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Abuse of older people in Aotearoa New Zealand

An examination of potential data sources

COMPASS RESEARCH CENTRE
FACULTY OF ARTS
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Waipapa Taumata Rau

An intertwining graphic motif has been developed for this report to represent the gathering of information and its dissemination into the public discourse.

This report was commissioned by the Ministry of Social Development. The report was prepared by Natalia Boven, Komathi Kolandai, Lisa Underwood, Arezoo Malihi, and Barry Milne.

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Supporting partners

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Executive summary

This project, carried out by COMPASS Research Centre at the University of Auckland, aims to identify and evaluate the potential utility of key data sources for providing information on the abuse of older people (AOP; also known as elder abuse) in Aotearoa New Zealand (NZ). A review was conducted to assess the availability of data that could be used to estimate the prevalence, scale, and characteristics of AOP. This included an examination of survey and administrative data sources, two interviews with data experts in Ministry of Social Development/Te Manatū Whakahiato Ora (MSD)-funded services, and consultation with relevant organisations by requesting that they complete a short survey about the data they hold.

The findings from this survey have been shared with MSD in a supplementary report. Only high-level findings from this survey are included in this report. This is to protect the confidentiality of organisations that provided information (please see the Methodology section for further information).

The review revealed that there has not been a dedicated prevalence survey of AOP in NZ. As such, it would not be possible to accurately estimate AOP's prevalence in this context. However, several data sources were identified that may provide information about the scale and/or characteristics of AOP in NZ.

The most useful survey data sources identified are the 2019 Family Violence Study, the New Zealand Crime and Victims Survey, and the New Zealand Longitudinal Study of Ageing.

The most useful survey data sources identified are the 2019 NZ Family Violence Study (NZFVS), the New Zealand Crime and Victims Survey (NZCVS), and the New Zealand Longitudinal Study of Ageing (NZLSA). The 2019 NZFVS was primarily focused on intimate partner violence, with a few questions relating to non-partner violence. The NZCVS aims to estimate the prevalence of various forms of crime, with a special interest in family violence in the more recent surveys. The NZLSA covered a wide range of topics and included the Vulnerability to Abuse Screening Scale (VASS). These surveys have different populations of interest, use different sampling methodologies, and measure experiences of abuse in different ways.

The most useful major administrative data sources identified are Accident Compensation Corporation (ACC; injury data), interRAI assessment (needs assessments with screening for AOP for those living in the community), the National Minimum Data Set (NMDS; publicly funded hospital discharges), and the New Zealand Police (recorded offences). Administrative data is likely to underestimate cases of AOP substantially. However, as these datasets are all

available through the Stats NZ Integrated Data Infrastructure (IDI) (Stats NZ, 2022) which contains linked administrative, Census and survey data, combining information across these data sources may be possible. The IDI is linked at the individual level, and as such it is possible to detect when an individual is classified as experiencing AOP across more than one dataset, which avoids double counting. Some agencies, particularly the New Zealand Police and ACC, have poor-quality ethnicity data. Using the IDI would also overcome these issues as it is possible to use total response source-ranked ethnicity data, although only to a low level of detail. Identifying a suitable denominator in the IDI (e.g., the usual resident population) to calculate prevalence and incidence rates is also straightforward.

The most useful administrative data sources identified are from ACC, interRAI assessments, publicly funded hospitalisations, and and New Zealand Police data.

Some of the most useful datasets held by individual organisations are from Elder Abuse Response Service (EARS) providers, and the banking sector.

The most useful datasets identified that are held by individual organisations are from Elder Abuse Response Providers and the banking sector.

The review identified several important data gaps. In particular, the review could not identify any current data sources on abuse in aged residential care or other institutions, or data sources specifically measuring spiritual and cultural abuse. Furthermore, most data sources containing information about AOP did not capture information about economic and financial abuse.

Acknowledgements and abbreviations

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We would also like to acknowledge the Whakarongorau Aotearoa and MSD staff members who allowed us to interview them to better understand the data held by organisations funded by MSD. Lastly, we would like to thank all the MSD staff who took the time to provide feedback on drafts of this report.

List of abbreviations

ACC	Accident Compensation Corporation
ACORN	Age Concern Online Repository Network
ANZSOC	Australia and New Zealand Standard Offence Classification
AOP	Abuse of Older People
EARS	Elder Abuse Response Services
GSS	General Social Survey
HART	Health and Ageing Research Team, Massey University
HSF	Household Survey Frame
HWR	Health, Work and Retirement Study
IDI	Integrated Data Infrastructure
MSD	Ministry of Social Development/Te Manatū Whakahiato Ora
NIA	National Intelligence Application
NMDS	National Minimum Data Set
NNPAC	National Non-Admitted Patient Collection
NZ	Aotearoa New Zealand
NZHS	New Zealand Health Survey
NZCVS	New Zealand Crime and Victims Survey

NZFVS	2019 New Zealand Family Violence Study
NZLSA	New Zealand Longitudinal Study of Ageing
PRIMHD	Programme for the Integration of Mental Health Data
PSU	Primary Sampling Units
VASS	Vulnerability to Abuse Screening Scale
WHO	World Health Organization

Introduction

Purpose and scope

The ideal approach to estimating the prevalence of an issue is to conduct a representative survey designed explicitly for this purpose. However, there has been no study designed specifically to estimate the prevalence of the abuse of older people (AOP; also known as elder abuse) in Aotearoa New Zealand (NZ), although some surveys do collect information relating to AOP.

The Centre of Methods and Policy Application in the Social Sciences (COMPASS) at Waipapa Taumata Rau/the University of Auckland was commissioned by the Ministry of Social Development/Te Manatū Whakahiato Ora (MSD) to conduct a review to identify key data sources and evaluate their potential utility for providing information on AOP. The central aim was to assess data sources that could be used to estimate the prevalence of AOP in NZ or to give a sense of the scale of the problem.

Data sources that lend themselves to quantitative analysis to better understand the characteristics, risk factors, correlates, and consequences of AOP were included. While qualitative studies are likely to provide rich data about the nature of AOP and its impacts on people's lives, these studies do not provide information about the prevalence of AOP or allow for statistical analyses of characteristics, risk factors, correlates, and consequences of AOP. Given this, the review primarily focused on data gathered by large organisations and major surveys.

Data held internally by MSD were not included. MSD may conduct an internal review to understand the opportunities of this data for understanding AOP in NZ.

MSD's Prevention of abuse of older people work programme

This project was commissioned as part of MSD's prevention of abuse of older people work programme[1]. The work programme focuses on building the foundations to better understand and prevent AOP in NZ and has four focus areas:

- Reviewing what is known and what is already happening to prevent the abuse of older people.
- Understanding the abuse of older people happening in NZ: prevalence, impacts, and drivers.
- Investing in opportunities to grow the prevention system around the abuse of older people.
- Testing what works (and doesn't work) in initiatives aiming to prevent the abuse of older people.

This project contributes to the 'Reviewing' focus area, and aims to identify and evaluate potential data sources about AOP in NZ. Secondary analyses of these data sources may provide insights into AOP's prevalence, scale, and characteristics. This review also identifies critical gaps in existing data sources that could inform further research in this area. The findings from this review are intended to support future work in this area to improve our understanding of AOP in NZ.

Defining abuse of older people

There is no single national definition of AOP in NZ. However, the World Health Organization (WHO) defines it as:

"A single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person" (WHO, 2022).

Furthermore, a recent Australian-based study that explored understandings of AOP through a series of focus groups produced the following definition for use in research contexts:

"A single or repeated act, or failure to act, including threats or distress to an older person. These occur when there is an expectation of trust and/or where there is a power imbalance between the party responsible and the older person" (Kaspiew et al., 2019, p.4).

1 See https://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/family-and-sexual-violence/prevention-of-abuse-of-older-people.html

Acts of elder abuse could include physical abuse, financial/economic abuse, emotional/psychological abuse, sexual abuse, social abuse (preventing an older person from seeing others), and neglect (Kaspiew et al., 2019). In addition to these forms of abuse, institutional abuse, referring to practices that do not respect older people's rights, may occur in residential care facilities and other institutional settings (Hynds & Leonard, 2023; MSD, 2019).

As noted by MSD, definitions of AOP are generally based on "a white, heterosexual, cisgender, middle-class perspective" (MSD, 2019, p. 24). Reflecting this bias, spiritual abuse (referring to practices that prevent older people from participating in spiritual activities) and cultural abuse (not treating older adults according to cultural norms) are absent from common conceptualisations of AOP (Hynds & Leonard, 2023; Thaggard et al., 2020). These forms of abuse are of special importance to Pacific elders (Thaggard et al., 2020). Furthermore, past research focused on healthy ageing among kaumātua has highlighted the importance of spiritual health (Hynds & Leonard, 2023; Oetzel et al., 2021).

For the purpose of this review, AOP is considered to cover the following forms of abuse: physical, psychological, emotional, sexual, financial, economic, social, institutional, spiritual, cultural, and neglect. Following Kaspiew et al. (2019), this review defines AOP as occurring within relationships of trust or where there are power imbalances. Self-neglect is not included in this review as it may have different characteristics to other forms of AOP (e.g., see Iris et al., 2010, for a conceptual model of self-neglect).

Background to abuse of older people in NZ

Emotional/psychological abuse is the most prevalent form of AOP in NZ, with financial AOP also common (MSD, 2019). Older adults often experience multiple forms of abuse (MSD, 2019). People aged over 80 years, those with worse health, Māori, those who are separated, divorced or widowed, and women, appear to be at greater risk of experiencing AOP (MSD, 2019; Waldegrave, 2015a). The most common perpetrators of AOP are family members, often adult children (Hynds & Leonard, 2023; MSD, 2019). AOP may also be committed by non-relative caregivers, whether at home or in institutional settings (MSD, 2019). Intimate partner violence where the victim is older also constitutes AOP (Fanslow et al., 2021).

Limitations to the analysis of secondary data sources

It is important to note that there are limitations to understanding AOP's prevalence, scale, and characteristics from analysing data collected for another purpose. Administrative data sets (data collected to facilitate the operation of an organisation) typically only capture information about individuals who engage with the organisation. As noted by Peri et al. (2009), AOP is likely to be underreported to service providers, and hence it is likely to be underestimated by administrative data. Underreporting is a known issue for family violence research (New Zealand Family Violence Clearinghouse, 2017a).

Despite these limitations, secondary data analysis may help provide a sense of the extent of AOP in NZ, particularly if information from multiple data sources is collated. Secondary data may also be useful to understand trends over time, the impact of policy changes, and to identify factors associated with AOP.

Methodology

Identifying and selecting data sources for evaluation

The initial stage of the review involved constructing a list of data sources that may hold information relating to AOP. This list was compiled by researchers at COMPASS in conjunction with MSD, and added to as new potential data sources were identified. These data sources fell into two broad categories: surveys, most of which were conducted by government agencies; and government or organisation administrative data sources. For the latter, publicly available contact details of relevant organisations were compiled through searching directories and individual organisation websites.

These data sources were evaluated in terms of their utility for understanding AOP's prevalence, scope, and nature in NZ. Major surveys and administrative data sources collected by larger organisations or the government were prioritised for investigation. These data sources are both more likely to collect a greater amount of data across a greater proportion of the population, and to collect data in a more standardised format, and are therefore more likely to be useful for the purpose of this review. That said, the list was compiled with the intention to 'cast a deliberately wide net', to reduce the risk of missing potentially useful AOP data sources. Consequently, many of the data sources examined had no or little data relating to AOP.

Accessing information about data sources

The methodologies employed to access information about data sources primarily fell into three categories:

1. Examining survey and administrative datasets.
2. Consultation with data/service experts of services funded by MSD.
3. Consultation with data/services experts of other organisations.

In addition to these pathways, input was occasionally sought by contacting researchers or data experts to request specific information.

Examining survey and administrative data

Where possible, publicly available information was used to assess whether a survey or administrative data source contained information relating to AOP that would be suitable for estimating the prevalence of AOP. This process included reviewing online questionnaires, data dictionaries, journal articles, and reports.

Many of the administrative data sources, and some survey data sources, are accessible through the Integrated Data Infrastructure (IDI)[2]. The IDI contains anonymised administrative, survey and Census records linked at the individual level, which is made available for research under strict conditions designed to protect the privacy of individuals and the confidentiality of their data (Stats NZ, 2022).

Consultation with data/service experts of services funded by MSD

MSD staff organised interviews with experts in the data collected by MSD-funded service providers. These interviews were with an expert at the Family and Sexual Harm Unit at Whakarongorau Aotearoa (NZ Telehealth Services), and key MSD staff involved in reviewing data collection at organisations contracted to provide EARS. These conversations typically covered similar topics to the structured questionnaires/interviews conducted with other organisations (see below). Responses were collated and are described in the section 'MSD-funded services data'.

Consultation with other organisations

Where data held by organisations could not be evaluated by either of the other pathways, information was sought by contacting organisations directly and asking them to complete a short questionnaire. Ethical approval for this consultation was provided by the University of Auckland Human Participants Ethics Committee on 17 July 2023 (reference: UAHPEC26359). All participants gave informed consent to take part.

2 See: https://www.stats.govt.nz/integrated-data/integrated-data-infrastructure/

As part of the ethical approval process, it was stipulated that information provided by organisations would be only for internal use by MSD. This was also stated in the information provided to organisations, and in the consent forms. Only very general key findings, which do not identify individual organisations, may be shared beyond the research team and MSD. Given that this report has been made publicly available, only general key findings from the consultation with organisations have been included in this report. More detailed findings have been provided to MSD in a supplementary report that is for internal purposes only.

Evaluation of data sources

Data sources were evaluated by considering the following elements:

- **Relevance** – does the data set contain information relating to AOP, and what forms of AOP are captured?
- **Detail about AOP** – does the data set capture information on the settings and relationships in which the abuse occurred?
- **Sample size/population size** – is the dataset large enough to conduct meaningful analyses for the overall population and for key population subgroups?
- **Representativeness** – how representative is the data of the older NZ population? Are individuals who don't live in community settings represented? Are Māori and Pacific Peoples well-represented?
- **Breadth of the data**
    - » Does the data contain information on other constructs that may be useful to understand the nature of AOP in NZ (e.g., gender, health status)?
    - » Does the data allow for comparisons over time?
- **Accessibility** – is it possible to access the data, and if so, what is the format of the data?

These aspects were evaluated considering the information gathered through the pathways described above. For example, the representativeness of a survey was assessed by considering the sampling methodology, response rate, and any comparisons conducted of the survey sample to the overall population by the researchers/organisation that conducted the survey.

Structure of the evaluation

Information about different datasets was gathered using different approaches, as described above. Therefore, the data sources have been summarised in different sections, as shown below. The discussion summarises key findings across all data sources, outlining essential gaps in the existing data about AOP.

Evaluation sections:

- **Large surveys** – information gathered through searching publicly available information,
- **Large administrative datasets** – information gathered by searching publicly available information,
- **MSD-funded services data** – MSD facilitated consultation pathway,
- **Data held by other organisations** – external consultation pathway.

Note that the same data source may be summarised in multiple sections if information was sought from different pathways. For example, EARS provider data is summarised under the 'MSD-funded services data' and the 'Data held by other organisations' sections as information was gathered both by interviewing MSD staff and from a survey response.

Large surveys

Scope of large survey evaluation

Publicly available information for eight large surveys was examined to assess whether they provided data relating to AOP, and the suitability of using them to estimate AOP's prevalence in NZ. These surveys can be broadly divided into government surveys and university research studies. Most are recurring surveys that resample a population each time they are administered. Others are longitudinal studies that follow up the same group of individuals over time.

Many surveys identify their samples using the Stats NZ Household Survey Frame (HSF; indicated by an asterisk in the list below). This survey frame is a list of private dwellings within Primary Sampling Units (PSUs) in the North Island, South Island, and Waiheke Island. Surveys utilising the HSF typically adjust the selection of PSUs to manage respondent burden by avoiding having the same areas overlap across different surveys (Ministry of Justice, 2022, 2023; Stats NZ, n.d.-a).

The HSF defines private dwellings as those not intended for public use and where people live independently (i.e., self-contained dwellings). Therefore, individuals who live in private houses or units in retirement villages should be in-scope for surveys using the HSF[3].

Older adults who reside in aged-care facilities, including rest homes, psycho-geriatric institutions, and dementia wards, are not covered by the HSF (Stats NZ, PC, 13 July 2023). These individuals may have increased vulnerability to abuse due to having higher health needs and greater dependence on carers (MSD, 2019; Yeung et al., 2015). Hence, surveys using the HSF may underestimate the prevalence of AOP. Of the surveys examined, only the 2013 Disability Survey included older adults living in non-private dwellings (Stats NZ, 2014a).

Notably, the quality of many government surveys has been affected by the Covid-19 pandemic. While the pandemic's impacts have been noted in the summaries below, these have not been reflected in the ratings. This is because these surveys are repeated frequently, and future iterations are unlikely to be substantially impacted by the Covid-19 pandemic.

3 The process for determining whether a unit in a retirement village is a private dwelling is not always clear-cut. Stats NZ field workers visit retirement villages to assess whether units can be considered private dwellings (Stats NZ, personal communication, 13 July 2023). * Indicates that the survey employed the HSF.

The following surveys were examined:

- 2019 NZ Family Violence Study (NZFVS; The University of Auckland)*
- Disability Survey (Stats NZ)
- General Social Survey (GSS; Stats NZ)*
- New Zealand Crime and Victims Survey (NZCVS; Ministry of Justice /Te Tāhū o te Ture)*
- New Zealand Health Survey (NZHS; Ministry of Health/Te Whatu Ora)*
- New Zealand Health, Work and Retirement Study (HWR; Massey University)
- New Zealand Longitudinal Study of Ageing (NZLSA; Massey University)
- Te Kupenga (Stats NZ)
- Te Puāwaitanga O Ngā Tapuwae Kia Ora Tonu/Life and Living in Advanced Age Cohort Study (LiLACS NZ; The University of Auckland).

1.1 2019 New Zealand Family Violence Study

Overall rating: Moderate

AOP data captured: detailed information about intimate partner violence and limited information about recent (previous 12 months) experiences of sexual violence perpetrated by non-partners among people living in the community.

The nature of the data. The 2019 NZFVS primarily focused on intimate partner violence (Fanslow et al., 2021). It expanded on the New Zealand Violence Against Women Study conducted in 2003 to cover a broader range of types of violence (including AOP by intimate partners). The study aimed to estimate the prevalence and trends of physical, sexual, psychological, and economic violence and abuse over time (Fanslow et al., 2021).

The 2019 NZFVS included items relating to violence perpetrated by non-partners, with these questions typically relating to the entire period of childhood (younger than 15 years) or adulthood (Fanslow et al., 2021; Malihi et al., 2021). Notably, the survey asked whether respondents experienced sexual violence in the 12-month period prior to the survey (P. Gulliver, PC, 6 September 2023).

The study also examined protective and modifiable risk factors for intimate partner violence, and associations of experiencing intimate partner violence with health outcomes and service use (Fanslow et al., 2021). As such, the survey captured information relating to relationship status, health and disability, life satisfaction, reproductive health, and social support (P. Gulliver, PC, 6 September 2023).

The population coverage and date range of the data. Data were collected between March 2017 and March 2019 from participants in Northland, Auckland, and Waikato (Fanslow et al., 2021). The survey population included adults (men and women) aged 16 years or older.

People living in rest homes, retirement villages, short-term residential and non-residential housing were excluded from the survey (Fanslow et al., 2021). Younger age groups were slightly underrepresented in the survey, whereas older age groups were somewhat overrepresented (Fanslow et al., 2021).

How the data were obtained. The 2019 NZFVS was a cross-sectional study employing face-to-face interviews.

A multi-stage probability-based sampling approach was employed. Initially, PSUs (typically between 50 and 100 dwellings) were sampled proportional to size. Systematic sampling was then employed within PSUs to identify dwellings (with minor dwellings excluded). Men and women were sampled from geographically separated PSUs (Fanslow et al., 2021). Survey information was sent to selected dwellings, using the Electoral Roll to obtain the names of residents (Fanslow et al., 2021). A participant of the specified gender was selected at random to participate; if no-one at the dwelling was of the specified gender, the dwelling was excluded (Fanslow et al., 2021).

The WHO Multi-Country Study on Violence Against Women scale (WHO, 2005) was used to assess exposure to intimate partner violence. The scale was modified to allow its use for men as well as women, to increase appropriateness for the NZ context, and to expand the types of abuse captured (Fanslow et al., 2021).

The final 2019 NZFVS questions were related to physical and sexual violence, psychological, economic and digital abuse, and controlling behaviours. There were further items on participants' physical and mental health, history of childhood abuse and adverse childhood experiences, cultural identification, safe and positive relationships, and their partner's problematic use of alcohol and pornography (Fanslow et al., 2021).

The final sample comprised 1,464 women and 1,423 men, with response rates similar across genders (61/64%), deprivation levels and ethnic groups (Fanslow et al., 2021). However, the 22% of households that refused to participate were not included in response rate estimates. Individuals could identify with multiple ethnicities, but results were only reported for prioritised ethnic groups (Fanslow et al., 2021)[4]. Overall, 974 responses (34%) were provided by people aged 60 and above (Fanslow et al., 2021).

Where the data can be found and any issues accessing the data. The University of Auckland holds 2019 NZFVS data. During a pilot study, participants reported that they preferred this data be held by the university and not shared with government agencies (Fanslow et al., 2021). Some data have been linked with information extracted from the NMDS and ACC datasets to examine health impacts, where consent was given. These data extracts are also held by the University of Auckland (Fanslow et al., 2021).

It is unlikely that 2019 NZFVS data would be shared with MSD. Instead, the researchers might provide aggregated data on the condition that participants' confidentiality and data storage preferences are respected.

The overall utility of the data, including recommendations for use/non-use. Overall, this data is likely of **moderate** utility for estimating the prevalence of AOP in NZ. 2019 NZFVS data are likely to be useful for estimating the prevalence of AOP that occurs in the context of intimate partner relationships for those living in the community, as well as for understanding protective factors, predisposing factors, and health consequences. Data from the survey could be used to estimate the prevalence of sexual violence within a 12-month period. The survey appears well-conducted with efforts to obtain good quality information on a sensitive topic (e.g., piloting, using a face-to-face interviewing mode). The survey also used validated measures and captured data on a wide range of types of abuse.

While 2019 NZFVS response rates were acceptable, those currently experiencing, or who recently experienced, intimate partner violence may have faced barriers to participation, which may bias the estimates of intimate partner violence downwards (Fanslow et al., 2021). Notably, the sampling frame excluded people living in rest homes and retirement villages (Fanslow et al., 2021).

2019 NZFVS data are unlikely to be sufficiently informative for understanding the prevalence of most forms of AOP perpetrated by non-partners, such as adult children, caregivers, or other residents in residential settings.

4 In NZ, many individuals identify with more than one ethnic group, but particularly the young and Māori or Pacific Peoples. Most data collection allows people to identify with more than one ethnicity, but some do not. Even when information is captured on multiple ethnicities, these are sometimes reduced to one ethnic group per person as part of data management. A common approach, 'prioritised ethnicity', allocates people with more than one ethnicity to a single group, typically in this order of priority: Māori, Pacific Peoples, Asian, Middle Eastern Latin American or African (MELAA), Other, and European. This approach leads to undercounts of non-Māori groups, especially Pacific Peoples, many of whom also identify as Māori, and can distort prevalence estimates among different ethnic groups (Boven et al., 2020). This approach fails to recognise individuals' complex ethnic identities. For these reasons, it is important that data collection allows individuals to identify with multiple ethnicities and to manage this information in a way that reflects this complexity – typically using total response (counting people in multiple ethnic groups) or single/combination (creating mutually exclusive single and combination categories) outputs.

1.2 Disability Survey

Overall rating: Very low | AOP data captured: None.

The nature of the data. The aims of the Stats NZ Disability Survey include estimating the prevalence of disability in NZ overall and across demographic groups, measuring differences in economic and social outcomes between those with and without disabilities, characterising the support needs of disabled people, and understanding barriers and enablers of participation for disabled people (Stats NZ, 2023b).

The population coverage and date range of the data. The Disability Survey was conducted as an amalgamation of the Household Disability Survey and the Disability Survey of Residential Facilities in 1996, 2001, 2006, and 2013 (Stats NZ, 2014a). The former includes disabled people living in community-based housing, while residential facilities for the latter mainly consist of aged-residential care and psychiatric care facilities. The 2023 Disability Survey will only include the Household Disability Survey (Stats NZ, 2023b).

How the data are obtained. The Disability Survey is a post-Census survey which uses responses to the Census of Population and Dwellings as the sampling frame (Stats NZ, 2023b). People of all ages are included in the target population. Children (under 15) and those with impairments that make it challenging to complete the survey can have their survey completed by their parent/carer (Stats NZ, 2023b).

A sample of 25,000 people will be selected for the 2023 Disability Survey with a response rate target of 80%. Those likely to be disabled, based on responses to the 2023 Census, will be oversampled to achieve responses from approximately 4,000 disabled people (Stats NZ, 2023b). Most surveys will be completed over the telephone, with a small proportion completed in person as necessary (Stats NZ, 2023b).

Where the data can be found and any issues accessing the data. The 2013 Disability Survey is available in the IDI (Stats NZ, 2023a).

The overall utility of the data, including recommendations for use/non-use. The overall utility of data from the Disability Survey is rated **very low**. There are no explicit questions relating to AOP in recent survey iterations (2013 and 2023) (Stats NZ, 2014a; Stats NZ, 2023b). The 2013 survey included experiences of crime, but these were general (Stats NZ, 2014a). There were no questions about fear of carers or any forms of neglect and/or abuse. Notably, these topics were raised during the survey consultation period but deemed too sensitive for a mandatory telephone survey conducted by an agency not equipped to provide support if abuse is reported (Stats NZ, 2023b). While the 2023 survey will ask about safety, this will only relate to perceptions of safety when alone at home or in the community (Stats NZ, 2023b).

Other opportunities. The sampling frame of residential facilities used for the 2013 Disability Survey may be useful for a survey of AOP experienced by those living in residential facilities.

1.3 General Social Survey

Overall rating: Very low | AOP data captured: None.

The nature of the data. The Stats NZ General Social Survey (GSS) is a representative two-yearly survey that examines social wellbeing among New Zealanders. The GSS covers a range of topics relating to wellbeing, including life satisfaction, social connectedness and social support, experiences of crime and discrimination, and health and disability (Stats NZ, n.d.-a). While each GSS survey iteration covers similar topics, some iterations collect more in-depth information about certain topics (Stats NZ, n.d.-a).

The population coverage and date range of the data. The GSS is a representative survey of adults (aged 15+) living in private dwellings (Stats NZ, n.d.-i). People aged 15 or older living in private dwellings are eligible to take part (Stats NZ, n.d.-a). People living permanently in institutions, including old-age homes, are excluded from the survey (Stats NZ, n.d.-c). The survey was conducted in 2008, 2010, 2012, 2014, 2016, 2018 and 2021 (Stats NZ, n.d.-d). Due to the Covid-19 pandemic, the 2020 iteration was postponed until 2021 (Stats NZ, n.d.-c). The next GSS will take place in 2023 (Stats NZ, 2023d).

How the data are obtained. The GSS uses a three-stage stratified sampling, initially from the HSF (Stats NZ, n.d.-c, n.d.-a). The sample size is generally around 8,000-8,500 respondents, but the 2021 survey only achieved a sample size of approximately 3,500 due to the impacts of the Covid-19 pandemic (Stats NZ, n.d.-c). The survey is completed via face-to-face interviews (Stats NZ, n.d.-c).

Where the data can be found and any issues accessing the data. GSS data for 2008 to 2021 are available in the IDI (Stats NZ, 2023a).

The overall utility of the data, including recommendations for use/non-use. The GSS does not contain items directly or implicitly relating to AOP, making it an inappropriate data source. While all iterations have included questions relating to crime, these do not ask specifically about crimes that occurred at home or in institutional settings, focusing instead on general experiences of crime or perceptions and fear of neighbourhood crime (e.g., the 2018 GSS contained extensive questions on fear of different types of crimes and perceptions of the amount of crime mainly relating to the neighbourhood of residence Stats NZ, n.d.-b).

1.4 New Zealand Crime and Victims Survey

Overall rating: Moderate

AOP data captured: Physical, sexual, and psychological forms of AOP for people living independently in the community and retirement communities.

The nature of the data. The Ministry of Justice/Te Tāhū o te Ture NZCVS is a nationwide annual survey that aims to estimate the prevalence of crimes, including those that have and have not been reported to the police (Ministry of Justice, 2022, 2023). The NZCVS replaces the NZ Crime and Safety Survey, which was conducted in 2006, 2009 and 2014 (Ministry of Justice, 2022, 2023). The NZCVS includes a core set of survey modules and revolving modules that differ each year (Ministry of Justice, 2022, 2023).

The NZCVS does not specifically ask about "crimes". Instead, it asks about events that participants have experienced – because those who have experienced crimes do not always identify such events as "crimes" (Ministry of Justice, 2022, 2023). Responses are coded into broad crime groupings using the Australia and New Zealand Standard Offence Classification (ANZSOC). Several of these groups may relate to AOP, such as assault, sexual assault, harassment and threatening behaviour, and theft. Notably, the 2020/21 and 2021/22 NZCVS revolving modules focused on family/whānau violence (Ministry of Justice, 2022, 2023).

Data are also collected on ethnicity, age, household composition, disability, psychological distress, income, relationship status, gender, sexual identity, housing tenure, and employment (Ministry of Justice, 2022, 2023).

The population coverage and date range of the data. The NZCVS has been conducted yearly since 2018, with some disruption from the Covid-19 pandemic (Ministry of Justice, 2022, 2023). The target population for the sample is NZ usual residents aged 15 and above who live in private dwellings (Ministry of Justice, 2022, 2023). Residents of retirement villages and other institutions who live independently in private permanent dwellings are eligible to participate in the survey, while those in hospital are not (Ministry of Justice, 2022). Cycle 5 of the survey, the latest cycle with publicly available data on methodology, was conducted between November 2021 and November 2022 (Ministry of Justice, 2023).

How the data are obtained. NZCVS participants are selected using a multi-stage probability-based cluster sample of individuals living in private dwellings from the HSF (Ministry of Justice, 2022). After sampling PSUs, NZ Post's Postal Address File and the Māori Electoral Roll are used to select dwellings for the main and Māori booster samples, respectively (Ministry of Justice, 2022, 2023). This design of the NZCVS aims to oversample Māori. The sampling approach used aims to ensure good coverage of areas with differing offence rates and

levels of deprivation (Ministry of Justice, 2022, 2023). If any people identify as Māori within dwellings, one of them is randomly selected to complete the survey. If no-one identifies as Māori within a dwelling, a non-Māori person is randomly chosen to complete the survey.

The NZCVS has a target sample of 8,000 individuals (Ministry of Justice, 2022, 2023). The 2019/2020 survey achieved a response rate of 80% (the target response rate) with 8,038 surveys (Ministry of Justice, 2020). However, more recent surveys have been affected by the Covid-19 pandemic (Ministry of Justice, 2022, 2023). For cycle 5 (2021/22) NZCVS, interviews were conducted with 5,326 participants, with an overall response rate of 71% (Ministry of Justice, 2023). Of the total sample, 1,624 individuals were recruited from a Māori booster sample (with a response rate of 70%; Ministry of Justice, 2023).

Where the data can be found and any issues accessing the data. NZCVS data from 2018 to 2022 for respondents who gave consent are available in the IDI (Stats NZ, 2023a). Consent for their data to be linked to the IDI was provided by 93% of respondents to cycle 5, while 95% of cycle 1 respondents who gave consent had their data successfully linked to existing IDI records (Ministry of Justice, 2022, 2023). Aggregated survey results are available on the Ministry of Justice website (Ministry of Justice, n.d.).

The overall utility of the data, including recommendations for use/non-use. Overall, the utility of NZCVS data for estimating the prevalence of the AOP is rated **moderate**. In general, the quality of NZCVS data is likely to be high; it is a well-conducted survey that uses a probability-based sampling design, has a relatively high response rate, and uses face-to-face data collection with trained interviewers (Ministry of Justice, 2022, 2023). Information collected on demographic and socioeconomic characteristics could be used to understand factors that increase vulnerability to AOP (Ministry of Justice, 2022, 2023). The data are also reasonably easy to access through the IDI with high consent and linkage rates (Ministry of Justice, 2022, 2023). However, survey iterations have been negatively impacted by the Covid-19 pandemic, both in terms of sample sizes, response rates, and survey modes employed (Ministry of Justice, 2022, 2023).

The overall utility of the NZCVS for estimating the prevalence of AOP differs by abuse type. The 2020/2021, and 2021/2022, surveys asked about family violence behaviours committed by a range of family members[5], not just intimate partners. Data from these cycles may be especially useful for estimating the prevalence of some forms of AOP. However, questions were not tailored to provide data on some of the most prevalent forms of AOP. In particular, while financial abuse is one of the most pervasive forms of AOP (MSD, 2019), economic abuse (which includes financial abuse) is out of the scope of the NZCVS (Ministry of Justice, 2022, 2023).

5 The classification scheme for victim's relationship to the offender is very detailed, including but not limited to partners, ex-partners, parents, children, paid caregivers, friends, and strangers (Ministry of Justice, 2022, 2023).

Notably, older adults living in private permanent dwellings as part of a retirement community are eligible to participate (Ministry of Justice, 2022, 2023). However, as the NZCVS only samples those in private residences, any crimes/abuse committed in care facilities are out of scope (Ministry of Justice, 2022).

1.5 New Zealand Health Survey

Overall rating: Very low | AOP data captured: None.

The nature of the data. The Ministry of Health NZHS is a continuous survey that monitors the health of New Zealanders and provides evidence for health policy decision-making (Ministry of Health, 2022a). A core set of questions is repeated yearly, with additional modules specific to particular survey years.

The population coverage and date range of the data. Since 2011, the NZHS has been conducted annually. The first survey (called the Household Health Survey) was conducted in 1992/1993, and the most recent survey for which information is available online was implemented in 2021/22 (Ministry of Health, 2023). The target population for the NZHS is people usually resident in NZ (Ministry of Health, 2022a). While people living in most types of non-private dwellings are excluded, recent iterations have included people living in old-age facilities to increase the coverage of older adults (Ministry of Health, 2022a).

How the data are obtained. The NZHS employs a dual sampling frame approach, using both the HSF and the Electoral Roll (Ministry of Health, 2022a). The HSF is used to sample PSUs within District Health Boards (DHBs), with probability proportional to the size of the PSU, and an adjustment to improve sampling of areas with large populations of Pacific or Asian Peoples (Ministry of Health, 2022a). The Electoral Roll sample is used to increase the number of Māori respondents by sampling from households where one or more member is reported as of Māori descent (Ministry of Health, 2022a). Households are then chosen using systematic sampling, and finally one adult and one child (if children are present in the household) are selected randomly to complete the survey (Ministry of Health, 2022a). Both Māori and non-Māori can be selected at the final sampling stage for both the area-based and Electoral Roll samples (Ministry of Health, 2022a).

In general, NZHS data collection takes place in person with child surveys completed by a caregiver (Ministry of Health, 2022). However, this was substituted with virtual interviewing during Covid-19 restrictions (Ministry of Health, 2022a). Covid-19 also affected the sample sizes and response rates for recent surveys. Prior to the Covid-19 pandemic, surveys typically achieved a response rate of around 80%, with a sample size of 13,572 adults and 4,503 children for the 2018/2019 iteration. However, the 2021/2022 survey only achieved an adult response rate of 53%, a child response rate of 56%, and sample sizes of 4,434 and 1,323, respectively (Ministry of Health, 2019, 2022a).

Where the data can be found and any issues accessing the data. NZHS data from 2011 to 2019 are available in the IDI (Stats NZ, 2023a)[6].

The overall utility of the data, including recommendations for use/non-use. The overall rating of the utility of NZHS data for estimating the prevalence of abuse of older people is **very low**. The datasets do not contain items explicitly relating to AOP.

Other opportunities. The survey includes respondents from within old-age facilities, so the Ministry of Health may be able to guide the best approaches for surveying this population.

1.6 New Zealand Health, Work and Retirement Study

Overall rating: Very low | AOP data captured: None.

The nature of the data. The NZ Health Work and Retirement Study (HWR) is a longitudinal study conducted by the Health and Ageing Research Team (HART) at Massey University. The HWR began in 2006 and primarily focuses on economic participation, social participation, and the health of adults aged 55 and above (Alpass et al., 2023). Follow-up surveys are completed every two years (Alpass et al., 2023). The HWR work programme also encompasses the New Zealand Longitudinal Study of Ageing (NZLSA; see below) and the Independence Contribution Connection Study.

The population coverage and date range of the data. The population of interest is adults aged 55 and above (Alpass et al., 2023; Towers, 2007). People of Māori descent were oversampled to ensure sufficient representation.

How the data were obtained. The initial HWR sample was drawn from the Electoral Rolls in 2006, with separate samples for the general and Māori descent rolls to allow oversampling of Māori participants (Alpass et al., 2023; Towers, 2007). The study recruited 6,661 participants aged 55-70, with 46% agreeing to participate in follow-up data collection waves (Alpass et al., 2023). Notably, people living in institutions (including nursing homes) were excluded from the HWR sample (Towers, 2007).

The HWR has been repeated every two years with top-up samples of adults aged 55 and above added from the Electoral Roll (Alpass et al., 2023). In addition to core questions, each data collection wave has focused on a particular topic (e.g., the impacts of the Covid-19 pandemic, housing; Alpass et al., 2023).

6 The NZHS was initially not allowed to be linked to non-health data in the IDI, but this policy has now changed.

Questionnaires were completed using telephone interviews and face-to-face health assessments (Alpass et al., 2023). Overall, 12,949 participants have contributed to the HWR study (Alpass et al., 2023).

Where the data can be found and any issues accessing the data. Anonymised HWR data may be shared with researchers by request. Requests for ethnicity data are reviewed by a Māori Advisory Group (Alpass et al., 2023).

The overall utility of the data, including recommendations for use/non-use. The overall utility of HWR data for estimating the prevalence of AOP people is **very low.** The datasets do not contain items specifically relating to AOP, and the sampling frame excludes those living in care facilities.

1.7 New Zealand Longitudinal Study of Ageing

Overall rating: Moderate

AOP data captured: Indicators of potential neglect, psychological abuse, and physical abuse from the Vulnerability to Abuse Screening Scale (VASS) for people living in the community.

The nature of the data. The NZLSA is an off-shoot of the HWR longitudinal study described above. The two NZLSA collection waves (in 2010 and 2012) covered a wide range of topics, including social support, health, work, safety, and caregiving, and quality of life (Towers & Stevenson, 2014). Importantly, both waves contained questions about AOP (C. Stevens, PC, 22 August 2023).

The population coverage and date range of the data. The NZLSA included individuals aged 50-84 (at 2010) living in the community (Towers & Stevenson, 2014).

How the data were obtained. The NZLSA included the 2010 sample from the HWR study, and additional samples to expand the age range (from approximately 59-74) and the sample size. The NZLSA sample included participants) who took part in an associated cross-sectional study on planning for retirement, participants from the NZLSA pilot study, and a sample drawn from the Electoral Roll (Towers & Stevenson, 2014). As with the HWR, Māori were oversampled (Towers & Stevenson, 2014).

NZLSA response rates were reasonably high (68-80% depending on the source of participants Towers & Stevenson, 2014). However, the sample was slightly more socioeconomically advantaged than the corresponding age-matched population (Towers & Stevenson, 2014). The final sample sizes for the 2010 and 2012 data collection waves were 3,311 and 2,984, respectively (Towers & Stevenson, 2014). Most responses were provided by completing questionnaires.

However, face-to-face interviews on select topics were conducted with a large subsample for both waves of the NZLSA (Towers & Stevenson, 2014).

The 2012 NZLSA data collection wave included the VASS, created for the Women's Health Australia study, and used to identify individuals at risk of AOP (Schofield et al., 2002; Schofield & Mishra, 2003). The VASS contains 12 items comprising four subscales relating to vulnerability, coercion, dejection, and dependence (Schofield & Mishra, 2003; Waldegrave, 2015a).

Notably, the VASS vulnerability and coercion subscales appeared to have greater face validity for AOP than the dejection and dependence subscales, and moderate construct validity (Schofield et al., 2002; Schofield & Mishra, 2003). Vulnerability consisted of the following dichotomous response items: "Are you afraid of anyone in your family?", "Has anyone close to you tried to hurt you or harm you recently?", and "Has anyone close to you called you names or put you down or made you feel bad recently?" (Schofield et al., 2002). Coercion consisted of the following items: "Does someone in your family make you stay in bed or tell you you're sick when you know you are not?", "Has anyone forced you to do things you didn't want to do?", and "Has anyone taken things that belong to you without your OK?" (Schofield et al., 2002).

The authors suggest that the vulnerability and coercion items (six in total) could be used as a brief screening tool for AOP, the former measuring vulnerability to abuse and the latter measuring psychological and physical abuse (Schofield et al., 2002). The dependence measure seems to relate to lack of autonomy and may indicate neglect, but it does not seem particularly useful as a screening tool for abuse (Schofield et al., 2002). Dejection appears to capture aspects of depression (Schofield et al., 2002). These findings were echoed by Woodhead (2018) who excluded the dependence and dejection measures from their analysis of the NZLSA data. Notably, this research also found relatively poor internal reliability for the individual VASS subscales but acceptable internal reliability for the scale overall (Woodhead, 2018).

The VASS has been validated against some life events expected to be related to the various constructs but not directly against an independent measure of AOP (Schofield et al., 2002; Schofield & Mishra, 2003).

Where the data can be found and any issues accessing the data. As with the HWR, the NZLSA data can be accessed by contacting the HART team (Towers & Stevenson, 2014).

The overall utility of the data, including recommendations for use/non-use. The overall utility of NZLSA data is rated **moderate**. The study used a validated screening tool for AOP, and the sample is reasonably representative of the NZ population, with oversampling of Māori to ensure sufficient representative and statistical power to measure patterns for this group. The data is also available from the researchers by request.

However, the VASS does not measure AOP directly; it is a screening tool that indicates abuse may be present. It is unclear how valid the VASS is for the NZ population of older adults, given that it was developed as a screening tool for Australian women, although Woodhead (2018) found similar characteristics for the scale when used for the NZLSA sample[7]. The scale contains an item relating to financial abuse (Waldegrave, 2015b), one of the most prevalent forms of AOP (MSD, 2019). As with many other datasets, the eligible population for NZLSA excluded those living in residential care facilities (Towers & Stevenson, 2014). Also, the most recent data are now 11 years old.

1.8 Te Kupenga

Overall rating: Low | AOP data captured: None.

The nature of the data. Te Kupenga was a Stats NZ post-Census survey that collected information on the cultural, social, and economic wellbeing of Māori in NZ (Stats NZ, 2014b; Stats NZ, 2018). It predominantly focused on aspects relating to cultural wellbeing, such as the use of te reo Māori and connection to tūrangawaewae (Stats NZ, 2014b; Stats NZ, 2018). Te Kupenga also contained items relating to several topics included in the GSS, such as health and discrimination (Stats NZ, 2018). There were some differences in the survey topics between the 2013 and 2018 survey iterations (Stats NZ, 2018).

The population coverage and date range of the data. Te Kupenga surveyed people of Māori descent and/or people identifying as Māori aged 15 and above (Stats NZ, 2018). The survey was conducted in 2013 and 2018 (Stats NZ, 2014b; Stats NZ, 2018).

How the data were obtained. Both the 2013 and 2018 Te Kupenga surveys were conducted as post-Census surveys, meaning that the respective Census was the sampling frame. Individuals were eligible for selection if they reported being of Māori descent and/or ethnicity, lived in a private dwelling, and were aged 15 or above (Stats NZ, 2018, 2020a; Theodore et al., 2023).

The design for the 2018 Census involved initially sampling a set of PSUs (Stats NZ, 2020a). Geographic stratification was then used to select PSUs from areas with different concentrations of Māori people, using information from the 2013 Census (Stats NZ, 2020a). Eligible individuals were then sampled from those PSUs (Stats NZ, 2020a). Te Kupenga surveys were conducted within weeks of the Census to reduce the extent of movement since the Census. As such, the 2018 Te Kupenga survey sampling used an interim Census file prior to the steps taken to mitigate issues created by the low 2018 Census response rate (Stats NZ, 2020a).

7 Several items from the VASS scale were also used to measure abuse of older people in a small study (n=128) which tested a peer support model to improve wellbeing among kaumātua (Oetzel et al., 2021).

Te Kupenga response rates were 73% and 74%, respectively, for 2013 and 2018 (Stats NZ, 2020a). The sample size was increased from around 5,500 people in 2013 to approximately 8,500 in 2018 (Stats NZ, 2018, 2020a).

Where the data can be found and any issues accessing the data. 2013 and 2018 Te Kupenga data are available in the IDI (Stats NZ, 2023a).

The overall utility of the data, including recommendations for use/non-use. Te Kupenga data's overall utility for estimating AOP's prevalence is rated **low**. Neither the 2013 nor 2018 surveys contained items relating directly to AOP.

Te Kupenga response rates, while lower than many other Stats NZ surveys, are acceptable. Issues with the 2018 Census appear to have introduced a small amount of bias to the 2018 Te Kupenga survey, mostly relating to men and younger people (Stats NZ, 2020a). However, adjusting the survey weights has addressed much of the bias (Stats NZ, 2020a).

Other opportunities. Te Kupenga collected information on the importance of Māori culture, religion, and spirituality for individuals, and the frequency in which they engaged with various cultural, spiritual, and religious activities (Stats NZ, 2014c; Stats NZ, 2020b). As such, it may be possible to estimate the proportion of older Māori adults at risk of spiritual abuse (practices that prevent older people from participating in spiritual activities; Hynds & Leonard, 2023; Thaggard et al., 2020). However, it would not be possible to determine whether these at-risk individuals were prevented from engaging in spiritual or cultural activities by caregivers or due to other barriers (e.g., poor health).

1.9 Te Puāwaitanga O Ngā Tapuwae Kia Ora Tonu/ Life and Living in Advanced Age

Overall rating: Very low | AOP data captured: None.

The nature of the data. LiLACs is a longitudinal cohort study of ageing among the 'older old', focusing on the importance of health and frailty, and cultural, social, and economic influences in relation to successful ageing (Hayman et al., 2012). The study engaged a Rōpū Kaitiaki o tikanga Māori (Māori Advisory Group) to ensure the research was conducted according to Māori cultural norms and used a Kaupapa Māori approach (Hayman et al., 2012; Kerse et al., 2015).

The population coverage and date range of the data. LiLACs examined outcomes for Māori aged 80-90 (born January 1920 to December 1930) and non-Māori aged 85 (born in 1925; Hayman et al., 2012). Differences in the age range for Māori and non-Māori participants reflect the lower life expectancy among Māori and the smaller proportion of Māori reaching older ages (Hayman et al., 2012). For equal explanatory

power, samples of equal sizes were drawn for Māori and non-Māori from the Lakes and Bay of Plenty District Health Board areas (Hayman et al., 2012). The first data collection wave took place in 2010 (Hayman et al., 2012).

How the data were obtained. Local organisations were subcontracted by LiLACs to recruit study participants, conduct interviews, and complete health assessments (Hayman et al., 2012). Eligible respondents were primarily identified through the Electoral Roll, but the sample was supplemented with respondents from primary care and primary health organisation databases (Hayman et al., 2012; Kerse et al., 2015). The study was advertised at community events, rest homes, in public places, and over the radio (Hayman et al., 2012). The final LiLACs samples comprised 421 Māori and 516 non-Māori participants (Kerse et al., 2015).

Face-to-face interviews were conducted, along with comprehensive health assessments (Hayman et al., 2012), with follow-up interviews and assessments conducted annually (Hayman et al., 2012). LiLACs Wave 3 (2012) also included interviews with carers (Kerse et al., 2015).

Where the data can be found and any issues accessing the data. LiLACs data are available through application. Applications are assessed by an academic leadership group (Kerse et al., 2015).

The overall utility of the data, including recommendations for use/non-use. The utility of LiLACs data for understanding the prevalence of AOP is rated **very low.** It does not appear that LiLACs collected any data relating to AOP.

Large administrative datasets

Scope of large administrative dataset evaluation

Administrative data are data that are collected to meet the operational demands of an agency (e.g., a NZ government agency). Administrative data sets often contain far more records than surveys, leading to precise estimates and the ability to produce estimates for small population subgroups. However, as administrative data are collected to meet operational needs, the constructs measured often do not precisely match constructs of interest. Furthermore, administrative data can have different biases depending on the type of data. For example, analyses by the Accident Compensation Corporation (ACC) demonstrated that some groups are less likely to lodge ACC claims (Bradley, 2021), whereas more frail older adults are disproportionately represented in interRAI data (Hall et al., 2022).

The administrative data sources discussed in this section were assessed primarily by examining publicly available information (e.g., online data dictionaries and questionnaires). Where organisations were contacted to complete a short survey about the administrative data sources they hold, information about administrative data sources is summarised in the section titled 'Other data held by organisations'.

Administrative datasets are continuously updated to include recent data. Most of the data sets discussed in this section are available through the IDI, indicated by an asterisk in the list below (Stats NZ, 2023a). Many are also available by request from the agency that collects the data, either by allowing access to the microdata or aggregated data. Online data dictionaries are sometimes out of date or contain limited information, so information about IDI sources was supplemented by accessing more detailed metadata available through the IDI wiki.

The following sources of administrative data were examined:

- Accident Compensation Corporation (ACC) data*
- Benefits dynamics data (MSD)*
- Court charges data (Ministry of Justice)*
- InterRAI assessment data (Ministry of Health)*
- National Minimum Dataset (NMDS; Ministry of Health)*
- National Non-Admitted Patient Collection (NNPAC; Ministry of Health)*
- New Zealand Police data (Ministry of Justice)*
- Programme for the Integration of Mental Health Data (PRIMHD; Ministry of Health)*
- Sentencing and remand data (Ara Poutama Aotearoa/Department of Corrections)*
- Serious Injury Outcome Indicators – composite data set
- SOCRATES – disability support services data.*

2.1 Accident Compensation Corporation data

Overall rating: Moderate

AOP data captured: Injuries caused by physical and sexual assaults for which an ACC claim was accepted.

The nature of the data. ACC datasets include records of claims submitted to ACC for injuries that occurred in NZ. These records include information about the claim, the client and payments made in relation to the claim (e.g., direct medical cost or income support; Stats NZ, n.d.-a). While records generally only relate to accepted claims, a small number of declined claims are included (Poland & Van Der Merwe, 2019).

In addition to injuries due to accidents, this dataset also includes injuries caused by physical assaults and injuries (including mental health issues) caused by sexual assault and rape. There is also a binary variable that indicates when an injury was caused by an assault (Stats NZ, n.d.-a).

The population coverage and date range of the data. ACC datasets include records for individuals with claims accepted for injuries that occurred in NZ. Some data is available from 1974, with payment data available from 2000 (Stats NZ, 2023a).

How the data are obtained. Data are collected by ACC staff directly from individuals or provided to ACC through a provider (e.g., a claim submitted by a medical professional; Stats NZ, n.d.-a).

Where the data can be found and any issues accessing the data. Currently, ACC data are available in the IDI from 1994 to March 2023 (Stats NZ, 2023a). Sensitive injuries (such as those caused by sexual assault) are handled separately from other claims and have a flag in the IDI data. ACC also provides access to injury statistics through data.govt.nz (data.govt.nz, 2023) and the Stats NZ website (Stats NZ, n.d.-f).

The overall utility of the data, including recommendations for use/non-use. The overall utility of ACC data to estimate the prevalence of physical AOP is rated **moderate**. It should capture all injuries where the victim presents to primary care (where a claim is submitted to cover that appointment and follow-up care).

However, claims for injuries due to assaults may not capture a large portion of non-physical AOP. ACC data also does not distinguish injuries caused by a person in a position of power and/or relationship of trust for the individual from injuries caused by another person (e.g., assault by a stranger). The latter falls outside the definition of AOP used in this report.

Methods used to classify ethnicity in ACC records are known to result in undercounts of both Māori (Stats NZ, n.d.-a), and Pacific Peoples (Bradley, 2021). However, this issue can be overcome by using ethnicity data from the source-ranked ethnicity table in the IDI. Further, recent analyses by ACC accessed through an Official Information Act request demonstrated that Māori and Pacific Peoples, especially women, submit fewer claims, especially for less serious injuries, compared to people who do not identify with Māori and Pacific Peoples ethnic groups (Bradley, 2021).

2.2 Benefits dynamics data

Overall rating: Very low | AOP data captured: None.

The nature of the data. The benefits dynamics data in the IDI consists of a number of tables capturing information including, but not limited to, benefits and other forms of income support, employment assistance and interventions, educational history, student loans and allowances, client characteristics, and debt to MSD (Stats NZ, n.d.-b). There do not appear to be any specific flags or variables regarding family violence or other forms of AOP.

The population coverage and date range of the data. The population coverage and date ranges differ across data sets, although in general data on benefits is available from 1990 to 2023 (Stats NZ, 2023a).

How the data were obtained. The data were obtained from administrative data capture (Stats NZ, n.d.-b).

Where the data can be found and any issues accessing the data. Data can be accessed through the IDI. MSD also publishes statistics relating to benefits and other services on their website[8].

The overall utility of the data, including recommendations for use/non-use. The overall utility of the data for understanding AOP in NZ is **very low**, as the data does not appear to contain any variables or flags relating to family violence or AOP.

Other opportunities. As the IDI MSD data is extensive, there may be opportunities to combine this data with indicators of AOP from other data sources to understand risk factors and consequences of AOP.

8 Please see https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/statistics/index.html

2.3 Court charges data

Overall rating: Very low | AOP data captured: None.

The nature of the data: Ministry of Justice data includes all NZ court charges with a charge outcome, regardless of whether the offender was convicted (Stats NZ, n.d.-c). Court charges data provides information about the defendant, the agency which brought the charges, the court name and location, the seriousness of the charge for those convicted, the date of the offence, and the specific offence type under NZ law (Stats NZ, n.d.-c). This data also includes a specific flag for family violence offences, including physical and sexual assault and breaching a protection order (Stats NZ, n.d.-c).

The population coverage and date range of the data. Court charges records cover all charges with a charge outcome, so data are not restricted to usual NZ residents. Data are available from 1992, but there is typically a delay between the offence occurring and a record appearing in this data source (Stats NZ, n.d.-c).

How the data are obtained. Data on court charges is extracted from the Ministry of Justice Case Management System (Stats NZ, n.d.-b).

Where the data can be found and any issues accessing the data. Currently, court charges data from 1992 to December 2022 are available in the IDI (Stats NZ, 2023a).

The overall utility of the data, including recommendations for use/non-use. The overall utility of court charges data for estimating the prevalence of AOP in NZ is rated **very low**. It is not possible to determine whether the victim of an offence was elderly, except for AOP-specific charges which are not likely to represent a large segment of charges within the scope of AOP.

2.4 InterRAI assessment data

Overall rating: Moderate

AOP data captured: Individuals at risk of AOP living in the community.

The nature of the data. InterRAI is used to assess health and social support needs and create care plans (Te Whatu Ora, 2023a). Assessments are completed for older individuals living in the community or care facilities.

InterRAI assessment in community settings includes screening for AOP that can trigger a more in-depth examination (Hall et al., 2022). This screening classifies the risk of abuse based on whether individuals report experiencing abuse or neglect and/or being afraid of family members or have poor hygiene. Additional

"stressors" are used to classify whether the risk of abuse is high or moderate. InterRAI assessments do not directly screen for financial abuse, one of the most common forms of AOP (MSD, 2019). InterRAI screening for AOP is not undertaken for those living in care facilities (Te Whatu Ora, PC, 9 September 2023).

The population coverage and date range of the data. There are data for all adults who have had an interRAI assessment since 2014. About 10% of the NZ population aged 65 and above had an interRAI assessment in 2017/18 (Stats NZ, n.d.-d). InterRAI assessments assess care needs, so this population is older and frailer than the population of older adults overall (Hall et al., 2022). InterRAI was introduced nationally in 2008-2012 and since 2015 is mandatory in aged residential care (Te Whatu Ora, 2023a).

How the data are obtained. Data are obtained through assessments by trained health professionals involving organised conversations with individuals and their family/carers (Stats NZ, n.d.-g).

Where the data can be found and any issues accessing the data. Currently, interRAI data are available from 2014 to June 2022 in the IDI (Stats NZ, 2023a). Aggregated data are available through the interRAI NZ website, and aggregated data or anonymised microdata can be requested from interRAI NZ (Te Whatu Ora, 2023a).

Only data for individuals who consent for their data to be used for research purposes is available online, by request, or through the IDI (Te Whatu Ora, 2023a). Consent rates are high – for example, 96% of adults eligible to be included in the study by Hall et al. (2022) gave consent for their data to be used for research.

The overall utility of the data, including recommendations for use/non-use. The overall utility of interRAI data for estimating the prevalence of AOP is rated **moderate.** Assessments collect a large amount of data in a standardised format that could be useful for identifying AOP occurrences, risk factors for AOP, and monitoring the impact of policy changes.

Rates of AOP estimated by combining screened individuals suspected of experiencing abuse and those for whom the assessment was unable to determine the presence of AOP seem implausibly low (4.8% for the Southern District Health Board; Hall et al., 2022). Currently, there is no gold-standard assessment of AOP against which to compare the screening tool to determine its sensitivity (Hall et al., 2022). There are many reasons that interRAI assessments may not identify occurrences of AOP. Assessments are sometimes conducted with other people present (e.g., family/carers; Stats NZ, n.d.-g). The lower rates reported among women may represent their greater reluctance to report abuse than men (Hall et al., 2022). An important limitation of this data set is that only those living in the community complete AOP screening.

2.5 National Minimum Data Set

Overall rating: Low to moderate

AOP data captured: Physical, sexual, and psychological abuse for people who present to hospitals.

The nature of the data. The Ministry of Health NMDS captures publicly and privately funded hospitalisation data (Te Whatu Ora, 2023b). Specifically, clinical information, including diagnoses, is recorded. Diagnosis data are recorded using ICD-10-AM codes, which include various codes for assault injuries and abuse:

- T74.1-T74.9. Maltreatment by neglect, physical, sexual or psychological abuse.
- X85-Y05. Detailed assault information, including the specific nature of the assault.
- Y06-T07. Relationship between victim and perpetrator of abuse or assault (e.g., partner/spouse, carer, other family member, official authorities).
- Y92. Place of occurrence of external cause of harm (e.g., at home, in aged-care facility).

A combination of this information may be useful for estimating the prevalence of AOP, and providing information about the types of abuse, relationship between the perpetrator and victim, and setting of the abuse. The ICD-10-AM codes currently available in the IDI do not capture information about financial abuse.

The population coverage and date range of the data. The data includes people discharged from hospitals, and hence covers all ages and is not restricted to the NZ usually resident population (Stats NZ, n.d.-l). Data for publicly funded hospital discharges are available from 1988, whereas data for privately funded hospital discharges are available from 2001 (Stats NZ, 2023a).

How the data are obtained. NMDS data are collected for administrative purposes by both publicly and privately funded hospitals and then collated by the Ministry of Health (Stats NZ, n.d.-m).

Where the data can be found and any issues accessing the data. NMDS data can be accessed in the IDI. Currently, public hospital data are available up to June 2022, and private hospital data to December 2020. (Stats NZ, 2023a). Summary statistics are available on the Te Whatu Ora webpage, while specific data may be requested directly from Te Whatu Ora (Te Whatu Ora, 2023c).

The overall utility of the data, including recommendations for use/non-use. The overall utility of the NMDS for estimating the prevalence of AOP is rated **low** to **moderate.** NMDS includes several different types of abuse and reasonably detailed information about the nature of the abuse. However, in many cases, people experiencing AOP will not present to the hospital, so this data source will underestimate the extent of AOP.

2.6 National Non-Admitted Patient Collection

Overall rating: Very low | AOP data captured: None.

The nature of the data. The NNPAC dataset includes information on services provided to non-admitted patients discharged in under three hours who do not receive general anaesthesia (Ministry of Health, 2020). The dataset includes emergency department visits, outpatient appointments, diagnostic and medical/surgical procedures, and services provided in the community. For outpatient procedures, individuals are captured in NNPAC if the procedure is expected to take less than three hours (Ministry of Health, 2020).

NNPAC includes purchase codes relating to services provided to individuals for the prevention and response to family violence abuse. However, there do not appear to be specific flags for family violence or abuse. There are no diagnostic codes that can be used to identify abuse (Gibb et al., 2019; Ministry of Health, 2020).

The population coverage and date range of the data. The data covers all individuals who had an emergency department visit lasting less than three hours or received a publicly funded outpatient health service (Ministry of Health, 2020). Data for NNPAC are available from 2007.

Where the data can be found and any issues accessing the data. Currently, data for NNPAC are available from 2007 to June 2022 in the IDI (Stats NZ, 2023a). As for NMDS, specific data may be requested directly from Te Whatu Ora (Te Whatu Ora, 2023c).

How the data are obtained. Data are provided to Stats NZ by the Ministry of Health who collate information from District Health Boards (Stats NZ, n.d.-h).

The overall utility of the data, including recommendations for use/non-use. The overall utility of NNPAC data for estimating the prevalence of AOP is rated **very low;** there are no diagnostic codes or flags for abuse.

2.7 New Zealand Police crime data

Overall rating: Low to moderate

AOP data captured: Information about victims and perpetrators of forms of AOP that constitute an offence and were reported to the police.

The nature of the data. The New Zealand Police crime datasets available in the IDI capture information about offences, victims, and offenders. Demographic data about victims, and offenders includes age, gender, ethnicity, and the relationship between the offender and victim (Stats NZ, n.d.-k). The relationship data is fairly detailed and includes a code for carers. Ethnicity data is coded to a single ethnicity representing the ethnic group "most strongly identified" (Stats NZ, n.d.-k). Data on offences includes offence type, coded to the Australian and New Zealand Standard Offence Classification (ANZSOC), offence date, and offence location (Stats NZ, n.d.-k). The ANZSOC classification codes for offences are varied and include assault, sexual assault, theft, and neglect of someone under care. There do not appear to be specific flags for AOP, although there are flags for family violence offences (New Zealand Family Violence Clearinghouse, 2017a).

The population coverage and date range of the data. As the data are included in three separate datasets, the availability of different types of police data and the observed populations differs (Stats NZ, 2023a). National Intelligence Application (NIA) links data are available from 2009 to February 2018 (Stats NZ, 2023a). NIA links data captures information on individuals and organisations listed in relation to an offence, excluding offences for which an infringement notice could be issued (Stats NZ, n.d.-k). The offenders' dataset is available from 2009 to February 2023. It captures information on individuals and organisations who have been proceeded against by New Zealand Police (Stats NZ, n.d.-k). The victims' dataset is available from 2014 to February 2023 (Stats NZ, 2023a). It captures information on victims in NZ (Stats NZ, n.d.-k). Importantly, the offenders' and victims' data will not always correspond (Stats NZ, n.d.-k)

How the data are obtained. Data are captured from the police operational database and are subject to change over time (Stats NZ, n.d.-k). In particular, data from the previous month is liable to change due to updates as investigations are completed, charges are made, and data entry is finished (Stats NZ, n.d.-k).

Where the data can be found and any issues accessing the data. Data is available in the IDI (Stats NZ, 2023a). Summary statistics are available on the New Zealand Police website (New Zealand Police, n.d.).

The overall utility of the data, including recommendations for use/non-use. The overall utility of New Zealand Police data for capturing information on AOP is rated **low to moderate**. These datasets appear to contain detailed

information about the relationships between offenders and victims, which could be useful for understanding the nature of AOP. However, they will only capture data about forms of AOP that constitute specific offences. Some forms of AOP, while harmful, may not be covered by a specific offence. For example, economic abuse includes both illegal and inappropriate use of an older person's financial resources (MSD, 2019).

Further, family violence offences are rarely reported to police (New Zealand Family Violence Clearinghouse, 2017a), and this is likely the case for AOP. Reporting practices are also variable over time and reflect operational demands (New Zealand Family Violence Clearinghouse, 2017a; Stats NZ, n.d.-k). Given the deficiencies in the ethnicity data captured in this data set, it is recommended that any secondary analyses of this data are conducted within the IDI to allow for linkage to source-ranked ethnicity data (data where the ethnicity data is sourced from different data sets in a ranked order according to the quality of the ethnicity data in each table).

2.8 Programme for the Integration of Mental Health Data

Overall rating: Very low | AOP data captured: None.

The nature of the data. PRIMHD includes information about publicly funded secondary care mental health and addiction services, including those provided by both District Health Boards and non-governmental organisations (Gibb et al., 2019; Social Investment Agency, 2019). Data on primary care for mental health services (i.e., general practitioner visits) are not included, nor is non-publicly funded secondary care, both of which are likely to capture individuals with mild to moderate mental health issues (Gibb et al., 2019). As such, PRIMHD data typically captures information on individuals with severe mental health and addiction issues (Gibb et al., 2019).

There are known issues with a number of PRIMHD data fields, such as incomplete reporting from non-governmental organisations and a large amount of missing diagnostic data (Social Investment Agency, 2019).

The population coverage and date range of the data. PRIMHD data captures those who received publicly funded secondary care services for mental health and addiction problems. Individuals who receive secondary care tend to have greater mental health and addiction needs than those who solely receive primary care for these issues (Gibb et al., 2019). There is also under coverage of older adults (65+) as some District Health Boards fund mental health and addiction services for this group principally as disability support services (Gibb et al., 2019; Social Investment Agency, 2019). PRIMHD data are available from 2008 (Stats NZ, 2023a).

Where the data can be found and any issues accessing the data. Currently, PRIMHD data from 2008 to June 2022 are available in the IDI (Stats NZ, 2023a).

How the data are obtained. Non-governmental organisations and District Health Boards provide data to the Ministry of Health, who collates this information (Stats NZ, n.d.-l).

The overall utility of the data, including recommendations for use/non-use. The overall utility of PRIMHD data for estimating the prevalence of AOP in NZ is rated as **very low.** It does not contain any specific flags for abuse or reliable and complete diagnostic data. Those over 65 who live in the Southern and Central Regions are also missing from these data as mental health and addition services are funded as disability support services for this age group (Gibb et al., 2019; Social Investment Agency, 2019).

2.9 Sentencing and remand data

Overall rating: Very low | AOP data captured: None.

The nature of the data. Corrections sentencing and remand data in the IDI includes information regarding the management of individuals on remand and those convicted and sentenced in NZ (Stats NZ, n.d.-e). It does not contain specific offences people have been charged with or convicted of (Stats NZ, n.d.-e). This data also does not appear to contain any variables or flags relating to assaults or abuse experienced while incarcerated (Stats NZ, n.d.-e).

The population coverage and date range of the data. The target population is convicted adults who have received non-monetary sentences. However, the actual observed population is all people who have spent time on remand or in prison in NZ (Stats NZ, n.d.-e). Corrections data are available from 1988 (Stats NZ, n.d.-e).

How the data are obtained. Corrections data are obtained as part of the management of individuals on remand or serving sentences (Stats NZ, n.d.-e).

Where the data can be found and any issues accessing the data. Currently, data from 1988 to December 2022 can be accessed through the IDI (Stats NZ, 2023a). Summary statistics are also available on the Ara Poutama Aotearoa/Department of Corrections website (Ara Poutama Aotearoa/Department of Corrections, 2023).

The overall utility of the data, including recommendations for use/non-use. The overall utility of Corrections data for estimating the prevalence of AOP is rated **very low.** The data does not capture information on the offence for which individuals were charged or sentenced or information regarding whether older people experienced abuse while incarcerated.

2.10 Serious Injury Outcome Indicators

Overall rating: Low

AOP data captured: Injuries due to assaults against older people.

The nature of the data. The Serious Injury Outcome Indicators dataset compiles information from multiple sources to estimate the number of serious injuries in NZ. Types of injury include assault, intentional self-harm and suicide, work-related accidents, drownings, falls, and motor vehicle accidents (Stats NZ, n.d.-n)[9].

The population coverage and date range of the data. These data are available from 1994 to 2021 and are reported for the NZ population overall, for children (aged 0-14 years), and for Māori (Stats NZ, n.d.-n). A protocol devised by the Injury Prevention Research Unit at the University of Otago for measuring the six key injury types was implemented from 2010 (Stats NZ, n.d.-n).

How the data were obtained. Data were obtained by combining several administrative sources on injuries in NZ. These include NMDS, Ministry of Health mortality data, ACC, Coronial Services, WorkSafe NZ, Water Safety NZ, the Ministry of Transport, and Stats NZ (Stats NZ, n.d.-n). Most of the data is derived from NMDS and Ministry of Health mortality data, using principal ICD-10 codes for injury (S00-T98; Injury Prevention Research Unit, n.d.).

Where the data can be found and any issues accessing the data. Some data, from approximately 2000-2021, are available through Aotearoa Data Explorer (Stats NZ, n.d.-j). More customised data is available online through the Injury Prevention Research Unit webpage, where a tool allows users to customise the data by type of injury, age range, gender, year of injury, and region (Injury Prevention Research Unit, n.d.). Notably, this tool only contains data until 2018 due to funding constraints (Injury Prevention Research Unit, n.d.).

The overall utility of the data, including recommendations for use/non-use. The overall utility of this data for estimating the prevalence of AOP is rated **low.** However, given that data is publicly available up until 2018, this could provide a useful benchmark for the number of assaults committed against older adults, although it is not possible to know whether these were committed by people known to the victim or by strangers. Notably, as for administrative data in general, this data is likely to underestimate the number of assaults.

9 We could not identify the target population from any publicly available information. As the data appears to count the number of occurrences of events across several data sets, the target population may not be well-defined.

2.11 SOCRATES – disability support services data

Overall rating: Very low | AOP data captured: None.

The nature of the data. The SOCRATES dataset (also known as the National Needs Assessment and Service Coordination Information System data) captures information about support services funded by the Ministry of Health for disabled people. SOCRATES data are sourced from information collected by the Needs Assessment Service Coordination (Stats NZ, 2023c). All disabled people must complete a needs assessment prior to receiving funded support services. The data captures demographic information, and information about individuals' disabilities and support needs, and the support services received. The data set includes current clients, past clients, and those who were assessed for support but deemed ineligible (Stats NZ, 2023c).

The population coverage and date range of the data. SOCRATES data includes disabled people assessed for funded disability support services (Stats NZ, 2023c). Data are available from 1988 to July 2022 in the IDI (Stats NZ, 2023c).

How the data were obtained. Data were obtained when individuals completed needs assessments. Individuals may receive additional needs assessments if their needs or circumstances change or if the services are not meeting their needs (Stats NZ, 2023c).

Where the data can be found and any issues accessing the data. Currently, SOCRATES data from 1998 up to July 2022 can be accessed through the IDI (Stats NZ, 2023c). As of July 2022, SOCRATES data is managed by Whaikaha: Ministry for Disabled People, having previously been managed by the Ministry of Health (Ministry of Health, 2022b).

The overall utility of the data, including recommendations for use/non-use. The overall utility of SOCRATES data for understanding the AOP is rated **very low.** These data do not appear to capture any information relating to AOP.

MSD-funded services data

This section of the report summarises interviews conducted with MSD staff or staff of organisations providing services with funding from MSD. Interviews were conducted regarding the following data sources:

- Whakarongorau Aotearoa
- Elder Abuse Response Service (EARS) providers – including Age Concern.

Whakarongorau Aotearoa operates telephone helplines across several concerns (e.g., addiction, family violence, health screening). One of these is the 'Elder Abuse Response Service' (EARS), which takes calls from people concerned that AOP may be occurring. An interview was conducted with a Senior Manager from Whakarongorau on 18 July 2023 to understand the nature of the data collected as part of operating the EARS helpline. The manager is responsible for the Family and Sexual Harm (FSH) Unit, which operates several helplines in addition to EARS.

In addition to the helpline described above, MSD funds 38 EARS providers to deliver support to individuals experiencing, or who may be experiencing, AOP. Of these, 15 are affiliated with Age Concern. Some of the EARS providers that MSD funds do not have AOP as their central area of service provision. An interview was conducted with a Senior Analyst from the Safe Strong Families and Communities Team at MSD on the 29 July 2023. This interview provided information on work undertaken by MSD to review EARS data. MSD staff also provided access to a monitoring report and example data, which informed the summary below.

3.1 Whakarongorau Aotearoa

Overall rating: Low to moderate

AOP data captured: Information about many different forms of abuse from those who contact the helpline.

The nature of the data. Whakarongorau Aotearoa collects information from callers using a combination of specified fields and free text client notes. The specified fields capture data on the age, gender, location, and ethnicity of callers, caller type, the reason for the contact and contact outcome (Whakarongorau Aotearoa, 2023). Caller type captures information on whether the caller was calling about themselves, a family member, a neighbour, 'other', or was calling in a professional capacity. Contact reasons include various forms of abuse, requesting information only, and 'other', with 'other' being the largest category for Q4 2023 (Whakarongorau Aotearoa, 2023). Some contacts are classified as 'hang-up/wrong number/prank'. Contact outcome captures information on the outcome of the contact, such as information provision or referral.

The population coverage and date range of the data. Calls to the EARS helpline are disproportionately made by women. Much demographic information is missing (see below); therefore, it is difficult to understand the population coverage of this data. The EARS helpline was launched in 2017 (New Zealand Family Violence Clearinghouse, 2017b) and operates continuously (24 hours a day, seven days a week).

The EARS helpline receives calls from individuals concerned that abuse is or may be occurring. Calls are most commonly made by older people experiencing abuse, although many are received from concerned others, such as family members, neighbours, and professionals. Several potential outcomes are captured, including but not limited to, referring callers to service providers in the region, providing information about the services available, and referring to New Zealand Police (Whakarongorau Aotearoa, 2023). It is rare for individuals to call because they are concerned about their own behaviour towards older adults under their care.

How the data are obtained. The EARS helpline is one component of the FSH Unit. The helplines are primarily staffed by counsellors and social workers, most of whom work across all helplines and are trained to connect callers to relevant services regardless of the helpline on which the call was received. Importantly, this means that a call that relates to AOP, but which is received by a different helpline (e.g., a call regarding intimate partner violence by an older person to the Shine helpline) will generally be managed by the helpline that received the call, rather than being transferred to the EARS helpline. This process is also true for other helplines operated by Whakarongorau (e.g., Healthline), which will only be transferred to the FSH Unit if the staff member who received the call feels that they are unable to adequately address the issues raised. Consequently, calls to the EARS helpline likely represent a subset of the total calls received by Whakarongorau regarding AOP.

While demographic information about callers is generally captured, some calls are made anonymously, and some callers may not be comfortable providing all or any demographic information. Also, helpline staff do not follow a specific script, as the primary focus is meeting callers' needs. Given the sensitivity of the issues that may be raised, it is not always appropriate for staff to ask for demographic information. In particular, caller ethnicity data is missing for most callers, and there is also substantial missing data for gender and age (Whakarongorau Aotearoa, 2023).

In addition to inbound calls, the EARS helpline team responds to email and text contacts with some data captured for these contact types (Whakarongorau Aotearoa, 2023).

Where the data can be found and any issues accessing the data. Data for all Whakarongorau helplines is stored in the SPECTRUM database, held and managed by Whakarongorau, who provide quarterly summaries about the EARS helpline to MSD to fulfil mandatory reporting requirements.

It is likely that Whakarongorau would provide specific, anonymised summary data with the support of MSD, subject to internal approval and sign-off for privacy issues. However, there are tighter privacy controls for individual client notes.

The overall utility of the data, including recommendations for use/non-use. The overall utility of Whakarongorau data for estimating the prevalence of AOP is rated **low to moderate.** While the data does provide some indication about the scope of AOP, the quality of the demographic data limits the usefulness of the Whakarongorau information for this purpose. Issues include large amounts of missing data, and that demographic data is recorded for the person who contacted the service, who may not necessarily be the person experiencing abuse. It is also likely that some calls that fall under the definition of AOP, such as intimate partner violence, are received by other helplines operated by the FSH Unit.

Some limitations could be overcome by accessing client notes from FSH helplines and using natural language processing to identify information about AOP. However, this is likely to be an involved process that would require access to client records in SPECTRUM, which Whakarongorau may be unlikely to provide.

3.2 Elder Abuse Response Service providers

Overall rating: Moderate

AOP data captured: Information about many different forms of abuse from those referrals regarding suspected AOP.

The nature of the data. Elder Abuse Response Service EARS provider data contains reasonably detailed information about the nature of the AOP that has occurred. Details includes the relationship of the victim to the alleged abuser, type of abuse, duration of the abuse, demographic information for the client (gender, age group, ethnic group, location), a basic risk assessment, whether the client is under an Enduring Power of Attorney, and whether the abuse was confirmed. Age Concern-affiliated EARS providers also captures information on the client living situation, whether the client and the alleged abuser are living together, whether the alleged abuser is financially dependent on the client, whether the client is receiving care from the alleged abuser, and demographic information about the alleged abuser, as well as factors increasing vulnerability to AOP.

The population coverage and date range of the data. The population covered includes older adults who may be experiencing AOP, whether in the community or residential settings. Referrals to Age Concern Auckland are most commonly received from the New Zealand Police, with other referral pathways including friends, family, neighbours, other support services, other government agencies, health professionals, financial institutions, or other services provided by Age Concern.

How the data are obtained. Data are recorded in the process of managing suspected AOP cases. All providers capture information through client notes. Age Concern-affiliated EARS providers capture a substantial amount of data through a series of checkboxes as part of the referral procedure.

Where the data can be found and any issues accessing the data. All but one EARS providers use data management systems to capture client information, although many also use spreadsheets. One provider only uses spreadsheets. All Age Concern-affiliated EARS providers use the Age Concern Online Repository Network (ACORN) data management system and another data management system in addition to ACORN.

The overall utility of the data, including recommendations for use/non-use. The overall utility of EARS provider data for understanding the nature of AOP is rated **moderate.** The data contains reasonably detailed information about the nature of AOP, including the relationships and settings of abuse. Some EARS provider data also captures information about the characteristics of alleged abusers in addition to victims of AOP.

However, recording practices vary across EARS providers, leading to differences in data quality. Different providers may capture different information or collect the same information in different ways. For example, the format of ethnicity data appears to vary across providers (and it appears that only one ethnic group is captured per person). These issues may complicate data analyses. Importantly, referrals to Age Concern-affiliated EARS providers only represent a subset of AOP incidences.

EARS provider client notes may also be a source of information about AOP, as all providers collect these. However, as for Whakarongorau helpline data, this would be a very involved process, and it is unlikely EARS providers would provide access to this information.

Data held by other organisations

Consultation was carried out with agencies and organisations that may provide services or collect data relating to AOP, but who are not funded by MSD to provide AOP-specific services.

The types of organisations contacted included the banking and insurance sectors, retirement communities, care and support organisations, complaints/dispute resolution schemes, gambling and domestic support charities, trusts and legal support services, health care providers, Ombudsman and commissioner schemes, and government agencies. Organisations completed a brief questionnaire to assess what data they hold that may relate to AOP (please see the Appendix for further details). In addition, some information was gathered by contacting experts directly. Of 41 organisations contacted, 15 provided responses. For ethics reasons, the identity of specific responding organisations cannot be provided here.

The most promising avenues for accessing aggregated information about economic and financial abuse are the banking sector, while EARS providers may be a useful source of information on other forms of AOP.

Notably, organisations in the banking sector typically expressed a willingness to share (anonymised) aggregated data to support AOP prevention efforts, so long as this complies with their policies regarding privacy and commercial sensitivity. This would require a new engagement process with the sector. Importantly, the way information about AOP is captured may differ across banking organisations. In general these organisations may only be able to share aggregated summary statistics about clients who accessed support relating to financial abuse, rather than data about all suspected cases of AOP that come to their attention.

It is important to note that much of the information collected by organisations about AOP is not standardised, as AOP is not the primary focus of most organisations contacted. Many of the organisations contacted did not capture specific information about AOP or captured very little information about AOP.

Some limited information may also be captured by complaints and Ombudsman schemes. To protect the confidentiality of responding organisations, it is not possible to provide further information about these organisations. Further details are included in the supplementary report detailing the findings from the consultation portion of this project.

Discussion

Summary of key findings

This report aimed to identify potential data sources on AOP in NZ and evaluate the potential utility of these data sources for estimating the prevalence of AOP, understanding the scope of AOP, or understanding the characteristics of AOP.

Accurately estimating the prevalence of AOP in NZ would require a well-designed survey dedicated to this purpose. There are no such surveys to date.

However, this examination has identified several data sources that may be useful for getting a sense of the scale of the problem and/or for understanding the characteristics of AOP in NZ. These data sources, summarised in Table 1, include a mix of survey and administrative data.

The most useful survey data sources identified are the 2019 NZ Family Violence Study (NZFVS), the New Zealand Crime and Victims Survey (NZCVS), and the New Zealand Longitudinal Study of Ageing (NZLSA). The 2019 NZFVS was primarily focused on intimate partner violence, with a few questions relating to non-partner violence. The NZCVS aims to estimate the prevalence of various forms of crime, with a special interest in family violence in the more recent surveys. The NZLSA covered a wide range of topics and included the VASS. These surveys have different populations of interest, use different sampling methodologies, and measure experiences of abuse in different ways.

The most useful major administrative data sources identified are ACC (injury data), interRAI assessment (needs assessments with screening for AOP for those living in the community), the NMDS (publicly funded hospital discharges), and New Zealand Police (recorded offences). Administrative data is likely to underestimate cases of AOP substantially. However, given that these datasets are all available in the IDI, combining information across these data sources may be possible. The IDI is linked at the individual level, and as such it is possible to detect when an individual is classified as experiencing AOP across more than one dataset, which avoids double counting.[10] Some agencies, particularly the New Zealand Police and ACC, have poor-quality ethnicity data. Using the IDI would also overcome these issues as it is possible to use total response source-ranked ethnicity data, although only to a low level of detail. Identifying a suitable denominator in the IDI (e.g., the usual resident population) to calculate prevalence and incidence rates is also straightforward.

The most useful datasets held by individual organisations are from the banking sector and EARS providers.

10 Noting that there are a small proportion of false links and missed links in the IDI. For further details on how linkage bias may affect analyses, please see Kvalsvig et al. (2019).

Accurately estimating the prevalence of AOP in NZ would require a well-designed survey dedicated to this purpose.

Table 1. Summary of the most promising data sources

Data source	2019 Family Violence Study
AOP data captured	Captures detailed information about intimate partner violence, and limited information about experiences of sexual violence perpetrated by non-partners in a 12-month period for people living in the community.
Key advantages	• Uses validated scales. • Reasonably high response rate. • Captures detailed information relating to intimate partner violence. • Captures a range of other useful data – including health, disability, and social support data. • Captures some information relating to economic abuse in the context of intimate partner violence. • Well-conducted.
Key drawbacks	• Excludes those living in retirement villages and aged residential care facilities. • Limited questions relating to non-partner violence. • Questions relating to economic abuse are not tailored towards the experiences of older people. • May be difficult to access survey data.

Data source	New Zealand Crime and Victims Survey
AOP data captured	Physical, sexual, and psychological forms of AOP for people living independently in the broader community and retirement communities.
Key advantages	• Uses validated scales. • Reasonably high response rate. • Captures detailed information relating to intimate partner violence. • Captures a range of other useful data – including health, disability, and social support data. • Captures some information relating to economic abuse in the context of intimate partner violence. • Well-conducted. • Microdata can be accessed through the IDI, with high linkage rates.
Key drawbacks	• Excludes people living in aged residential care facilities (living non-independently). • Economic abuse is out of scope.

Data source	New Zealand Longitudinal Survey of Ageing
AOP data captured	Indicators of potential neglect, psychological abuse, and physical abuse from the Vulnerability to Abuse Screening Scale for people living in the community.
Key advantages	• Reasonably high response rates (note that the survey samples are sourced from the Electoral Roll and other surveys). • Oversampled Māori. • Captures other useful data, (e.g., health status and social support). • Data is available from researchers by request.
Key drawbacks	• Excludes people living in aged residential care facilities (only includes people living in the community). • Sample for NZLSA drawn from different sources. • VASS scale indicates an individual may be at risk of abuse, rather than that they are experiencing abuse. • VASS scale only contains one item relating to economic abuse. • Data is reasonably out-of-date (2010 and 2012).

Table 1. Summary of the most promising data sources

Data source	Accident Compensation Corporation
AOP data captured	Injuries caused by physical and sexual assaults for which an ACC claim was accepted.
Key advantages	• Should capture visits to general practitioners and follow-up care relating to injuries caused by AOP. • Includes a flag for injuries caused by physical and sexual assaults. • Microdata can be accessed through the IDI.
Key drawbacks	• ACC data is only likely to capture a limited subset of AOP cases. • There may be access barriers for Māori and Pacific Peoples. • May not be able to identify assault injuries that fall within the AOP definition from those caused by strangers.

Data source	InterRAI Assessment Data
AOP data captured	Individuals at risk of AOP living in the community.
Key advantages	• Research has been undertaken to examine and improve the sensitivity of the interRAI for detecting AOP (Hall et al., 2022). • About 10% of the population of older people receive an interRAI assessment per year. • Data is ongoing, allowing for comparisons over time. • While the data is not representative, this population may be more at risk of AOP due to having higher health needs/increased vulnerability.
Key drawbacks	• Screening for AOP is only completed for those living in the community. • There is no gold-standard measure of AOP with which to compare to (Hall et al., 2022), meaning it is not possible to reliably estimate sensitivity for the screening tool. • Data is not representative of the population of older adults overall (frailer).

Data source	National Minimum Data Set
AOP data captured	Physical, sexual, and psychological abuse for people who present to hospitals.
Key advantages	• Contains diagnostic codes for various forms or indicators of AOP. • Microdata can be accessed through the IDI. • May also include information about the types of injuries experienced for physical AOP.
Key drawbacks	• Hospitalisation data is only likely to capture a limited subset of AOP.

Table 1. Summary of the most promising data sources

Data source	Elder Abuse Response Services Data, including Age Concern Data
AOP data captured	Information about many different forms of abuse from referrals and calls regarding suspected AOP.
Key advantages	• Collects reasonably detailed information about the nature of the AOP and referral pathways.
Key drawbacks	• Lack of standardisation of collections. • Only collects information about a single ethnic group per person.

Data source	Banking Data
AOP data captured	Financial and economic abuse (primarily).
Key advantages	• Captures information about financial and economic abuse, which is not well-captured by other data sources. • Depending on the use of the data, likely to be willing to provide (anonymised) aggregated summary statistics. • Respondents expressed a strong interest in AOP prevention efforts and a willingness to provide data to support these efforts so long as this complied with requirements to protect privacy and commercial sensitivity.
Key drawbacks	• Data may be collected differently by different organisations. • Banks may only be able to provide information about clients who wished to access support for financial abuse, not all suspected cases of AOP they detect.

Data source	New Zealand Police Data
AOP data captured	Information about victims and perpetrators of forms of AOP that constitute an offence and were reported to the police.
Key advantages	• Includes a flag for family violence, allowing these cases to be identified more easily. • Contains reasonably detailed codes for the relationship between the victim and the perpetrator. • Microdata can be accessed through the IDI.
Key drawbacks	• New Zealand Police data is only likely to capture a limited subset of AOP – most family violence incidents are not reported to police (New Zealand Family Violence Clearinghouse, 2017a).

The less promising data sets identified are summarised in Table 2. Most of these data sets did not contain any information about AOP.

Table 2. Summary of the less promising data sources

Data source	AOP data captured	Additional comments
Disability Survey	None	The sampling frame of residential facilities used for the 2013 Disability Survey may be useful for a survey of AOP experienced by those living in residential facilities.
General Social Survey	None	
New Zealand Health Survey	None	
New Zealand Health, Work and Retirement Study	None	
Te Kupenga	None	Collected information on the importance of Māori culture, religion, and spirituality for individuals, and the frequency in which they engaged with various cultural, spiritual, and religious activities (Stats NZ, 2014c; Stats NZ, 2020b). This may be used to identify kaumātua at ***risk*** of spiritual abuse.
Te Puāwaitanga O Ngā Tapuwae Kia Ora Tonu/Life and Living in Advanced Age Cohort Study (LiLACS NZ)	None	
Benefits dynamics data	None	
Court charges data	None	
National Non-Admitted Patient Collection	None	
Programme for the Integration of Mental Health data	None	
Sentencing and remand data	None	
Serious Injury Outcome Indicators – composite data set	None	Injuries due to assaults.
SOCRATES – disability support services data	None	
Whakarongorau Aotearoa data	Information about many different forms of abuse from those who contact the helpline	Large amounts of missing demographic data. Demographic data captured for callers, who are not always the person experiencing AOP. Calls regarding AOP may be received on other helplines. This data may be useful for some purposes but is unlikely to be useful for understanding the prevalence of AOP.

Key data gaps

One of this report's key findings is that no data sources are designed specifically to estimate AOP in NZ. The review has also highlighted critical data gaps concerning the populations and type of AOP covered in the data sources that were identified and evaluated.

Data gap – older adults who are not living in the community:

- No comprehensive data sources about experiences of AOP for people living within aged residential care or other institutions were identified.
- Given their higher health needs and increased vulnerability, this population may be especially vulnerable to AOP.
- There may be more opportunities to detect and prevent AOP in this setting, given the high level of supervision that occurs in these settings (Te Whatu Ora, PC, 9 September 2023).
- There are some organisations that may capture information about AOP within aged residential care who did not respond to our survey request. It may be worth contacting some of these organisations directly to understand what data they capture.

Data gap – financial/economic abuse and spiritual/cultural abuse:

- There is limited data on financial and economic AOP outside of that captured by the banking sector.
- The 2019 NZ Family Violence Study collected some data on financial and economic abuse in relation to intimate partner violence but was not focused on AOP.
- No information is available about spiritual and cultural AOP (with the possible exception of Te Kupenga). Spiritual and cultural abuse are significant to Pacific Peoples (and likely other ethnic groups) but are excluded from most conceptions of AOP (Thaggard et al., 2020).

It is important to note that there may be data sources about AOP that were missed by this review, either because we are unaware of the data sources or erroneously assumed that they did not contain data relating to AOP. While we cast 'a wide net' in selecting data sources for examination, it is still possible that data sources may have inadvertently been missed.

Using secondary analyses to understand AOP

This review evaluated data sources that may contain information about AOP that could be accessed for secondary data analysis. There are challenges associated with data analyses to understand AOP that warrant brief mention:

- As data are collected for different purposes, there is likely incongruence between the definition of AOP captured by the data and what is used in the analysis. Definition inconsistency is likely to be a challenge when using administrative data. For example, the ACC data contains a flag for injuries due to assaults, but it is not possible to determine whether the injuries were caused by a person known to the victim or a stranger.
- It is necessary to use an age cut-off to define older people to conduct secondary analyses. This can be problematic as people age at different rates (MSD, 2019). Importantly, given systemic inequities, Māori and Pacific Peoples often experience age-related diseases earlier than Pākehā (Kerse et al., 2015; MSD, 2019).
- Finally, administrative data is likely to substantially underestimate AOP rates as it depends on the use of related services (Peri et al., 2009). This issue is apparent in research on family violence (New Zealand Family Violence Clearinghouse, 2017a).

Recommendations

Immediate investigation using existing data sources:

1. Use the IDI data to analyse potential correlates of AOP by:
    - » Constructing measures of having experienced AOP using the NMDS, ACC data, interRAI data, and New Zealand Police data.
    - » Forming a cohort of people who are usually resident in NZ with the resident population table.
    - » Sourcing total response ethnic group data from the personal details table, or if more detailed ethnicity data is required, the 2013 and 2018 Censuses.
    - » Sourcing family structure information from the 2013 and 2018 Censuses.
    - » Sourcing information on other potential correlates such as health status, disability status, and socioeconomic position from various tables in the IDI.
2. Use the New Zealand Crime and Victims Survey data in the IDI to analyse potential correlates of AOP. Note that while it is possible to access summary data through other routes, the ability to link to other data sets in the IDI, and the analytic flexibility offered by accessing microdata, makes this option preferable.
3. Engage with the researchers who conducted the 2019 New Zealand Family Violence Study to explore whether it may be possible to request access to summary statistics relating to intimate partner violence and recent sexual harm experiences among older people.

4. Engage with the banking sector to explore whether it may be possible to request access to summary statistics relating to the financial and economic abuse of older people.
5. Engage with EARS providers to explore whether it may be possible to request access to summary statistics relating to abuse of older people.
6. Use published material from the New Zealand Longitudinal Survey (e.g., Waldegrave, 2015; Woodhead, 2018; Yeung et al., 2015) to complement learnings from secondary analyses of other data sources.

Future data collection:

1. Consider conducting a prevalence study designed to accurately measure the prevalence of AOP. Such a study should consider the following issues:
    - How best to measure the wide-ranging forms of AOP, including spiritual and cultural abuse.
    - How best to tailor measures of AOP to the NZ context and ensure that measures are valid and meaningful across different ethnic groups.
    - How to ensure the safety of participants is maintained (please see Fanslow et al., 2021 for a discussion of some approaches to modifying the sampling approach to manage these risks in the intimate partner violence context).
    - How best to manage the shame around AOP during data collection to protect the wellbeing of participants, and to mitigate lower disclosure due to shame.
    - How best to survey people living independently in retirement communities[11] and in the wider community.
2. Consider whether it is feasible to survey people living in aged residential care, and how to conduct such a survey ethically given the frailty of people living in this setting. Importantly, this population may be especially vulnerable to AOP given their increased frailty.

Recommendations for further reviews:

1. Engage with the aged residential care sector, and government bodies responsible for overseeing this sector, to identify opportunities to better understand:
    - The extent and nature of AOP occurring in aged residential care.
    - Approaches to mitigating the risks of AOP in aged residential care.
    - Approaches to monitoring AOP in aged residential care.

11 Please see Connolly et al. (2019) for a discussion of the challenges of surveying retirement village residents.

2. Conduct qualitative research examining the meaning of AOP across different population groups in NZ, similar to recent research in Australia (Kaspiew et al., 2019). This could inform future prevalence studies. This should pay special attention to spiritual and cultural abuse as research has highlighted the importance of these aspects of AOP to Pacific Peoples (Thaggard et al., 2020) and is likely of high importance to other ethnic groups, although there is a paucity of literature on the topic.

Conclusion

While there are data sources that capture information relating to AOP in NZ, no dedicated prevalence studies have been conducted meaning that it is not possible to accurately estimate prevalence of AOP from existing data. However, there are many potential data sources that may provide insights into the scale and nature of AOP. These include the New Zealand Crime and Victims Survey, the 2019 NZ Family Violence Study, the New Zealand Longitudinal Study of Ageing, various administrative data sources accessible through the IDI, and data from the banking sector and EARS providers. Key data gaps were identified around spiritual and cultural abuse, economic and financial abuse, and abuse in aged residential care.

Appendix: Survey materials

Survey methodology

A seven-item online questionnaire (see below) was administered using Qualtrics. The questionnaire included the definition of AOP used in this report. The aim was to identify what data, if any, organisations hold on AOP in order to evaluate (i) which organisations hold data relating to AOP, and the type of data they hold; (ii) the way in which the data are stored; and (iii) the client base (e.g., age, geographic region) of the organisations. The items were developed by COMPASS and reviewed by MSD. The questionnaire was designed to gather sufficient information to assess whether a data source is likely to be useful for understanding AOP while minimising respondent burden.

Professional contact details for individuals at selected organisations were gathered by searching public-facing websites and, in a small number of cases, through contacts at MSD and COMPASS. These individuals/organisations were then approached by email. Most of these email invitations were sent on 14 August 2023, with follow-up emails sent on 11 September 2023. However, the initial contact for some organisations was made within this period for various reasons (e.g., the organisation was added to the potential data sources list after 14 August, delays in finding a suitable contact email, etc.).

Email invitations included some background to the consultation, ethical approval details, an attached Participation Information Sheet, a definition of AOP, contact details for the research team and the AOP work programme, and a link to the questionnaire (see Appendix). Respondents were also able to complete a video interview with a researcher rather than completing the questionnaire (no organisations requested this option).

Of the 41 organisations contacted, 15 provided responses.

Questionnaire

1. **What is the name of your organisation?**

   We are trying to identify organisations that may collect information relating to the abuse of older people (also known as elder abuse).

   For the purposes of this research, abuse of older people is understood 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.

   These acts may include physical abuse, psychological and emotional abuse, financial and economic abuse, sexual abuse, social abuse and isolation, and neglect.

2. **a) Does your organisation collect information relating to the abuse of older people?**

   Select option that applies: Yes → proceed to q2b | No → skip to q8.

   b) If so, what aspects of abuse of older people are captured?
   Select all that apply:

   a) Physical abuse

   b) Sexual abuse

   c) Psychological and emotional abuse

   d) Financial and economic abuse

   e) Social abuse and isolation

   f) Neglect

   g) Other, please specify.

3. **Does the information your organisation collects relate to:**
   Select all that apply:

   a) Perpetrators of abuse of older people

   b) Victims of abuse of older people

   c) Third party observations or reports of abuse of older people.

4. **We are wondering about the characteristics of clients who use your services. Roughly speaking:**

   a) What is the **approximate** age range of your clients?

   b) What region(s) of the country does your organisation serve?

   c) What communities does your organisation serve (e.g., specific ethnicities or specific health groups)?

   d) **Approximately** how many people does your organisation serve?

5. **What format is the information recorded in (e.g., client management system, spreadsheets, database)?**

6. **The data your organisation holds may contain insights into abuse of older people. What are your organisation's policies around sharing summary statistics with external organisations (e.g., counts of people experiencing abuse of older people)?**

7. **Are there any important caveats for using this information to understand abuse of older people, or anything else that you think warrants consideration?**

8. **Are you happy for your organisation to be named in the summary of findings report that will be provided to the Ministry of Social Development? a) Yes; b) No.**

Email invitation and Participant Information Sheet

Kia ora,

My name is Natalia Boven and I am from COMPASS Research Centre, University of Auckland.

We are carrying out consultation to identify information sources on abuse of older people (also known as elder abuse) in Aotearoa New Zealand. For the purposes of this research, abuse of older people is understood as a single or repeated act or failure to act, including threats, that results in harm or distress to an older person.

The work has been commissioned by the Ministry of Social Development and was granted ethical approval by the University of Auckland Human Participants Ethics Committee on 17/07/2023 [reference number UAHPEC26359].

Given the nature of your organisation's services, we believe you might have the information we seek. We are requesting that you please answer a few questions about the information your organisation collects or please forward this email along to someone within the organisation with the appropriate expertise. The attached Participation Information Sheet outlines the purpose of the research, the consent process, and other key pieces of information.

If you have any questions about this research, please email natalia.boven@auckland.ac.nz and we would be happy to provide further information.

If you are interested in undertaking this research, please click the link below, which will guide you through the consent process before beginning the survey:

https://auckland.au1.qualtrics.com/jfe/form/SV_elnEOWDs0iVsbf8

Or if you would prefer to talk this through with us instead, we would be happy to set up a video call. Please email me natalia.boven@auckland.ac.nz to arrange a video call, and work through the consent process.

If you would like to learn more about the Ministry of Social Development's Prevention of Abuse of Older People work programme, please click here. You can contact the team supporting this work programme on Prevention_of_AOP@msd.govt.nz.

Thank you very much for your time and consideration.

Ngā mihi,

Natalia

Natalia Boven (she/her), Postdoctoral Research Fellow | COMPASS Research Centre, University of Auckland

Participant Information Sheet

COMPASS RESEARCH CENTRE
FACULTY OF ARTS
UNIVERSITY OF AUCKLAND
Waipapa Taumata Rau

Evaluating potential data sources on abuse of older people in Aotearoa New Zealand

What is this research about? This research aims to identify sources of data on the abuse of older people (also known as elder abuse) in Aotearoa New Zealand. For this purpose, we are contacting organisations that may hold information relating to the abuse of older people and asking them to answer a few questions about this information.

For the purposes of this research, abuse of older people is understood 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.

These acts may include physical abuse, psychological and emotional abuse, financial and economic abuse, sexual abuse, social abuse and isolation, and neglect.

Who is conducting and funding the research? This research is being conducted by the University of Auckland through the Centre of Methods and Policy Application in the Social Sciences (COMPASS Research Centre, http://www.compass.auckland.ac.nz). The researchers are Assoc Prof Barry Milne, Dr Natalia Boven and Dr Komathi Kolandai. This research was commissioned by the Ministry of Social Development as part of their Prevention of Abuse of Older People work programme.

What am I being asked to do? To complete a short questionnaire that will take around 5-10 minutes. The questionnaire can be completed online through the 'Qualtrics' survey programme. If you would prefer, we are also happy to have a video call to take you through the questionnaire.

What is the questionnaire about? The questionnaire is about whether your organisation collects information relating to the abuse of older people. For organisations that do collect this type of information, we are also asking about the characteristics of this information. This is so we can understand how useful this information would be for understanding how common abuse of older people is in Aotearoa New Zealand.

It is important to note that we are not asking you to provide any information about the abuse of older people to us – we are just asking you to tell us about the types of information you collect. We are also not asking about any abuse of older people you may have experienced or may be aware of.

What do I get for responding? You may not benefit directly from responding. However, you will contribute to understanding the extent of abuse of older people in Aotearoa New Zealand. Your responses may influence how information about the abuse of older people is collected in the future.

Are there any risks I should be aware of? No, we do not foresee any risks or harm (physical or psychological) to you that may result from taking part in this research.

How were my name and contact details identified? Your name and contact details were identified by searching publicly available information online, or through our networks of professional contacts.

Will my participation be confidential? Your name, contact details, consent form, and responses will be kept confidential to the research team and will not be shared with anyone – including the Ministry of Social Development. The information provided will be summarised in a report that will be provided to the Ministry of Social Development. As part of the questionnaire, we will ask you if you are happy for your organisation to be named in the report. Your organisation will only be named in the report if you explicitly give consent for this. If you state that you would like your organisation's name to be kept confidential, we will also take care to not include any information in the report that may allow someone to identify your organisation.

What if I can't participate or choose not to? Participation is voluntary, and you should not feel pressured to respond. If you would rather not participate, simply reply to the email we sent you and indicate you would not like to participate.

Can I withdraw myself after I have participated? Yes, you may withdraw from the study without needing to provide a reason. All you need to do is contact us by email within two weeks of completing the questionnaire or video interview.

What happens after the responses have been collected? The responses will be summarised in a report that will be provided to the Ministry of Social Development. The overall report will not be made publicly available, although the key findings from the report, and sections of the report that collate information gathered from publicly available sources, may be made publicly available in some form by the Ministry of Social Development.

How long will data be stored for? Questionnaire responses (including notes if the questionnaire is completed by video call) and consent forms will be stored securely on the University Research drive for 6 years, after which time they will be deleted.

Who should I contact if I have any questions about this research? You may contact us by email at natalia.boven@auckland.ac.nz.

If you would like to learn more about the Ministry of Social Development's Prevention of Abuse of Older People work programme, please click here. You can contact the team supporting this work programme on Prevention_of_AOP@msd.govt.nz.

How do I agree to participate? We have provided all relevant information about this research in this sheet, and you can contact the researchers with any questions you may have before participating. If you would like to complete the questionnaire online, please click the link below which will guide you through the consent process before beginning the survey:

https://auckland.au1.qualtrics.com/jfe/form/SV_elnEOWDs0iVsbf8

If you prefer to complete to complete the questionnaire by interview over a video call, please email Natalia Boven natalia.boven@auckland.ac.nz to arrange a video call and work through the consent process.

Researcher contact details
Dr Natalia Boven natalia.boven@auckland.ac.nz
Assoc Professor Barry Milne b.milne@auckland.ac.nz
Dr Komathi Kolandai komathi.kolandai-matchett@auckland.ac.nz

UAHPEC Chair contact details
For any queries regarding ethical concerns, you may contact:
The Chair, the University of Auckland Human Participants Ethics Committee,
Office of Research Strategy and Integrity, University of Auckland,
Private Bag 92019, Auckland 1142. Telephone: 09 923 3711.
Email: humanethics@auckland.ac.nz.

Approved by the University of Auckland Human Participants Ethics Committee on 17/07/2023 for 3 years. Reference Number: 26359.

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