other ethnic groups) in this study, although for a few it continued into their older years.

Family trusts and businesses created sources of dispute and abuse for older NZ European people, leading to financial abuse and disenfranchisement. Financial abuse impacted older NZ European people emotionally and was connected to their marginalisation. While financial abuse can exist in the absence of emotional abuse, it also impacts career and employment opportunities. Emotional and economic abuse was perpetrated mainly by family members (primarily children, including stepchildren and grandchildren), while sometimes the perpetrator of the abuse was the partner of an adult child. However, these forms of abuse could also occur through friendships.

Older NZ European participants struggled to obtain the advice and support they needed, especially if they needed to prevent further abuse or leave an abusive situation. It was noted that older NZ European men in this study found help-seeking problematic, as services like women's refuge were set up to meet women's safety needs. There were no apparent differences in the manifestations of abuse across the age groups, except for those aged 85–89 years. For these participants, perpetrators used their age and stereotypes about older people to their advantage and as a control mechanism, arguing the older person had dementia and was no longer able to control aspects of their lives. These claims were often endorsed by health professionals who then did not give these older people space to disclose their abuse. Further, IPV, control, and coercion (such as telling lies) were associated with being isolated from support systems and other whānau.

The long-term impacts of the abuse for older NZ European women in this study were far-reaching. These impacts included: becoming isolated; destruction of family relationships and disconnection from family, especially grandchildren; feeling belittled and not taken seriously; negative influence on their employment and career; and an altered expected life course.

Māori

For Māori participants, the term 'abuse' created confusion for some and was not something with which they connected. Generally, AOP for Māori did not begin at an older age. Instead, it started earlier in their lives, but the nature of the harm and mistreatment changed its manifestation as Māori entered older age. Abuse of older Māori in this study triggered past trauma and mental health issues for those with a history of these. Their abuse was entangled with historical trauma, intergenerational violence and trauma, and systemic oppression linked to colonisation – something most participants experienced.

A significant portion of AOP for Māori in this study was structural, related to government policies and agencies that failed to meet their needs. Having worked hard and paid taxes throughout their lives, the

retirement plans they envisioned fell short of their expectations – they believed they would be well cared for in their older age. Insufficient funds, and the price of food and rent which often exceeded what their NZ Super provided, were problematic. Some older Māori participants linked abuse to the government, its agencies, and the colonisation of Māori, as tangata whenua.

Several older Māori participants named the government (including government agencies and services, and the people who worked within them) as their primary abuser. They experienced systemic entrapment, whereby they were unable to effectively access the support needed to leave or address the abuse they were experiencing. Instead, they encountered people who treated them disrespectfully and with racism. The decisions these people made negatively impacted their ability to have a safe and comfortable retirement, as they were unable to access entitlements typically available to older individuals. For instance, recent government decisions have negatively impacted Māori, such as restrictions on benefits and social housing that then have a flow-on effect for older Māori. One participant described having to go to the hospital in an ambulance, only to be diverted to an after-hours medical facility that cost $100 – money they did not have. Another participant without internet access discussed an unaffordable rent increase, and was unable to secure any financial assistance because the Work and Income NZ (WINZ) representative was unwilling to help.

'Land grabbing' occurred for some older Māori participants when whānau claimed their Māori whenua (Māori land), which they were unaware they needed to lodge a Māori Land Court claim for on the passing of their tūpuna (ancestors). These participants saw this as a form of structural abuse. This appeared to be associated with older Māori needing knowledge about wills and claiming Māori whenua. We found that some older Māori participants, while knowing about wills, did not fully understand what constituted a legally valid will.

Financial constraints hindered the ability of older Māori in this study to meet cultural obligations, such as manaakitanga (hospitality, kindness, generosity), adding to their burden. Forms of abuse for older Māori in this study also included: the withholding of physical support and assistance when needed; not having sufficient money to be the "good" nanny or koro they aspired to be; experiencing child-to-mother violence; public shaming via social media; and neglect, such as not being able to afford heating or being denied heating because of the costs. In some geographical areas, such as rural areas, access to affordable heating and warm, dry housing was limited. Also, the inability to access kaimoana, cultural kai (food), was also considered a form of neglect.

Abuse of older Māori occurred in numerous other ways that included being taken advantage of when reliant on whānau members to assist them to meet their needs, isolation from their mokopuna, and financial abuse when they asked for the repayment of money they had loaned. Some participants

reported that their mobile data was accessed by individuals parking outside their homes, resulting in large phone bills and negative financial impacts. With limited incomes, this was perceived by participants as AOP.

Cultural & spiritual abuse happened when older Māori were unable to attain the aspirations and expectations of being a kaumātua, kuia, or kauheke for their whānau. Many participants reported experiencing '"hard times" in their older age, which meant they could not fulfil their expectations of being a "good" kaumātua, kuia, or kauheke for their mokopuna – they only had their aroha (love, compassion) to share. Furthermore, the weaponisation of their mokopuna, including threats to restrict participants' access to them, was seen as inappropriate and immoral manipulation by the participants' adult children. Their mokopuna were used as a form of coercive control. These participants considered this as psychological and emotional abuse, submitting to their adult children's demands because of the importance of mokopuna in their lives. Older Māori in this study viewed this as AOP.

Older Māori in this study also reported being subjected to acts of coercion, manipulation, and control, such as parents leaving mokopuna or grandchildren in their care and then not returning for days, witnessing the abuse of others, and being powerless to intervene or resolve the situation. Generational differences in attitudes and language contributed to confusion, misunderstandings, and frustrations that promoted abusive behaviours and environments. For instance, older Māori participants reported a lack of respect or regard for their status (as kuia, kaumātua, kauheke), which was perceived to influence younger people to act abusively toward them.

While older Māori people wanted to live as Māori, for some the demands on them to participate in te ao Māori, whānau, hapū, iwi, and hapori events created a cultural burden and a sense of inadequacy for those fulfilling such roles. The older Māori in this study reported not possessing fluency in te reo or the depth of understanding of mātauranga (Māori knowledge) that informed tikanga (the customary system of values and practices) at such events.

Whakamā (embarrassment, shame) stopped older Māori from speaking out. The cultural imperative to act with aroha and manaakitanga was very evident among the older Māori people participating. However, participants shared how the burden associated with increased cultural demands is exacerbated when they are unable to manaakitanga because of the associated financial costs – money they did not have. The impacts of abuse for older Māori were also varied, including: a sense of powerlessness perpetuated by social norms; conflict; whakamā and embarrassment, entangled with self-blame; a lack of autonomy and agency to act in ways they desired; and, for some, being confronted with racism regularly.

Pacific peoples

Avoiding public shame in the Pacific culture means that abuse is most often kept within the family, and open discussions and interventions are deterred. Older Pacific people in this study reported the importance of containing any abuse within the family and addressing it in-house, which was referred to it as “the Pacific way”. This avoided public humiliation and shame, but we found it could also perpetuate neglect and exploitation for some older Pacific people. Even mentioning AOP was viewed by some participants as ‘cursing’ or ‘badmouthing’ their family members. Thus, preventing disclosures of abuse was maintained by compliance with this strong cultural norm, resulting in silence and secrecy, which was of paramount importance among older Pacific people in this study.

Physical abuse was less common among Pacific peoples in this study, but neglect and exploitation were significant issues. Furthermore, the demands on many Pacific families to work and earn money, often for long hours and multiple jobs, meant that older Pacific people came to NZ with the expectation that they would undertake childcare and domestic work, such as cooking and cleaning. This was counter to the revered and respected status older Pacific people possessed in their island nations. Thus, AOP for older Pacific participants occurred within the context of acculturation to NZ and the tensions this created. It also included social, psychological, and cultural dimensions.

In this study, older Pacific people often lived in multigenerational households. ARC facilities are generally not considered a culturally appropriate or acceptable option. Nevertheless, they reported neglect when living with families in the form of isolation, causing them to retreat to their bedrooms. Older Pacific people talked about being treated as “child-minders” and “housemaids”, with expectations to cook, clean, and care for the children, and without this work being reciprocated. This engendered feelings of exploitation and disrespect.

The church played a pivotal social and support role for Pacific participants. However, some participants discussed their inability to attend their preferred churches or socialise with their friends because their host family participated at a different church. Older Pacific people’s reliance on others for transport negatively impacted their access to shopping, doctor’s visits, and attending their own church (in contrast to attending the church of the relatives they were living with). This dependence on others for socialising, transportation (to attend church, health appointments, and go shopping), and basic needs was disempowering and further isolated them. As a result, it promoted a loss of autonomy and sense of isolation among participants, leaving them feeling abused, culturally and spiritually.

For older Pacific people in this study, cultural and financial abuse were intertwined. For instance, older Samoan people reported the harmful burden of cultural expectations placed on them by their families

living in Samoa. For example, fa'alevaleve (financial contribution) demands were unaffordable and considered excessive. Participants noted there was a lack of reciprocation of financial contributions when their families had special events.

- We found that despite Pacific cultures having a strong emphasis on respect and obedience toward elders who are held in high regard, participants reported that this revered status has been diminished and demeaned. Feeling like they were housemaids and child-minders, and having their health, social, and religious needs neglected, resulted in a loss of status as an elder. Consequently, they felt exploited, isolated, lonely, and entrapped because of their dependency on others. The impacts of the abuse on older Pacific people in this study were connected to feeling alone, shame, humiliation, and belittlement, especially if not kept within the family.

Disabled people

- Disabled people in this study experienced multiple forms of harm rather than discrete manifestations of one or two types of abuse. Participants expressed the outcomes of abuse and how it made them feel, rather than referring to discrete forms of abuse. This may be because the disabled people in this study experienced a complex interweaving of multiple forms of abuse. Therefore, AOP for people with disabilities is complex. For example, disabled people can also experience caregiver abuse, and they are at greater risk of ongoing neglect because some participants relied on other people to meet some of their needs.

- The impacts of abuse left participants with an array of feelings, with outcomes resulting in financial loss and denigration, including experiences of rage and objectification.

Summary of the manifestations of abuse

- AOP is a multifaceted phenomenon that manifests in various forms across different cohorts. Typical forms of abuse include psychological, financial, cultural, and neglect. The older people participating in this study commonly expressed feelings of invisibility, silence, marginalisation, and isolation. Systemic failures and cultural norms can exacerbate these feelings.

- Nevertheless, each cohort AOP had unique manifestations:

- For older NZ European participants, abuse generally originated from family relationships and involved financial, emotional, and psychological dimensions. Stereotypes about age were commonly used to exert control and marginalisation.
- For the older Māori interviewed, their abuse was often connected to intergenerational violence and trauma, historical trauma, contemporary disenfranchisement, and systemic oppression. Financial constraints and cultural demands could further burden older Māori, particularly when they are unable to fulfil their roles as kaumātua, kuia, and kauheke with their mokopuna, or to adhere to ritenga (customary cultural practices and tikanga).
- For the older Pacific people interviewed, acculturation to NZ and the social demands on families was a driver for cultural & spiritual abuse. Abuse occurred in the form of neglect and exploitation, with these participants feeling their status was diminished and demeaned when treated without reciprocity for their work.
- For the disabled people interviewed, abuse was multi-layered and could involve people outside of their families, such as caregivers. Thus, abuse involved physical neglect, caregiver harm, and financial and emotional abuse. This left these participants financially and emotionally depleted.

AOP across all population groups led participants to feel isolated, powerless, and ashamed. It influenced their social, cultural, and financial environments. Given the differences between the cohorts, the findings highlighted the need for tailored prevention and intervention approaches that recognise and respect the cultural and unique contexts of older people, including the different manifestations of abuse.

3.5 Intergenerational and lifetime violence and trauma

As previously mentioned, abuse across participants in the four cohorts did not necessarily begin as participants entered older age. This was especially apparent for the older Māori cohort, with many participants reporting experiences of intergenerational violence and trauma. However, while there are possible similarities in the manifestations and impacts of AOP beginning in older age, compared to those with intergenerational and lifetime forms of violence and trauma, it varied across cohorts. This section highlights the significance of intergenerational and lifetime violence and trauma for each cohort.

NZ European

- In this study, most older NZ European people and their families had experienced some form of trauma in their lifetime, including previous IPV earlier in life. This trauma ranged from

intergenerational abuse (mainly emotional and physical) to addictions and mental health issues. For some NZ European participants, the ongoing effects of past abuse, broken relationships, and absent parents (sometimes through death) in childhood impacted their family and partner relationships. For others, the abuse was multi-generational (i.e. occurring between older people, their adult children, their grandchildren, and sometimes great-grandchildren) and could include siblings and cousins. In the presence of multi-generational abuse, older people had restrictions placed on them by their adult children or adult grandchildren to access their grandchildren or great-grandchildren, which they maintained was also a form of abuse.

For older NZ European participants, abuse was multi-generational, often centred between parents (i.e. the older person) and their adult children, or the parent generation (siblings) and nieces, nephews, and so on, sometimes including grandchildren. Interview participants reported that the partners of the younger generation were usually involved in the abuse. Sometimes, it appeared via coercive control or manipulation of the older person's adult child. Grandchildren were also often central to the abuse. In some cases, disputes over how to care for grandchildren appeared to be a catalyst for AOP. Restricting grandparents' access to grandchildren was often part of their abuser's tactics to coerce and manipulate participants into complying with their demands. Participants whose adult children used their grandchildren experienced harm and considered it a form of AOP.

Māori

Intergenerational violence and trauma for Māori in this study involved a complex intersection between te ao Māori (the Māori world) and te ao Pākehā (the Pākehā world). Evident was the dominance of the Pākehā world, particularly state violence and trauma, which negatively impacted older Māori participants. They identified the government, agencies, and services as significant perpetrators of abuse in their lives.

Intergenerational violence and trauma affected the acquisition of ritenga, as evidenced when older Māori felt inadequate when called upon to lead whaikōrero (to deliver a formal speech), kaikaranga (a woman who makes a ceremonial call), and other roles in cultural events. Furthermore, as kaumātua, kuia, and kauheke, they aspired to be for the mokopuna, but having access to them was restricted, and they were financially challenged to provide for them. These left participants feeling they had only their aroha to give.

- The violence in the lives of older Māori participants appeared to be associated with unresolved lifetime violence and trauma, and the neighbourhoods they resided in.

Understanding the context of intergenerational violence and trauma, the role of standing in two worlds (i.e. Māori and Pākehā), and its interplay with the abuse of older Māori is essential for responding appropriately to their abuse as older people.

Pacific peoples

Most older Pacific people interviewed had some form of trauma in their lifetime and their families. This ranged from intergenerational emotional and physical abuse to some reporting addiction and mental health issues. Relatively common were reports of previous abuse by a partner in their earlier life. However, participants' reluctance to talk about the topic of abuse meant they did not delve into intergenerational and lifetime abuse.

Disabled people

In this study, older disabled people who reported early childhood or early adulthood trauma indicated that their past exposure to abuse impacted their conceptions of self. Further, earlier experiences contributed to disabled older people being able to detect early indicators of abuse. Patterns of abuse and their abusers' strategies, particularly coercive control and manipulation, eroded the self-confidence of disabled participants over time. This compromised their belief that they could effectively address the AOP they were experiencing. If they did seek help, they would receive responses that would minimise their abuser's actions, especially in situations where their abuser had already laid a narrative about the disabled person's cognitive capacity.

3.6 Contributing factors to the continuation of abuse

A variety of factors contribute to the continuation of AOP, and these differ across cohorts. These factors may also be more clearly associated with systemic and structural issues, which are presented separately in this report.

NZ European

- Older NZ European participants claimed the 'system' (which included general practitioners (GPs), lawyers, people working at WINZ and MSD) colluded with perpetrators of their abuse by supporting the perpetrator's perspectives and needs. Participants reported perpetrators were able to spin a narrative to doctors or lawyers, for example, that participants lacked cognitive competency or had signs of dementia, so they needed to enact an EPOA.

Participants also reported that they often did this without their knowledge or presence. With their credibility in question, this then made obtaining advice and support a struggle for older NZ European participants, especially when they needed to leave an abusive situation or prevent further abuse.

- Older NZ European men in this study reported a lack of available support outside of women's refuges. Older women also found support options limited because they were most likely to experience coercion, emotional, and financial forms of abuse. Therefore, they often did not meet the criteria for support from a women's refuge, leaving them unsupported in a time of need.

- Grandchildren were often used to manipulate older NZ European participants. This manipulation was accompanied by potential and real threats to stop their access to their grandchildren. The threat of never seeing their grandchildren was a powerful and effective weapon to keep an older person silent about the abuse they endured. It also caused them psychological and emotional distress and harm.

Māori

- Unresolved intergenerational violence and trauma enabled the abuse that older Māori participants experienced. However, systemic and structural factors had a significant role in keeping older Māori in abusive situations. This created difficulties in accessing the support they needed promptly, or simply having their needs met at all. Further, their aspirations for their older years and retirement potentially played a role in the continuation of abuse, as they try hard to make up the financial deficits with their aroha, especially for their mokopuna.

Pacific peoples

- Pacific cultural norms and expectations discouraged older Pacific people in this study from talking about or disclosing the abuse and neglect they suffered, which enabled its continuation. Disclosure of abuse and neglect has a collective impact on their family, especially their status in the Pacific community. Adding complexity to this cultural norm is the role of acculturation in the dominant culture and context of NZ. It was not unusual for older Pacific participants to report that they came to NZ to assist families struggling with long working hours and childcare. Therefore, in this study, older Pacific people may transition from a status of high esteem to feeling neglected and receiving little or nothing in

return to meet their cultural, emotional, and social needs. Furthermore, they had a loss of social connections, and for those who had been in NZ for extended periods, their inability to attend their church further isolated them.

Disabled people

- For disabled people in this study, many factors, sometimes co-occurring, were identified as enabling the continuation of abuse. Disability-related dependence on someone to meet their physical and social needs, (e.g. intersects with ageism, the onset of disability, impairment, and mental illness). In this way, the need to rely on someone could assist abusers to frame disabled people in this study as being dependent upon them. A further deterrent to leaving their relationship or not disclosing their abuse can be their need for physical assistance and financial security, because the costs associated with leaving an abusive intimate partner relationship are a barrier.

- In this study, disabled people's sense of duty to others can enable their abuser to exercise coercive control and entrap them into an abusive relationship. According to participants, abusers used threats (potential and real) and manipulation involving restricting access to their grandchildren and demands to hand over money, purchasing assets like cars, or engaging in activities against an older person's wishes (such as child-minding), which impacted on their wellbeing. The strategies their abuser utilises can make a disabled person more dependent.

- Contributing factors included early childhood and adulthood trauma. Childhood trauma is often reported by disabled women who shared gendered narratives that minimised their own needs at the expense of their family's needs. Therefore, these participants were reluctant to seek legal protection or police intervention to avoid family members having a criminal record or being imprisoned. Instead, disabled people participating in this study assumed responsibility for their adult child's behaviour, because they described themselves as poor parents due to their childhood trauma, and as being detrimental to their grandchildren.

- In this study, alienation of disabled people left them with limited support options and opportunities to seek help and to disclose their abuse. Coupled with gaslighting,[8] it eroded participants' confidence. It also compromised their sense of self, making it difficult to remove themselves from the abuse if physically able to. These insidious tactics used by an abuser served to isolate disabled people from their social networks and professionals, such as doctors and lawyers.

- Abusers also questioned the disabled people's sanity and decision-making capacity, raising concerns about their memory loss, dementia, and erratic moods. Seeking help was framed as the disabled person's paranoia and compromised mental capacity – this created a space for health professionals to collude with their abuser unknowingly. Furthermore, disabled people in this study who experienced IPV often lacked the emotional resources necessary to deal with such situations.

- Substance use negatively impacted participants' confidence and motivation, leaving them feeling like they were unable to confront their abuser. Having an abuser who shared disabled people's details publicly (such as struggles with substance use) and within their social network resulted in these participants withdrawing from this. This reduced their support options and therefore increased their compliance with an abuser's demands. Reluctance to seek help is also driven by an unwillingness to be a burden, feelings of shame, a desire for stoicism, and a commitment to upholding family loyalty. Consequently, disabled people in this study had inadequate support, such as legal protection and police intervention. When accessed, these supports often resulted in ageism, not being believed, and having their psychological capacity questioned, all of which diminished their confidence.

Summary of contributing factors for the continuation of abuse

- Among those participating in this study, contributing factors to the continuation of abuse varied by cohort:

[8] Gaslighting is a subtle form of psychological manipulation that distorts the reality of victims, so they question their sanity and judgement.

- For older NZ Europeans, contributing factors include systemic issues and a lack of support for the older person. It also involved the manipulation of grandchildren and emotional and financial abuse.
- Older Māori faced unresolved intergenerational violence and trauma that contributed to ongoing abuse. Also, systemic factors and the people working within agencies and services perpetuated abuse.
- For older Pacific people, cultural norms and expectations associated with not sharing abuse were a key contributing factor. Together with acculturation challenges for older Pacific people coming to live in NZ to support their families, this contributed to their neglect and abuse, not helped by the loss of their social connections and isolation from the community and church.
- Some disabled people's reliance on others for support, together with drivers for abuse (like ageism, financial insecurity, coercive control, and alienation), enabled the continuation of abuse, which is aided by mental health issues, substance use, and perpetrators' collusion with professionals. In this study, disabled people's sense of shame, inner strength, and family loyalty also contributed to having limited support.

3.7 Protective and risk factors

Participants' stories revealed protective factors that served to buffer and safeguard older people from abuse, harm, and mistreatment. This section presents the protective and risk factors identified across the four cohorts (also summarised in Table 3).

NZ European

Protective factors for older NZ European people included financial wellbeing, education and 'know-how', supportive networks (friends or family), and individual resilience (wellbeing initiatives). However, some factors contributed to the risk of AOP among older NZ European people.

- A strong sense of family and caring for others is associated with older NZ European people's susceptibility to financial and emotional abuse by family and non-family members. Isolation from family support was a risk factor for NZ European participants, whether it was geographical or across their life course, and can be linked with previous family trauma.

Disputes over ownership and distribution of family trusts, as well as property owned by parents, were relatively common among older NZ European participants. This was complicated when ex-partners'

children (i.e. stepchildren) or other relatives felt they had a claim to a share of property, even while an older person was still living. This seemed to result from earlier disputes and abuse, rather than being the sole starting point of AOP.

Several participants reported receiving poor legal advice when setting up family trusts and wills, which left them vulnerable to being taken to court for a significant portion of their assets or property – in some cases, by the relatives of an ex-partner. Part of the dispute over resource distribution was centred on expectations regarding care. While not mentioned in all cases, those (mostly older NZ European women) who had provided a lot of care to sick or disabled relatives (partner, siblings, children, etc) were expected to continue that care with no financial gain or recognition for their time and financial support, sometimes over many decades. In some cases, property disputes meant that the provisions made for disabled adult children or children with a mental health condition were destroyed.

Māori

For older Māori, cultural and social connectedness served as a buffer and protection from harm within whānau. Also, fostering positive engagement with Kaupapa Māori services (services informed by te ao Māori, tikanga, and mātauranga Māori) created safe environments for older Māori participants and provided a form of social support. Kaupapa Māori services offer culturally-based engagement and involvement in whānau and hapū events. These services provided a Māori face and advocacy to older Māori in times of need.

Older Māori participants valued their connectedness to whānau and whakapapa, which underpinned their sense of commitment and aroha to their whānau, especially mokopuna. Nonetheless, this commitment, along with being older (and for some reliance on whānau members for support) placed some participants at risk of AOP. While the nature of harm and mistreatment changed in their older years, lifelong and intergenerational violence and trauma heightened their risk of abuse. Participants reported difficulty in preventing or addressing various forms of abuse in their lives, including IPV, and adult child or grandchild-to-parent violence. Isolation played a key role in their risk of AOP. We noted that 'P' (methamphetamine) use by whānau members and their friends was also a risk factor for these participants.

Poverty and housing costs create economic pressures that intensified the strained whānau relationships and stress of older Māori in this study, who had few options to resolve their situations. This was compounded by the systemic and structural abuse and neglect that further reduced options for older Māori in this study.

Asset and financial abuse for struggling older Māori participants was problematic and resulted in the loss of their whenua and any home on it. Some Māori participants were unaware of the need or how to legally secure their land by lodging a claim with the Māori Land Court. They discussed how this was further compounded by their lack of understanding of the legalities of wills, leading them to believe they or their whānau members had made a valid will. These examples left them feeling vulnerable to other whānau members taking their assets.

- A belief that government agencies were abusive was compounded by a general lack of trust in them, something held by older Māori participants, which exacerbated their risk of abuse. This mistrust led them to avoid government agencies unless it is an absolute necessity to engage with them. This situation then leads to their needs not being addressed or met.

Pacific peoples

For some older Pacific participants, the church and/or their relationship with God helped them navigate the abuse they were experiencing. Moreover, these older Pacific people's connection with their church provided them with social engagement with others like themselves. However, this could be considered more palliative than protective in that social engagement provided relief from their situations but did not prevent further AOP.

The strong social cohesion evident in the cultural norms and practices of Pacific families and communities ironically also contributed to the risk of AOP for Pacific peoples. As mentioned previously, avoiding bringing shame and disrepute to the family deterred them from speaking about abuse, harm or mistreatment. Also, older Pacific people in this study discussed practices such as fa'alavelave (Samoan gift-giving) and maintaining church attendance, which caused financial burdens and stress for older Pacific participants who were already struggling financially. Further, the cultural preference to live with family (rather than in aged care facilities) placed Pacific participants at risk of harm and mistreatment when family members were not equipped with the necessary knowledge, skills, resources, and emotions to provide the appropriate care that older Pacific people need.

Their risk is further heightened when older Pacific people come to NZ to assist families who must work. As previously mentioned, older Pacific people told us that without oversight they felt taken advantage of without anyone recognising or attending to their needs. When they were reliant on the family they were living with for transportation, they were at risk of not having their spiritual, social, and health needs met.

- Although Pacific cultures strongly value family, respect, and obedience toward older people, who are highly regarded, the acculturation into New Zealand society of older Pacific people (in this study) weakens these cultural norms and increases their risk of AOP. Thus,

the cultural expectation of respect and consideration for the reality of some older Pacific people was not always met, as they are treated disrespectfully and with neglect.

Disabled older people

A protective intimate partner appeared to shield the repercussions of abuse by an adult child or grandchild. Disabled people participating in this research reported that employment is also a significant protective factor from abuse. It counters isolation and provides a distraction and a sense of sanctuary from the abuse. Work strengthened a disabled person's identity significantly, whereas abuse within the family eroded a person's confidence and sense of being. The workplace enabled older people who were being abused to feel valued and reinforced their ability to contribute.

However, in some situations, we found that a disabled participant's worldview and belief systems prevented the internalisation of emotional and psychological abuse tactics focused on compromising a disabled person's agency. Examples of these tactics include threats to cease family interactions, particularly when grandchildren are used as a means of coercion. Some participants identified their abuser's tactics and called their bluff, although fear and disempowerment often led disabled people to comply because they feared losing contact with their grandchildren. In the process, these individuals maintained their agency to make decisions (i.e. the decision to comply or not).

Five primary risk factors significantly contribute to the abuse of disabled people. First, a change in marital status coincides with the initiation or escalation of AOP, whereby their protective partner no longer lives in the home or has passed away. Disabled people in this study commonly reported that financial abuse by their children or grandchildren occurred following their spouse's death. In addition to economic loss, it caused psychological, emotional, and physical harm. In all cases, control of finances, pressure to provide an EPOA, or being harassed into moving into a retirement home arose from paternalistic decision-making by an abuser. The researchers found these descriptions constituted infantilisation.

Secondly, some disabled participants reported ongoing precarity related to accessible social housing, which resulted in frequent upheavals in their housing and economic situations. This could be associated with natural disasters (e.g. the Christchurch earthquakes and the after-effects of Cyclone Gabrielle). Sometimes they moved to a home that was not accessible, which increased their reliance on others. Participants recounted heightened stress levels, which exacerbated grief associated with moving out of their "home" or the loss of a partner or carer. Moving house, sometimes at a great distance, resulted in the loss of social support networks, eroding the protective influence of social surveillance, enabling abuse to remain unchecked. This intensified disabled older people's sense of isolation and impacted their ability

to cope with natural disaster stressors. Within this context, natural disasters increased the propensity for financial abuse associated with being targeted.

Thirdly, being a parent or grandparent of children with neurodiversity (such as autism or foetal alcohol spectrum disorder (FASD)) exposed some disabled people in this study to repeated exposure to child or grandchild-to-parent or grandparent abuse, including daily violent rages. These participants reported their understanding of how only those with an adult child or grandchild who had a co-morbid diagnosis (e.g. FASD and autism) were entitled to disability-related support, and police and/or Oranga Tamariki interventions. Participants also commented that the risk to their adult child or grandchild potentially increased when help was sought from agencies that had a criminogenic response rather than a whānau-centred health response.

Fourthly, a significant risk factor occurs when ageism intersects with the onset of a disability, impairment, or mental illness. Acquiring a disability in older age, such as vision impairment, brings a sense of isolation, leading to reliance on someone, and can result in the exploitation of disabled people in this study. Furthermore, infantilisation (commonly because the older person may have memory loss) and claims of reduced physical and psychological capacity escalated levels of coercive control, eroding a disabled person's agency. This isn't easy to counter within broader ageist beliefs and practices. Abusers' concerns and corresponding interventions were disproportionate to the emerging issues, even when disabled people reported being assessed and told they were well. Evident was a continual framing of disabled people in this study as having diminished cognitive capacity and allegations of dementia.

Fifthly, co-occurring mental illness diagnoses and compromised mental acuity related to psychotropic medications increased a disabled person's vulnerability to psychological and emotional abuse, with tactics like gaslighting making abuse challenging to navigate. Disabled people experienced alienation and ongoing infantilisation in the presence of substance abuse disorders – in these cases, their abuser weaponised the older person's drug and alcohol use. For instance, disabled people could experience a loss of agency following a disclosure of a substance use disorder, a fall, or hospitalisation.

Summary of protective and risk factors for older people

Several protective factors serve to mitigate and protect older people when confronted with abuse, harm, and mistreatment. What was clear was the nuanced differences between the cohorts and the importance of cultural connectedness for older Māori and Pacific peoples (see Table 4). These differences are summarised as follows:

- NZ European: Financial stability, education, supportive networks, and individual resilience are key protective factors.

- Māori: Cultural and social connectedness, along with engagement with Kaupapa Māori services, provide vital support and advocacy.
- Pacific peoples: Connection with church communities and faith acts as a source of social engagement and emotional support.
- Disabled people: Protective intimate partners, employment opportunities, and strong belief systems counter isolation and maintain agency against coercive tactics, such as threats involving family or grandchildren.
- However, for participants, risk factors often intersect with relationship status, ageism, systemic issues, financial insecurity, and social isolation, which create environments where abuse can persist without intervention. Participants faced a variety of risk factors that heighten their susceptibility to abuse, including:
- A change in marital status: A loss of a protective partner through separation or death increases the risk of financial exploitation by family members and emotional harm.
- Social and economic upheaval: Events like natural disasters can displace older people, disconnecting them from their social support networks and enabling unchecked abuse.
- Parenting or grandparenting children with neurodiversity and disorders like FASD: Those participants living with daily violent outbursts from children or grandchildren with FASD, especially with other diagnoses, exposed disabled people to harm that is compounded by ineffective systemic support.
- Intersection of ageism and disability: Acquiring disabilities[9] in older age can lead to infantilisation, coercive control, and exploitation, as abusers manipulate perceived diminished capacities. Age and disability intersect with aspects of the lives of the disabled people in this study in the ways outlined above, increasing vulnerability to various forms of AOP. For instance, co-occurring mental illness and impairment increased participants' sense of isolation and vulnerability to exploitation due to their cognitive capacity being questioned.

[9] Disabled people participating in this study included those who entered later life with a disability and those who acquired disabilities in older age.

- Mental illness and substance use disorders: Abusers weaponised disabled people with co-occurring mental illnesses, psychotropic medications, and substances, further isolating them and eroding their confidence and sense of agency.

Table 3. Summary of protective and risk factors

	Protective factors	Risk factors	Common risk factors
NZ European	• Financial stability • Education • Supportive networks • Individual resilience	• Susceptibility to financial and emotional abuse • Family disputes over assets • Access to poor legal advice	• Change in relationship or marital status • Loss of protective partner • Upheaval of economic situations and access to social support networks • Parenting adult child or grandchild/mokopuna with trauma, mental health, or neurodiversity • Intersection of ageism and disability or increasing reliance on others for support • Mental illness and substance use disorders
Māori	• Cultural and social connectedness • Engagement with Kaupapa Māori services • Having support and advocacy	• Increasing reliance on whānau • Lifelong and intergenerational histories of abuse and mistreatment • Inability to address abuse • Living in a whare (house) with people using 'P' • Poverty and housing • Lack of understanding about asset and financial matters	
Pacific peoples	• Connection with church community • Social engagement associated with faith • Emotional support	• Avoiding shame and family disrepute • Practices of gift-giving cause financial burden • Family members unequipped to care for the older member • Change in perceptions of the 'elder' status	
Disabled people	• Protective partners • Employment opportunities • Strong belief systems that counter isolation	• Change in marital or relationship status • Precarity and lack of accessible housing • Parenting adult children or grandchildren and	

	Protective factors	Risk factors	Common risk factors
	• Maintaining agency, especially coercive control tactics	mokopuna with mental health and neurodiversity issues • Acquiring disability at an older age • Infantilisation • Framing diminished cognitive capacity • Allegations of dementia	

3.8 Weaponisation (manipulation) of grandchildren and mokopuna

Various forms of manipulation involving grandchildren and mokopuna were evident across the four cohorts. Mokopuna and grandchildren were intentionally used to harm or abuse their grandparents. In this study, older people, especially older Māori, talked about threats of restricting their access to their mokopuna and grandchildren, resulting in psychological and emotional harm and distress, and financial abuse, leading to their compliance with an abuser's demands.

Nonetheless, differences were apparent in the Pacific and Māori cohorts. For Māori, insufficient money impacted the ability of kaumātua, kuia, or kauheke to be a "good" nanny or koro. Whakamā created feelings of inadequacy as a grandparent. This inadequacy is a significant psychological, spiritual, and emotional harm older Māori experience. For some older Pacific participants, intergenerational conflict arose about the rearing of children – in some cases, this earlier conflict could contribute to a situation of AOP in later life.

3.9 Systemic and structural issues

Systemic and structural issues were evident across the four cohorts, whereby the 'family violence' or 'senior' response systems are part of the unintended entrapment of an older person in relationships with an abuser. Evident in this study was the use of legislation and regulations by an abuser to control and manipulate an older person. However, it should be noted that these issues were not evident for older Pacific participants.

NZ European

- NZ European participants' understanding of family violence and senior response systems contributed to their risk of an abuser's manipulation and control. Participants perceived that seemingly less dangerous types of abuse, such as emotional or financial abuse, were less harmful than physical abuse but resulted in a lack of support from the legal and health systems. These systems did not readily recognise or support participants wanting to leave manipulative partner or family relationships.

The systemic issues older NZ European participants discussed related to a perceived lack of support for those experiencing AOP, which was extended beyond legal advice to include the roles of medical and health practitioners, as well as agencies such as the police and the MSD. While only one participant mentioned the challenges she had dealing with a son (with a criminal background) who abused her, we considered this may be a common experience for many older people whose children or other relatives move in and out of the justice system.

The impacts of AOP were significant, affecting many parts of a NZ European participant's life. For some, it had career and financial implications, including the need to change careers or jobs, as well as losing savings intended for retirement. For many participants, the stress of abuse and a lack of support to stop it led to poor mental health outcomes, including alcohol and other addictions, depression, and anxiety. Lack of confidence and isolation were key negative impacts, with those experiencing abuse remaining isolated in the face of a lack of understanding by others, a fear of the stigma of being abused, or trying to seek support and not finding any.

Māori

- Social marginalisation leads to isolation and exclusion, especially where Māori values and tikanga conflict with Western values and ways of doing things, and impacting help-seeking, such as accessing services like food banks. Many Māori participants articulated that the government, government agencies, and services were their primary abusers. These participants had little or no trust in the system designed to help them. Policy decisions and the people working within these systems were reported to make their retirement difficult, marked by poverty, high food costs, and high rents. Furthermore, engaging with these services was problematic, as they encountered people who treated them with disrespect and racism, which did little to help them. These factors, in turn, trapped them in situations with their abusers. Māori participants talked about their reluctance to speak out about

abusers within their whānau for fear of the consequences of involving police and other agencies.

Disabled people

- In this study, disabled people reported a lack of systemic support when they requested help. Those caring for an adult child or grandchild with neurodiversity and other conditions (like FASD), and who were experiencing caregiver abuse, reported a lack of response from police and agencies like Oranga Tamariki. For instance, participants discussed the need for support from the police and Oranga Tamariki to promote a family or whānau wellbeing perspective. But if they called the police, for example, they reported receiving a criminogenic response rather than a whānau-centred approach.
- Conversely, abusers of disabled people alleged that they had dementia and cognitive incompetence with health professionals and lawyers. The affected older disabled people reported difficulty in getting anyone to believe they did not have these conditions, even when assessments confirmed an absence of dementia or cognitive incompetence. Yet, it was their abuser who was viewed as being credible. In these ways, abusers were then able to leverage matrimonial property legislation – the Property (Relationships) Act 1977 PPPR Act 1988 – to relieve the older disabled person of their property and assets.

Summary of systemic and structural issues

- Systemic and structural issues exacerbate AOP by enabling manipulation and control through legal frameworks, inadequate support systems, and services operating with societal stereotypes of older people. For NZ European participants, gaps in the family violence and senior response system failed to address less visible forms of abuse, such as emotional and financial abuse. This led to their isolation and poor mental health outcomes. Older Māori people reported systemic and structural abuse, marginalisation, and racism within government services, cementing poverty in their lives and creating little or no trust in the support systems. Disabled people faced challenges in refuting false claims that they have dementia or cognitive incompetence. This enabled their abusers to exploit legal provisions to acquire their assets. While systemic and structural abuse for older Pacific people was not discussed, the invisibility of their abuse and neglect within closed family systems that do not disclose or discuss their harm, and mistreatment entrapped them in family situations where they felt abused and neglected. Across all groups, systemic failures often trapped older individuals in abusive relationships or situations, with limited avenues for intervention or support.
- In the following sections, we present in detail each cohort's AOP experiences and participants' voices.



Part 2: Population group experiences of AOP

4 POPULATION GROUP: NZ EUROPEAN OLDER PEOPLE'S EXPERIENCES OF AOP

4.1 Introduction

This section presents the in-depth findings for the older NZ European population group, illustrated with quotes from participants. Following this, the candidate themes that illustrate participant experiences highlight AOP for older NZ Europeans in the study. The following themes were identified: *Partner abuse is less common*; *Histories of trauma and abuse*; *Abuse by family members*; *Family trusts and businesses*; *Intergenerational relationships and abuse*; *A neglectful, ignorant, or abusive system*; and, *Impacts of AOP*. The section begins with a description of the participants.

4.2 Participants

A total of 18 NZ European older people were interviewed for this research. Of these, 13 were female and five were male. Most perpetrators[10] were family members, ranging from some who were abused by partners, parents, siblings, children (and stepchildren), grandchildren, and other relatives. NZ European participants reported their children (including stepchildren and children-in-law) were more likely to harm an older person (see Appendix Table 2 in Appendix A).

Most participants identified situations in which perpetrator(s) employed more than one type of abuse, with predominant forms being emotional and financial abuse, followed by physical, verbal, and coercive control. Sexual abuse and stalking behaviours were less common forms of AOP reported. This included threats as well as the abuse itself. AOP is complicated, involving multiple types of abuse, and often over a long time (see Appendix Table 3 in Appendix A). Most of the older people interviewed talked about histories of 'trauma' in either their past or their families. Some of this trauma was intergenerational, with

[10] The Family Violence Death Review Committee (2016) recognised that the use of the word perpetrator is somewhat problematic as it often overlooks a person's victim status that can be held simultaneously, particularly where intergenerational violence and trauma exist.

parents of older people experiencing mental health or addiction issues, while some older people's trauma related to earlier relationships or mental health.

4.3 Themes

Partner abuse is less common

Partner abuse was a less common type of abuse experienced by NZ European participants in this research. Only four participants experienced AOP from a current or an ex-partner. Two women continued to experience their ex-partners' coercive control and emotional abuse, while two others experienced coercive control and manipulation in their current relationships. In one instance, a woman's partner engaged in stalking (soon to be a legal offence),[11] as well as manipulative and fraudulent behaviour aimed at extracting money from her, and he had isolated her from family and friends.

He surrounded me by separating me from my family and friends through all this chaos. And I didn't realise how this was designed to keep me unaware of what was really going on. For example, he was taking out car loans, credit cards and things in my name because I had good credit. He learned how to do that. He's a very skilled identity theft artist. (NZE2)

Another woman began a relationship with a male colleague that resembled a close friendship. He frequently manipulated her emotionally and used her loneliness to gain money from her. He often used fraudulent stories of illness or crisis to acquire her money. In both cases, the women involved faced difficulties in obtaining legal or other forms of support to escape their situations. In the end, they both moved away from their abuser.

While our research did not investigate intimate partner abuse in connection with partners of children of NZ European older people, we found some instances in which the male partners of daughters appeared to be complicit, if not instrumental, in the daughter's abuse of their parent. In one case, the participant

[11] The Crimes Legislation (Stalking and Harassment) Amendment Bill will make stalking and harassment a criminal offence in the Crimes Act 1961, and will be added to the Harassment Act 1997, Sentencing Act 2002, Family Violence Act 2018, Arms Act 1983, and the Evidence Act 2006.

witnessed the results of intimate partner abuse of his daughter. He indicated that this played into his daughter's and her partner's financial and emotional abuse.

I caught my daughter one morning with a black eye and bruises on her body, and I addressed that with him, and I took photos of them, and that was the price I paid. (DD8)

In another instance, while the older woman did not mention physical abuse, she felt that her daughter was controlled or brainwashed by her new partner.

The really sad part, the really hurtful part, was telling me that I had Alzheimer's. So then, when I wanted to take the money out of the trust as trustee, my lawyer said, "We're going to have to get a form filled out, testament of capacity." So that if they come back at her [the lawyer]*, she said. I had to go to the doctor and get it done. So, if they come back at her, she can say, "Well, the doctor says she's capable."* (DD4)

This was pivotal in changing her parenting style, which ultimately led to a lack of relationship with her grandchildren.

Histories of trauma and abuse

While each of the NZ European older people discussed their current AOP, many of them also reported histories of trauma and abuse. Some of this was extreme, such as one participant who experienced sexual and physical abuse from a brother, who perpetrated financial, emotional, and physical abuse to her and her parents. Several older people's current abuse stemmed from earlier (sometimes decades earlier) relationships, with perpetrators including ex-partners, stepchildren, and the ex-partners of ex-partners:

That [historical] *abuse that I've suffered still impacts me very deeply today. And I'm still petrified of him, because anytime I have to stand up to him over something with our intellectually disabled daughter, he goes and complains to other people and continues to spread the lies that he* [has already] *spread.* (DD1)

Despite this research focusing on current abuse, the NZ European older people talked about encountering someone who abused them in their earlier life. This occurred because the older person returned to their hometown (where they grew up), or to NZ from overseas, thereby re-encountering their abuser. For example, a mother of a '501 deportee' stated:

When he was very young, 12 or 13, I had been hit by him a few times. One time, he shoved me fair across the kitchen. But he went to Australia when he was 20. (DD5)

Mental health issues occurred in many of the older people's family backgrounds. These occurrences spanned a range of situations, from parents who were refugees or fought in World War II, to partners with mental health issues and to the older people themselves, who had been in and out of mental health care throughout their adult lives. Past abuse, broken relationships, and absent parents in childhood (sometimes through death) had ongoing impacts on older people's family and partner relationships.

But in the end, I got married and had a son. I've ended up looking after him quite a bit because I had a fair few hang-ups about leaving him with anybody, because my mum had gone off to work when I was quite young [and did not come back]. *I'd had problems with my brothers with sexual abuse and bullying and things, just being left alone. I just really felt I couldn't leave him* [son] *with people.* (DD17)

The patterns of past trauma and abuse appeared to influence broken and challenging family relationships intergenerationally. Two participants reported abuse towards themselves as older people by a parent. In each case, their parent was abusive towards them and their other parent. As one participant explained, while her mother had always been 'difficult' or abusive towards her family to some extent, it worsened as her parents aged and as her father became frailer. Her mother's manipulative personality and age meant that it was nearly impossible for her to seek help from healthcare professionals who viewed her abusive mother as a "nice, old lady". In this situation, she had to distance herself from her father, who she loved and wanted to protect, to shield herself from her mother's ongoing emotional abuse.

That's why I wanted to do this [the interview] *because I don't think people, when you think of older people, you think they're being abused by somebody like me, you don't think that that person* [a parent] *is the abuser. You don't think that person can be abusing their partner, abusing their daughter. It just doesn't figure* [make sense]. *It doesn't figure, and that's why people need to know, because you're powerless. You're absolutely powerless to do anything. Nobody can help because there's no complaint, there's no paper trail, there's nothing.* (DD18)

Abuse by family members

Family members perpetrated most of the abuse of older NZ Europeans (see Appendix Table 2 in Appendix A). In some cases, gendered expectations of older women to care for their broader family, such as brothers, parents, nieces, or nephews, appeared to be catalysts for the abuse. In one instance, a participant experienced verbal abuse from her brothers, their children, and sometimes other family members. This was because it was perceived that she was not caring for her brothers sufficiently when they had significant illnesses, despite her own illness.

> *I've got abusive texts there from relatives. They're keyboard warriors. They won't ring me up and confront me, or confront me face-to-face. I'll get it via Facebook, or I'll get it on*

text. You'd be horrified when you saw some of this stuff, and it's completely unfounded. Different books that I read say, "People who project their stuff onto you are their own problem, but they project it onto you because you're a likely ... victim." (DD7)

For some participants, an expectation from family or parents that they care for the older parents or other family members was connected to financial abuse, which occurred through the contesting of wills or family trust arrangements. For example, the following older woman had worked in her family's business alongside her father for most of her life and then cared for him after her mother passed away.

But it's been like that forever. It's just all gone on the one person. And the hospice nurse with Mum said it was the same with Mum. Nobody helped with Mum either, and a million excuses [for] *why they weren't helping. And the hospice nurse says, "This is what happens. One person will pick up a task and everybody else will go, 'Oh great, they'll do everything' and just leave." (DD17)*

While the brothers were financially well-off and had had little involvement with the family business, property, or care of their parents, they contested the family trust and its distribution. Their abuse towards both their sister and parents included threatening behaviours such as break-ins and property destruction, verbal abuse, threats of physical abuse, and litigious action to gain control of their father's money and of the family trust, including his pension.

Family trusts and businesses

For a small subset of NZ European older people, family trusts or family businesses appeared to instigate family breakdowns and AOP. They found it challenging to discuss these situations because they were financially comfortable families, causing the lines between legality and abusive behaviour difficult to articulate. For example, one older person discussed how their two sons had emotionally and verbally abused them, severing their relationship, which also included their connection with their grandchildren, over a family trust.

So, this money just got stuck [deposited] *into the family trust under their names, paying less tax on it, easy. So, then we struck a snag. We went to close the family trust, and to do so, the children had to sign a form called a forgiveness of debt. And two of our children, then in their late 30s, early 40s, refused to sign the form. They'd never put in a cent, any of them, but legally, we had to do that.* (DD9)

This situation, which included withholding relationships with grandchildren, had negative consequences for this older person. They were financially well-off, compared to another older person who had invested his savings in his daughter's business before their relationship broke down. In his case, the older person

secured the rental in his daughter's name so that she could receive accommodation allowances. At the same time as he established a multi-generational household, he also set up a business as managing director with his daughter's partner. When their relationships broke down, leading to personal abuse, the business experienced difficulties. Subsequently, the business was liquidated, leaving the older person with no financial resources. He was evicted from his home (their home), had no access to his grandchildren, and was potentially held legally responsible for the failed business:

> *I was the managing director of the company. He owns the company in his name, but I was the managing director, so legally I was obliged to have that information at hand. And I was family. See my son-in-law, it was to be his business. At the end of the day, I didn't even want it. I was just building it for them. Probably in another year or two, it would've been all his. So, he disappeared, took all the information that I needed to keep myself out of trouble. And now I can't provide it.* (DD8)

In other examples, wills or family trusts were challenged by the children of ex-partners (separated or deceased) and other relatives, especially when property of high value was involved.

Intergenerational relationships and abuse

AOP was often multigenerational (i.e. occurring across the generations of family members) in the NZ European cohort. Relationships with grandchildren were frequently part of AOP for these participants, typically through parents restricting contact between the older person, the grandparent, and their grandchildren. One older person's daughter lived overseas with a partner and her children (from a previous relationship). She was concerned about the way her grandson was being treated. Her daughter ultimately denied her any contact with her grandchildren because she did not comply with the way she was raising the grandson.

> *If you don't behave, I'm going to stop you from seeing your grandson.* (DD4)

Emotional, verbal, and sometimes financial abuse from the older person's children appeared to be in part caused by the older person raising concerns about the safety of grandchildren.

A neglectful, ignorant, or abusive system

Overall, most NZ European participants struggled to access the advice and support that they needed to leave or prevent their abusive situation. Older males perceived it was harder to get support because most support systems, such as women's refuges, were set up with women in mind. Social expectations that men were not victim-survivors of abuse added barriers in some instances.

> *And I think that she knew that I was vulnerable. And of course, the older I got, the more vulnerable I became, because those support systems are just not there. No social circles, no guys that I could speak to. So, pretty crazy times.* (DD10)

Lawyers were often entangled in broader situations, especially when property, family trusts, or wills were involved. Several older NZ European participants spoke of receiving poor advice from lawyers that left them vulnerable to the legal manipulation they experienced. Others spoke of how lawyers and the courts were used to manipulate the older person and to abuse them financially.

For older people who were aged 75 years and over, their mental health background was used against them by their abuser. Often, this occurred in conjunction with medical professionals, whose involvement was to assess an older person as no longer mentally capable of controlling and managing their health, property, or finances. Several older people spoke of how seeking one-off counselling, upon the advice of their GP, led to having a record of mental health issues, which could then count against them when reporting AOP. Participants were less likely to be believed because of their 'mental health' histories.

> *I did go for some of those free episodes of counselling. You know you can get four free counselling episodes and that. But I've learned not to do that and not to ask for that, because my GP wrote down, in my records, that I had mental health issues.* (DD1)

Younger abusers were more easily believed and trusted than older people, who could be perceived as vulnerable or not of sound mind.

> *She still says, "No, he didn't hurt me. My grandma's crazy. She's schizophrenic." So that's the card. "My grandma's on medication. She's stopped taking her pills." And when they hear that that's it...* (DD12)

One older woman spoke of the difficulties in managing her son. He was deported from Australia to her residence with no-one asking her or checking on her first. This left her alone in dealing with his verbal, emotional, and physical abuse as well as his ongoing addiction issues. The police were not well prepared to deal with this situation, which appeared to challenge the standard practice for supporting people being abused by family members. In one instance, she was told she could not get a trespass order because she had 'invited' her son and received rent from him.

> *And I mean, all I wanted was a, what do you call it? A trespass order against him. But, I was told by the community constable that I couldn't have one because I invited him into my home and I took rent off him. I said, "Rent? Don't be ridiculous. He paid absolutely nothing." And I've been scratching away on the pension and feeding him as well as myself, honestly.* (DD5)

Impacts of AOP

The impact of AOP often led to isolation from family and friends and to assigning blame to oneself for the situation. This was especially so when participants' children perpetrated abuse. For example:

> *And honestly. I mean, I often wonder. It wouldn't really matter. Maybe he would've still turned out the same no matter what. I blame myself a lot for it all because I went* [to work], *and I wasn't home when he used to come home from school. And I hate myself for that now. But I think it's probably a lot of it's genetic with him anyway, because his father, well, is a compulsive gambler and alcoholic.* (DD5)

The response of organisations or people when an older person sought help compounded their situation. Several older people expressed how they felt they were labelled a "troublemaker" for speaking up about the abuse. Age further compounded unhelpful responses, and several NZ European older people noted they were not taken seriously.

> *Absolutely not. And I think they figured out pretty quickly that I was a troublemaker and someone whom they didn't have to pay attention to. And, it was pretty debilitating, actually.* (DD2)

AOP often destroys multigenerational family relationships. This was frequently done through the children of the older people, thereby blocking access to their grandchildren. Sometimes it had a broader impact through several siblings and their families, and beyond.

> *But after all this started, we're blocked. All the family are blocked. If you send them an email, it just bounces. They do an internet site for their business. Try and access that, and it gets blocked. They've moved, no forwarding address. They just made sure that they can't be contacted. So, they've got away with it.* (DD14)

For other older people, it had long-term negative impacts on their approach to various relationships, from personal to business to those within the community. The following account of an older person illustrates this in an example involving an ex-partner.

> *And so, I've told my children that I don't want any of my ex-husband's family in my life. I don't want them. And as far as his wife goes, I don't want her in my life either ... I'm much more hyper-vigilant about people, very wary. And I keep to myself a lot. I'm quite okay with my own company, so that's okay. But I do go out. I haven't excused myself from the world. I still go out and do things.* (DD4)

Isolation was a common ongoing impact arising from abuse as a NZ European older person. In addition to the above examples, self-blame or stigma related to the abuse meant that some older people distanced themselves from family or friends, no longer able or comfortable to share their experiences.

Financial abuse has financial, career, and life course impacts. Some older people still had sufficient financial resources to live comfortably, even after businesses were dissolved, trusts redistributed, or property was lost. However, they were often left without employment or career prospects, facing an entirely new view of retirement, or with uncertain housing arrangements.

> *Oh, we're done. We're done. Dad's settled. He made them an offer. It includes the inheritance, includes the, what is the wording? They acknowledge that it settles the Testamentary Trust Act, whatever it is. So, it covers that as well … but they got a good chunk. They got a good chunk each. And dad said, "I'm not leaving it until I die, because who knows what happens then? Let's do it now." And that way, he's still got a reasonable amount left. But, it's not the same as having enough to be able to buy into a rest home.* (DD14)

Overall, the emotional impact of AOP for NZ European participants, regardless of the perpetrator or type of abuse, had long-term profound impacts.

> *Vulnerable, yeah. Less self-worth, low self-esteem, all that sort of thing. You just get knocked down bit by bit.* (DD7)

> *It also got to the stage where I'd end up drinking before I went home and drove home, which I got a serving from my doctor about. Well, I needed to talk to someone, and it came out, and he just actually got quite angry with me, and rightly so. Drinking and driving was just so wrong.* (DD10)

4.4 Summary

Most perpetrators of abuse for older NZ European participants were family members. Those we spoke to were most likely to report emotional and financial abuse, followed by physical and verbal abuse, and coercive control. Notably, partner abuse was less common among older NZ European participants than other cohorts interviewed, although for a few participants it continued into their older years. Many NZ European participants reported histories of abuse and violence that had ongoing impacts on their family and partner relationships. Abuse of some NZ European people was multigenerational and involved restricted access to grandchildren.

In this study, AOP perpetrated by family members was often gendered, with, for example, expectations to care for an ageing parent. Family trusts and businesses were a source of dispute and AOP, often

leading to financial abuse and disenfranchisement. Gaining advice and support was a struggle for most NZ European participants, especially when they needed to leave an abusive situation or prevent the abuse.

The abuse of older NZ European people in this study has far-reaching and long-term impacts, such as isolation, disconnection from family (especially their grandchildren), and feeling belittled. AOP for NZ European participants also disrupted their employment and careers, altering their life course, and leaving them financially disenfranchised.

5 POPULATION GROUP: OLDER MĀORI PEOPLE'S EXPERIENCES OF AOP

5.1 Introduction

This section presents the in-depth findings for the older Māori population group, illustrated with quotes from participants. Following this, the candidate themes that illustrate the participants' experiences highlight AOP for older Māori. The following themes were identified: *AOP for Māori*; *Histories of violence*; *Isolation*; *COVID-19 lockdowns*; *Intimate partner violence*; *Grandparents raising mokopuna*; *Adult child-to-mother abuse*; *Asset and financial abuse*; and *Systemic and structural abuse and neglect*. The section begins with a description of the participants.

5.2 Participants

Fifteen older Māori participants aged between 55–79 years took part in the study (see Appendix Table 1 in Appendix A). They were mostly women (66.7%, n=10), while five participants were men (33.3%, n=5). Ten identified solely as Māori ethnicity, while five declared dual ethnicities (three to NZ European and two to Cook Island Māori).

As mentioned earlier, most older Māori were interviewed in kanohi-ki-te-kanohi (face-to-face) hui. Six older Māori participated in a wānanga, with two electing to conduct separate kanohi-ki-te-kanohi interviews after the wānanga.

5.3 Themes

AOP for Māori

Older Māori people shared with us their anticipation and hope of retirement, despite a lifetime of hard work and paying taxes, contrasted negatively with the reality. Rather than what they envisioned, their retirement was challenging with prohibitive rental, food, and heating costs. Consequently, they were unable to fulfil their cultural roles as kuia and kaumātua to their mokopuna. They reported being confined to awhi (embrace and cherish) their children and mokopuna, unable to help them financially

and in other ways. For example, they said it broke their hearts that they could only offer aroha (compassion, empathy, and love) to their mokopuna.

> *Kids are constantly ringing up for money, and we have nothing to give them. And it feels ... It breaks your heart not to be able to help them.* (MA-00S7)

For the majority of older Māori in this study, their abuse did not start when they reached older age. Many talked about their abuse or exposure to violence and abuse as tamariki and taitamariki/taiohi/rangatahi. However, the harm and mistreatment that they encountered as an older person manifested differently as they entered older age.

For older Māori people, abuse occurs in several ways. They talked about being taken advantage of because they are older, dependent on other whānau members, isolated, and experiencing financial and asset abuse. They also discussed institutions, services they access, and the people within them as a significant form of abuse in their lives.

> *The older you get, the more alone you are. Because people have moved on with their lives and they've solved their problems. And you're looked at as a problem.* (MA-008)

> *It* [AOP] *is when you're intentionally taking advantage of a person's age and stage of their life and their development, their situation, so that they're dependent on you. As the kuia kaumātua, they're dependent on another family member or a caregiver to provide support for them, and they're often taken advantage of.* (MA-006)

Histories of violence

Harm and mistreatment for many older Māori we spoke with existed earlier in their lives. However, the abuse manifested in different ways. A number of the older Māori recounted histories of violence and abuse, often starting early in their life.

> [Growing up] *there was an overabundance of alcohol, and I was brought up in a family that was predominantly male because I, myself, have six brothers, no sisters. In our family, there was a lack of empathy and sympathy.* (MA-007)

Abuse started early in life for the following older person. In and out of the hospital, foster care homes, and a faith-based care facility run by nuns, she was sexually violated by a variety of people, including her doctor and siblings, when she was older. She was eventually adopted into a non-Māori family, losing her connections to her birth family and name.

> *Until 8–9, I was in and out of the hospital. Because my mother would have beaten me so badly, I'd gone in and out of foster care homes where there was the bashing, which was put down to racism again, because the white families didn't want a Māori girl. And then the nuns intervened, and they said, "I don't think we should leave* [older person's name] *at home over the summer with her mum." And so, they took me to one of the school teachers. And then my mum asked that woman in front of me to adopt me because she didn't love me anymore. And so, from there, my doctor started sexually abusing me, and I hadn't been adopted yet. I lived with them for nearly a year, and then he died.* (MA-005)

This older Māori woman reflected on growing up and living a life of being sexually violated by people she should have been able to trust, but who abused her, diminished her mana, violated her tapu, and removed her dignity.

> *That's perhaps something that's led to me, and my trauma bonds with violence, to play that role* [victim]*. I would, I would believe so. But it's an adopted behaviour. However, more so, I'm the victim of that* [traumatic violence]*. My family would have me, and those close to me, believe it's my fault. I don't quite believe that.* (MA-005)

Isolation

Isolation and loneliness were consequences of older Māori people being harmed and mistreated. The impetus for their isolation ranged from the death of a significant person in the whānau to exposure to racism, control, and psychological abuse, to the public psychological abuse on social media. Following the death of a son, the following participant described the sudden isolation despite the whānau (adult children and mokopuna) being previously close-knit.

> *We were close, and the next minute, all of a sudden, they're not picking up my calls. And if I do miss one, I try to ring back, but they don't answer. I sort of cry myself to sleep. And I went to bed last night, just lay there thinking.* (MA-004)

The emergence of a partner's racism, control, and isolation as a form of psychological harm and mistreatment, who previously had not been abusive, occurred for one woman as an older person.

> *I think it was quite apparent from my early fifties with* [partner's name] *that he didn't like the fact that I was of Māori descent. He didn't say anything in the first years, but then he made comments* [as an older person] *that were quite derogatory towards Māori, and my giving and loving way to my whānau. And over time, he corroded that, and he distanced me from what made me strong.* (MA-008)

In response to the psychological abuse and her partner's sabotage of her ability to be financially independent by forcing her to become bankrupt, one woman reported responding by silencing herself with the aid of her rosary beads.

> [It] *just zombied me. So it made me comply. Everything was just catered, and it was okay. And he was happier because I voiced less. I was calmer and compliant. And, if he walked out* [to go to another woman]*, that was okay. "See you when you want to come back."* [In response to help, her whānau told her] *"You made your nest, lie in it." And I felt very dirty. Very dirty, like a prostitute doing it.* (MA-008)

This older Māori woman received little support, and without the backing of her whānau, she was forced into marriage by her partner. His violence emerged as he aged and became unwell. This caused her to live in a heightened and constant state of anxiety.

> *So now he throws things at me. If he's not happy, I could expect a vase to come flying, but I don't know why. So, I'm always in heightened anxiety – every little snap or sound, I expect that to connect.* (MA-008)

In most cases, older Māori participants were left to deal with their isolation and loneliness on their own, with no support for the psychological harm, mistreatment, and trauma they endured, without support and the difficulty associated with caring for a highly dependent older person.

> *My family, my kids, thought that I was deserting him when I put him in a rest home, but it just got to the stage that he was too much for me. … Absolutely. They all hated on me, and I said, well, I put it to them, "How often do you fellas go and visit dad in the rest home? Or even come to the house to visit him?" Never. Never.* (MA-001)

COVID-19 lockdowns

Some older Māori described feeling disconnected from their whānau and the difficulties in maintaining contact with loved ones during the COVID-19 lockdowns. They missed their daily contact with their mokopuna and mokomoko (great-grandchildren). For those participants with a partner in an ARC facility, a cost was incurred to maintain contact and assist the aged care facility in settling their whānau member, usually their partner.

> *Also, COVID. I remember travelling four hours down there from* [rural town] *to* [city]*, to the rest home, and just sitting outside the window looking at him. Because he'd ring me up and he'd be crying because nobody could see him, and he hadn't seen me for so long. So, me and my moko went there. And, they put him in his chair, put him up close to the window, and you get on our*

phone and talk to one another. He was happy for the half-hour or hour talk through the window, even though he couldn't ... he could see us, but he couldn't touch us, but he was happy. And, I did travel four hours down and four hours back. I think to myself that was probably the best thing I could have ever done for him, even though I couldn't really afford that travel. But, to lift him a bit out of the doldrums, because everybody was feeling that in the rest home. (MA-001)

Intimate partner violence

While some older Māori participants mentioned experiencing IPV during their adulthood as an extension of the abuse they lived with as a tamariki and younger person, other participants talked about IPV in their older years. One woman spoke about observing her mother abusing her stepfather, which she referred to as "elderly abuse" [sic].

> *I saw a lot of elderly abuse* [sic] *through my mother, with my stepfather, and my mother being the stronger personality of the two. It was really heart-wrenching. It was heart-wrenching, it was emotional abuse, and I never saw physical abuse. But yeah, definitely it was abuse, but it was from my mother to my stepfather. Yeah, personal put-downs, not good enough. It was never good enough. Could never do a job properly. And, yeah, basically, he carried all of her hara* [offending]*, and it was quite turbulent.* (MA-004)

For some, the harm and mistreatment arising from IPV continued. However, for one older Māori woman, her partner's admission to an aged residential facility, because of a significant physical impairment he had, served as a buffer from her husband's abusive behaviour.

> *He* [the doctor] *put it to me like this, "If he doesn't go into a rest home, you'll probably end up going to a rest home or else something worse." I knew what he was talking about. My husband could be the death of me. I thought about it, and I thought, "No, I'm not going to let my husband do that to me."* (MA-001)

Financial and psychological abuse went together. For one participant, her partner engaged in manipulating factors that significantly impacted her business, ultimately leading to its failure. This resulted in not only a loss of autonomy and agency, but also a loss of income. Her partner also blatantly had relationships with other women. This woman talked about the ease of getting into an abusive relationship when one grows up in an environment where family violence is prevalent. She explained how the subtlety of financial abuse formed part of her partner's psychological harm.

> *I think that the psychological harm started after I turned 50. ... "You owe me, you owe me for my time." The other thing that he withdrew from was* [paying for things]*. I found that I was paying*

for everything. So, if you go to have takeaways, it would be convenient if he didn't have his money or a cup of coffee, just didn't. He intended that I support him. (MA-008)

Her partner's control increased with time. Because she engaged in over-eating in response to her abusive situation, her partner then demanded she have bariatric surgery because she was no good to him dead.

And then when I emotionally ate and got bigger and bigger and got to 165 kilos, he was the one who said to me, because I'd had a few heart attacks, "You're not good to me if you're dead, so you're going to have bariatric surgery." So, he was the one who said that, and then he said, "And, then we're going to cut off the skin." (MA-008)

Grandparents raising mokopuna

Some older Māori talked about raising their mokopuna, often because their parents had violence, alcohol, and/or substance abuse in their lives that impacted their care and protection. However, their mokopuna frequently came with behavioural issues, and had been exposed to meth and alcohol during pregnancy and their early life.

Despite the aroha and commitment Māori participants had for their mokopuna, their daily care for them impacted their wairua and stamina, despite having several services available in their lives. Raising their mokopuna was challenging, and they often lacked the necessary resources to assist them. Within this context, the following participant questioned whether it was a form of AOP for Māori.

But just for the mere fact that they're at that age and stage in their life where they're looking after the mokopuna. I don't know if that's abuse, but they've certainly been taken for bloody [granted] *... They shouldn't be doing that. They shouldn't have to live their senior years looking after their mokopuna. It's really sad. That's sad. … And the children are challenging, because they've come from parents. They've been removed from their parents because of their drug use, and a lot of the tamariki have been exposed to alcohol and drugs in utero while pregnant.* (MA-006)

Yet, the following older Māori woman talked about her contemplations of leaving a legacy for her mokopuna, despite the abuse in her life. Reflecting on her tūpuna's moemoeā (ancestors' dreams) for her – her mother, her grandmother, and her great-grandmother's – within the context of her reality, she acknowledged it was not what they aspired for her.

And what I'm weighing up is the pros and cons of how much I'm willing to give now and show this learning with my grandchildren and my children. Because it's [the abuse] *already distanced me from my children to a degree, 'cause they've lived with it. But my grandchildren were born to it,*

> *and that's different for me. … I think, to say that the other thing that makes me feel connected is to know that my mother would not have wanted this for me, nor her mother, nor her mother. And they've fought battles throughout their lives, just a little bit better for your children. That's the love, the aroha. And I'm just going, "Whatever" by being so passive.* (MA-008)

In one instance, an older Māori woman's aroha and manaakitanga led her to care for another older person in his late 70s with a history of alcoholism, dementia, and who was sometimes violent. This older Māori woman, also in her late 70s, recounted the challenges, especially the need to monitor him 24/7 – he frequently wandered onto the road. He had fallen, injuring himself, and was almost hit by a car another time. She talked about the difficulty in caring for him and being unable to get help – his family would not care for him, and she was unable to get support for services or admission to a dementia unit.

> *I tell them I want a live person* [not someone online]. *I need somebody live. I need a nurse. I need a doctor. I need someone to help me get him into a rest home. But they have to have a lock-up ward or even one of those alarm things once the door opens; they have them in* [overseas country]. *If you open a door and they go, "Beep, beep, beep, beep, beep." It's on their legs. That might be a better way. He's not violent, but he can be. I mean, he has punched my back three times. But it doesn't hurt. His punches are only weak.* (MA-00S3)

Adult child-to-mother violence

Child-to-mother violence is something that is not often recognised, but extends beyond participants' tamariki and taitamariki to their children as adults. One participant talked about the psychological violence by her daughter on social media and podcasts. This very public form of psychological abuse made it difficult for her to address or stop it. Triggering anxiety and responses to past trauma, it has destroyed her friendships and relationships and caused her to stay in her home, sometimes unable to move.

> *I don't even see women lately because I've been so anxious. … I'm purposely asking if they know my daughter, because that will be my boundary. I can't. I can't trust myself around people because of the narrative they're receiving. And I don't say anything. That's the thing. I don't defend myself. I don't speak about her* [abusive daughter]. *If it does come up, you know, I don't rise. … I do my best to transcend it, but I feel f*****, or I don't talk about.* (MA-005)

Asset and financial abuse

Some older Māori discussed 'asset grabbing' by other whānau members, and to a lesser extent, financial abuse.

Asset grabbing

Several older Māori people discussed asset grabbing, which involved taking land or other possessions, such as a home or its contents. This is about the taking of land, their tūrangawaewae, by wider whānau members despite land transferring to the 'next-of-kin' of a relative who passes away. Unless those inheriting the land legally claimed it, it could then be claimed by others.

Several older Māori also reported being subjected to the confiscation of their assets, including household property and nefarious land claims, through the Māori Land Court. For this older Māori person, asset grabbing extended beyond the taking of assets and involved exploitation.

> *He claimed all my possessions, even my household possessions, my beds, everything. He claimed this, claimed everything. And then he purchased this property up at* [rural area]*, which was a run-down lodge. And said that I could live there if I worked with the workmen to tidy it up and so on. At that stage, there was a lot of verbal abuse, and if I wasn't moving fast enough for him, he'd say, "Move faster, you don't do enough." And I was working from six in the morning to midnight, almost, seven days a week.* (MA-008)

The following participant explained how easy it was for some whānau members to claim legally 'unclaimed' land.

> *Some of them are just moving in* [to the rohe (area)]*, like, just grandkids. They're not coming in as siblings – so many of them. The thing is, because we've lost all our loved ones. We've lost all our ancestors now. And then all our kaumātua are gone. I think the oldest one today would be what? 89, 90 something? Not many. And, not many can speak to us anymore. That's why they're jumping in, pinching land. They go to the Māori Land Court and examine the land registers. "Oh yes, I'll jump into that." And they do that. They fight for it. They claim. They're going to places where they can claim. If people own land and haven't claimed it, they put their names on it. You sit in a dark room or another room* [in the Māori Land Court] *on your own to have a look. And that's what they do. They have a look, and they say, "Oh, so-and-so is 80 something and he's the only owner, but he hasn't got the ... Where's the siblings to carry on?" What do they do? They take it. Yeah, they claim it. But then it's up to us. So, I found a lot at the court when we last went. I can't remember, eh? About a couple of weeks ago, my family and I went to the Māori Land Court. And then I asked for my dad's blocks … None of us had come to claim* [the land] *because we were only kids.* (MA-00S3)

Asset grabbing also occurred in the context of a lack of understanding about wills and the necessary steps to ensure the documents were legally valid. Not possessing the necessary knowledge of wills and their

legality, and not knowing where to get information, leaves older Māori open to abuse – participants indicated whānau were not always loving. Some older Māori did not believe in wills, thinking they could transfer ownership of assets. However, the absence of legally valid wills created problems for some older Māori.

For this older Māori woman, her dying daughter, who also had a mental illness, ended up with three invalid wills. However, this did not stop her niece from acting on the will she had made with the participant's daughter, selling all her assets illegally. This older woman is now forced to take legal action to ensure her daughter's wishes are realised.

> *My daughter made three wills. The first will was with me, then we worked it out. My other daughter came from Australia, and then she asked that she do her will. But my daughter had* [significant mental illness]. *That daughter of mine did it. But I said to her, everything else, the vehicles, and all that, don't worry about that. Then, she did it. She did the will, but it wasn't with a lawyer. ... We didn't go through that. The* [participant's niece] *came from* [another region] *to go in. And then, my daughter asked her to do her will. She had three wills. … Now, the thing was my niece said the lawyer would give us a call and read the will. I said, "Yes, it's got to be read straight after the funeral." … It didn't come. She* [the niece] *didn't do it legally, but she told me she had the power of attorney, but my daughter passed away, so there's no one there to look after*. (MA-00S3)

The niece of this older Māori woman subjected her to "nasty" verbal and psychological abuse and threats. The unrelenting stress and need to resolve the issues according to what her daughter wanted left this older Māori woman anxious, sick, and unable to eat.

Financial abuse

In this research, older Māori people did not talk about financial abuse to any great extent. They did talk about it in terms of whānau members asking for loans, theft of money to buy vapes, and theft of their mobile phone data. Whānau members, such as children, sisters, or nephews, requested money but did not repay it. What was difficult for the older Māori affected was being forced to ask for it back.

> *And the other one was a cash request and was quite demanding at times. "Oh, you can afford it. I'll pay you back later on." And then waiting, waiting, waiting and finally got it back. But the disgust of having to ask as if it was my responsibility to remind them to pay me back. Yeah, that's abuse to me at any level. And coming from a nephew who is often drug-induced, and I've just said in the last five, six years, "No. No, I'm not giving you money. Sure as hell, I ain't giving you money*

> *to smoke P or to buy you cigarettes or alcohol. So don't ask me again." End of story.* (MA-009)

Financial abuse also included the theft of money for vaping by younger whānau members, and also data credits on their phones by Wi-Fi "hotspotting". These older Māori people said they would receive large phone bills because people were using their phones outside their homes to connect to a hotspot.

> *And they sit outside. Then you get a big bill, and you wonder where the hell it came from. When did I do that?* [They connect] *to the electronics and all that stuff.* (MA-00S7)

Participants noted that unless they knew what to look for on their phones, they were unaware that others could do this. The consequence of this form of financial abuse was the inability to afford necessities like food, heating, and rent.

The failure to realise their aspirations as older people due to insufficient financial resources and assets was an issue for Māori participants. They discussed struggling financially so they could give their whānau everything, only to receive nothing in return in their older age. So instead of being able to help their mokopuna and mokomoko (great-grandchildren), they tried to instil loving feelings and teach them right from wrong when they could. But they also countered this, saying that young people were not always ungrateful or in a position to receive knowledge and wisdom.

Systemic and structural abuse and neglect

Most older Māori participants talked about institutional and systemic abuse and neglect in some form when engaging with government agencies and health and social services. They shared experiences of being treated disrespectfully, which impacted their mana (dignity), and of neglect, which they concluded was AOP. Institutional and systemic abuse and neglect manifested in various ways – such as a lack of access to timely healthcare, sub-standard communication, neglectful care of whānau in ARC, and abuse in the workplace. As one older Māori woman stated:

> *I think being taken advantage of, like services out there using their power over the elderly, those that are using their services who are elderly, such as mechanics.* (MA-006)

Institutional and systemic abuse manifested for them in several ways, for example:

- unacceptable and differential waiting times compared to others waiting for services (especially in health)
- their questions left unanswered
- neglect of health and social needs

- directed to unaffordable services, such as being redirected to costly health services, without any communication or consent
- provision of internet-based services (especially for health needs) that they are unable to engage with
- avoidance of accessing health services primarily because of costs

There was a perception among several older Māori participants that the government only looks after the "rich", despite the many years they had worked hard in manual jobs, paid taxes, and their expectation to be looked after in their retirement. Superannuation did not cover the rising and exorbitant costs for housing, food, and healthcare, for instance. The government and the decisions they made that negatively impacted older Māori were viewed as the "biggest abusers" in their lives. These participants believed people working in government agencies wanted people like them, older Māori, to die. Participants repeatedly discussed the lack of compassion shown by government officials (Ministers, policy-makers) and agency staff.

> *The government is the biggest abuser. We have worked all our lives. It seems like they want people to die. There are long waits and people* [in services] *you can't understand.* (MA-00S7)

> *Yes, as long as the government doesn't want us to die first. Our needs are not being addressed – it's neglect. They give you pills and send you home. It's confusing because you can't understand what they say.* (MA-00S8)

Poor access to timely health care

Many older Māori participants talked about feeling abused when accessing health services. This abuse presented in various forms – not receiving timely health services, being left for considerable lengths of time waiting for services, being re-routed to health services they cannot afford, and not receiving the support and resources to care for themselves or a whānau member, such as a partner. Māori older people discussed this as a form of AOP by the health system.

For the following older Māori woman, abuse occurred in the form of being denied timely health services. She explained that this was related to the higher health needs and resources required for those ageing, despite the significant impact of their health conditions on their quality of life. With a decrease in income, the following older Māori woman explained that she had to forgo private health insurance due to its prohibitive costs as people age. This meant a loss of choice in where and how to access timely healthcare.

> *So, as an older person regarding health abuse. I've been declined appointments. And I wonder because there's such a high need, whether it's because of my age. ... And I see it as also an employee of* [a health service]*, the older people up here have to wait for appointments for quite serious operations or care, because they're older.* (MA-009)

Also, struggling to manage the complex and evolving health needs of a dependent partner or whānau members, older Māori participants reported not being able to access the necessary support and resources they needed to care for them. For instance, caring for a partner with dementia presents increasing challenges to provide safe care and stop his abuse. It was suggested that she go to her GP, who had previously shifted the focus to her (not her partner's deteriorating health) and prescribed an antidepressant medication.

> *But I pulled her* [social worker] *aside and I said, "Look, it's not good for me. There must be something going on with him."* [I was] *trying to find a reason. Well, they did their tests and what have you. And they sent out a social worker to our environment. The social worker sat down with me, and a psychiatrist, a psychologist, I'm not sure, went outside with* [partner's name] *to talk to him. When she* [social worker] *was with me, I said, "It's not good. He is throwing things at me. He is abusing me." She recommended that I see my doctor. Of which I didn't because the last time I saw my doctor, he put me on Prozac. I think being offered someone who is familiar with* [living with an abusive person]*, not saying go to a doctor. Go and see some counselling or something. And these are the people who are available for you to talk to.* (MA-008)

A common concern among older Māori was the long wait to see a health professional. This occurred even when they were acutely unwell and very sick. We heard from one older Māori person that the ambulance did not take him to the hospital because of high demand on the emergency service. Instead, and without any communication, the ambulance took him to an after-hours health service that charged $100, which he could not afford.

> *Hey, I was sent here by ambulance, because they had no ambulance to take me to the hospital."*[12] *"I'm sorry, but it costs $100." … I got stressed, and* [you] *know what I did? I left the building and walked out. But it* [the bill for $100] *comes in the mail. But it makes you wonder why you go in the ambulance, to the hospital, and it costs you nothing. But the ambulance, they sent me here because they had no ambulance to take me to the hospital. So, they sent me down to*

[12] The town this older Māori resided in involved travel of 40 km to and from the hospital.

A&E [accident and emergency] *down here. The first thing they said to me was, "Oh, it's $100."* (MA-00S2)

For another older person, her partner was left in an overcrowded emergency department despite his condition deteriorating:

> *They said, "Well, in that time he's waited to get that scan, his blood pressure had dropped very low, and it's got to the stage where they couldn't help him anymore." By the time I got that call, I was halfway to* [the city]. *So, I got there to* [city hospital]*, and my husband looked terrible. But, because of the overcrowding and everything, they weren't able to give him a scan straight away. I honestly believe that he was put in the 'can't-be-bothered basket'.* (MA-001)

Other older Māori shared similar stories:

> *I go to* [town, to the] *marae there. I went to the clinic, and I was sick. The nurse turns around and gives me a chit to go to Urgent Care when I'm sitting in my doctor's office. And then, I had to wait five hours in Urgent Care to see a doctor, who told me that they were just as busy as my doctors. So why did they do that?* (MA-OOS4)

> *Here in* [colloquial name for town]*, at the A&E* [accident and emergency]*, you can wait up to five hours.* (MA-00S7)

Initially, the following Māori woman was told her partner would die within 24 hours and to call the whānau, but he continued to live for several days. This caused financial strain, so she requested putea (funds) of $200 to help cover the expenses. However, the ARC facility where her partner resided controlled her access to the money.

> *I needed putea, I needed money, and so I said to the rest home, "Oh, I need to get some money because I'm going backwards and forwards, with the COVID[13] and everything." It was draining on my bank balance. They gave me a phone number to call, and I contacted them. This guy said to me, "Well, you really don't have access to those funds." I said, "Yes, I do, because I have power of attorney." And I said, "We made sure to do that, so people like you couldn't tell me no, but even if I didn't have power of attorney, I'm his next of kin, so I'd like to take some money." … I was only*

[13]The ARC facility would ring this older Māori woman during the COVID-19 lockdowns when her partner became difficult to manage. Her presence, albeit on the outside of the care facility, settled him down. These regular trips cost her money that she often could not afford.

going to take out maybe $200, but he goes, "Oh, well, we're not sure about that. We don't think you should have that money." The minute they turned around, and they said that to me, I said, "Bugger, you mongrels." … It was terrible, absolutely terrible. So, they said to me, "Oh, well, it's going to take at least two weeks," and I did get it after two weeks. (MA-001)

Sub-standard communication

Older Māori participants reported that important communication with health professionals compromised the outcomes of the interaction. This problem was related to engagement with international nurses and doctors who, older Māori said, spoke to them disrespectfully. Also, they could not understand what they were saying, meaning they often left without knowing or understanding what was wrong and what their medications were for. Participants attributed this difficulty in communication to the accents of these health professionals and the rapidity with which they spoke.

Just disrespect. Not so much European, but they were the ones who brought these people into the country. But their respect for us is not there [lacking]. *You know the way they speak to you. I got to the stage now. I look at them … I can't stand to look at them. It's just, "What are you talking about?" But you know, just to me, they're rude people, the way they treat you.* (MA-00S2)

The other communication issue raised by older Māori people was being directed to online doctor consultations. They felt that talking to the "TV" was challenging to engage with and understand what was being said. These older Māori people questioned how someone sitting "somewhere in the country" could honestly assess them, with some wondering whether they were talking to a robot or AI (artificial intelligence) rather than a real doctor. They preferred kanohi-ki-te-kanohi (face-to-face) interactions with doctors and others about their wellbeing:

Well, I took him [partner] *there for an assessment. The doctor did it, but did nothing much. And then, the woman who was working with him was the one who organised his stay in* [town], *for a respite centre over there. So, that was it. And then, I come to* [health centre], *over here. And they've done that, the doctor … But the doctor is on the box* [online] *here. "Hello? Who are you? Where are you? Now, where are you talking to me from?" "Oh, Wellington." Oh. No use to me. (MA-00S3)*

And that doctor on the TV is probably a robot. (MA-00S7)

We just changed to [health centre, without a doctor]. *We enjoyed* [the health centre], *but then I got a bit sick speaking to the TV* [online consultation], *you know? Speak to the doctors. Talking to the doctor on the TV. … And I look at it* [the TV], *and I thought, "Oh gee, this doesn't make sense. I'm talking to a doctor on the TV." (MA-00S2)*

Neglectful care of whānau in aged residential care

Having to put a whānau member into an ARC facility was difficult for older Māori in this study, mainly because they could not care for them in a way that was tika, pono, and with aroha – a culturally safe way. They talked about the distress when the quality of care of their loved one in ARC was sub-optimal:

> *I was happy with the way he was treated initially, but little things started to surface that irked me. And one of them was that I felt they didn't take better care of the patients. In one case, my husband rang me up early in the morning and said he was lying in his bed, and it was full of urine. So, I quickly jumped in my vehicle and went to see him. I lifted the sheet, and I could see it. So, he had a catheter, it had pulled up, the bag had pulled up, and therefore, it was coming out onto the bed. And when I lifted the sheet and saw it, I was absolutely disgusted. He was lying in that* [urine] *for, and you could see it was for a long period of time. So, I said to him, "Why don't you get the nurses to change you?" "Oh, they said they're too busy." I said* [to the Manager]*, "This isn't good enough. He should have been changed before breakfast." They informed him that they were too busy to change him and that he had to wait till after breakfast. I said, "Well, this is half past 10 now, and he's still not changed." (MA-001)*

Abuse in the workplace

We found that older Māori continued to engage in some form of employment to financially make ends meet, especially as most did not own their own homes. Some older Māori participants talked about the abuse they encountered within their workplaces. They commented on how the new employment environment and policies did not align well with Māori values (such as tika, pono, aroha, and manaakitanga), which they found stressful.

However, despite the skills and value they contributed to workplaces, they encountered discrimination and biases. The arrogance of people operating under biases and discrimination, according to one woman, made it abusive. As the following older Māori woman stated, it is more than being Māori and more than themselves alone, but anti-gender stances that also play a role in the abuse they endured.

> *And so, I had to deal with these sorts of things* [bias and discrimination] *quite frequently. I used to take it personally, because I was in charge, and I found that was quite abusive, because ... It was abusive, not because these people were ignorant — because you can deal with ignorance — but because they were arrogant. … I found it abusive because they thought ill of their fellow people. … They were anti-woman, anti-gender, and anti-*[everything in general]… (MA-007)

> *You work all your life, and then you have to work through your retirement as well. But if you've spent all your money. When you've worked and spent all your money in your life bringing up your*

children, and that, and you're expected to own your own house and things. Not everybody has a home. (MA-00S2)

One older Māori man coped with stressful situations, in response to ageist comments, by talking to himself.

And so, I would always be told that things like, I was "Over the hill." And I used to say, "Well, hang on a minute." I say, "I might be over the hill, but I'm not under it yet." (MA-007)

Forced to take a significant decrease (approximately $25 per hour) in her hourly rate, and receiving only a total of $7.50 pay rise over almost eight years, resulted in the following older Māori woman feeling devalued and abused. When reflecting on those she worked with, and comparing her work conditions and context to theirs, she reported being discriminated against as an older person.

And so, as an older person, when you talk about elderly abuse [sic]*, you feel devalued and abused, really, because your life skills and your previous employment skills, well, to me, were devalued by the* [place of employment]*. And I think, because, to my way of thinking, they get so much government funding that there is no reason why they can't pay their staff to enable them better to remain, so they don't have an issue with retention. … I overheard a conversation, just an informal conversation about how they're now moving towards employing older people because they're more reliant, they're more settled, they're more ethically and morally able than the younger ones that they previously employed. So yeah, to me, that's almost like discrimination because you're older.* (MA-009)

One older Māori woman talked about living with Post-Traumatic Stress Disorder (PTSD) following abuse by three co-workers, which included sexual abuse by one of her co-workers. This left her feeling devalued, especially as other co-workers closed ranks and the abuse was never resolved satisfactorily.

I had issues before I left the [place of employment] *with post-traumatic stress syndrome because I was abused three times by three different male officers, not prisoners, officers. And that was after my husband had left the job.* (MA-009)

The embedded discrimination, bias, and racism in the workplaces that older Māori in this study found themselves having to work in were considered by participants as stressful and abusive. It is a form of institutional and systemic AOP, especially for older Māori people.

5.4 Impacts of AOP

The older Māori participants in this research suffered a wide range of effects from AOP. As evident in the participant quotes in the preceding commentary, AOP negatively impacted their wairua, mana, tapu, and dignity. They also experienced unrelenting stress and heightened anxiety. Factors such as their inability to fulfil their roles and aspirations as kaumātua, kuia, and kauheke had cultural & spiritual impacts, particularly when they were disconnected from their whānau, who had previously been a source of strength, and when there had been a violation of their whakapapa. In this study, we found that this led to isolation, loneliness, and a sense of disconnection. Notably, in the face of racism and trauma, older Māori participants expressed a lack of trust in others to support them and respond to the AOP they were experiencing.

5.5 Summary

Many older Māori who participated in this study had histories of lifelong abuse, although the nature of harm and mistreatment in their older years changed. Older Māori thought they would be looked after in their retirement. However, they shared that despite working hard their entire lives and paying their taxes, their retirement reality was far from what they had envisioned. This meant they could not realise their aspirations as kauheke (elder) – they thought they would be looked after in their retirement. Critically, they were unable to fulfil their roles and aspirations as kuia, kaumatua, or kauheke, especially in their relationships with their mokopuna – participants viewed this as a form of cultural & spiritual abuse.

Older Māori participants experienced abuse in several ways, such as:

- Systemic and structural abuse and neglect were a significant form of abuse for several older Māori that included the government (decision-making that caused them and their whānau harm), government agencies, services, and the people within them (who treated them disrespectfully and in racist ways).
- Being taken advantage of because they were older and, for some, reliance on other whānau members to have their needs met.
- Isolation from whānau, especially their mokopuna.
- Financial abuse, including an inability to help when whānau needed financial help; if they lent money, they would have to ask for it to be repaid.
- Some older Māori experienced adult child-to-mother abuse.

IPV could continue for some older Māori, accompanied by a combination of financial and psychological abuse. Isolation and loneliness were consequences of the death of a key whānau member, or harm, mistreatment, and abuse arising from exposure to racism, control, and psychological abuse or abuse on social media. Participants also reported that as grandparents raising mokopuna (because of their parents' situations), or caring for an older partner or whānau member, they did so with inadequate resources and support, which impacted their wairua and stamina.

The impacts of AOP for older Māori participants have cultural & spiritual effects that occurred in several ways, such as: diminished mana, violation of tapu, and a loss of dignity; unrelenting stress and heightened anxiety; inability to fulfil cultural roles and aspirations that accompany kaumātua, kuia, and kauheke status; disconnection from whānau and violation of whakapapa; and isolation and loneliness. Most older Māori reported a lack of trust in others.

6 POPULATION GROUP: OLDER PACIFIC PEOPLE'S EXPERIENCES OF AOP

6.1 Introduction

This section presents the in-depth findings for the older Pacific population group, illustrated with quotes from participants. Following this, the candidate themes that illustrate the AOP experiences of older Pacific participants are identified: *An offshoot of Pacific people's acculturation*; *Disrespect of older Pacific people's status*; and *It's a culturally sensitive issue that engenders shame*. The section begins with a description of the participants.

6.2 Participants

Twenty-one individuals identifying as belonging to a Pacific ethnic group participated in the qualitative interviews (see Appendix Table 1 in Appendix A). Almost half (n=10) identified ethnically as Samoan, seven as Tongan, five as Cook Island Māori, two as Fijian, and one as Niuean. They were aged 55–89 years, with the majority in the 55–59 (n=5) and 70–74 (n=9) age groups. Just over three-quarters (76.2%) were women, and almost one-quarter (23.8%) identified as men.

As mentioned earlier in this report, five interviews were conducted in the Samoan language, transcribed and translated into English by the Samoan interviewer. Otherwise, all other interviews were conducted in English. In appreciation of their time and for sharing their stories, a mea'alo'fa was given to the older Pacific people participating – a cultural form of reciprocity.

6.3 Themes

An offshoot of Pacific people's acculturation

The AOP experiences of Pacific peoples occur as they attempt to accommodate traditional cultural practices within the NZ social context and reconcile traditional values with Western and generational ones. This manifested in various ways across those participating in the talanoa. For instance, the conventional practice of family members caring for older Pacific people rather than in ARC is common in

NZ. One older Pacific person spoke of the problematic and contested decision-making by her family members to place an older relative into an ARC facility:

> *Four of them* [older relative's adult children] *said no to putting her in a rest home. And then, all the rest said yes to putting her in a rest home, including some of those overseas. Because they said that it'll help* [the elderly relative's name] *more because she'll have nurses 24/7 and stuff like that* [other support]*. And in my mind, we were a family. I was so confused how her sons and daughters would put her in a rest home.* (P015)

Conflicts manifested in a range of ways, as evident in the cultural practices of fa'alavelave and the maintenance of traditional church attendance. Wanting to adhere to the Samoan customary practice of fa'alavelave – traditional ceremonial gift-giving for extended family events and occasions – is an example of a practice that participants were unable to fulfil in the NZ context. One older person discussed a conflict she had with her brothers over fa'alavelave.

> [The participant's brothers] *complained to me that I was an embarrassment and humiliating our family because I had not prepared any envelopes of monetary gifts, nor any food for a cup of tea for my in-laws who came over that night. They* [the brothers] *were so angry, and they started throwing angry words at me, belittling me, and saying that I did not know how to perform our Samoan culture. And then they verbally abused me by saying, "We are a family with high status. We don't do things like that. What you are doing is making us look so low, and it is a disgrace and blah blah blah." And they continued saying more words that were very hurtful*. (P003)

Another Samoan older person described the financial burden that fa'alavelave placed upon her and her family:

> *So, we perform the culture, but it is the people's pride where they want huge amounts of things from us to give in this gift-giving. And at the end of the day, no one comes back and would ask me, "Is there enough money for you to buy bread for your children?" "Have you paid off the plot where your children's father is buried?" "Have the funeral director's bills been paid for?" And like, those kinds of things. And no, no one comes back and asks me that kind of question.* (P004)

Religious affiliation and church attendance are other cultural practices that can sometimes be difficult to maintain in NZ. These practices can unintentionally give rise to forms of cultural & spiritual abuse. One older Pacific person, who relied on family members for transport to church, said she was prevented from attending her church:

> *They force me to go to their church, but I really don't want to go there. I want to go to my own church*. (P001)

When unable to attend their preferred church, other older Pacific people spoke of being socially cut off from friends and relatives after they switched to a different church or denomination.

> *What's happening right now, since this new conversion from* [the Catholic church] *to our church, now* [the Methodist church]*, most of my friends and relatives have left us* [cut their ties]*. So, from this move to the new church, they don't contact us anymore.* (P003)

> *Those people tried to talk to me and were anti towards my beliefs, trying to convince me to leave the Methodist church and go back to serving the Congregational Christian Church, but I just brushed them off and said, "Huh! Whatever." You know, I respond to them, saying that the church is the church. The most important thing is I attend. People of the village* [who now live in NZ] *give us that look because they know that we have returned to the Methodist church. You should see them eyeing us. They say, "We go here, we go there." I really feel sad because of their attitude towards my beliefs, minding my own business, and not looking at their own.* (P004)

All the examples above demonstrate how the abuse of Pacific participants arose when traditional cultural values and practices are challenged for older people in various ways by living life in NZ. These occurred whether it be traditional care of the elderly by family members, financial contributions to family events, or religious practices. In short, abuse among older Pacific people living in NZ emerged from a process of acculturation in which older Pacific migrants had to adapt to the cultural change necessitated by immigration to NZ.

Disrespect of older Pacific people's social status

Pacific cultures place a strong emphasis on respect and obedience toward elders who are held in high regard. However, in the economic context of NZ, we found that these cultural values can be inadvertently undermined when both parents are working full-time to support multi-generational households. As already mentioned, participants (grandparents) are relied upon for childcare and domestic work. In these situations, some Pacific participants expressed feeling they were treated as "free labour". Some participants described feeling as though they were treated like housemaids.

> *Culturally, I think they are disrespectful towards me. In the Samoan culture, they should respect their elders. This is common knowledge. We give utmost respect to our elders. But, like I said before, they treat me as if I am a housemaid. I do the dishes, and even do all the chores at home, cleaning and tidying the house, doing the washing, and the lot. And even if I tried to talk to them about wanting to go places, they would always say they were busy, and no one was available. Yet, I could see that they were going to wherever they wanted to go*. (P001)

Another participant, who also felt she was treated like a "housemaid" by her daughter, with whom she was living, described a conversation she had with her concerned son.

> *My son said, "We know that you are doing everything at home. But that's not right. You are our elder, our mother. You cannot do the chores at home, and you should not be doing them. It should be us, your children, who are supposed to do the chores at home and do everything for you, our mother. But, oh my gosh, you are our elder, you have grown really old and advanced in years, yet at your house, your daughter is expecting you to do the chores. That's not right."* (P002)

Some participants also reported being ignored or that their needs were neglected. In this way, their high social status as elders was being disrespected. For example, one participant described how she is treated by her daughter and her partner (with whom the older person was living).

> *Every time I say or tell them something, they just ignore me. They just do their own thing. They treat me differently now. So, what I do is, I just go and do my normal chores, and once I finish them, I just come to my room and sit inside my room, feeling all alone*. (P002)

Another Pacific older person described how her family members do not prioritise her healthcare needs.

> *The other concern for me is having difficulty asking them* [older person's niece and her family, with whom she lives] *if I want to see a doctor. They always say they are busy and that their cars are unavailable because they are using them for work. It is going to see the doctor, as I find it difficult to have someone say yes to taking me to the clinic*. (P005)

Another Pacific older person, living with her daughter and partner, described how they had not consulted her on an important family decision about living arrangements.

> *No, they never talked to me about them* [daughter's partner's nieces] *moving in with us. So, the partner just up and went and got his nieces to stay with us. I thought to myself, "I lived with just my daughter and I, and we were fine. But now, my daughter's partner's relatives are starting to come to our place, and it's like they are taking over our family space.*" (P003)

The examples above represent various ways in which older Pacific people feel their status as elders is diminished and disrespected, an infraction of a cultural value which can be seen as a form of cultural abuse. It also represents the erosion of cultural beliefs and values regarding the status of older Pacific people in this research, the forms of exploitation, isolation, loneliness, and entrapment related to dependency on others to live their daily lives.

It's a culturally sensitive issue that engenders shame

For many Pacific peoples in this research, AOP is a highly sensitive issue. We found there was a widespread reluctance to discuss abuse because it engendered feelings of shame. Consequently, many participants protected their families to avoid community scrutiny. Driven by the desire to uphold family reputation and not bring the 'family name' into disrepute is paramount among older Pacific people. This extended to confidentially discussing the issue within the context of an interview. Speaking out about AOP was commonly viewed as 'badmouthing' or 'cursing' one's family members. These sensitivities are reflected in the following comments by participants:

> *It's swept under the rug at the time. I just feel like it's a need that doesn't really get talked about*. (P014)

> *But I guess as Pacific Islanders, they generally like to deal with the situation in their own hands type thing, without external sources or resources, if that makes sense. So that's always been the case, at least with my experience. It has never really involved any third party.* And it's about [saving] *face as well. You want to try and contain it within your family and not embarrass yourself out in public. So, a lot of it is dealt with in-house or within the family. It may not necessarily resolve or be the best outcome, but that's just how things are done*. (P010)

> *I cannot share* [abuse] *with my other family members because it is embarrassing. I feel embarrassed to do that because of our relationship. I cannot go and share with others what I am going through with them* [niece and her family] *because I am staying with them. It was them who first came to my rescue when I had problems. So, I am just being patient with what is going on at home now. And I don't want everyone to know about what's going on at our home. It's not nice if people see and know what's happening at our place. I don't like people knowing about our family issues*. (P001)

Because of the social consequences that disgrace older Pacific people's families, they comply with expectations of family members, keep silent about any abuse, and engage in secrecy. The reluctance to discuss abuse by older Pacific people and other family members means their suffering goes unrecognised. Importantly, the social and cultural shame attached to being abused as a Pacific older person means they are unlikely to engage in help-seeking behaviours – consequently, it remains undetected.

6.4 Summary

Older Pacific people avoided talking about AOP because doing so brought shame to their families. This avoidance is driven by the desire to uphold the family's reputation and not bring their 'family name' into disrepute. There were social consequences for transgressing this cultural norm. In this study, older Pacific people living in NZ experienced abuse related to acculturation, meaning their aspirations and expectations for older age are not met.

Culturally, older Pacific people are usually cared for by their families in their older age. According to the participants:

- ARC facilities are not viewed as an option for the care of older Pacific people.
- The demands on Pacific families to work and earn money mean that participants were expected to undertake childcare and domestic work (i.e. cleaning and cooking).
- Cultural practices, such as fa'alavelave and maintaining traditional church attendance, caused financial burdens and stress for older Pacific people.
- Older Pacific people talked about not being able to access their church, instead being forced to attend their family's church, at the expense of maintaining their spiritual and social wellbeing.
- The impacts of AOP for older Pacific participants relate to Pacific cultures' substantial value placed on the respect and obedience toward elders, who are held in high regard. Older Pacific people reported AOP:
    - Diminished and demeaned their status.
    - Left them feeling like housemaids, having their health, social, and religious needs neglected.
    - Meant the absence or loss of status resulted in them feeling exploited, isolated, lonely, and entrapped because of their dependency on their families.

7 POPULATION GROUP: OLDER DISABLED PEOPLE'S EXPERIENCES OF AOP

7.1 Introduction

This section presents the in-depth findings for the older disabled population group, illustrated with participant quotes. Following this, the candidate themes that represent the AOP experiences for older disabled participants. The following themes were identified: *Protective factors*; *Risk factors*; *Factors enabling the continuance of abuse*; and *Impact of AOP*. The section begins with a description of the participants.

7.2 Participants

Seventeen disabled people participated. They were aged between 65–89, with the majority falling within the 65–79-year age range (see Appendix Table 1 in Appendix A). They were predominantly women (82%), with men comprising 18% of the disabled people interviewed. Three-quarters (76.5%) identified ethnically as NZ European, while 11.8% identified ethnically as Māori, with the remaining participants identifying with the 'Other' category.

A range of people perpetrate AOP for disabled people in this research (see Appendix B). They most likely experienced emotional, psychological, and financial abuse, followed by infantilisation and familial isolation.

7.3 Themes

In this study, disabled people's narratives tended to be outcome-centred in nature. While those interviewed used descriptors (such as physical, psychological, emotional, and financial abuse and neglect) to describe their experiences, it was more common for them to explain how the abuse made them feel or describe the outcomes arising from their abuse. The following themes were identified, highlighting AOP for older disabled participants.

Protective factors

Three primary protective factors for people with disabilities against AOP were identified: supportive partners, employment, and protective epistemologies and cognitive negation.

Supportive partners

Supportive partners were recognised as influential in mitigating the effects of AOP. Their presence often acted as a buffer, shielding the disabled participants from intensified harm and providing a semblance of resilience. On the contrary, when supportive partners were no longer present – often due to circumstances like the death of a spouse – the absence of this protective layer enabled the escalation of abusive behaviours. Intimate relationships, therefore, played a dual role: they were both sources of comfort and shields against further harm.

In this study, disabled people experiencing abuse from an adult child or grandchild described their intimate partner as bolstering their resilience by shielding them from the full repercussions of this form of AOP. Conversely, when they were no longer available to act as a buffer, disabled participants reported an escalation in abuse.

> *After my husband died, the abuse ramped up. When he was alive, he was tough, and he was a straight shooter. He didn't mince words. He said how it was, and I loved that about him. Although they had been abusive for years, my husband managed to keep them at bay. Things escalated as soon as he died. It was so hard. It was just me. I no longer had a buffer.*

Employment

Employment was repeatedly referenced as a significant protective factor from AOP. On one level, employment countered an individual's isolation. More significantly, for those participants who were experiencing abuse in or surrounding their home, such as neighbour or familial perpetrators, employment became a distraction, sanctuary, and escape from the abuse. Such descriptions reflected aspects of avoidance, coping by escaping the situation. Thus, employment served as a refuge or a means to escape a distressing situation temporarily. By continuing to work, employment acted as a distraction from the abuse and created a sense of normalcy or purpose in their life. It also provided a degree of emotional relief and a sense of personal agency.

> *I was working. I loved my work, and that was my escape. I just put on a mask, and I just threw everything into it* [work].

> *There was all this stuff going on at home. But while I was at work, it was a welcome distraction.*

Work friends were quite important to me. Even though I wasn't talking about myself to them, just talking to them gave me a lot of 'out'.

In addition to employment being described in various ways as a coping mechanism, participants shared how work bolstered their confidence and identity. This was especially important as disabled people in this study unanimously described multiple forms of neighbour or familial abuse that progressively eroded their confidence and sense of self.

My job is my identity. I've had some fabulous jobs and I've worked really hard. And I'm good at what I do. Working is everything to me. My self-esteem, my everything, is my work. That's why I'm still working well past retirement.

I became a really good worker of helping people. I went out of my way to make sure everyone got what they needed, and that made me feel good, which probably took away the bad feelings I was feeling. I was getting the good feelings from work.

Protective worldviews and cognitive negation

Disabled people in this study commonly described perpetrators as engaging in psychological, emotional, and familial isolation abuse. Such tactics generally occurred over time and resulted in the incremental erosion of the older person's sense of agency. Notably, in this study, disabled people's compromised sense of self and agency resulted in their succumbing to the perpetrator's demands.

Multiple examples were offered by the disabled people interviewed of perpetrators' attempts to extort money and goods, or some other form of capitulation. They did this by either instilling a sense of confusion, mental exhaustion, fear, or capitalising on the disabled person's vulnerability in these situations. In this study, the most common form of abuse was isolation from their family, either actual or threatened. In this way, familial interactions were weaponised, resulting in disabled participants being prevented from or threatened with the possibility of not seeing or spending time with their family members and grandchildren:

Threatening that I wouldn't be able to see my grandchildren didn't worry me. If it's going to be like that, "Take your kids," I said, "They will come back when they are older."

Significantly, a small number of participants described such tactics as having little impact and attributed their cognitive resilience to the protective role of their various mindsets, including belief systems and attitudes. These participants were able to identify the perpetrator's behaviour or verbal communication as abusive and negated such efforts by engaging in a variety of cognitive strategies that reinforced their

agency. Common to each of these cognitive strategies was 'the acceptability of loss', which encompassed accepting the inevitability of threatened losses by viewing them as temporary.

Risk factors

Beliefs that privilege the importance of family

In this study, disabled people encountered several risk factors and, conversely, their beliefs in the importance of family were something that was used against them. Each mindset (such as the importance of grandchildren, the sanctity of family, and protecting the perpetrator) participants held was foundational to their identity and belief systems, founded on the centrality of family and their essential role within the family structure. Significantly, disabled participants reported perpetrators leveraging the importance of family and capitalising on the effect of the potential loss of family to manipulate and attempt to control them.

The importance of grandchildren

A typical mindset of disabled people in this study was the central importance of grandchildren. On one level, disabled people described wanting a relationship with their grandchildren. More significantly, participants expressed a redemption discourse in various ways, whereby grandchildren represented a second chance. This was especially common amongst those who felt that they, themselves, had not been the best parent.

Perpetrators were repeatedly described as weaponising meaningful familial relationships and capitalising on disabled people's desire for a close relationship with their grandchildren. Across participants, they were informed that unless they succumbed to the perpetrator's coercive demands, all access to their grandchildren would cease. Demands included the disabled person providing money, purchasing assets, and undertaking activities that were counter to their wishes, such as child-minding at the expense of their wellbeing:

> *It started with psychological abuse, trying to get money, and my daughter and grandson started saying I wouldn't be able to see my great-grandchild if I didn't buy them a car.*
>
> *My daughter-in-law came to me and said, "If you don't start behaving better, you're going to lose your grandchildren and your family."*

Integral to the weaponisation of grandchildren, many disabled participants shared that it would be easier to cut ties with their abusive children if there were no grandchildren.

The sanctity of family

Linked to early childhood trauma, some participants described having developed mindsets that privileged the importance of family. They had decided early in their lives to ensure their children would be cared for and not experience the trauma they had experienced in childhood. Notably, these participants identified as female. It was common for them to share particularly gendered narratives that minimised their own needs at the expense of their families.

> *I think that I have allowed myself to be in this situation because my mother wasn't around when I was younger. So, I've always wanted to assist, but it's come to the point now where the money is abused.*

> *I put in a filter inside me that said, "I have to make this marriage work." Family was so important to me, especially for the kids to have a father. My mother had turned us against our father. We were ashamed of him. It was something that I lived with, and I wanted my children to have a father that they're proud of. And family is* [just] *as important as your marriage. The two go together.*

Protecting the perpetrator

Arising from family-centric mindsets was a reluctance of disabled people in this study to seek legal protections or police intervention because they did not want their family member to have a criminal record or be imprisoned. They described the outcomes as detrimental to the older person's grandchildren. Significantly, this reluctance was amplified in situations where they assumed blame for their child's behaviour, such as stating that they had been a poor parent. In this vein, their refusal to engage with the police was akin to a form of penance:

> *If I hadn't abused him* [adult child]*, he wouldn't have abused me. I deserve how he treats me.*

> *I'd never call them* [the police] *on my son. I would never do that. I wouldn't do that to his kids or his wife.*

Change in marital status

As previously mentioned, a change in marital status often coincided with the initiation or escalation of AOP for disabled people in this study. The most reported occurrence involved financial abuse perpetrated by the disabled person's children or grandchildren following the death of a spouse. In these situations, the partner's death represented the loss of protection, whereby the partner would have supported the disabled participant in navigating the abuse. It is noteworthy that although the abuse centred on material gain, financial abuse also incorporated psychological, emotional, and physical harm.

> *When he died, the abuse started because he was gone. I was gutted with grief, and it was hard. My daughter and granddaughter just started chipping away at me, wanting money, saying all sorts* [of things]. S*aying I should move out of the house. They were basically trying to get the house. Then physical violence started with my granddaughter, with me and my son.*

Less commonly reported was the co-occurrence of AOP along with a disabled person's divorce or separation. An example included a separated woman abused by her neighbour. The neighbour engaged in slander, accusations of criminal behaviour, and physical intimidation.

Natural disasters

The impact of natural disasters was commonly raised as a risk factor for the abuse of disabled participants. Those participants who lived through the Christchurch earthquakes described repeated episodes of moving into social housing and economic upheaval, sometimes moving considerable distances, which coincided with heightened levels of stress and grief.

> *It was all like a big psychological web going down. At the time, everything was a mess. Christchurch was a mess. And if you had other things going on in your life, it made coping really hard.*

Moving house and location resulted in the loss of their local social support networks and accessible housing. Significantly, the loss of local support represented an erosion of the protective influence arising from social surveillance, and the loss of social support provided an opportunity for abuse to occur unchecked. Equally, the loss of social support intensified disabled people's sense of isolation and ability to cope with the stressors associated with the earthquakes. Isolation was especially pronounced among those participants who were single. It is within this context that some older disabled people described having been targeted for an individual's financial gain.

> *I met this chap after the earthquake. He was five years younger than me. I was living in limbo, and he came along and helped me, like shovelling up the liquefaction and everything. I wasn't coping, so to have that bit of help was great. And paperwork was coming from* [construction company's name]*, insurance companies … and I could not look at anything. I just, I wasn't coping. And he said, "Well, you're gonna have to deal with it." And I said, "Well, will you have a look?" So, he had a look at it. I look back now, and I realise red flags were there, and that is when I gave him the opportunity of taking over my life.*

Invisibility of child-to-parent and grandchild-to-grandparent abuse

In this study, disabled people who were parents or grandparents caring for their children with mental health or neurodiversity unanimously described repeated exposure to child-to-parent and grandchild-to-grandparent abuse. Abuse included daily violent rages, verbal abuse, and threats to their person. Across these participants were accounts of structural entrapment, whereby police, health, and mental health-related agencies offered no support other than incarceration. Consequently, and wanting to protect their children or grandchildren, disabled participants described feeling compelled to look after their children or grandchildren themselves. However, this commitment resulted in extreme levels of isolation and living in high-risk, abusive environments for these participants.

> *People don't understand the trauma associated with FASD. As a parent, I can only describe it as lifelong abuse and violence. Their needs are primarily not being met throughout their life course, and then there's the cumulative impact of that. So, the caregivers are suffering because of it, because they always pick up the pieces, whatever age, often it's lifelong.*

Significantly, although acknowledged as a disorder, participants understood that only those with co-morbid diagnoses, such as autism, are entitled to disability-related support, police and Oranga Tamariki interventions. Participants shared they quickly learnt not to seek help from either the police or Oranga Tamariki to avoid a criminogenic response (rather than a whānau-centred health response) that placed their family member at risk.

> *It's almost better, in our case, to have our windows smashed, to be occasionally hit out at, to be psychologically abused, sometimes daily, than it is for the consequences of having our young person removed with his level of disability and impairment. Why? Because he would be on the f****** streets. He would be on a bench. He would be self-harming. He would harm others. He would be so unstable. He would be unmedicated. Nobody would check any of that. I mean, he would basically be either imprisoned, being bashed up by others because of his Tourette's-like reaction and anxieties in the cell, or double-bunked and murdered.*

The intersection of ageism, disability, and impairment

The intersection of ageism and the onset of a disability, impairment, or mental illness was also identified as a significant risk factor for the abuse of older disabled people in this study. It manifests through isolation, infantilisation, and substance use.

Isolation

Some disabled people described a sense of isolation after acquiring a disability in older age, such as vision impairment. With hindsight, they described feeling targeted, whereby an individual would offer some support, which evolved into a trusted relationship progressing to the disabled person's reliance on that individual. This process resulted in the disabled person's exploitation.

> *I felt relieved that there was someone to look after me, you know, because my eyesight was going. It started with little offers of help. He offered to drive me. He would drive me around, and I thought, "Well, I've got no worries because he'll take me wherever I need to go." However, I gradually became more reliant on him, which meant that I gave him more control, ultimately taking my power away.*

Infantilisation

Disabled people provided multiple examples of infantilisation[14] co-occurring with escalating coercive control. In all situations, the perpetrators attempted to erode the older person's agency by asserting they had reduced physical or psychological capacity, assertions that were difficult to counter within wider ageist beliefs and practices. In all occurrences, disabled people stated that the perpetrators' concerns and the comparable interventions were disproportionate to the emerging issues.

The intersection of ageism and disability was commonly related to allegations of cognitive decline, whereby perpetrators continually framed those interviewed as having compromised capacity and assertions of dementia. Significantly, attempts to infantilise disabled people in this study continued despite cognitive assessments failing to identify any concerns about their mental capacity and capability.

Infantilisation was enacted concerning an older person's mental illness. The combination of severe co-occurring mental illness diagnoses and compromised mental acuity associated with psychotropic medications reportedly made the disabled people in this research particularly vulnerable to the impact of psychological and emotional abuse. In this situation, tactics such as gaslighting were complicated to navigate.

[14] Infantilisation refers to the treatment of competent adults like a child.

Substance use

Those disabled people with substance abuse disorders described perpetrators weaponising their drug or alcohol use, which resulted in their alienation and continued infantilisation. Examples included loss of agency following the older person's disclosure of a substance abuse disorder, following a fall or after their hospitalisation. In all situations, infantilisation resulted in perpetrators either controlling their finances, putting pressure on the disabled people to provide the perpetrator with an EPOA, or feeling goaded into moving to a retirement home.

> *I think he's doing it* [controlling their finances] *because he thinks that if I have money, I'll spend it on booze. But I've been sober for nearly six months.*
>
> *I'm only 71. I do get unwell, it's just the nature of the game with me. I get various things, falls and stuff like that. But I'm far too young to be going into a rest home.*

The intersection of resources, migrant status, disability, and impairment

Two disabled people described having moved to NZ after the death of their husbands, each residing with their respective sons and their wives. Both participants described financial abuse over an extended period. One disabled person's daughter-in-law had taken control of their bank account and withdrew funds without their consent. Similarly, the second older person's son had taken control of her finances without her permission. They described shame associated with being treated with disrespect and feeling "powerless" because of their compromised mobility, and of feeling socially isolated. Neither had been able to establish a supportive social network in NZ.

Factors enabling the continuation of abuse

In addition to risk and protective factors, disabled people often contextualised their risks in terms of factors that enabled or facilitated the continuation of the abuse. Such enabling factors were an essential component of effective prevention and interventions. These factors included: early childhood and early adulthood trauma; a reluctance to access social networks; alienation; ageism; negative help-seeking experiences; disability-related dependence; the need for financial security; a lack of emotional resources; and substance use. Enabling the continuation of abuse is the disabled people's disability-related reliance on others, often framed as their being dependent on the perpetrator. This makes it challenging to obtain support.

> *My partner has been so amazing. I really need him because I can hardly get up the steps.*
>
> *I've become reliant on him.*

Early childhood and early adulthood trauma

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

> *If I hadn't experienced abuse in childhood, I don't think I would be in this situation now. You just wouldn't put up with it, would you? You'd say, "You don't treat women like that." And then off you would go. There's a conditioning that happens. You don't see it as abuse. They're in a bad mood or they've got pain or whatever.*

Reluctance to access support from social networks

All disabled people interviewed described having been initially reluctant to disclose their abuse experiences. On one level, reluctance was attributed to their limited support options. Ten of the 17 participants stated they had a trusted friend or family member whom they could either disclose their abuse experiences to or ask for help. Two disabled people said that their only recourse would be to enlist the support of their primary care physician. The remaining five participants described not having a trusted person in their lives whom they could either disclose the abuse to or ask for help.

In addition to limited support options, most participants stated that they had only sought help after the abuse had escalated to a point that they were worried about their physical safety or wellbeing. Across the participants, reluctance to engage in help-seeking was attributed to one or more of the following factors: not wanting to be a burden, a sense of shame that they were experiencing abuse, stoicism, and the erosion of their self-esteem as an outcome of the abuse.

> *It* [the abuse] *made me feel little. I lost all my power. I lost me. Because I was being treated like that, I just took it and went within myself. And I didn't tell people, so nobody really knew.*
>
> *I just think people don't want to know, you know, they're all busy with their lives. You know, people are busy.*
>
> *You don't reach out to people. Friends have their issues. So, you just sort of try and handle it yourself. And there was really no reason to ring the police, after all, it was my daughter.*

Lacking social networks is not always associated with the reluctance of a disabled person. It can be related to the perpetrator's insidious tactic to alienate participants from their limited social networks, thereby reducing opportunities for disabled people to disclose the abuse or seek help. The most common form of alienation involved perpetrators fabricating concern about their cognitive decline, including

compromised mental health, memory loss, dementia, and erratic moods. Establishing doubt reportedly negated the participant's help-seeking as disclosures of abuse were attributed to compromised mental capacity.

A second form of alienation occurred when perpetrators positioned themselves as victims of the participant's alleged erratic and abusive behaviour. Within this context, the perpetrator cultivated sympathy and support, redirecting support from the victim's social network towards themselves. Notably, those in their social network, including their lawyer and doctor, effectively but inadvertently colluded with the perpetrator.

> *Oh, it just made me so ill. It just made me so, so ill. I went down to the doctors thinking, "Oh well," and I was shaking like a leaf all the time. And I was crying all the time. I couldn't talk to anybody without crying. And I went to the doctor, and she says, "What's your problem,* [participant's name]*?" And I just sort of sat there for a minute in silence. And I said to her, "I've got problems at home." I didn't know how to start. I didn't know how to come across it. And he had already been there. And she says, "Well, I'm sorry* [participant's name]*." And she* [the doctor] *had never, ever spoken to me like she did. And she said, "Well, I'm sorry* [participant's name]*, but the law is the law." 'Cos he was with me for those years, and he was entitled to half. It didn't matter whether I was the one who put all the money in.*

Finally, alienation also resulted from disabled people's shame, experienced when perpetrators shared their personal details within their social network. This tactic was common amongst disabled people who were struggling with substance abuse, and their private struggles were made public. As a result, out of shame, they retreated from their network, which meant that they had decreased support options and, in turn, heightened compliance with their perpetrator's demands.

Ageism was a driver for the continuation of the abuse of disabled people in this research. While family

loyalty often underscored a reluctance to seek legal protections or police intervention, some participants also described reticence because they feared they would not be believed. Significantly, this reluctance was traced to a concern that ageism, coupled with the perpetrator's testimony, would cast the victim in an unfavourable light. Aggravating a reluctance to access the police for support was a loss of confidence, and participants questioned their capacity. This was an outcome of emotional and psychological abuse, including gaslighting, whereby disabled people in this study had been regularly accused of being "demented" or "insane".

> *I see myself back then as if I'd lost all my power, and I was dying. I felt I'd been trodden on, you know, and just squashed into the carpet. I think probably if I'd rung the police, I would have*

looked like the one who had the problem. You see, when you're older, you are invisible. And an older person saying things against two younger people. You know, I could have easily looked like I was the mad one. 'Cos it is your word against them. And they were saying awful things like, "You should be in a home." "You're demented." They were saying things like this to me, which was really nasty 'cos I knew it wasn't true. But you tell someone something as many times as you do, you know, and you begin to wonder if there is some truth about it.

Enabling the continuation of abuse was a disabled person's substance use. Seven disabled people declared having a substance use disorder, most commonly alcoholism. For these participants, the use of alcohol and other drugs began as a form of self-medication to relieve depression and anxiety associated with their abuse. While effective in the short term, substance use reportedly had a paradoxical effect and negatively impacted their confidence and motivation, especially in terms of confronting the perpetrator.

When I was drinking, it was hard to think clearly. Drinking makes you anxious. I didn't have any energy. No confidence, and I would just procrastinate.

Leaving an abusive intimate partner relationship incurs financial costs and is described by disabled people as a significant barrier. Such costs need to be appreciated in terms of the disabled person not having sufficient financial resources or employment prospects to live independently without the ongoing stress associated with a lack of economic security. Also, leaving or overcoming a perpetrator's control and manipulation required disabled people to possess the emotional resources. The intersection of age with prolonged abuse impeded help-seeking and leaving an abusive relationship. The lack of emotional resources was especially discussed in relation to IPV.

One of the reasons I really decided, yes, I'd like to talk to you is that if you can get a message out there, that someone is taking this kind of abuse or alcohol abuse. If it's in their mind to leave, make sure they do it soon enough. Because when you get elderly, you haven't got the same resources anymore. You don't have the same emotional strength that it takes to organise to be able to leave and start again.

Negative help-seeking experiences

Seven participants talked about reporting an offence to the police. Three participants who reported financial abuse to the police described an unsatisfactory response, informed that the issue was not a police matter. For example, a disabled person was repeatedly manipulated into buying her child and grandchild cars. To avoid a family member's failure to pay for car registration and insurance, the participant described how they retained the vehicles in their name and as the legal owner. Despite being

the owner, the police minimised the unauthorised sale of the cars and informed the participant that there was nothing they could do.

> *I got a letter in the mail saying that the number plates of the car that I had bought for my daughter had been changed, and it was no longer my car. So, I rang the police and I said, "How can this happen? This is my car." And they said, "Well, if the number plates have been changed, it's not your car." And I said, "It is my car, I've got the registration." They said, "You haven't got the registration for the new plates." And I said, "So my car's gone?" I told them that I bought it for my daughter, but it's really in my name, so it's my car. And sure enough, what my daughter had done was hand the plates into the police station and got new plates for the car. So, she then owned the car. I told the police, and they said, "Well, there's nothing we can do."*

Three disabled participants who are caregivers for children or grandchildren with mental health and/or neurodiversity with violent behaviours unanimously described the inadequacy of police and health service responses. Rather than an integrated, holistic response, current police and mental health frameworks were described as privileging crisis response situations and relying on legal mechanisms and deterrents, such as protection orders and the threat of imprisonment. Instead of support, participants caring for a child or adult who was violent, for example, described being repeatedly de-victimised.

> *The police, in fact, ignore us. They de-victimise us. We are victims all of the time, but the police talk about the victims that he's* [adult child] *harmed in the community when he's* [adult child] *been, say, arrested for being drunk and disorderly. The poor police are the victims. They got kicked at. That's what he goes to court for. But it's never what we are trying to say. We need help at home. And we want a whānau approach.*

The one positive interaction with the police involved a disabled person who reported their adult child assaulting them. In this situation, the police were described as efficient in terms of crisis response, as well as ensuring the older person received ongoing support through a local NGO.

7.4 Impact of AOP

In this study, the disabled people's experiences of abuse had significant physical, emotional, psychological, social, and spiritual consequences. Participants offered several confronting responses to a question about how their experiences of abuse had impacted their wellbeing. Key impacts of AOP include:

- Financial loss typically involves the loss of money and/or assets through extortion and one or more of the following forms of abuse: infantilisation; familial isolation; manipulation into an intimate partner relationship; emotional and psychological abuse; or physical abuse, whereby physical assault is actual or threatened. Notably, collusion, whether implicit or unintentional, was commonly reported by disabled people participating in the research as a supporting strategy.

- Denigration, where the regular and continual belittling of disabled people occurred in conjunction with verbal, emotional, psychological, and financial abuse, and environmental violence (i.e. the throwing and breaking of objects).

- Subservience commonly occurred in relation to a family member's expectation that disabled participants would provide child-minding, cleaning, or other duties. It happened through the incremental erosion of a disabled person's agency through one or more of the following forms of abuse: infantilisation, familial isolation, financial, emotional, and psychological abuse.

- Helplessness – a sense of helplessness was common across all participant narratives. Those disabled people in the study who had experienced abuse for extended periods equally enlisted descriptors such as isolation, desperation, powerlessness, "wanting to die", and "I have lost my identity". Notably, an extreme sense of helplessness was described by those who were experiencing adult child-to-parent or grandchild-to-grandparent abuse. Parents and grandparents of an adult child or child, especially those with neurodiversity and mental health challenges, reported this with violent outbursts. Despite repeatedly asking for help from the police and other agencies, these participants were left unsupported.

Across participants, wellbeing was framed holistically with physical, emotional, psychological, social, and spiritual consequences.

> *My wellbeing? I don't think I have got it* [wellbeing]. *I feel like my wellbeing is here. When I go home ... I just get through it until I get back to work.*

Reinforcing the multifaceted impact of AOP, disabled people in this study commonly referred to wide-reaching impacts such as being powerless, having a loss of self-identity, compromised financial wellbeing, compromised mental health, compromised physical health, and social isolation. Table 4 contains examples of these impacts.

Table 4. Examples of the impact of abuse on older disabled people

Impact	Disabled person's account
Powerlessness	*It just makes me feel … I crave, I crave for a loving relationship with my son, and I do reach out to him and tell him I love him. I hope you're having a great day and all that, but it just destroys me. It just inside. It just it's I'm like I said, I'm very positive, but some days I've just sometimes even going back, I just came to my mind I'd go to bed and just cry … It just makes me feel so powerless.*
Loss of self-identity	*It robs you. Of the ability to be yourself. And no matter how hard you work on that. You. You can't stop it. It's only when you're away from it that you can try to regain what you've lost.*
Compromised financial wellbeing	*My biggest fear was being retired, with no way to look after myself. He has stolen all my money, and I am left with nothing. My biggest fear has come to fruition.*
Compromised mental health	*Anxiety* *PTSD* *Insomnia* *Panic attacks* *Self-harm* *Substance dependency* *Memory loss*
Compromised physical health	*Repeated hospitalisations* *High blood pressure*
Social isolation	*I hide a lot of things from people like my neighbour. I've got nice neighbours. I've got the old man next door and a nice woman next door. They don't know anything about my family. They talk about their kids and everything, what they're doing, where they're going. And I just, you know, don't say anything. You're not telling people the real truth. And my girlfriend, who I love dearly, she doesn't know half of what's gone on since her son died because she's actually grieving herself.*

7.5 Summary

Older disabled people in this research identified protective factors that buffered the impacts of being abused. These included:

- Supportive partners, who boosted their sense of resilience.
- Employment, which provided older disabled people with a place to escape their abusive environments and boosted their confidence and identity.

- Utilising protective epistemologies and cognitive negation as strategies to fortify their resilience and to resist the confusion, mental exhaustion, fear, and learned helplessness that an older person's abuser instils in them.

Despite these protective factors, disabled people participants identified areas where they were limited, highlighting several risk factors. A significant risk factor for older people with disabilities is the intersection of ageism and the onset of a disability, impairment, or mental illness that is enabled by isolation, infantilisation, and substance use. Other risk factors included:

- Contrary to protective epistemologies and cognitive negation, in this study older disabled people's beliefs that privileged the importance of the family, the sanctity of the family, and protecting perpetrators of abuse to avoid potential consequences such as a criminal record or imprisonment, were also risk factors.
- A change in marital status that results in the loss of a person who protected an older person from abuse.
- Natural disasters and the COVID-19 pandemic caused significant disruptions for disabled people in this research, both socially and financially, especially when they need to change houses, which results in the loss of essential support systems and accessible housing.
- An invisible form of abuse is child-to-parent or grandchild-to-grandparent abuse, whereby the older disabled person is also caring for a child or grandchild who has mental health issues or neurodiversity, such as FASD or similar conditions. This can expose them to violent rages and challenging behaviours with little or no support from police or other support agencies.

Factors that enable the continuation of abuse include histories of early childhood and adulthood trauma, a reluctance to access support from social networks, and negative help-seeking experiences. Finally, the impacts of AOP for disabled people interviewed included powerlessness, loss of identity, compromised financial wellbeing, compromised mental and physical health, and social isolation.



Part 3: Discussion and recommendations

8 DISCUSSION

8.1 Summary

- Notably, the synthesis in Section 4 and the detailed cohort findings (supported by participants' voices) and Sections 5-8 highlights the variations and nuances between the cohorts' experiences of AOP. Familial isolation, infantilisation, and weaponising grandchildren and mokopuna were common forms of abuse across the cohorts.
- Participants spoke explicitly about the harms associated with the intentional denial of access to their grandchildren and mokopuna. It is a form of psychological and emotional abuse and coercive control. Thus, in participants' minds, this is abuse that causes them harm, involves an imbalance of power, and denies their rights. In the case of Māori older people, this was seen as a transgression against whakapapa.
- The study highlights systemic and structural abuse faced by older people across the population groups.
- Older Māori participants experience racism and marginalisation when interacting with government agencies and service providers. Their lack of trust extends to a distrust of systems and services.
- Pacific people's abuse remains invisible, mainly due to cultural sensitivities related to talking about abuse and avoiding shame for the family. This inadvertently entraps them in situations of neglect or exploitation within family systems.
- Disabled people in this study often fell victim to false claims of cognitive incompetence, which abusers use to seize their assets.
- Overall, participants perceived that systemic failures exacerbate abusive relationships, leaving these older individuals with limited means to escape or to seek intervention.

8.2 Conceptualising AOP

Our understanding of AOP has increased significantly over the last 20 years. However, this field remains relatively embryonic, and our knowledge of AOP continues to evolve. Many of the findings in this report

are evident in international research and frameworks on AOP and older people's wellbeing (UN, 1991; Madrid International Plan of Action on Ageing, 2002; WHO, 2024, 2025). The shifting nature of our understanding lends itself to continually ensuring that the way we define AOP, along with the various abusive tactics, adequately reflects the experiences of older people.

Emerging forms of abuse

Various definitions and theoretical stances exist for AOP. Theoretical stances take different positions to help understand this complex and multifaceted issue affecting older people:

- Intrapersonal – Social learning
- Interpersonal – Social exchange, caregiver stress, and dyadic conflict
- Sociocultural – Power and control
- Multisystemic – Ecological and sociocultural context (Alias et al., 2023)

These various perspectives on the drivers of AOP can provide helpful insights. Multisystemic Theory (Roberto & Teaster 2017, cited by Alias et al., 2023),[15] is based on the Center for Disease Control and Prevention (CDC) research and Bronfenbrenner's ecological model. It is a more recent approach that incorporates the ecosystems and sociocultural contexts impacting individuals living with elder abuse and others who are involved in their lives, like family and whānau. Notably, it includes the intersectionality of an older person's identity and forms of oppression (such as age, gender, race/ethnicity, employment, poverty), relationship dynamics, impacts of AOP, relationship with other's lives, and the social and societal responses to older people. Intersectionality becomes an essential analytic lens when considering AOP because older people often occupy more than one identity, all of which can be compounding in their effects. For older people who occupy multiple identities, such as those aged 75 who identify as Māori, Pacific, and disabled, intersectionality helps in understanding how these sociocultural contexts intersect and the additional impacts they have when viewing AOP from a single perspective. These factors contribute to the complexities associated with understanding AOP.

AOP presents in myriad forms and combinations that include physical, psychological, emotional, financial, and sexual harm, and neglect, violence and abuse. Undeniably, it causes harm and diminishes the dignity and mana (status and authority) of an older person, who is often without the necessary support to stop it. Across AOP and violence-related studies in general, abuse has been commonly described as comprising

[15] The citation for the original work: Roberto, K. A., Teaster, P. B. (2017). *Theorizing elder abuse*. In: Dong, X.Q. (Ed.). *Elder Abuse: Research, Practice and Policy* (pp. 21–41). Springer, Cham, Switzerland.

financial, physical, psychological, neglect, and sexual acts (Qu et al., 2021), whereas others also include emotional abuse, abandonment, and spiritual abuse (Roguski & Atwool, 2024; Rzeszut, 2017). Also, more recently, the role of collusion and coercion has gained a greater understanding, while a growing acknowledgment of entrapment at personal, social, and structural levels has provided a much-needed theoretical and analytical framework (Roguski & Atwool, 2024; Tomlie et al., 2018; Wilson et al., 2019). Complementing the shifting nature of AOP research, additional forms of abuse arose from an analysis of participants' harm and mistreatment experiences as older people in this study. The following discussion focuses on these forms of abuse: familial isolation, infantilisation, cultural & spiritual abuse, the weaponisation of grandchildren and mokopuna, and systemic and structural abuse. First, definitional considerations are discussed.

Definitional considerations

There is no consensus over what constitutes AOP. At its most simple, Rosalie Wolf (2000) suggested "elder [sic] abuse" encompassed all types of abuse or maltreatment toward older adults. Abusive acts could be intentional or unintentional, including acts of commission (abuse) or omission (neglect), and that abuse or maltreatment includes physical, psychological, emotional, and financial abuse and neglect. The impact includes suffering, loss, and/or a decreased quality of life. Whether an act was neglectful or abusive centred on duration, frequency, severity, and consequences. Importantly, an older person's perception of an abusive action, coupled with its cultural context, was significant to the identification of abuse and intervention (Wolf, 2000).

Currently, NZ has yet to adopt an official definition of AOP. In the absence of a universally agreed-upon definition, the current study adopted the definition proposed by Kaspiew et al. (2019) to frame an Australian prevalence study of AOP. Several tensions arise when this definition is juxtaposed against the narratives of participants in the current *National Study*. These tensions present an opportunity to develop a definition of AOP that is appropriate for the NZ context.

Significantly, the emphasis placed on 'an expectation of trust' (Kaspiew et al., 2019) refers to an existing relationship between the abused older person and their perpetrator(s). This interpretation is supported by the fact that Kaspiew et al. (2019) derived their definition from *Action on Elder Abuse in the United Kingdom* (1995), which was later adopted by the WHO (WHO, 2008). Within this context, AOP was defined 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* [emphasis added]. (WHO, 2008, p. 1)

Restricting AOP to 'an expectation of trust' at an interpersonal level is problematic, as there is an implicit assumption that the older person knows the perpetrator. Within this interpretation, five types of abuse experiences, relevant to the *National Study*, risk exclusion:

- abuse perpetrated via the internet, such as identity theft, scams, and financial abuse that targets older cohorts
- harm arising from people residing in the older person's neighbourhood, and where there is an absence of trust or any form of interpersonal connection
- harm and mistreatment by people within the services that older people interact with
- cultural & spiritual abuse, whereby older people's cultural status and roles are not realised because of abuse
- systemic and structural abuse, whereby government and agency decisions, policies, and systems or structures significantly disadvantage older people
- work colleagues, where again, there is an absence of trust or any history of a relationship.

Without a doubt, these are all forms of AOP that result in harm for older people and necessitate a response. However, when thinking about AOP within the context of family violence, the drivers and responses are different. At one level, not all harm of older people should be considered abuse, and for some people in this study, family members were instigators of abuse and harm via the internet. Moreover, older people did talk about harm and mistreatment that could be considered outside the realm of AOP and family violence. Importantly, they perceived this within the context of abuse and being abused. What we did find was that the tactics used by abusers, such as weaponisation of grandchildren and mokopuna, familial isolation, infantilisation, and breaches of filial piety, enabled them to mask their harm and mistreatment and should be considered as forms of AOP.

Power imbalance

Framing AOP in relation to a 'power imbalance' risks differing definitional interpretations. First, the use of 'power imbalance' might be interpreted as reflecting a form of relationship that positions the older person as reliant upon another person, within an interpersonal context. An interpersonal interpretation of 'power imbalance' aligns with the Australian prevalence study's exclusion criteria (i.e. the exclusion of people living in institutional settings) (Qu et al., 2021). It also complements the AOP literature, which has described abuse within caregiver, lawyer, and health provider relationships. The potential for unintentional collusion between abusers and lawyers, health providers, and social workers can be related to minimising the possibility of AOP by people involved in an older person's life (Schmeidel et al., 2012).

An alternative, and more inclusive, interpretation frames an imbalance of power within a macro-level context, whereby societal inequities, such as ageism, effectively place older persons in an inequitable position of power. This interpretation of 'power imbalance' is tautological and demands more rigorous definitional analysis.

A final dilemma arising from the 'power imbalance' criterion is understanding the inherent power imbalances within the workings of government and society. In this regard, 'harm or distress to an older person' through their interactions with government agencies or service providers would meet the criteria for AOP. Indeed, the current study found that several older Māori participants reported the biggest abusers in their lives were the government, government agencies, and service providers. Understandably, the reading of 'power imbalance' reinforces the need to include institutional (systemic and structural) settings in studies about the harm and mistreatment of older people. The national survey, He Waka Eke Noa, undertaken by Simmonds et al. (2022) with Māori, found systemic and structural violence was a significant issue resulting in not only abusive and violent responses, but also having their needs unmet.

Alongside the power imbalance that can exist in perceptions of older people is the notion of victims of AOP. Despite older people fulfilling the 'ideal' victim status according to Bows et al. (2023), their research with professionals (from across a range of health, criminal justice, and domestic violence services) found they failed to recognise older people as victims. As a consequence, there is a risk that older people who are victimised, including older men, remain invisible and silent. Bows et al.'s (2023) research on professionals' perceptions of victim status reinforces the likelihood of them deeming that older women and men are not victims of AOP.

Intention of abusers

Intention is a dimension of AOP that focuses on an abuser's plan to commit an act or fail to act that results in harm or distress to an older person. The WHO (2025) definition of AOP states:

> *The abuse of older people, also known as elder abuse, is an intentional act, or failure to act, by a caregiver or another person in a relationship involving an expectation of trust that causes harm to an adult 60 years and older.* (para. 1)

The inclusion of the 'intention' of the abuser is a crucial feature of the WHO definition. In contrast, the Australian prevalence study omitted intention from its definition of AOP because there was limited support in the scoping study for its inclusion due to its roots in criminal law (Kaspiew et al., 2019). This study identified intent as a significant defining feature of AOP. As such, the exclusion, of intent risks discounting the experiences of older people who have been specifically targeted, and therefore

precludes the development of tailored responses. For example, one participant in this study described meeting a stranger who purposefully ingratiated himself into her life, secured their trust, and coupled with a combination of psychological and emotional abuse exploited her financially. At the end of a three-and-a-half-year period, because of the perpetrator's successful use of the Property (Relationships) Act 1976, this older person described being close to destitute.

Age

Finally, there is a risk that an age-based criterion for AOP, such as the WHO's reference to 60 years, implies that the abuse in question occurs discretely and manifests after a particular age. In the current study, many participants described that the abuse they were currently experiencing had first manifested in either childhood or early or middle adulthood, well below the study's threshold of 55 years. Notably, abuse types that occurred before 55 years of age included child abuse and neglect, family violence, intimate partner, child-to-parent, and grandchild-to-grandparent abuse.

Onset of abuse

Participants who experienced abuse and violence across their lifetime reported that with increasing age they were categorised as older people. They also talked about how the nature of abuse and violence changed, something Goergen and Beaulieu (2013) confirmed. They stated:

> *People at every stage of the life course can be affected by interpersonal violence, starting with infanticide [sic] and child abuse and reaching into very old age. Some of these phenomena, such as intimate partner violence, may appear at different stages of the life course and extend over long periods of time.* (p. 1220)

They concluded that AOP, including mistreatment of older people, can be considered a "life-course specific" form of violence. Age, an indicator of retirement, is also attached to being classified as an older person. Undoubtedly, increasing age has physical and cognitive consequences, which increase the likelihood of needing others to provide support and assistance with various needs associated with daily living. But advancing age can also be accompanied by deficits in cognitive and communication capacities. For many older people, increasing age increases their susceptibility to abuse and breaches of trust, laying the foundations for AOP (Goergen & Beaulieu, 2013).

AOP as a culturally sensitive issue

The notion of profound shame highlights that AOP is a personal and culturally sensitive issue for some. In this study, we found that Pacific people's cultural values and beliefs associated with upholding the family's reputation meant their experiences of AOP remained invisible, engendering a sense of shame in

some participants, particularly when offenders were family members. During recruitment for this study, we found that many older Pacific people did not wish to participate in the research because they 'didn't want to get anyone in trouble' and 'didn't want to rock the boat'. This theme is also strongly echoed by findings from previous research. Thaggard et al. (2023) and Boon-Nanai et al. (2022) noted that AOP is rarely talked about within Pacific communities and is a:

> *…culturally sensitive issue to Pacific Islanders and any form of abuse of the older person, who should be held in high regard, is associated with shame.* (Thaggard et al., 2023, p. 439)

> *Saving face is important, and it is not surprising that the participants were hesitant to divulge their true views and experiences.* (Boon-Nanai et al., 2022, p. 1605)

Similarly, the NZLSA study reported that:

> *…[t]he sensitivity around the issue of elder abuse was raised by participants, with one participant commenting that, there might be some families that abuse their Elders, it's really hard to know for sure because even when the professionals come from the agencies, the Elders try to protect the family because of the fakama thing, the shame.* (Tamasese et al., 2014, p. 68)

Another aspect found in this study is that the types of AOP often overlapped. For example, while Samoan elders perceive traditional fa'alavelave gift-giving as an important cultural practice, it places excessive financial burdens upon them. They reported concern that others considered their financial contributions to be inadequate. The verbal responses may be classified as both financial abuse and cultural abuse. Likewise, when an older Pacific person was denied the ability to attend their church, this may be a form of spiritual abuse and neglect. Or when an older Pacific person was belittled or disrespected, despite their status as an elder, this could qualify as emotional abuse as well as cultural abuse. We found that no matter the types and combinations of AOP, these older people felt abused and mistreated, impacting their help-seeking.

These findings complement previous studies that have identified shame, embarrassment, self-blame, and low self-esteem as personal barriers to help-seeking (Fraga Dominguez et al., 2019; Storey, 2020). A desire to keep the abuse private, particularly where it involved friends or family members, was nominated as the reason for not disclosing abuse by more than one-quarter of participants who experienced financial harm and emotional mistreatment in a study focusing on perpetrator identity and disclosure patterns (Acierno et al., 2020).

8.3 Framing abuse experiences

Participant narratives highlighted a possible disjuncture between how AOP research is often reported and how they describe their experiences. This divide is significant in terms of the:

1. Risk that conventional operationalisation, analysis, and reporting of AOP experiences may be static or lack agility to identify emerging and 'non-conforming' trends, and
2. Development of prevention and intervention efforts in response to AOP and the accompanying messaging needs to resonate with older people and be inclusive of their realities and lived experiences. This may differ from the everyday language commonly used to understand AOP.

The first possible point of disjuncture rests on the tendency for AOP research and abuse studies in general to frame abuse as discrete manifestations, such as physical abuse, emotional, psychological abuse, financial abuse, sexual abuse, and neglect (Phelan & Ayalon, 2020). As such, little attention is given to the context within which AOP occurs, and that is predominantly a pattern of harm over time. It was common for the current study's participants to describe simultaneously experiencing multiple forms of abuse, which could involve one or multiple perpetrators.

Moreover, this research found a common theme across the cohorts that older people's stories did not just focus on the types of abuse and the context within which it occurred. It also spoke to their silence, invisibility, and isolation that marginalised them. All the while, the perpetrator(s) of their abuse intentionally colluded with people in services. This, in turn, left them powerless and helpless because no-one listened to their stories – it made help-seeking challenging. Despite older people fulfilling the criteria of an 'ideal' victim, according to Bows et al. (2023), their research with professionals (from across a range of health, criminal justice, and domestic violence services) found they failed to recognise older people as victims. Further research is needed to explore AOP holistically and the contexts within which it occurs, to capture the full range of AOP experiences more comprehensively.

8.4 Emerging forms of AOP

Weaponising grandchildren and mokopuna

Nōku te tūranga, nō koutou te mana

The responsibility is mine, the status and authority lies with you.

(Starship, 2019)[16]

The whakataukī that begins this section acknowledges the crucial role of kuia, kaumātua, and kauheke in raising mokopuna (the future generation). In the past, older Māori were the nurturers of mokopuna and whānau, engaging in kōrero tuku iho (imparting mātauranga and mōhio or wisdom) embedded in the interrelation of past, present, and future, and inspiring their mokopuna as they journey into the future. This whakataukī is a reminder of the mana kuia, kaumātua, and kauheke (elders) possess and their roles in the lives of mokopuna and whānau. It also speaks to how violence and abuse compromise their ability to fulfil their responsibility to mokopuna in a way they desire. This occurs whether it is lifetime abuse or making its presence as an older person, or whether it is physical, psychological and emotional, or financial.

This research found that the weaponisation of grandchildren and mokopuna was a strategy used by abusers across the NZ European, Māori, and disabled people cohorts. Older people's relationship with their grandchildren and mokopuna was a priority, and in these situations, it appeared that the benefits of access to them exceeded the consequences of abuse. In this way, abusers can continue their harm and mistreatment of an older person with a degree of certainty that they would not disclose the abuse they are living with.

Child and adolescent to parent violence and abuse (CAPVA)

In this research, we found that CAPVA[17] was a form of AOP for several older people across the cohorts, including those who are caring for or who have adult children living with them. For those older people with a neurodiverse adult child(ren), this was a significant issue that participants indicated they required whānau ora-type support rather than involvement of the police, which invariably risked a criminogenic

[16] Source of Whakataukī: https://starship.org.nz/safekids/nokukuteturanganokoutoutemana

[17] Child and adolescent to parent violence and abuse (CAPVA) is sometimes referred to as CPVA (i.e. child-to-parent violence and abuse).

response. Yet, securing help and support was difficult for those older people reporting this often-unknown form of family violence.

In 2010, Ryan and Wilson conducted a small qualitative study with five Māori women aged 30–60 to explore their experiences of abuse by a son or daughter. They found Māori women kept this abuse secret, protecting their son or daughter, not knowing who to go to, and all the while living with its detrimental effects. Isolated from their whānau and other support networks, these women reported being physically, emotionally, mentally, and spiritually unwell, suffering depression, isolation, self-blame, and suicidal ideation. They concluded there was a lack of response from health and other support agencies. They identified a need to recognise child-to-mother violence and the importance of providing appropriate support.

Tempest's (2024) substantive and comprehensive review of the literature on CAPVA for VisAble focused on this invisible form of family violence. In their report, Tempest highlighted the under-reporting of CAPVA, for a host of reasons, including the fear that their child will be removed from their care. Our research on AOP highlights participants' stories of caring for their adult children or young people, experiencing similar things as Tempest reveals – the isolation, self-blame, responses with the potential for detrimental outcomes, and suicidal ideation. In addition to Tempest providing clear advice for those responding to parents, it also affirmed what we found with older people with adult children or grandchildren in their care who are at times violent, their reticence to seek assistance, and when they asked for help, the risk of inappropriate responses:

> *Most families will not disclose their experiences, or the true extent of what is going on, for fear of being judged, threatened with having their child removed, an escalation in the violence, or their child being criminalised. Gaining parents' trust and believing without minimising what they are saying, helps to remove barriers to disclosing. Asking parents what they need, what they have already tried, and what outcome they want, shifts control back to them. Parents are often realistic in their expectations and already know that this is not a quick or easy fix.* (p. 48)

Townsend's (2024) Churchill Fellowship Report identified that NZ has yet to identify CAPVA as a significant issue, citing that CAPVA conservatively makes up 3%–10% of police family harm callouts. The research by Tempest (2024), Ryan and Wilson (2010), and Townsend (2024), like this research with older people, cites the reticence to report CAPVA because of the risk of criminal and punitive approaches to an adult or adolescent child who they remain emotionally connected to and love. However, without exposing the existence of CAPVA, especially for older people living in NZ, there is a high risk of preventable serious harm in addition to the intergenerational transmission of this form of family violence. Townsend concluded that:

> *Aotearoa look at this from a public health/social investment lens to determine where to prioritise and focus our efforts. A key finding was the strong co-occurrence within some families of other forms of family and sexual violence and other adverse childhood experiences. I would recommend that working intensively and therapeutically with all family members presenting with family or sexual violence offers an effective early intervention opportunity that may prevent CAPVA from occurring later. Given the high co-occurrence with neurodevelopmental disability additional supports for this cohort would be an obvious area for investment and prevention.* (p. 12)

Townsend outlines what NZ can learn from countries like Australia, which have a developed strategic state and federal approaches to CAPVA, incorporating it in their reduction of violence against women and children. This includes attention to identifying those at risk of abuse and violence and the provision of funded wrap-around support for the family and whānau. From the stories of the older people in this research, such an approach is greatly needed. Also, the lack of awareness and absence of CAPVA in policy needs to be resolved to promote help-seeking of this relatively hidden form of AOP.

Familial isolation and abuse

Multiple participants described familial isolation, either actual or threatened, as a frequent and extremely distressing form of abuse. This abuse involved the weaponisation of familial interactions (i.e. the older person was threatened with the possibility of, or prevented from accessing or engaging with, family members). Significantly, rather than family members in general, this form of abuse mainly centred on preventing the older person from having access to their grandchildren and mokopuna, disrupting an essential relationship for participants.

The AOP literature makes little reference to familial isolation as a form of abuse. However, we found minimal discussion generally frames the older person's access to grandchildren as a form of psychological abuse. For example, Qu et al. (2021) make a loose reference to familial isolation under the rubric of psychological abuse with the inclusion of the following prevalence study survey question, about whether someone has prevented an older person "from seeing or contacting family members (e.g. grandchildren) or your doctor/nurse" (p. 41).

Rather than classifying familial isolation abuse solely as a form of psychological abuse, participants' holistic experiences evidenced it as also a violation of social and cultural expectations, something mentioned by others (Breheny & Stephens, 2012; Breheny et al., 2013). For example, the cultural & spiritual expectations of older Māori and Pacific people to play protective roles in their grandchildren's and mokopuna's lives. Moreover, the impact of restricting or withholding access to grandchildren and mokopuna as an abuse tactic to elicit money or assets (like a new car) was pervasive, resulting in

emotional, physical, spiritual, and psychological distress and illness. Some participants referred to this as AOP because of the harm it caused to them.

For Māori, kaumātua, kuia, and kauheke can play an essential role in the care and development of their mokopuna – familial isolation was an affront to this lifelong cultural expectation. We found the use of grandchildren and mokopuna as an abuse tactic was intentional in nature, perpetrated by an adult child or grandchild, knowing it would cause harm and isolate an older person from their family or whānau. Social, economic, and technological changes over time have impacted the lives of whānau throughout the life course of older Māori. To some extent, these roles have been unravelled by external forces. The importance of these impacts can be understood as familial isolation that dismantles an older person's identity, which is inextricably linked to how a society values a person's roles, family interactions, social status, and experiences (Hossain et al., 2018).

Infantilisation

Infantilisation is a form of abuse in which a competent adult, regardless of age, is treated like a child (Epstein et al., 2023). Adverse outcomes associated with infantilisation include a loss of sense of control over one's life, increased depression and anxiety, anger directed toward caregivers or authority figures, lower self-esteem, suicidality, and damage to relationships (Epstein et al., 2023). In reference to older people, infantilisation has often been framed within a benevolence discourse. Coupled with ageism, it is assumed that an older person requires care, is monitored excessively, excluded from decision-making, and demeaned via patronising forms of communication, such as speech patterns commonly associated with adult-to-infant communication (Chrisler et al., 2016; Harwood et al., 1993; Higashi et al., 2012).

In the current study, infantilisation emerged as an insidious tactic, especially for disabled people, whereby accusations of reduced capacity were strategically employed to erode a person's agency in the hope that decision-making powers would be transferred to the perpetrator. This included decisions related to the older person's care, finances, and assets.

Infantilisation was described as escalating levels of coercive control that were inversely related to the older person experiencing spiralling levels of anxiety and panic, confusion, and depression. These outcomes were primarily attributed to difficulties participants encountered in attempting to counter assertions of their reduced capacity. Arguably, the prevalence of ageism makes it easier for an older person who may be experiencing, or who an abuser deems to be in, cognitive decline to be labelled as such.

Yet, suggestions of reduced capacity were often founded upon a modicum of truth, such as the older person recently forgetting appointments, a lapse that participants attributed to growing tensions

between themselves and the perpetrator. In all examples, participants asserted that the perpetrators' concerns and the corresponding interventions were disproportionate to the emerging issues. Finally, perpetrators were variously described as expertly enlisting the support of third parties, such as medical providers, lawyers, family members, and those in the older person's social network. In all reported cases, third parties had inadvertently colluded with the perpetrator, negating the older person's autonomy and agency, instead of engaging in a process of infantilisation.

8.5 Cultural & spiritual abuse

Cultural & spiritual abuse occurs when an abuser intentionally takes actions that disrupt an older person engaging in their customary practices (by acts of commission and omission). This negatively impacts the older person's wellbeing, and for Māori and Pacific participants, caused spiritual harm and was perceived as abuse and cultural disconnection. For example, customary cultural practices that older Māori and Pacific people practice over a lifetime shape their expectations for being older persons. Further, causing familial isolation by withholding access to their grandchildren or mokopuna created a sense of being culturally and spiritually abused. Experienced by older Māori and Pacific people, it can be thought of as acts of commission and omission by an abuser on one level. Likewise, when transport is denied (omission) and an older person is unable to attend the church of their choice and socially engage with other older people with common interests, this can be considered cultural & spiritual abuse.

In these instances, abusers adopt mechanisms of control, denying social interaction, and using intrusion on the older person's sense of identity and wellbeing to fulfil their needs. Demasure (2022) maintained that spiritual abuse occurs at the nexus of moral, spiritual, and psychological dimensions that fulfil their needs. Cultural & spiritual abuse plays out differently for older Māori and Pacific people. The *National Study's Prevalence Survey* included 13 cultural & spiritual measures, which may shed further light on the extent of this type of abuse among older people (see Meehan et al., 2026).

Māori

Māori, tangata whenua of NZ, and their cultural values, beliefs, and tikanga are embedded with protective factors that historically kept everyone safe and protected within whānau and hapū. Violence and abusive acts, especially against wāhine and tamariki, were transgressions of their tapu status and diminished their mana (Wilson, 2023). Nevertheless, contemporary Māori have a complicated history of colonisation whereby historical violence and disconnection from land, language, and cultural practices were used to assimilate Māori to British cultural norms. Consequently, older Māori can be located on a

continuum that spans having been immersed in customary hapū and marae tikanga and kawa to those who are reconnecting to their Māori culture, and others who are aware of their Māori whakapapa but have limited knowledge beyond this. Therefore, some whānau Māori may not possess the cultural values (such as aroha, manaakitanga, mana, and tapu), beliefs, and tikanga that promote protection and safety among their members. For instance, some whānau live with intergenerational violence and trauma and/or contemporary socio-economic deprivation that likely increases the susceptibility of older Māori to AOP (Wilson, 2023).

For older Māori, isolation and control over who they can or cannot spend time with, especially their mokopuna, impacts their mauri and wairua. Rather than focusing on individuals, Māori is a culture that focuses on the collective whānau members (and hapū in some cases), so whakapapa and whanaungatanga are of critical importance. On the other hand, participants reported being asked to undertake customary cultural practices as they age, such as whaikōrero (formal speaking) or kaikaranga (calling people to a place). This created stress and anxiety because the impacts of colonisation mean that they have been discouraged from speaking te reo Māori in their earlier life, or their whānau has been disconnected from their tūrangawaewae (a place to stand) and marae (a place for gathering).

Pacific peoples

Pacific peoples living in NZ represent diverse Pacific island nations, and have differing worldviews that inform their values, beliefs, and practices. Their communities often centre around their church, which contributes to their social, and cultural & spiritual, wellbeing. Like other population groups, complexity surrounds how older Pacific people experience cultural & spiritual abuse. The harm and mistreatment of older Pacific people living in NZ are situated within the context of migration to this country and the process of acculturation to its society and culture. Most older Pacific people were born in the Pacific Islands. According to the 2023 census, 85% of Pacific peoples aged 65 years and over were born overseas (Statistics New Zealand, 2025).

In NZ, older Pacific people often strive to maintain their traditional customs, cultural practices, and conservative values in the European-dominated, cosmopolitan NZ context, where liberal secular values prevail and an emphasis on individualism is prevalent. Pacific cultures tend to be characterised by values of collectivism, social conformity, gerontocracy, spirituality, and the primacy of the family unit in social organisation. Traditionally, in Polynesian cultures, the family unit is a large, extended family with a hierarchy of well-defined roles, involving mutual obligations between family members, underpinned by values of love and service. Resources are shared among the extended family, and prestige and achievements reflect on the family as well as the individual (Pearson, 1992). Caring for young children is also a responsibility shared across the extended family.

Older Pacific people (often referred to as 'elders') are accorded a high social status characterised by honour and deference, and this is reinforced by systems of social governance in which chiefly titles are only bestowed upon middle-aged and older people (Pearson, 1992; Tamasese et al., 2014). There is a strong emphasis on respect and obedience towards older Pacific people. As such, they play a primary role in the transmission of cultural knowledge to younger generations, including language, genealogy, ancestral land issues, and cultural protocols.

In NZ, Pacific peoples have larger households on average than the general population and are more likely to live in multi-generational households with extended family. Older Pacific people in NZ consider their wellbeing to be based on a deep faith in the Christian God, harmonious relations with family, and a sense of belonging to social groups and community with a shared identity and common interests (Neville et al., 2024).

The current research found that older Pacific participants were unlikely to speak out about their abuse and can therefore experience inadvertent neglect and exploitation as they contribute to family life with little or no reciprocation for their contributions. Isolation and loneliness within the family they were living with was complicated by younger people who might have different values and beliefs, especially about older people. Moreover, participants in this study viewed younger people as no longer holding the respect and esteem for older people in their midst. Reliance on others for transportation to meet religious, health, and other social needs increases the likelihood that these fundamental needs will go unmet. These factors impacted their feelings of being misused and abused, which in turn influenced their cultural & spiritual wellbeing.

Breaches of filial piety

Filial piety, or the elevated and revered respect for and position of older people within society, has been framed as a central normative value among Māori, Pacific, other population groups, and some participants with disabilities in this study. Filial piety has been identified as a protective factor against AOP (Lee et al., 2013). Similarly, a breach of filial piety has been associated with adverse outcomes, such as depression and extreme isolation (Dong, 2015; Xin & Zi, 2023).

The current research found that older Māori and Pacific people experienced breaches of familial piety. A tension existed between these older people and their kaumātua or 'elder' status, which, as they were socialised over their lifetime, attracted respect and esteem from others. In reality, younger people treated participants with disrespect and indifference. Participants described feeling unvalued, disrespected, and dismissed, which impacted their sense of identity.

AOP among older Pacific people is often experienced as a disrespect of their revered social status in Pacific cultures. In this sense, it is a form of cultural abuse. This theme is also reiterated in previous research, but in different ways. Boon-Nanai et al. (2022; 2021) found that older Pacific people felt disrespected when they were expected to care for their grandchildren for long periods.

> *Extended periods of childcare constituted a notable form of disrespect, in which a traditional and cherished element of the Pacific way of life [shared parenting across the extended family] was exploited and abused.* (p. 453)

> *Samoan elderly people in New Zealand have been treated as babysitters due to financial necessity, as adult children seek to save on childcare costs and afford housing.* (p. 409)

Breaches of filial piety could be considered an unseen and unintentional form of abuse that impacts an older person's well-being.

Online and digital harm as a form of AOP

Digital and online platforms, such as social media, can be used to psychologically and socially abuse older people. While scamming and similar fraudulent activities are referred to in terms of digital abuse outside of the family violence context, we found that family or whānau members, such as an older child, can use social media to abuse their parent, causing significant psychological harm. Digital harm occurs not just within the sphere of monetary fraud, but also abuse and misinformation that is targeted at diminishing and demeaning older people, including kaumātua and kuia, in disrespectful ways. Amokura Panoho,[18] Poutātaki Mātauranga Māori for NetSafe here in NZ, indicated:

> *These global shifts intensify and amplify local risks and must be anticipated and recognised in how we frame prevention, support and policy responses.*

While the evidence relating to online harm within the context of AOP and family and whānau harm is scant, this is an area that needs more attention. Most research focuses on online and digital harm outside the family context. Pacheco (2025) reported that one in five people over 60 in NZ experienced at least one form of online persecution, such as "offensive name-calling, purposeful embarrassment, stalking, physical threats, harassment over a sustained period of time, and sexual harassment" (p. 105). Participants in the current study who talked about their adult children or grandchildren who engaged in

[18] Personal communication 2 October 2025.

their psychological abuse on social media, for example, felt disempowered and unable to address the very public nature of this form of abuse.

8.6 Acculturation

For older Pacific people, AOP is driven by the challenges of acculturation into life in NZ. The role that older people play in the social structure of Pacific Island societies differs in essential ways from the roles they fulfil in NZ. Consequently, overseas-born older Pacific people have had to adapt to NZ's social, cultural, and economic environments. It is in this context that we found much of the abuse experienced by older Pacific people exists.

These findings resonate with previous studies of older abuse among Pacific peoples in NZ where living in NZ challenged Pacific values and practices. As part of the wider New Zealand Longitudinal Study of Ageing (NZLSA), Tamasese et al. (2014) conducted focus groups with 112 Pacific older adults aged 60 years or older living in Wellington to investigate their perspectives on ageing. Specific focus groups were held for Tokelauan, Niuean, Tongan, Cook Islands, and Samoan elders, with separate sessions for men and women. The Pacific Elder Abuse Research Project (Boon-Nanai et al., 2021; 2022; Thaggard et al., 2023) conducted focus groups with 50 older Pacific people aged 58–75 years living in Auckland. Participants were drawn from a range of ethnic groups, including Niuean, Tokelauan, Tuvaluan, Samoan, Tongan, Cook Island Māori, and Fijian. The focus groups, conducted in English, investigated older Pacific people's experiences, perceptions, and interpretations of AOP among their communities in NZ.

A key conclusion from the NZLSA study was that:

> *New Zealand life and dominant mainstream values about ageing and older people are challenging Pacific values and practices in relation to Elders.* (Tamasese et al., 2014, p. 14)

Thaggard et al. (2023) also noted that:

> *[I]n New Zealand, migration and the influence of Western societal values have brought change to the Pacific communities' traditional social structures … [which] … has led to some intergenerational tension due to the disparity between Western and traditional cultural values.* (p. 439)

These conclusions closely align with this study's findings on the acculturation of older Pacific people.

Many examples of the challenges of acculturation raised by older Pacific people in the current research were also raised by participants in the NZLSA study. For example, the issue of ARC was also mentioned by participants in this study.

> *Some families are forced to consider residential care for their Elders even when they worry about how they will be perceived by others. It is a difficult decision to reconcile because by their own values they have not fulfilled their duty and love for their Elders.* (Tamasese et al., 2014, p. 32)

Similarly, the Pacific Elder Abuse Research Project found that neglect was related to participants' aversion to the use of rest homes for older Pacific people, which was believed to be counter to fa'asamoa and fa'akerisiano (Christian) values (Boon-Nanai et al., 2021; Thaggard et al., 2023). Some older Pacific people are open to living in ARC if Pacific-specific facilities were available. For example, Tokelauan participants in the NZLSA study:

> *…suggested that their Elders would benefit from being able to establish their own residential home … [where they] … would be able to enjoy their time together, speaking their own language, enjoying their own familiar foods, carrying out their own activity programmes and playing dominoes … [which] … would help them feel contented and as though they were living together in Tokelau again.* (Tamasese et al., 2014, p. 30)

However, older Pacific people and their families, who are open to the idea of rest homes, face a lack of Pacific-specific facilities in NZ, which means these families feel they must take on the care of their older relatives themselves. This, in turn, can challenge those providing care without the necessary knowledge and skills to care for an older person with needs and negatively impact household finances if an adult child needs to stop or reduce their work hours to become the caregiver (as well as the stress of such a role). Among Pacific communities, there may also be a lack of awareness of entitlements or services available to such caregivers, such as the Supported Living Payment, paid family care, and respite support services (including the Carer Support Subsidy) (Tamasese et al., 2014).

The acculturation-related challenge of attending church in NZ when reliant on family members for transport was also a finding of the Pacific Elder Abuse Research Project. Two of the participants were unable to attend church. One said:

> *Sometimes, I want to go to church, but no-one takes me. Everybody has their own lives, and they don't think about me!* (cited in Thaggard et al., 2023, p. 449).

Another research study involving focus groups with older Pacific people about their experiences of ageing found that childcare responsibilities were sometimes a barrier to accessing healthcare.

> *Many [participants] relied on family for getting to and from health-care services … Some had little time or capacity to attend to their own health-care needs because they were caring for grandchildren and family.* (Neville et al., 2022)

In the NZLSA study, Cook Islands elders reported that they:

> *…found that their grandchildren were sometimes reactive and disrespectful in ways that would never be acceptable in the Cook Islands [and that] [t]he transmission of important cultural knowledge and heritage information was sometimes not being taken seriously by the younger generation*. (Tamasese et al., 2014, p. 64)

Finally, some of the findings from this study may become less relevant to future generations of older Pacific people, who will be predominantly NZ-born. For them, the challenges of cultural adaptation faced by their Island-born ancestors a generation earlier may no longer apply, and a new set of challenges may emerge.

8.7 Limitations

This research has several limitations. First, the research has a significant gender imbalance, with women making up three-quarters (74.6%) of the collective group of participants, but men comprised only one-quarter (25.3%). While we have captured some nuances of men's experiences of AOP, the findings are skewed toward women's experiences. Therefore, we recommend more research with men experiencing AOP.

Each of the population groups (cohorts) is relatively small in number, even though the sample sizes are not unusual for qualitative research. We recommend exercising caution when applying the findings. However, the in-depth interviews with participants offer valuable insights into AOP experiences across the population groups. We are also aware that in enabling self-identification and using a broad definition for the disabled people's cohort (ranging from those who have lived a lifetime with disability to those who have acquired a disability as they age, and the wide range of disabilities that exist) further research is warranted. Furthermore, the parameters of this research, such as the timeframe, limited the ability to gather the multitude of experiences people with disabilities live with. Thus, this report may not account for those living with one or more of the broad range of disabilities.

We also recognise that participants in this research may have held multiple intersecting identities, such as those identifying with one or more ethnic groups, gender, or disability. We did not collect data to

discuss the intersecting identities of older people in this research, and we would recommend that future AOP research include this in the demographic information they collect.

9 RECOMMENDATIONS

This report raises several issues for attention and contributes to the evidence on AOP in NZ. Thus, we offer several recommendations and link these to Te Aorerekura and key organisations. We suggest that, given the differences between the cohorts in the manifestations of AOP, consideration should be given to ensuring Māori, Pacific, and disabled service providers are involved in addressing them (i.e. Te Tiriti o Waitangi addressing Māori equity). Moreover, an intersectional lens should be used to capture the compounding and intersecting forms of oppression that impact older people. In contrast, Pacific and disabled equity should be Pacific-led and disabled-led. Such an approach would optimise addressing each recommendation for these population groups.

9.1 Addressing structural and systemic barriers

1. **Incorporate Te Tiriti o Waitangi principles into policy development, to ensure equitable outcomes for all older people living in NZ while respecting Māori rights and interests.**

   This study revealed differences in how older people experience AOP between the four cohorts. Thus, adopting a universal approach to addressing AOP will likely not address the differences between cohorts. The principles of Te Tiriti o Waitangi should guide policy development, ensuring that decisions are led by the respective service providers, with policy-makers, to ensure that prevention and intervention strategies meet the needs of older people. For instance, financial abuse presents differently for NZ European and Māori – older NZ European mostly referred to financial and asset abuse involving family members. In contrast, older Māori mostly struggled without sufficient financial resources and worried that they had nothing to give their mokopuna. This points to the need to commission and resource Māori with Kaupapa Māori or Māori-centred services for addressing AOP. NZ European, on the other hand, need a different approach that likely involves reviews of the legislative mechanisms and unintentional collusion between legal and health professionals and abusers of older people. Pacific peoples need to lead the resolution of the findings relating to older Pacific people participating in this research. Finally, disabled people have not just age and disability to consider, but also other intersecting issues, including access to appropriate services.

   Focus organisations: *Centre for Family Violence and Sexual Violence Prevention, Office for Seniors, MSD*

   Te Aorerekura Action Plan 2: *Investing and commissioning well, Keeping people safe*

2. Inclusion of AOP in cross-sector and cross-government strategies, informed by intersectionality related to older people, that aim to raise awareness of the subtleties and complexities of AOP to aid in its detection and the development of interventions.

   This study highlighted the complexities that are associated with AOP. These complexities include poverty, housing, unemployment, past histories of violence and trauma, and intergenerational trauma, among others. Such strategies need to be informed by intersectionality and the compounding forms of oppression that older people can experience. Importantly, a national dialogue needs to be held and be inclusive of cross-government and cross-sector agreement to address AOP.

   Focus organisations: *Centre for Family Violence and Sexual Violence Prevention, Office for Seniors, MSD*

   Te Aorerekura Action Plan 2: *Investing and commissioning well, Keeping people safe*

3. Prioritise the development of national and targeted awareness and intervention strategies aimed at identifying and reducing financial AOP.

   Central to reducing financial AOP is understanding the various ways in which perpetrators manipulate and control older people and their finances. Financial abuse, accompanied by emotional and psychological abuse, was pervasive across the population groups, although it manifests in different ways. Strategies need to reflect this complexity because perpetrators use subtle and subversive ways of manipulating and controlling older people, often accompanied by threats to withhold access to their grandchildren and mokopuna or isolation from their family. These are strong enablers of financial abuse to occur. Financial abuse also involves unintended collusion through the coercion of health or legal professionals who do not question claims of diminished capacity of an older person – raising awareness among these professions is critical. Therefore, national and targeted cross-sector strategies are required. Importantly, this recommendation needs to acknowledge the structural and systemic barriers that exist.

   Focus organisations: *Office for Seniors, Centre for Family Violence and Sexual Violence Prevention, Law Commission, Banking and legal professions, Te Whatu Ora*

   Te Aorerekura Action Plan 2: *Keeping people safe, Stopping violence*

4. Considerations should be given to the inclusion of weaponising of grandchildren and mokopuna, familial isolation, infantilisation, breaches of filial piety, and cultural & spiritual abuse into the definition of AOP and any screening tools used with older people to detect the harm and mistreatment.

The research confirmed that AOP presents in a myriad of forms and combinations.

The definition of AOP used in the *National Study* needs to be reviewed to be broader, capturing better tactics that enable and hide AOP. This study found that weaponising of grandchildren and mokopuna, familial isolation, infantilisation, and breaches of filial piety are all significant tactics used by perpetrators in their AOP to manipulate and control older people, and ensure its invisibility and continuation. These forms of abuse diminish the dignity and mana of an older person, who is frequently unable to stop it.

Drawing from the research and Qu et al. (2021), the following revised definition of AOP is recommended:

> *AOP refers to the intentional action or treatment of an older person in a single or repeated act or failure to act, including threats, weaponising of grandchildren and mokopuna, familial isolation, infantilisation, breaches of filial piety, and cultural & spiritual abuse. Such actions, singularly or in combination, are considered abuse resulting in the harm or distress of an older person. The harm or distress experienced by an older person includes physical, emotional, or psychological pain that occurs where an expectation of trust and/or a power imbalance exists between the party perpetrating the abuse and the older person.*

These tactics ensure an older person's silence, with harm and mistreatment remaining invisible and not disclosed. The consequences of not detecting AOP are:

- AOP continues, causing relentless harm without redress
- there are ongoing, and often traumatic, cultural & spiritual, psychological, emotional, financial, and social harms (such as suffering, distress, loss, and/or decreased quality of life) arising from their abuse and neglect
- critical social, religious, and health needs are likely to remain unmet

Participants also discussed that overlaps between perpetrator and victim were evident, where intergenerational trauma and violence meant that an older person may have been abusive in their earlier life, but as an older person they are the victim of AOP. The presence of unresolved trauma and extreme shame contributes to these older people avoiding seeking help.

Focus organisations: *Office for Seniors, Centre for Family Violence and Sexual Violence Prevention*

Te Aorerekura Action Plan 2: *Keeping people safe, Stopping violence*

5. Address the systemic and structural barriers that make it difficult for an older person to disclose the abuse impacting their quality of life and obtaining the timely support required to meet their needs.

The *National Study* found systemic failures exacerbate abusive relationships, leaving older people with limited means to escape or seek intervention for AOP. While the experiences of systemic and structural violence varied across the four population groups, some aspects could be addressed. For instance, promoting respectful and mana-enhancing engagement practices is key to building older people's trust in those who work within services.

Focus organisations: *MSD, Ministry of Health, Te Whatu Ora, Office for Seniors, Centre for Family Violence and Sexual Violence Prevention*

Te Aorerekura Action Plan 2: *Keeping people safe*

6. **Review the Protection of Personal and Property Rights (PPPR) Act 1988 to define "best interests" and include supported decision-making.**

The PPPR Act 1988 and the Property (Relationships) Act 1976 legislation are utilised by perpetrators to manipulate older people for financial and asset gain. An urgent review is required of legislation that enables the financial and asset AOP. Primarily, legislation lacks adequate clarity in its definition of "best interests" and its focus on substituted decision-making excludes the older person. The Law Commission is currently reviewing the PPPR Act regarding adult decision-making capacity.[19] Any review of legislation must consider the unintended consequences that negatively impact the person whose interests are being protected. Thus, a balance needs to be struck between risk and protective factors. There is always an opportunity for older persons to be included in any decision, in accordance with their capacity, such as supported decision-making. Participants' recounting of financial and asset abuse signals inadequate monitoring and protection related to this legislation.

When an older person is perceived to have diminished capacity to make decisions about their welfare, the legislation enables someone (an EPOA) to be authorised to make decisions on the older person's behalf and in their best interests. This is substituted decision-making. However, the notion of "best interests" outlined in this PPPR Act is not clearly defined and open to interpretation. Furthermore, supported decision-making, which involves the older person in decisions about their welfare, is not included in the PPPR Act. Excluding older people, especially those who are disabled, from decision-making about their welfare perpetuates the potential for AOP to occur.

[19] See the Law Commission for details about this review (https://www.lawcom.govt.nz/our-work/review-of-adult-decision-making-capacity-law/tab/overview), which has a slightly different focus.

Focus organisations: *Law Commission, Office for Seniors, Centre for Family Violence and Sexual Violence Prevention*

Te Aorerekura Action Plan 2: *Keeping people safe, Stopping violence*

9.2 Improving responses to AOP

7. **Commissioning of services with Non-Government Organisations should ensure tailored and nuanced approaches to the prevention and interventions for the abuse of older people living in NZ.**

   A key finding from this study is that, while similarities exist across the four cohorts, significant differences exist in the manifestations and experiences of abuse that can substantially influence the effectiveness of prevention and intervention activities. Context is an important consideration, not only between differing population groups, but also between geographic locations (rural, provincial, and urban), which mean approaches also need to consider the place where interventions are to be delivered. Tailored place-based approaches enable the critical differences between groups of older people to be included in prevention and intervention activities.

   Focus organisations: *Centre for Family Violence and Sexual Violence Prevention, MSD, NGOs*

   Te Aorerekura Action Plan 2: *Investing and commissioning well, Keeping people safe, Stopping violence*

8. **Provide older people with dedicated counselling and support to manage and heal from the abuse and trauma they have experienced across their lifetime or as older people.**

   Well and healthy older people are needed to optimise opportunities for enhanced quality of life. Many participants in this research had histories of abuse in their earlier lives – Māori participants talked about intergenerational trauma and violence they carried into their older age. Similarly, older disabled people had experienced multiple forms of abuse in childhood or early adulthood. Yet, many were unable to access counselling and support to manage their trauma and abuse and, therefore, the opportunities to heal. Trauma and violence-informed approaches to healing are needed for not just older people themselves, but also for their whānau, where intergenerational violence and trauma or histories of violence and abuse are evident.

   Focus organisations: *Te Whatu Ora, ACC, Office for Seniors, Centre for Family Violence and Sexual Violence Prevention*

   Te Aorerekura Action Plan 2: *Keeping people safe*

9. Use both Tempest's (2024) and Townsend's (2024) reports to develop policy and interventions for preventing and responding to child and adolescent to parent violence and abuse (CAPVA).

   This research found that CAPVA is an issue detrimentally affecting older people, especially those in the disabled cohort. Research shows it is an invisible form of family violence that victim-survivors are often reticent to disclose or talk about, particularly if such activities risk the older person's (adult) child or adolescent being charged for assault and similar charges. We recommend that CAPVA be recognised and treated as an under-reported form of family violence that requires clear policies focused on prevention and response strategies aimed at enhancing family and whānau wellbeing. Contingent on a successful approach would be funding to raise people's awareness throughout NZ, and to develop a trauma and violence-informed and whānau-focused response plan for intervention and healing.

   Focus organisations: *Centre for Family Violence and Sexual Violence Prevention Te Whatu Ora, MSD, ACC, Office for Seniors*

   Te Aorerekura Action Plan 2: *Keeping people safe*

10. Develop policy that focuses on responding to the needs of older men who are victim-survivors of AOP and their need to access timely gender-appropriate services.

    In this study, men reported difficulty in accessing support and assistance for the AOP they were experiencing because the services available were designed to meet the needs of women. However, older women also reported challenges in accessing services. With increasing age, people become increasingly vulnerable and need to rely on others for support. This vulnerability and the need for help from other people mean that men are susceptible to AOP in their older years. The absence of services available for older men to access, especially when wanting to leave an abusive situation, is also a structural and systemic issue that prevents their needs from being met.

    Focus organisations: *Office for Seniors, Centre for Family Violence and Sexual Violence Prevention, MSD, NGOs*

    Te Aorerekura Action Plan 2: *Keeping people safe, Stopping violence*

11. Explore third-party mechanisms to protect older disabled people who have had their agency removed and are isolated from other people and sources of help.

    In this research, the 'othering' of older disabled people was enabled through tactics like familial isolation. We found that age and disability led to disabled people losing their voice, aided by a range of coercive control and manipulative strategies used by the perpetrators of AOP. Notably, the

intersection of age, disability, and AOP has a compounding and cumulative effect that makes it increasingly difficult to get their need for help and support heard. When disabled people are non-verbal, this makes it more difficult to express their safety and security needs. Disabled people living with AOP are often without advocates and need a third-party mechanism that aims to protect them when their agency has been removed.

Focus organisations: *Office for Seniors, Whaikaha – Ministry for Disabled People, Centre for Family Violence and Sexual Violence Prevention, MSD, NGOs*

Te Aorerekura Action Plan 2: *Keeping people safe, Preventing violence*

9.3 Keeping older people safe

12. **Establish alternative housing for older people who are being harmed and unable to extricate themselves from their abusers and unsafe homes.**

    Due to the nature of AOP, older people may find themselves with few options for securing a safe place to live because they lack the financial means or have lost their homes. Some participants reported being unable to access women's refuges and having no other options. Men also reported being unable to access services and alternative housing. Safe housing is needed for older people who have been abused, especially in circumstances where they have been 'evicted' from what was their home. Special consideration should be given to older adults at risk of further harm.

    Focus organisations: *Office for Seniors, MSD, Kāinga Ora, Centre for Family Violence and Sexual Violence Prevention*

    Te Aorerekura Action Plan 2: *Keeping people safe*

13. **Establish effective responses to older men who were experiencing AOP, including alternative housing or a refuge to separate them from the perpetrator of the abuse and be safe.**

    While small in number in this research, older men experiencing AOP reported few options for support to address their situations. The services they encountered for the provision of family violence were gendered and were not appropriate for men to access.

    Focus organisations: *Office for Seniors, MSD, Kāinga Ora, Centre for Family Violence and Sexual Violence Prevention*

    Te Aorerekura Action Plan 2: *Keeping people safe*

14. **Provide support and respite care for older people caring for adult children or grandchildren and mokopuna with neurodiversity and mental health issues and high support needs, who can be violent.**

    Not all older people have access to support and respite (through Disability Support Services) when they care for an adult child or grandchild with neurodiversity and mental health issues. Some older people are exposed daily to violence and violent rages. They reported the difficulties in caring for their adult children and grandchildren, with no relief or options to get support. These older people are coping with the disabilities or conditions that often accompany ageing.

    Focus organisations: *Office for Seniors, MSD, Te Whatu Ora, Centre for Family Violence and Sexual Violence Prevention, Whaikaha – Ministry of Disabled People*

    Te Aorerekura Action Plan 2: *Keeping people safe, Stopping violence*

9.4 Workforce development

15. **Raise awareness of AOP among the health, legal, police, disability, and social sector workforces.**

    Building on the second action plan for Te Aorerekura, workforce development should include training on AOP, particularly for the health, legal, police, disability, and social sectors. Specifically, there is a need to provide training on ageism, AOP and its myriad of forms (including those found in this study), perpetrator tactics (such as the inadvertent collusion, manipulation, and coercive control), how these manifest differently from other forms of family violence and IPV, and social, systemic, and perpetrator entrapment in relationships with perpetrators of their abuse.

    Focus organisations*: Centre for the Prevention of Family and Sexual Violence with the Office for Seniors*

    Te Aorerekura Action Plan 2*: Keeping people safe, Stopping violence*

16. **Specialist training on AOP is needed for police, health professionals, and lawyers. Specifically, this training should include ageism, AOP and its forms, perpetrator use of coercive control, manipulation, and entrapment, the different manifestations compared to other forms of family violence and IPV, and social and systemic entrapment of older people in relationships with perpetrators of AOP.**

    AOP has similarities with family violence, but also has differences. Across the four cohorts, older people talked about seeking help from police, health, legal, and women's refuge services for assistance with stopping the abuse they were living with. However, they were likely experiencing financial and emotional abuse, which was not seen to warrant attention. Furthermore, perpetrators

often colluded with police, health professionals or lawyers, setting a narrative highlighting older people's alleged cognitive impairment or dementia for the perpetrator's financial gain. Specialist training focused on AOP is essential for responding more effectively to AOP. This research found that people often acted inadvertently on ageist assumptions and beliefs that enabled the perpetration of abuse, while minimising the older people's perspectives and experiences. This training should also be linked to the screening and risk assessment tools for AOP.

Focus organisations: *Office for Seniors, Education providers of health, legal, and police workforces, Te Whatu Ora, Centre for Family Violence and Sexual Violence Prevention*

Te Aorerekura Action Plan 2: *Strengthening our workforce*

17. Include in training about AOP, the role of inadvertent collusion with perpetrators of AOP and its role in systemic and structural violence older people encounter.

Key to addressing systemic and structural violence is understanding the role of staff, especially those in government agencies, the police, health and the legal profession, in the inadvertent collusion with the perpetrators of AOP. This research found that perpetrators provide narratives to people working in government agencies, health, and legal professionals about older people that draw on ageist stereotypes that they lack the necessary cognitive competency to make decisions for themselves. This is part of their suite of coercive control and manipulation tactics. They use people in subtle and sophisticated ways to acquire an older person's money and/or assets. When older people seek help, they are then not believed.

Focus organisations: *Office for Seniors, Centre for Family Violence and Sexual Violence Prevention, MSD, Ministry of Health, Ministry of Justice, Police, Lawyers, Education providers*

Te Aorerekura Action Plan 2: *Keeping people safe, Stopping violence*

18. Work with Pacific community leaders focused on the care of older people on strategies to detect the abuse of older Pacific people and develop culturally appropriate interventions, especially related to exploitation, neglect, and breaches of filial piety.

Speaking about abuse is discouraged within and outside of Pacific families because of the shame it creates for the family. It is a cultural transgression to talk about AOP. In this way, silence keeps AOP hidden. Older Pacific people coming to NZ to assist in the care of family members and their children are at risk of exploitation and isolation, which is accompanied by a sense of loneliness. Neglect occurs when older Pacific people are reliant on family members to meet their needs, such as transportation to access health clinics, shops, and the church. Furthermore, the cultural concept of gift-giving within

the contexts of family events in NZ, their island nation, and the church, exerted considerable financial stress for Pacific participants in this research.

Respect underpins the revered status of older Pacific people, something expected as they attain older age. Yet, participants reported that younger family members lacked respect and instead belittled older people, avoiding conversations with older Pacific people living in the same home.

Focus organisations: *Pacific community leaders, Office for Seniors, Centre for Family Violence and Sexual Violence Prevention*

Te Aorerekura Action Plan 2: *Keeping people safe*

9.5 Raising awareness

19. **Institute a national campaign that is aimed at raising awareness of AOP among the NZ public.**

It has become apparent in this study with older people that families and whānau play a significant role in AOP. Older people across the cohorts discussed how they were manipulated and controlled financially, emotionally, and spiritually, which caused them harm and mistreatment. This resulted in them feeling abused, isolated, and unsupported. For the Māori and Pacific cohorts, cultural & spiritual abuse was evident, which prevented them from engaging in cultural events and activities and in realising their aspirations for their older age. Furthermore, disabled older people can also be reliant on others to support them in their daily lives.

Focus organisations: *Centre for Family Violence and Sexual Violence Prevention, MSD, Ministry of Health, Ministry of Justice, Police, Lawyers*

Te Aorerekura Action Plan 2: *Keeping people safe*

20. **Raise awareness about the intentional use of grandchildren and mokopuna to exploit older people and obtain their assets and/or money.**

The use of grandchildren and mokopuna as a strategy in the AOP is a powerful lever that results in an older person's silence about and compliance with the abuser and their demands. The threat to remove access to grandchildren and mokopuna is potent, and participants discussed the psychological and emotional harm this caused to them. Older people in this study went to great lengths to avoid losing access and contact with their grandchildren and mokopuna. Such threats and actions were intentional and can be categorised as coercive control strategies by perpetrators of

abuse. There needs to be an awareness that using grandchildren and mokopuna in the commission of AOP is unacceptable.

Focus organisations: *Office for Seniors, MSD, Centre for Family Violence and Sexual Violence Prevention, Iwi Leaders Forum, Education providers*

Te Aorerekura Action Plan 2: *Keeping people safe*

21. Provide education about online abuse targeting older people, which also includes guidance on protection regarding mobile devices and social media through cross-sector collaboration, such as the Office of Seniors (Digital Literacy) and NetSafe.

Online and digital platforms are a growing and evolving form of psychological and financial abuse. Participants reported online abuse targeting older people by family and non-family members was a source of significant psychological abuse that they were unable to respond to. The impacts were greater when the perpetrator of the abuse was a family member, including adult children. Furthermore, older people often do not understand how to protect themselves when using their mobile devices, such as phones, exposing them to unauthorised access to their personal information and data. This specific area requires targeted education of older people about these risks and equipping them with practical strategies to protect their information and data from unauthorised access.

Focus organisations: *Office for Seniors (Digital Literacy), Centre for Family Violence and Sexual Violence Prevention, NetSafe, Iwi Leaders Group – Pou Tangata*

Te Aorerekura Action Plan 2: *Keeping people safe*

22. Raise awareness among older people about wills and the requirements for a will to be legally and validly executed.

We noted a lack of knowledge among participants about wills, which was a point of manipulation that perpetrators exploit as part of their strategies for financial abuse. Not all older people understand the requirements for creating a legally valid will, and the inability to execute a 'will' was a source of stress and distress.

Focus organisations: *Office for Seniors, Law Commission, Lawyers*

Te Aorerekura: *Keeping people safe*

23. Liaise with the National Iwi Leaders Group – Pou Tangata to raise awareness among whānau Māori about how to legally transfer land from one generation to the next.

An area of financial and asset abuse was the loss of whenua for the older people's whānau. Participants were unaware of the consequences of not going through the legal processes upon the passing of their tūpuna. Being unaware of the need to register a claim with the Māori Land Court left older people exposed to someone in their wider whānau claiming their whenua and, in some cases, their home. This left them homeless and without any asset (i.e. whenua) to start again.

Focus organisations: *Iwi Leaders Group – Pou Tangata, Office for Seniors, Law Commission, Lawyers*

Te Aorerekura: *Keeping people safe*

9.6 Further research

24. **Undertake more in-depth qualitative research with each of the population groups, especially men, to garner a deeper understanding of the unique contexts and experiences of AOP from the perspectives of older people.**

While this research provides valuable insights into the experiences of AOP for older people, it is limited by the sample size of each cohort and its gender bias toward women, who comprised almost 75% of the participants. While similarities existed between all four cohorts, each cohort experienced AOP in unique ways. In building a knowledge base around AOP within NZ, further qualitative research that is aimed at understanding the context and experiences of AOP is warranted. For disabled people, research needs to explore in depth the differing experiences of those who have lived with their disability over their lifetime, and those who have acquired a disability as an older person.

Focus organisations: *Centre for Family Violence and Sexual Violence Prevention, Office for Seniors, MSD, Ministry of Health, Te Whatu Ora*

Te Aorerekura Action Plan 2: *Keeping people safe, Preventing violence*

25. **Undertake research that focuses on AOP occurring within aged care residential settings and provide space for older people residing in these care facilities and their whānau to have a voice about their care.**

We heard from several older people in this study who expressed concerns about the abuse of their partners or older persons in ARC. This was out of scope for this research. Many Māori participants expressed concerns about making decisions about their older people needing to be placed in ARC. The prevalence of abuse in ARC settings and other institutions, such as hospitals, is not captured in the *National Study* (except for the administrative data report, see Chen et al., 2026), and the extent of AOP in these settings is anecdotal and unknown. Seeing an older person in aged care who has the

signs of being abused is distressing for older people, yet they talked about being powerless to do anything.

Focus organisations: *Office for Seniors, MSD, Ministry of Health, Te Whatu Ora*

Te Aorerekura Action Plan 2: *Keeping people safe*

9.7 Conclusion

The qualitative component of the *National Study*, with the four cohorts (older NZ European, Māori, Pacific, and disabled people) highlights the complexity and multifaceted nature of abuse among older populations. By combining these qualitative insights with quantitative data and economic analysis, this project contributes to a deeper understanding of AOP, to inform policy and commissioning decisions about the workforce development and service responses needed to prevent AOP. The findings of this study provide a platform to inform the development of actionable strategies targeted at better protecting and supporting older people in NZ, by tailoring these to population groups that protect and support older people in NZ into the future.

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Appendix A – Participant details in tables

Appendix Table 1. Age group distribution (number) by cohort (n)

AGE GROUP (YEARS)	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90-94	95-99	≥100	No age given
NZ European (n=18)	1	3	4	4	4	1	1	-	-	-	
Māori (n=15)	4	2	3	2	3	-	-	-	-	-	1
Pacific peoples (n=21)	5	1	1	2	4	3	1	-	-	-	4
Disabled people (n=17)	1	-	6	2	5	2	1	-	-	-	-

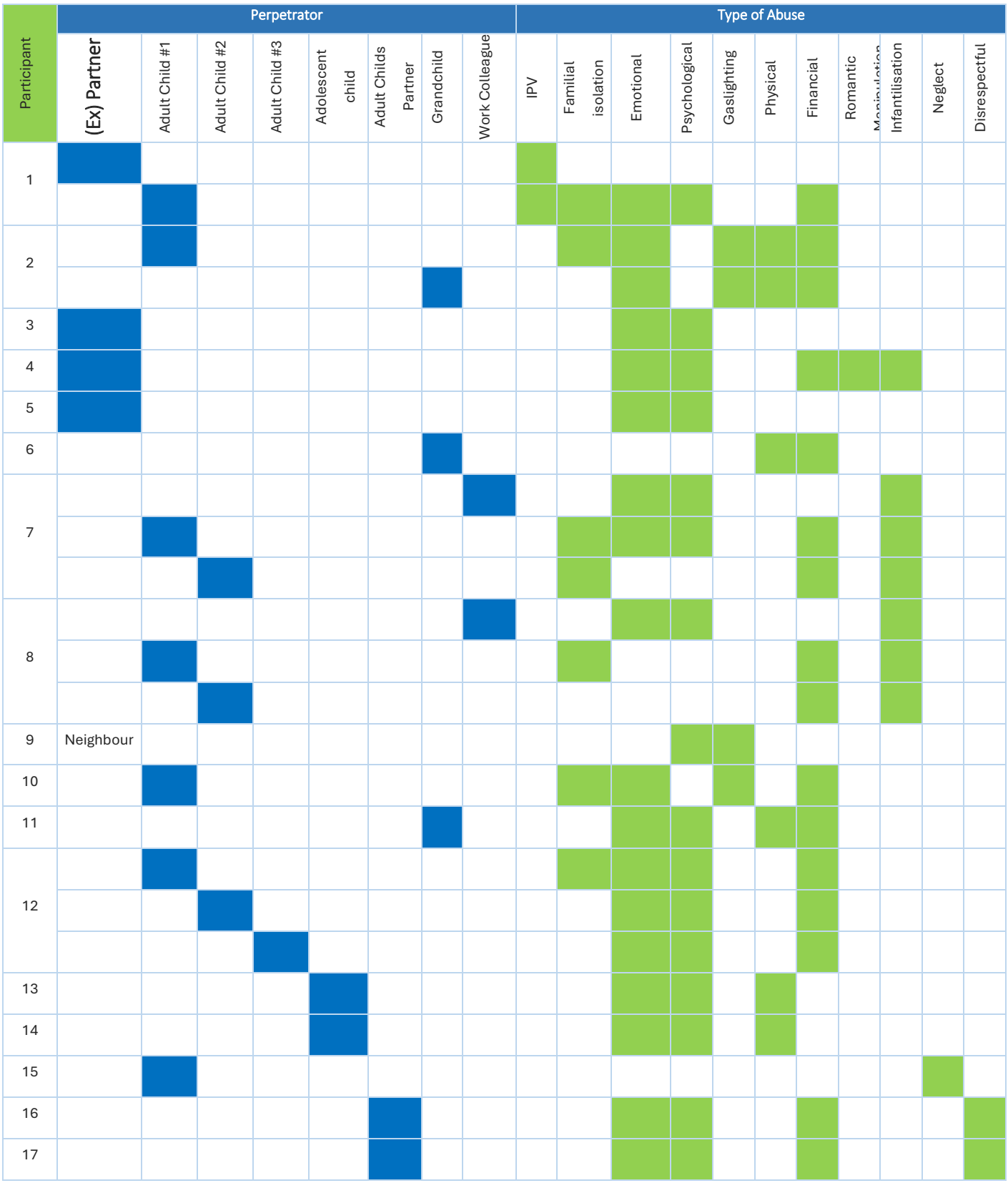
Appendix Table 2. Perpetrators' relationship to NZ European older people

Perpetrator relationship	Number of participants
Partner or ex-partner	4
Parent	2
Children | stepchildren | children-in-law	8
Grandchildren	1
Siblings	1
Wider family	1
Wider work or social circle	4

Appendix Table 3. Summary of the types of abuse NZ European older people talked about

Type of abuse	Participants experiencing abuse (numbers)
Emotional	15
Physical	5
Verbal	5
Financial	8
Coercive control	4
Sexual	1
Stalking behaviour	2

Appendix B – Types of abuse and perpetrators of AOP for disabled people





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