Inquiry into Elder Abuse in Queensland

Submission No:	51
Submitted by:	Australian & New Zealand Society for Geriatric Medicine
Publication:	Making the submission and your name public
Attachments:	See attachment
Submitter Comments:	

8 April 2025

Education, Arts and Communities Committee
Parliament House
Queensland 4000

By email: eacc@parliament.qld.gov.au

Dear Colleagues,

Thank you for the opportunity to provide comment on the Queensland Parliament's Education, Arts and Communities Committee inquiry into elder abuse in Queensland. The Australian and New Zealand Society for Geriatric Medicine (ANZSGM) is the peak professional body for geriatricians and other medical practitioners who wish to advance equitable access to the highest quality care and foster excellence in health care of older persons in Australia and New Zealand.

ANZSGM acknowledges the important role the inquiry will play in examining the abuse and mistreatment of older people in Queensland and in preventing and responding to these incidences in the future

Elder abuse is a complex health, justice and social issue that can have devastating physical, mental, financial, social and emotional wellbeing consequences for older people, their families, and communities. As geriatricians, we agree that we must do more to prevent and respond to these abuses.

We attach the ANZSGM Position Statement 'Abuse of the Older Person' which outlines ANZSGM's recommendations and critical issues around The Role of the Medical Professional and Multidisciplinary Teams in identifying and responding to Elder Abuse. We hope that this resource will provide clarity and guidance around the inquiry and help to advocate for the rights of older people.

Please contact our Chief Executive Officer Alison King on [redacted]
or [redacted] if you require any further information.

Yours sincerely,

[redacted]

Dr Robert O'Sullivan MBBS, FRACP
President, Australian and New Zealand Society for Geriatric Medicine

ANZSGM Position Statement

Abuse of the Older Person

About the Australian and New Zealand Society for Geriatric Medicine (ANZSGM)

The ANZSGM is a society of medical practitioners engaged in the practice of Geriatric Medicine or related disciplines. Membership of the Society is open to registered medical practitioners who demonstrate a commitment to clinical practice, research, education and administration in Geriatric Medicine and allied specialties and to those undergoing training in these fields.

Acknowledgements

The original author of this position statement was Dr Sue Kurrle in 2003. The updated version was led by Dr. Patricia Reyes, finalised in October 2022.

This work has been supported by the Policy & Planning Committee and Communications Officer.

Introduction

People are living longer and better and are now expected to live almost 10 years longer than they did 50 years ago. In 2018, 15.7 % of Australians (3.9 million) were aged 65 and over. This proportion is expected to increase to 22 % by 2056 (8.7 million people) [1]. Although most people will grow old well, often there is an accumulation of chronic illness and morbidity with age, creating vulnerabilities, physical and psychological dependencies which potentiate abuse of the older person.

Abuse of the older person or elder abuse, as it is known internationally, is the last of the forms of familial violence that has come to public attention[2], so it is still under-recognized and under-reported. Lagging behind child abuse and domestic violence, there is a need for better frameworks and resources to ensure protection and safeguarding of the older adult, given its strong association with negative emotional and physical health, manifesting in increased hospitalization and mortality [28].

Given its multifactorial and sensitive nature, addressing elder abuse is quite complex. Multiple systematic reviews[3, 4] have concluded that there is inadequate evidence to assess the effects of any particular intervention on occurrence and recurrence of abuse. Interventions range from crisis and emergency care, provision of community support services and respite accommodation, counseling and mediation, police and legal intervention (restraining orders, review and revocation of powers of attorney), and applications for guardianship and financial management[2]. There is evidence that prevention and management requires a multi-pronged approach involving multiple agencies and disciplines, employing a variety of interventions, not acting in isolation [5, 6, 26, 27, 29]. Many programs to combat elder abuse have been developed and implemented with a focus on education and multi-disciplinary involvement, with potential to work in low-resource environments, however, the use of high quality study design is rare and further robust research is required[6].

There has been increasing awareness into the identification and response to elder abuse with the landscape changing rapidly in Australia and New Zealand, informed by the numerous formal inquiries into elder abuse at state, territory and national levels in the last decade. Previously, most state/ territory governments established Elder Abuse Helplines and funded abuse prevention and advocacy services but a national framework was lacking.

Key national research studies from the Australian Institute of Family Studies (AIFS) and National Ageing Research Institute (NARI) have provided an analysis of elder abuse in the Australian context [7] and a review of outcomes of previous interventions[8,9]. The Australian Law Reform Commission (ALRC) Inquiry and Report into Elder Abuse in 2017[10] provided a national perspective combining separate efforts and providing a collection of knowledge from the various states and agencies delivering elder abuse services.

In New Zealand, research from the Office for Senior Citizens (OSC) based on the New Zealand Longitudinal Study of Ageing (NZLSA) established prevalence and projections of elder abuse[30, 31] while the current state of elder abuse responses and services were reviewed by the Ministry of Social Development (MSD)[33], informing a national strategy for future Elder Abuse Response Services (EARS) [34].

Defining the Problem

Abuse of Older People or Elder Abuse is defined as a *single or repeated act, or lack of appropriate action, occurring within a relationship where there is an expectation of trust, and which causes harm or distress to an older person (*WHO 1995, 2007) [12]. It may be intentional or unintentional.

Variations in definition exist as the description of an older person differ, affecting estimates of prevalence and incidence locally and internationally. The WHO and most international units use the age of 60. In Australia, as per the Australian Bureau of Statistics, the age of 65 is used in the definition of "elder or older", correlating with ability to access aged care services. For Aboriginal and Torres Strait Islanders, this age is lowered to 50 due to significant differences in life expectancy.

Emphasizing the nature of the trust relationship, this definition excludes other forms of abuse, such as self-neglect or abuse from strangers or more distant acquaintances. This paper will include elder abuse occurring in residential aged care settings from carers as well as resident to resident abuse.

Exploring definitions further, Clare and colleagues [13] debate the definition based on age, given that elder abuse can occur in younger people. They propose assessment of capacity for self-care and self-protection to be the fundamental basis. Further areas of contention in the definition include what constitutes a relationship of trust, intentionality, and carer stress as pre-determining factors[14].

Abuse takes many forms, as outlined in the table below. These may occur in combination, with psychological abuse usually enabling other forms of abuse, such as financial abuse. Differentiating the types is important as the interventions and safeguards depend on the nature of the abuse.

Financial	Illegal or improper use/management of an older person's money, property or other financial resources. Examples: misappropriation of money, abuse of power of attorney, forced changes to wills and other legal documents.
Physical	Intentionally inflicting physical pain, injury, or physical coercion. Examples: hitting, slapping, physical or chemical restraint.
Psychological	Infliction of mental stress involving actions and threats that cause isolation, fear of violence, restricting and preventing social contact with others, deprivation, and feelings of shame or powerlessness. Examples: humiliation, name-calling, intimidation, blackmail, social isolation.
Sexual	Unwanted sexual acts including sexual contact, rape, language or exploitative behaviours where the older person's consent has not been obtained, where consent has been obtained through coercion, or where the older person is unable to consent due to cognitive incapacity.
Neglect	The failure of a responsible person to provide the necessities of life such as adequate food, shelter, clothing, hygiene, medical or dental care.

Prevalence: A hidden problem

Elder abuse is a hidden problem[15]. Due to its complicated aetiology, it may be under-recognised and under-reported by both victims and their family and carers. Prevalence estimates vary widely due to difference in definitions, methodology and contexts.

Internationally, Yon and colleagues in 2017, on review of studies from 52 countries from diverse regions, report 1 in 6 people (15.7%) over the age of 60 experienced some form of abuse in the community in the previous year[16], with rates of abuse even higher in institutions such as nursing homes and long-term care facilities[17]. Cooper[18] reports a much wider range between 3.2% and 27.5%, with significantly higher rates among more vulnerable older people. In certain populations such as a rural setting in China, rates are higher, with Wu and colleagues showing more than one third of elderly reporting elder abuse [19].

The New Zealand Longitudinal Study of Ageing (NZLSA), using the Vulnerability to Abuse Screening Scale (VASS) established a prevalence of 10% with women and older people divorced, separated or widowed at increased risk. Older Maori were at 2.5 times more risk relative to non-Maori older adults. [30, 31]

The National Elder Abuse Prevalence Study released in 2021 showed slightly higher prevalence estimates in Australia at 14.8 % with similar rates in men and women. The most common form of abuse is psychological abuse (11.7%), followed by neglect (2.9%), financial (2.1%), physical (1.8%) and sexual abuse (1%). Up to 3.5% of respondents reported multiple types of abuse[35].

Aetiology: A complex interaction

No single factor can explain the complex issue of elder abuse[2]. There are risk factors for both the older person and the alleged abuser. For the older person, increased functional dependence from cognitive, mental health or physical impairments puts them at highest risk of abuse. Social isolation, poverty, and traumatic life events, including interpersonal and domestic violence, have well-established associations with elder abuse[7].

Risk factors for the abuser include poor mental health, gambling or substance abuse/ dependence, social isolation, dependency on the victim, and poverty. Carer stress due to increased pressures of caring for a disabled family member, possibly superimposed on other causative factors, is well-known. Bagshaw et al. describes a recent risk factor for financial abuse, ‘inheritance impatience’, where the abuser is a family member with a sense of entitlement to the older person’s property[21].

Other contributing factors include dysfunctional family dynamics and a shared living situation, where in some families, violence is considered normal or culturally acceptable, and this may continue for generations. In some cases, the abuser may have suffered abuse as a child by the person they are now abusing or there may have been a history of marital conflict, now resulting in spouse abuse. ‘Carer abuse or reverse abuse’ occurs when the carer is abused by the person they are caring for, most commonly, in the context of dementia[2].

Cultural contexts must be considered as perceptions of abuse are culturally mediated [14]; abuse in one culture maybe the norm in another. For example, in India, admission into a nursing home is a form of elder abuse as it is considered a form of neglect or abandonment by family normally responsible for care, mandated by fines and even imprisonment. In the Australian culturally and linguistically diverse (CALD) population, vulnerabilities are present due to language and literacy issues, as well as social isolation, and unwillingness to disclose abuse due to the social stigma associated with it, [14] and the potential conflict caused by cross-generational expectations in relation to care[7].

In Aboriginal and Torres Strait Islanders (ATSI) culture, understanding abuse and its occurrence is complex starting with terminology with the term 'elder' referring to the appointed community representative, not necessarily an older person. Similarly, in Maori society, the definition of elders or Kaumātua, depends on age (mid-sixties), knowledge of tribal history and traditions, and the presence of other potential elders for younger generations to refer to. Life expectancy is lower in Indigenous Australians and access to aged care services starts at 50, so definitions of elder abuse apply at this age[14].

Financial abuse is the most common form of abuse in Aboriginal communities with Aboriginal norms in relation to reciprocity, expectation of shared resources, and kinship, implicated as potential risk factors [7]. In Maori communities, spiritual and cultural abuse often overlaid other forms of abuse with intergenerational differences emerging as a contributing factor[36].

Within institutions, abuse occurs when standards of care are low, staff are poorly trained or paid and overworked, and policies are geared towards benefiting the institution instead of the residents. On a societal level, ageism and its associated negative attitudes towards the experience of ageing, acts as a type of prejudice that enables abusive behaviour against older people perceived to be frail and weak, and leads to overlooking its consequences, rendering victims of abuse invisible.

Identifying and Responding to Elder Abuse: The Role of the Medical Professional and the Multidisciplinary Team

Doctors and other health care professionals are at the front line of identifying and responding to abuse of the older person as they are in the position to assess the first signs of abuse and question the patient if they suspect abuse. They should be able to establish the plausibility of the explanations of the victim or perpetrator based on knowledge of their medical conditions and risk factors as well as have the ability to assess cognitive capacity. They are responsible for treatment of injuries or health problems that may arise from abuse, be it in the primary care, clinic, or hospital setting.

However, failure to identify abuse is the rule with fewer than 5% of cases reported despite mandatory reporting laws in the US [22]. Schneider and colleagues explored the barriers to detection and reporting in primary care. Physicians perceived that other patient clinical care issues, time limitations and maintaining trust in the clinician-patient relationship outweighed the importance of detecting and pursuing suspected cases of elder abuse. Social workers, although having the most knowledge and experience related to

elder abuse, relied on doctors to detect potential abusive situations and to work with them in making appropriate referrals[23].

More training and education is required for doctors and all health professionals who have an interface with older people and possibly elder abuse. Ries and Mansfield [24] summarize available screening tools developed to assist clinicians in the early detection of abuse in primary care, and Worrilow summarizes the screening tools in the emergency setting [25].

Geriatricians are ideally placed, within a multidisciplinary team, to be involved in both the assessment and confirmation of suspected abuse as well as intervention. Multidisciplinary teams (MDT) or inter-professional teams are the hallmark of abuse treatment programs[26]. Mosqueda and colleagues institutionalized the Vulnerable Adult Specialist Team (VAST) model of the MDT integrating Adult Protective Services and criminal justice agencies with medical experts who were helpful in confirming abuse, documenting impaired capacity, reviewing medications and medical conditions, facilitating the conservatorship process, persuading the client or family to take action, and supporting the need for law enforcement involvement[27]. Thus, the most important task for the doctor is to recognize and identify abuse and be familiar with the resources for intervention in their local community, and be able to refer to, or coordinate these resources as necessary.

Interventions – the evidence base

The appropriate response to elder abuse is to offer the most effective, but least restrictive and intrusive, support or assistance. It is important to take a non-judgmental approach, and in many cases, it may be appropriate to look at the situation with two victims, rather than a victim and an abuser[2]. The older person should always be involved in decisions about his/her care, including respecting their decision to not take action, if they choose to do so. Ethical dilemmas may arise when balancing the rights of the older person and the clinician's duty of care[2]: Autonomy and self-determination, privacy and confidentiality need to be balanced with supported or surrogate decision making, prefaced by intact capacity for decision making.

Different types of abuse require different interventions. For example, in cases of physical abuse, where there are immediate safety concerns or a crime has been observed, police or ambulance must be called immediately and the older person is removed from immediate danger. Most often, provision of community support services is what is required for carer stress, neglect or psychological abuse. Financial exploitation may require review of power of attorney, financial management, legal intervention or guardianship application. Counseling and mediation aim to help the victim cope with abuse or repair dysfunctional family dynamics. No single discipline is capable of sufficiently resolving all types of abuse, therefore, a multidisciplinary approach with teams sharing the responsibility, is the holistic approach[26].

To date, there are no large, high quality, randomized control trials on specific interventions for elder abuse. Systematic reviews[3,4,5] have not identified specific intervention programs effective in preventing or reducing abuse. However, the World Health Organization in its *2015 Report on Ageing and Health* [29] noted case study examples supporting several effective strategies including multidisciplinary teams, providing helplines and websites, monitoring by financial institutions and conducting public campaigns.

Australian states have responded to elder abuse in a variety of ways, through various providers and frameworks. Most governments established Elder Abuse Helplines and funded abuse prevention and advocacy services, as well as information resources. For example, the interagency protocol in New South Wales outline a 5-step practical approach and lists support and referral resources.

In 2018, the Australian Federal Government responded to the ALRC recommendations funding Australia's first National Elder Abuse Plan (2019-23) [11]. It details five priority areas for action including strengthening service responses, helping people better plan for their future and strengthening safeguards for vulnerable people. Funding was provided for establishing the Elder Abuse Knowledge Hub and establishing and evaluating Support Service Trials, which include Specialist Elder Abuse Units, Health Justice Partnerships and Mediation Services.

In New Zealand, the Ministry of Social Development (MSD) contracts providers across Aotearoa to deliver Elder Abuse Response Services (EARS). In 2020, they released their proposed future funding strategy, committing increased investment to providers to deliver best-practice services, delivered as an integrated response to an increasingly diverse ageing population, and recognising elder abuse as a key family violence service[34].

Prevention is still key

Primary prevention aims to stop all forms of abuse and violence before they occur with whole-of-population initiatives that address its drivers. For financial abuse, this would take the form of increased financial literacy combined with strong regulatory frameworks to safeguard the older adult within both financial and legal institutions. There is a call for stronger legislative protections governing powers of attorney and guardianship, including a national registry to improve consistency and transparency of financial management. Criminal justice responses play a role in prevention. There is ongoing debate regarding mandatory reporting and criminalization of elder abuse.

Secondary prevention or early intervention aims to change the trajectory for individuals identified to be at risk of abuse. South Australia was the first in Australia to establish an Adult Safeguarding Unit in 2018, holding statutory responsibility for responding to reports of abuse. In 2019, New South Wales established the Ageing and Disability Commissioner Act legislating increased powers to investigate and respond to abuse in home and community settings, including execution of search warrants and sharing information with relevant agencies.

Tertiary prevention or response supports survivors and holds perpetrators to account, aiming to prevent recurrence of abuse and violence. In an 8 year longitudinal study, Acierno and colleagues, demonstrated that the presence of social supports consistently prevented negative health outcomes [29]. Family mediation, if initiated early, can be effective and be preferred by the older person over legal action, giving them a voice and allowing them to be heard [14]. Family Care or Group Conferences refocuses from the individual to the family, fostering cooperation among family members, could be an effective way to strengthen community action against elder abuse [26].

References

1. Australian Institute of Health and Welfare (AIHW) (2017). Older Australia at a Glance. Accessible at https://www.aihw.gov.au/reports/older-eople/older-australia-at-a-glance/contents/summary
2. Kurrle SE (2003). Australian Society for Geriatric Medicine Position Statement No. 1: Elder Abuse
3. Ploeg, J, Fear, J, Hutchison B, Macmillan M, Bolan G. (2009). A Systematic Review of Interventions for Elder Abuse, Journal of Elder Abuse and Neglect, 21:3, 187-219, DOI: 10.1080/08946560902997181.
4. Baker PRA, Francis DP, Hairi NN, Othman S, Choo WY. Interventions for preventing abuse in the elderly. *Cochrane Database of Systematic Reviews (*2016), Issue 8. Art. No.: CD010321. DOI: 10.1002/14651858.CD010321.pub2
5. Teaster, PB, Nerenberg, L (2003). A National Look at Elder Abuse Multidisciplinary Teams. Report for the National Committee for the Prevention of Elder Abuse. National Center on Elder Abuse. Journal of Elder Abuse and Neglect. 15 (3-4): 91-107
6. Rosen T, Woman A, Dion S, Delgado D, Demetres M, Beckman R, Lees K, Snyder R, Berman A, Fuller T, Lacks M. (2019). Review of Programs to Combat Elder Mistreatment: Focus on Hospitals and Level of Resources Needed. Journal of the American Geriatrics Society. 67:1286-94.
7. Kaspiew R, Carson R, & Rhoades H. (2016). Elder abuse: Understanding issues, frameworks and responses. Melbourne: Australian Institute of Family Studies.
8. Vrantsidis F, Dow B, Joosten M, Blakey, J (2016) The Older Person's Experience: Outcomes of Interventions into Elder Abuse. Senior Rights Victoria and the National Ageing Research Institute.
9. Dow B, (2018) Elder Abuse Community Action Plan for Victoria. National Ageing Research Institute and Senior Rights Victoria, Melbourne.
10. Australian Law Reform Commission (ALRC). Elder Abuse – A National Legal Response. ALRC Report 131 (2017). Accessible at https://www.alrc.gov.au/publication/elder-abuse-a-national-legal-response-alrc-report-131/
11. National Plan to Respond to the Abuse of Older Australians (Elder Abuse) 2019–2023. (2018). Accessible at https://www.ag.gov.au/sites/default/files/2020-03/National-plan-to-respond-to-the-abuse-of-older-australians-elder
12. World Health Organization. (2008). A global response to elder abuse and neglect: building primary health care capacity to deal with the problem worldwide: main report. Accessible at https://www.who.int/publications/i/item/a-global-response-to-elder-abuse-and-neglect-building-primary-health-care-capacity-to-deal-with-the-problem-world-wide-main-report
13. Clare, M., Blundell, B., & Clare, J. (2011). Examination of the extent of elder abuse in Western Australia: A qualitative and quantitative investigation of existing agency policy, service responses and recorded data. Crawley, WA: Crime research Centre
14. Dow B, Brijnath B,. (2019) Elder abuse: context, concepts, and challenges. Australia's welfare 2019 data insights. Australia's welfare series no.14. Cat.no. AUS 226. Canberra:AIHW.

15. Kurrle, S.E. (1992) Abuse of the elderly: a hidden problem. Australian Family Physician 21(12): 1742 -1748
16. Yon Y, Mikton CR, Gassoumis ZD, Wilber KH. (2017). Elder abuse prevalence in community settings: a systematic review and meta-analysis.Lancet Glob Health. 2017 Feb;5(2):e147-e156. https://www.ncbi.nlm.nih.gov/pubmed/28104184
17. Yon Y, Ramiro-Gonzalez M, Mikton C, Huber M, Sethi D. (2018) The prevalence of elder abuse in institutional settings: a systematic review and meta-analysis. European Journal of Public Health. https://www.ncbi.nlm.nih.gov/pubmed/29878101
18. Cooper C, Selwood A, Livingston G. (2008). The prevalence of elder abuse and neglect: a systematic review. *Age and Ageing,* 2008;37:151–60.
19. Wu L, Chen H, Hu Y, Xiang H, Yu X, Zhang T, et al. (2012). Prevalence and associated factors of elder mistreatment in a rural community in People's Republic of China: a cross sectional study. *PLoS One* **7**(3):e33857
20. Joosten M, Gartoulla P, Feldman P, Brijnath B, Dow B. (2020). Seven years of elder abuse data in Victoria (2012–2019), National Ageing Research Institute in partnership with Seniors Rights Victoria, August 2020, Melbourne, Australia.
21. Bagshaw D, Wendt S, Zannettino L, Adams V. (2013). Financial abuse of older people by family members: views and experiences of older Australians and their family members. AustralIan Social Work 66(1):86-103.
22. Acierno R, Hernandez MA, Amstadter AB, et.al. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: the National Elder Mistreatment Study. Am J Public Health. 100:292–297. [PubMed: 20019303]
23. Schmeidel A, Daly J, Rosenbaum M, SchmuCh G, Joerst G. (2012). Healthcare Professionals' Perspectives on Barriers to Elder Abuse Detection and Reporting in Primary Care Settings. J Elder Abuse Negl. 24(1): 17–36. DOI:10.1080/08946566.2011.608044.
24. Ries N, Mansfield E. (2018) Elder Abuse: The role of general practitioners in community-based screening and multidisciplinary action. Aust J Gen Pract. Apr; 47(4):235-238. DOI: 10.31128/AFP-08-17-4322.
25. Worrilow W, (2015). Physician Screening for Elder Abuse in the Emergency Department: A literature review. *Division of Education Research Scholar Program. Accessible at* https://scholarlyworks.lvhn.org/research-scholars-posters/432/.
26. Wilson D, Ratajewicz S, Els, C, Asirifi M. (2011). Evidence-Based approaches to Remedy and Prevent Abuse of Community-Dwelling Older Persons. Nursing Research and Practice. DOI:10.1155/2011/861484.
27. Mosqueda L, Burnight K, Liao S, Kemp B. (2004). Advancing the Field of Elder Mistreatment: A New Model of Integration of Social and Medical Services. The Gerontologist. 44, 5 (703-708).
28. World Health Organization (2015). Report on Health and Ageing. https://www.who.int/publications/i/item/world-report-on-ageing-and-health

29. Acierno R, Hernandez-Tejada A, Anetzberger G, Loew D, Muzzy W. (2017). The National Elder Mistreatment Study: An 8-year longitudinal study of outcomes, Journal of Elder Abuse & Neglect, 29:4, 254-269, DOI: 10.1080/08946566.2017.1365031
30. Office for Senior Citizens (2015). Towards gaining a greater understanding of Elder Abuse and Neglect in New Zealand. Accessible at https://officeforseniors.govt.nz/our-work/raising-awareness-of-elder-abuse/elder-abuse-resources/
31. Waldegrave, C. (2015). Measuring Elder Abuse in New Zealand: Findings from the New Zealand Longitudinal Study of Ageing (NZLSA). Accessible at https://officeforseniors.govt.nz/our-work/raising-awareness-of-elder-abuse/elder-abuse-resources/
32. Parosanu A, Marshall C. (2020). Korero Tahi: A Pilot Project on Using Restorative Approaches for Addressing Harms Experienced by Older Persons. Accessible at https://officeforseniors.govt.nz/our-work/raising-awareness-of-elder-abuse/elder-abuse-resources/
33. Ministry of Social Development (2019). Elder Abuse in Aotearoa: The role and current state of MSDs Elder Abuse Response Services. Accessible at https://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/initiatives/family-and-sexual-violence/elder-abuse-in-aotearoa.pdf
34. Ministry of Social Development (2020). Elder Abuse in Aotearoa: The proposed future strategy for Elder Abuse Response Services. Accessible at https://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/initiatives/family-and-sexual-violence/elder-abuse-in-aotearoa.pdf
35. Qu L, Kaspiew R, Carson R, Roopani D, De Maio J, Harvey J, Horsfall B. (2021). National Elder Abuse Prevalence Study: Final Report. Accessible at https://aifs.gov.au/research/research-reports/national-elder-abuse-prevalence-study-final-report
36. Thaggard, S., Boon-Nanai, J., Tautolo, ES. *et al.* Experiences of Elder Abuse in Pacific Island Communities of Aotearoa New Zealand: a Cultural Lens. *Population Ageing* (2020). https://doi.org/10.1007/s12062-020-09318-y