ATTACHMENT MH 4

This is the attachment marked "**MH 4**" referred to in the witness statement of Dr Pat Tuohy, Ms Helen Fraser and Ms Miranda Ritchie dated 11 August 2015.

MINISTRY OF HEALTH
MANATŪ HAUORA

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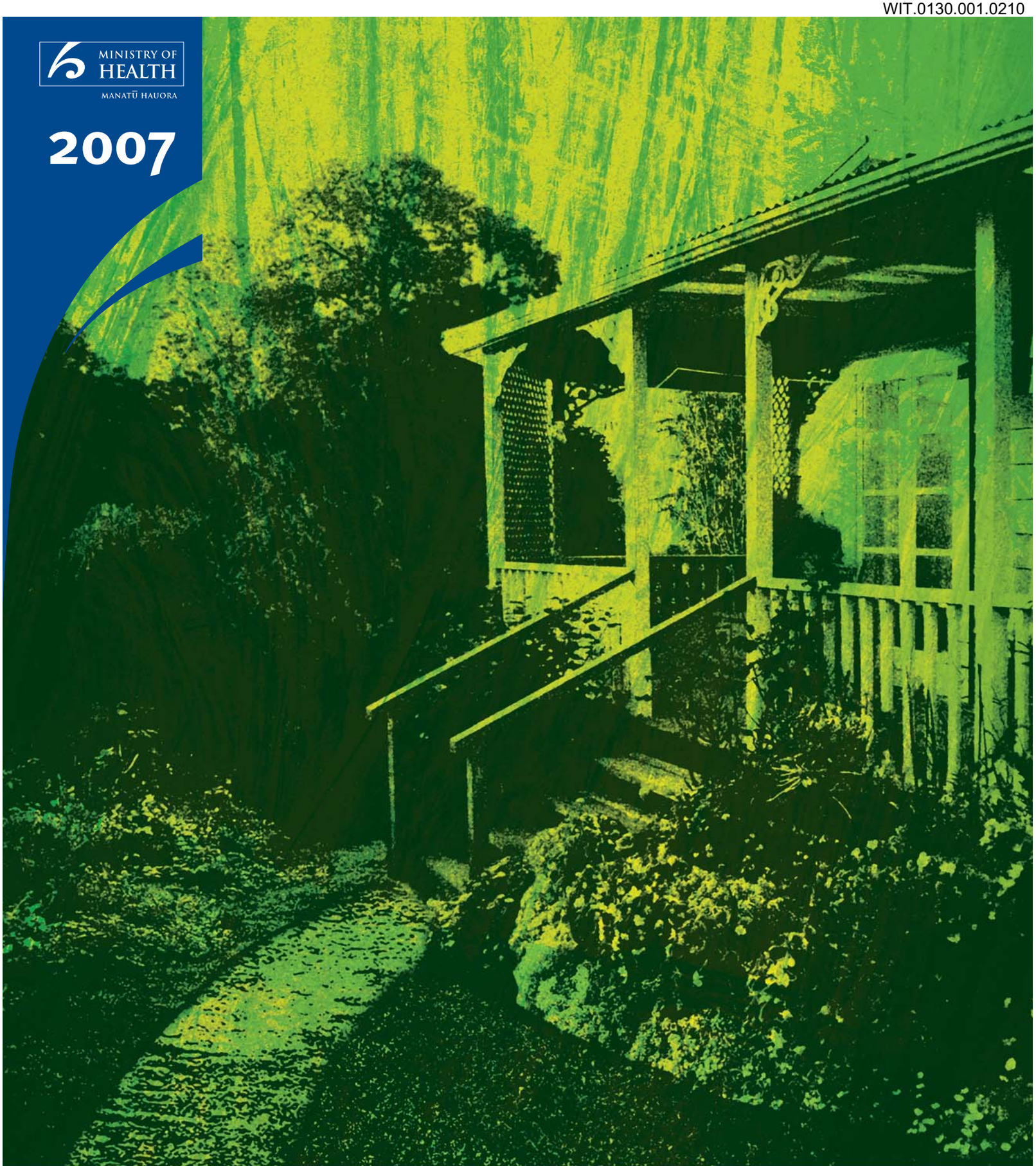
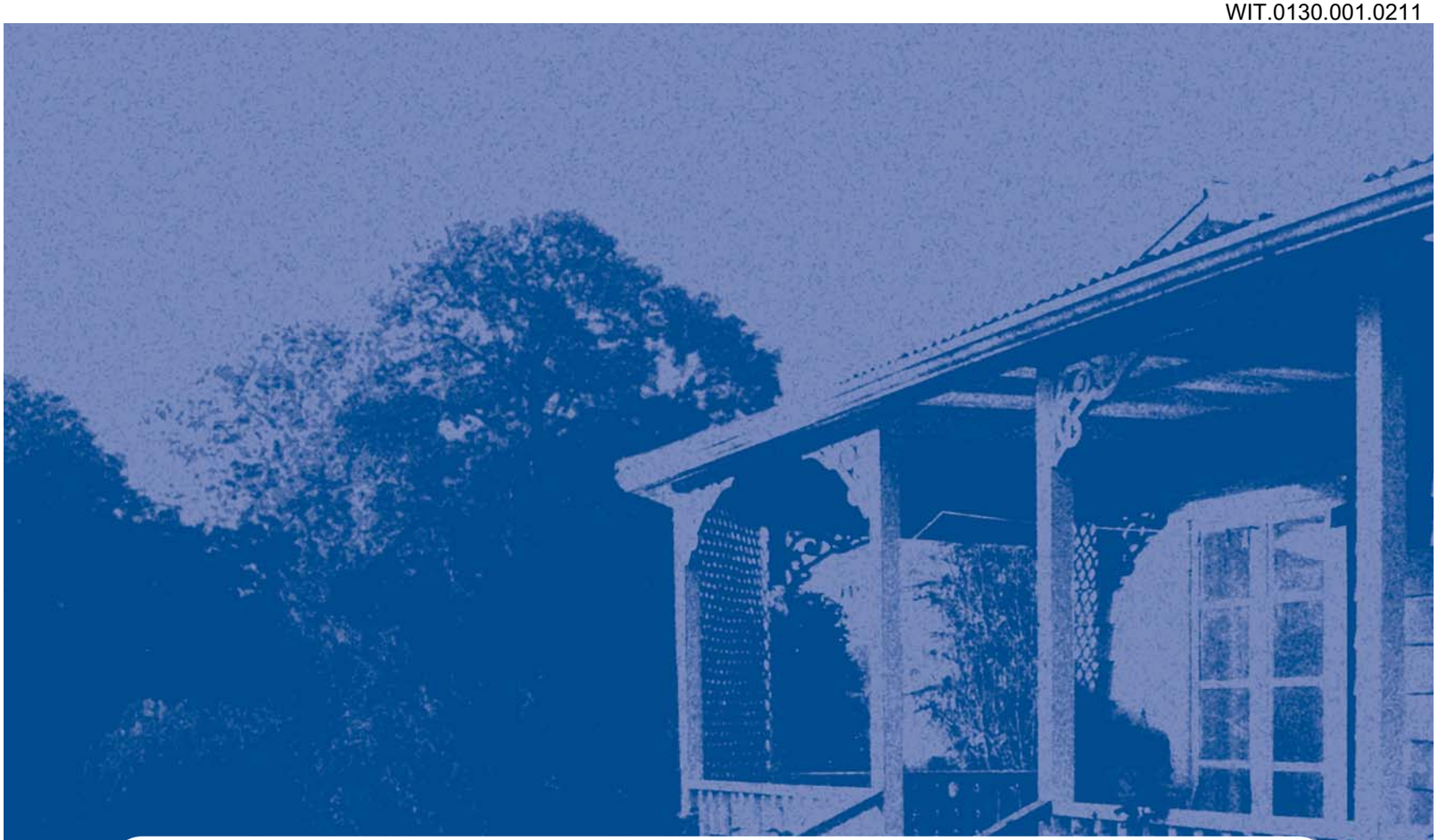


Family Violence Intervention Guidelines

Elder Abuse and Neglect



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Foreword

The reduction of interpersonal violence is a key objective of the New Zealand Health Strategy. I am therefore pleased to release the final in the set of family violence guidelines produced by the Ministry of Health – the *Family Violence Intervention Guidelines: Elder abuse and neglect*. These guidelines have been produced to support you, as health providers, to assist older persons experiencing abuse.

Elder abuse occurs in many different settings, including private homes, residential care settings and hospitals. Older persons experiencing abuse are less able to remain active, contributing members of the community. They commonly experience adverse effects on their physical and mental health, finances, living arrangements and family relationships and supports.

These guidelines set out principles of intervention that will apply to a variety of health professionals and a number of settings. They will assist health care professionals to identify, support and empower those experiencing elder abuse, and they offer guidance on how to undertake preliminary risk assessment and safety planning, and how to determine appropriate referral options.

Health care providers are increasingly recognised as key players in New Zealand's effort to eliminate all forms of family violence. Older people are significant users of health and disability support services, and those experiencing abuse use services at higher rates than others. Health care providers are therefore in an ideal position to engage in the early identification, support and referral of persons experiencing elder abuse.

Family violence is unacceptable. We need commitment by health care providers and many other groups working together to make a difference.

Stephen McKernan

Director-General of Health

Acknowledgments

The Ministry of Health and Age Concern New Zealand would like to acknowledge Kathy Glasgow and Dr Janet Fanslow for their work in producing these guidelines.

We would particularly like to thank Te Oranga Kaumātua Kuia Disability Support Service and Te Puni Kōkiri for input to the Māori section, and TOA Pacific for their input to the Pacific section. We would also like to acknowledge the contributors to all sections of the *Family Violence Intervention Guidelines: Child and partner abuse*, from which the original draft of these guidelines was developed.

We would like to thank Jo Elvidge, for her management of the project, and Betty Jeanne Eydt and Jayne McKendry, for the time and effort they put in to advising on drafts of these guidelines.

We appreciate the assistance and advice of the following Advisory Committee in the production of these guidelines.

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Our sincere thanks to the people and groups who presented submissions and the New Zealand Guidelines Group for input and advice on earlier drafts.

Endorsements

- Age Concern New Zealand
- Carers New Zealand
- College of Nurses Aotearoa (NZ) Inc
- Ministry of Social Development
- New Zealand Geriatric Society
- New Zealand Home Health Association
- New Zealand Medical Association
- Office for Senior Citizens
- Royal New Zealand College of General Practitioners

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Introduction

Purpose

These *Family Violence Intervention Guidelines: Elder abuse and neglect* present a six-step model for health care providers to use when identifying and responding to elder abuse.[1] The guidelines are intended to be used by health care professionals to:

- assist them to identify elder abuse and neglect
- support and empower those experiencing elder abuse or neglect
- undertake preliminary risk assessment and safety planning
- determine appropriate referral options for co-ordinated intervention and follow-up.

The guidelines are a practical tool to help providers make safe and effective interventions that will assist those experiencing elder abuse or neglect. They have been written as a generic guideline, setting out principles of intervention that will apply to a variety of health professionals and a number of settings.

When we think about family violence, we usually think about physical violence, yet the experience of abuse impacts equally on mental, social and spiritual health. The Māori model of health, Te Whare Tapa Wha (Durie, 1994), is probably the most helpful in understanding the impact of abuse. Described simply, Te Whare Tapa Wha is made up of four dimensions:

- taha wairua (spiritual) – the capacity for faith and wider communion
- taha hinengaro (mental) – the capacity to communicate, think and feel
- taha tinana (physical) – the capacity for physical growth and development
- taha whānau (extended family) – the capacity to belong, share and to care.

All of these capacities are diminished by the experience of abuse and violence. Early identification and intervention is important to minimise damage to all these aspects of health.

Background to the guidelines

In 1995 the Government requested that all departments prepare a response plan to family violence. In 1998 the Ministry of Health published *Family Violence: Guidelines for the development of practice protocols*. In 2001 the Ministry of Health Family Violence Project was instigated to develop practice guidelines and begin training of health care providers.

Family Violence Intervention Guidelines: Child and partner abuse (Fanslow, 2002) were published by the Ministry of Health in 2002. The present document completes the set of Ministry of Health guidelines on family violence.

[1] For the purposes of this document 'elder abuse' includes elder neglect. For a detailed definition, see the Glossary.

Guideline development process

This document is a best-practice consensus-based guideline based on expert opinion and supported by available evidence from local and international elder abuse research and information. The guidelines have been developed with the support of Age Concern New Zealand and in consultation with health care providers, health professional bodies, and elder abuse prevention and family violence advocates. The guidelines follow the same format as the *Family Violence Intervention Guidelines: Child and partner abuse.*

In 2003 an expert advisory group was established to assist and advise on the development of draft elder abuse guidelines. The amended draft guidelines were then circulated to a wider reference group of key stakeholders, including health service providers, professional bodies, older persons advocacy groups and elder abuse practitioners.

A review of elder abuse literature included electronic and manual searches of key texts and publications, local and international intervention guidelines and protocols, and research articles published in journals and on international elder abuse websites. Information was also sought from elder abuse service providers and academics involved in elder abuse research.

Elder abuse remains an emerging issue, and evidence to validate approaches is scarce (see Fallon, 2006; Fanslow, 2005). Where there is a lack of evidence from studies, these guidelines are based on expert opinion. The guidelines should be reviewed and updated as further information becomes available, in accordance with Ministry of Health policy.

Implementation of the guidelines

The following conditions will ensure effective use of the guidelines:

- familiarisation of management and staff with the guidelines
- development of local policies/protocols and role allocation
- availability of practitioners knowledgeable in responding to elder abuse and neglect
- established referral pathways and inter-agency protocols.

Health care providers working with abuse or neglect require appropriate education and support in the use of the guidelines. The dynamics of elder abuse are often complex (see Lachs and Pillemer, 2004; Bergeron, 2001; Wolf, 2000; Swanson, 1998), so working as part of a multidisciplinary team is recommended (Fallon, 2006; Fanslow, 2005; Keys, 2003; Age Concern New Zealand, 1992). A collaborative and cross-sector approach, with co-ordination by a key service provider/case manager, will enable solutions to be found that are meaningful to the older person and will ensure support for those working with elder abuse and neglect (see Section B, p.27).

Services for preventing and responding to elder abuse and neglect (EANP services) are available in most main centres and can provide support, advice and education. They may be a first point of contact for health care providers responding to actual or suspected cases of elder abuse (see Appendix D, p.57). For areas where there are no established EANP services these guidelines contain information that may assist with the development of elder abuse protocols and procedures.

These guidelines complement the evidence-based guideline Assessment Processes for Older People (NZGG, 2003b),[2] which recommends that multidimensional assessment include assessment for abuse. (See Appendix C, p.56, for links between elder abuse assessment and proactive or comprehensive needs assessment.) Effective processes for identifying and responding to elder abuse form one element of the integrated continuum of care approach to services for older people that underpins the New Zealand Health of Older People Strategy (Ministry of Health, 2002).

[2] Available from www.nzgg.org.nz

How to use these guidelines

This document presents a six-step approach to identifying and responding to instances of suspected or actual elder abuse or neglect.

The six steps are:

(1) Identify

(2) Support and Empower

(3) Assess Risk

(4) Plan Safety

(5) Document

(6) Refer

These steps are explained in detail in Section C, p.33.

A summary lift-out sheet is included in the back of the guidelines for daily use.

Additional information to assist with implementing the guidelines is contained in the following appendices:

- A: Signs and symptoms associated with elder abuse and neglect
- B: Risk factors for elder abuse and neglect
- C: Elder abuse screening recommendations
- D: Contact details of elder abuse and neglect services
- E: Example: Elder abuse assessment and referral form
- F: Example: Form to authorise photographing injuries
- G: Working with carers in situations of elder abuse and neglect
- H: Cognitive impairment, dementia and elder abuse and neglect
- I: Outline of the key service provider/case manager's role
- J: Checklist for health care providers
- K: Example form to record referral agency contact information
- L: Reporting incidents of abuse and 'whistle blowing'.

Health professionals' role in assisting persons experiencing abuse

Health care providers are increasingly recognised as key players in New Zealand's effort to eliminate all forms of family violence, including elder abuse. In policy documents and consultations with health consumers, family violence was consistently ranked as one of the top priorities for health care providers to address (Ministry of Social Development, 2004; Minister of Health, 2000; Health Funding Authority, 1998).

Individuals who experience violence and abuse seek care from health care providers far more often and for a greater range of health problems than individuals who have not experienced violence and abuse, and older people are significant users of health and disability support services. Health care providers are therefore in an ideal position to engage in early identification, support and referral of persons experiencing elder abuse.

However, health care providers can often treat patients without enquiring about violence and therefore do not recognise or address what may be an important underlying cause of their health problems. Even when abuse results in injuries that were clearly inflicted by another person, health care providers may record the injuries and treat the presenting problem without enquiring about the cause of the injuries or making appropriate referrals.

Barriers to a more proactive response to partner abuse by health care providers have been identified. These may also inhibit health care responses to elder abuse:*

- lack of comfort with the issue
- lack of training and information on the prevalence and health impact of abuse
- lack of formal protocols and institutional support for responding
- perceived lack of time to address the problem
- lack of confidence in referral agencies.

*(Maxwell et al, 2000; Spinola et al, 1998; Kljakovic and Keenan, 1995; Sugg and Inui, 1992).

Successful efforts to counteract these barriers include the development of recommended procedures for responding to abuse, and the provision of training and education for providers on how to incorporate these procedures into their current practice (Age Concern New Zealand, 1999, 1992; HealthLink South and Presbyterian Support, 1999. (See also Appendix J, p.69).

Overview

Section A: An overview of elder abuse and neglect

Elder abuse: a universal problem

Elder abuse is a universal problem. It is not limited to any one gender, religious, cultural, ethnic or income group. Elder abuse may occur in many different settings, including private homes, residential care settings and hospitals.

What is elder abuse?

For the purposes of this document elder abuse is defined as:

> *...a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.*[3] (Action on Elder Abuse, 2004; WHO/INPEA, 2002)

Elder neglect is included in this definition, and for the purposes of this document 'abuse' should be read as 'abuse or neglect'. Neglect may be intentional (active neglect), or may occur as a result of the carer's condition, inadequate knowledge or disputing of the value of a service (passive neglect). See the Glossary for a full definition of elder neglect.

Self-neglect is an additional category that does not fit neatly into the definition above. It is considered in this document because health care providers may need to respond to situations of self-neglect and to assess whether a situation is one of neglect by others, self-neglect or a combination of the two.

Definitions require consideration of the cultural context. Interpretations of what constitutes abuse and the appropriateness of response can vary. At the individual level, meanings of abuse may include, for example, disrespect, dishonour, lack of esteem shown to kaumātua, or ignoring the needs of older people. It is important to keep in mind the impact abuse has on the older person when determining whether elder abuse has occurred.

Five commonly identified categories of elder abuse are:

- *physical abuse:* infliction of physical pain, injury or force, including medication abuse (deliberate or accidental misuse of medication and prescriptions that sedate or result in harm to the older person) and inappropriate use of restraint or confinement that causes pain or bodily harm
- *sexual abuse:* any forced, coerced or exploitive sexual behaviour or threats imposed on an individual, including sexual acts imposed on a person unable to give consent, or sexual activity that an adult lacking mental capacity is unable to understand
- *psychological/emotional abuse:* any behaviour that causes anguish, stress or fear, including verbal abuse, intimidation, harassment, damage to property, threats of physical or sexual abuse, and the removal of decision-making powers
- *financial/material abuse:* illegal or improper use of funds or other resources, and/or exploitation
- *neglect:* occurs as a result of another person failing to meet the physical and emotional needs of an older person.

[3] A number of definitions on elder abuse exist. This definition was developed by the UK's Action on Elder Abuse in 1995 and subsequently has been adopted by the International Network for the Prevention of Elder Abuse. It is similar to, and not in conflict with, the definitions in current use in New Zealand by the main providers of elder abuse and neglect prevention and intervention services.

An additional category of abuse currently causing concern in New Zealand, and in some other countries, is abuse of enduring power of attorney. This occurs when a person who has been given enduring power of attorney abuses their powers and fails to operate in the best interests of the older person. Financial abuse and psychological abuse are the two main forms of abuse by persons holding enduring power of attorney (Age Concern New Zealand, 2004).

Other sub-types of abuse identified in the literature that can be grouped within, or may cut across, the above categories include:*

- partner abuse (abuse or neglect within a life-long or recent partnership)
- institutional abuse (such as that occurring within residential care where a policy or practice results in abuse or neglect)
- abuse by discrimination, disrespect and ageist attitudes (including behaviour that is perceived by older people as dishonouring or insulting)
- structural/societal or systemic abuse (marginalisation of older persons, by, for example, social or economic policies).

*(Age Concern New Zealand, 2005; Action on Elder Abuse, 2004; United Nations, 2002; Wolf, 2000; McDonald and Collins, 2000)

Who is abused?

Any older woman or man may experience elder abuse. Those with dementia or those who have difficulty communicating may be more vulnerable to abuse than others.

Who abuses?

This can be anyone dealing with an older person, including a:

- partner, adult child or other relative
- friend, neighbour or visitor
- patient or resident
- health care provider, caregiver, or other social or support worker
- residential care facility owner or manager
- volunteer worker
- person managing an older person's affairs (eg, attorney or guardian).

Analyses of cases seen by elder abuse services found that family members were most often identified as the abuser, in particular adult sons or daughters (40% of abusers) or the spouse or partner of an older person (15% of abusers) (Age Concern New Zealand, 2005; Hong et al, 2004).

Where does it happen?

Elder abuse and neglect may occur in any setting, rural or urban, and can affect older people living on their own or living with others. It can occur in private homes or within a residential care or health care setting. In hospital, elder abuse may occur in rehabilitation and continuing care wards, as well as in acute wards, day care, emergency and outpatient departments, and any other area where the care of older people is provided.

The possible signs of abuse

There are a range of indicators that may suggest the possibility of some kind of abuse or neglect (Krug et al, 2002; Wolf, 2000). None of them absolutely mean that abuse has taken place, but should raise suspicions and encourage a more thorough assessment. A list of alert features is provided in Section C 1.3, p.34, and signs and symptoms of abuse are provided in Appendix A, p.51.

Why does it happen?

Elder abuse occurs for many reasons. There may be a background of family violence, or a history of a poor long-term relationship between the abused and the abuser. Carers may be struggling with their role. The impact of dementia, alcohol or other substance abuse or mental health problems can contribute. A list of risk factors is provided in Appendix B, p.54 (Refer Fallon, 2006; Krug et al, 2002; Age Concern New Zealand, 1992).

In the case of financial abuse the dynamics can differ, because abuse may be premeditated and motivated by greed as much as by economic stress.

Factors that can increase the likelihood of elder abuse

These include situations where:

- a family undergoes an unforeseen or unfavourable change in circumstances
- there is a history of poor relationships or abuse between family members
- difficulties emerge as a result of role reversal (eg, if a father or mother becomes dependent on a son or daughter)
- family members are isolated and lack other relationships which give social, physical and emotional satisfaction
- a carer has been forced to change lifestyle as a result of caring
- the older person requires a level of care beyond the capacity of the carer
- there are difficulties due to hearing, visual or speech impairments
- a carer has conflicting responsibilities or financial difficulties
- a carer has not received help or support
- the older person refuses adequate support for themselves or their carer
- the older person has an illness or dementia that can cause unpredictable or repetitive behaviour, wandering or aggression, or major changes in personality
- financial pressures and/or beliefs about rights of inheritance or ownership lead to control of finances, property or resources.

Factors that can contribute to abuse within hospitals or care settings

Abuse may be more likely in a care setting or hospital where there are:

- staff working in isolation
- staff inadequately trained to provide care and to respond to challenging behaviour
- staff poorly supervised
- low staffing levels and/or frequent use of agency staff
- high staff sickness levels or a rapid turnover of staff
- staff with low self-esteem, or who are stressed or ‘burnt out’
- staff who have a criminal history, personality disorder or abuse drugs or alcohol
- inappropriate/poor staff skill mixes and poor staff/patient ratios
- inadequate management supports
- over-cramped or poor working conditions and environment
- care settings isolated from other parts of the hospital or community
- attitudes or behaviours that disregard the safety of patients or residents.

Consequences of elder abuse

For the person experiencing abuse there may be wide-ranging and long-term effects on their physical and mental health, finances, living arrangements and family relationships and supports (see Lachs and Pillemer, 2004). Those affected are at increased risk of being placed in a nursing home (Lachs et al, 2002) and may be at increased risk of premature death (Lachs et al, 1998). Elder abuse and neglect also contributes to the continuation of family violence and poor family functioning.

Preventing elder abuse – what you can do

- Learn to recognise the signs and types of abuse, both obvious and hidden.
- Know how you should respond in cases of abuse. Find out your practice's or employing agency's policy and procedures on abuse.
- Collaborate with other professionals when responding to abuse. Identify the key professional or agency taking responsibility for the response.
- Develop your own policy and procedures in conjunction with local referral agencies.
- Listen to older people, residents and colleagues and observe any unusual or sudden changes in behaviour or practice.
- Know how to ask older people and carers appropriate questions.
- Support and encourage others to improve their knowledge about abuse.
- Support and encourage research into abuse and intervention techniques.

Additional information on elder abuse is provided in *Promoting the Rights and Well being of Older People and Those who Care for Them: A resource kit about elder abuse and neglect* (Age Concern New Zealand, 1992), available at www.ageconcern.org.nz.

Links between elder abuse and other forms of family violence

Elder abuse shares a number of characteristics with other forms of family violence (Fanslow, 2005; Dunlop et al, 2000; Korbin et al, 1989). As with partner abuse and child abuse, elder abuse is largely hidden, private and under reported (see Fallon, 2006). Victims and families are often isolated, and in a weakened, powerless and dependent position, and families often lack support. There is often a history of family conflict, alcohol/drug abuse, psychological problems, low self-esteem and/or unemployment (Lachs and Pillemer, 2004; Gnaedinger, 1989).

There are a number of differences, however. For example, gender differences are less clear-cut than in cases of partner abuse. In elder abuse both men and women may abuse or neglect (Thompson and Atkins, 1996). Similarly, both older men and older women are at risk of being abused, although older women are at greater risk according to most studies (Fallon, 2006).

Issues of power and control can also be more complex. The older person may be dependent on others, making them vulnerable to abuse. However, the abuser may also be financially and emotionally dependent on the older person (Wolf, 2000; Anetzberger, 1987; Pillemer, 1986).

In comparison with child abuse, older people are (generally) legally competent adults, able to make their own decisions about where they live, with whom they live and how they live. Older people may choose to remain in a living situation which is not physically, psychologically or financially safe for them. Such a decision made by a competent adult needs to be respected and options for improving safety within this context need to be explored.

Other issues may complicate the picture in situations of elder abuse. For example, it may be a situation where there is pre-existing family conflict, or it may be partner abuse occurring between older people. Sometimes an older person may be abusing their partner and/or caregiver due to dementia or other conditions. There can also be specific elements that require specialist services, such as issues of consent and assessment of mental capacity, occurrence of abuse within rest homes and institutions, and/or responding to financial and material abuse.

Issues such as these make it essential that generalisations are not made uncritically from other forms of family violence to elder abuse without consideration of the whole picture and investigation of all issues involved.

Elder abuse in New Zealand

No population-based studies of elder abuse have been conducted in New Zealand (Fanslow, 2005). However, most research estimates 2 to 5% of the older population may be victims of elder abuse (Thomas, 2002; NCEA, 1998; Swanson, 1998). Reports from the 2001 Census show that there were 450,426 people aged 65 and over living in New Zealand, which means there could be between 9008 (2%) and 22,520 (5%) older New Zealanders suffering some form of abuse and neglect. US research estimates that only 16% of the actual number of abuse incidents reach service agencies (Thompson and Atkins, 1996).

Of the 2441 cases of abuse or neglect seen by Age Concern New Zealand's elder abuse and neglect services between July 1998 and June 2001, most presented for psychological abuse (56%), followed by financial/material abuse (46%), physical abuse (22%), active and passive neglect (18%), and sexual abuse (3%) (Age Concern New Zealand, 2002). Almost half of all clients experienced more than one type of abuse or neglect. Analysis of referrals shows that people experiencing abuse were predominantly New Zealand European (86%) aged between 70 and 84 (62%) and most commonly living alone (40%) or in residential care (20%). Among referrals, more women experienced abuse (68%) and slightly more men were abusers (55%). The majority of alleged abusers were members of the older person's family, with sons and daughters the highest category of abusers (see also Age Concern New Zealand, 2005).

International data shows similar trends. A National Elder Abuse Incidence Study in the United States (Thompson and Atkins, 1996) found that 90% of abusers were a family member, most commonly an adult child (43.7%), with spouses the next highest category of abusers (19%). Men were the abusers in 52.5% of cases for all types of abuse, while women were more likely to be abused than men, (60-76%). The oldest elders (80 years and over) were abused and/or neglected at a rate two to three times their proportion in the population (see also NCEA, 1998).

Cultural perspectives on elder abuse

Research on cultural perspectives is limited, partly because differences occur both within and across ethnic and cultural groups (Moon and Benton, 2000), and partly because data on ethnicity is not always captured in records of abuse. Indications are that notions of gender equality and power and control in families differ according to religious and cultural belief systems and traditions.

Differing cultural perspectives exist on what constitutes elder abuse (Moon, 2000), and cultural groups respond differently to varying approaches to education and intervention (Age Concern New Zealand, 1999; Tatara, 1998; Safer Community Council, 1997). Commonalities across cultures do exist (K Dawson and Te Oranga Kaumātua Kuia, personal communications, 2004 and 2003; M Hamani and TOA Pacific, personal communications, 2004 and 2003). For example, the most frequent forms of abuse are the same for European, Māori and Pacific New Zealanders: psychological abuse and material abuse or neglect. However, the motivation or rationale for this abuse or neglect may be culturally determined and will require a culturally appropriate response (see Fallon, 2006).

The next sections provide background information on the main minority population groups in New Zealand and suggest principles and actions for cultural competence in elder abuse assessment and intervention.

Māori

Māori and elder abuse

This section aims to enable health care providers to have some understanding of the issues that underpin abuse and neglect for Māori, and strategies to improve responsiveness to Māori.

What do we know about Māori and elder abuse?

The proportion of older Māori is currently small but is rapidly growing. Numbers of older Māori are projected to increase by eight times within the next 50 years (Statistics, New Zealand 1998). The prevalence of elder abuse among Māori has not been established.

Information from Māori service providers indicates that financial abuse and emotional abuse are more common forms of elder abuse than physical or sexual abuse (K Dawson and Te Oranga Kaumātua Kuia, personal communications, 2004 and 2003; Dawson, 2002a). Often there will be long-standing family issues that may need to be addressed, and a history of family violence may be present. The older person may be experiencing grief at a loss of trust, aroha and support from whānau. In addition, in a high proportion of cases seen by Māori elder abuse service providers, the client has some form of dementia.

Asking for help is likely to be difficult for many Māori, as a sense of shame and stigma can be associated with elder abuse (K Dawson and Te Oranga Kaumātua Kuia, personal communications, 2004 and 2003; Dawson, 2002a). It is important that health care providers gain an understanding about the dynamics of family violence and the social and cultural influences. This understanding can help health care providers to demonstrate attitudes and actions that are supportive and that will encourage koroua and kuia to access help when needed.

The occurrence of abuse in Māori whānau has both historical and contemporary causes and can be attributed to the complex interaction of many sociological, economic and cultural factors. These factors may include:*

- the impacts of colonisation, including the break-down of traditional Māori social structures and systems of discipline and justice
- loss of te reo Māori and traditional beliefs, values and philosophy for many Māori and the impact of this on identity, roles and relationships
- a change in the way violence is viewed, from being a public iwi and hapū concern to a private whānau issue
- urbanisation and associated isolation of Māori throughout city suburbs, often resulting in social isolation and dislocation from support networks
- hardship experienced by many Māori associated with poor educational achievement, low income and restricted employment opportunities.

*(Barnes, 2000)

Older Māori have traditionally been treated with respect as leaders of iwi, hapū and whānau.

> *Implicit in this status of older Māori has been expectations of them and their kaumātua roles within the tribe: to be the spiritual leaders, mediators in conflict, guardians of cultural integrity, and mentors to younger members of the whānau, hapū and iwi. The acceptance of these influential roles by (older Māori) is a considerable, often arduous responsibility. In return whānau and/or hapū have traditionally recognised a responsibility to look after the comfort and needs of kaumātua.* (NZGG, 2003b, citing Durie, 1999)

Social changes over recent decades have had a significant impact on older Māori. Some elders have experienced the loss of te reo Māori and feel unable to pass on the Māori tikanga (cultural values and beliefs), with a resulting loss of their traditional relationships. In addition, personal expectations have changed and some older Māori now wish for more time to live their own lives, as opposed to fulfiling traditional role commitments (Dawson, 2002a; Durie, 1999).

Fewer whānau members care for elders due to the need to move away to find employment. These social and economic changes contribute to the whānau's difficulty in providing continuity of traditional whānau-based care of older Māori (K Dawson and Te Oranga Kaumātua Kuia, personal communications, 2004 and 2003; Durie, 1999).

There remain a number of older Māori who have English as a second language and who feel alienated from mainstream culture and institutions, including health services. As a result their access to support can be limited.

Māori service providers ensure that the wellbeing of older Māori is maintained within a 'whānau ora', holistic, culture-specific model of assessment and response (Dawson, 2002b; Durie, 1994). Pivotal to this approach, is the emphasis on collaborative decision-making (NZGG, 2003b; Dawson, 2002b). Meeting with the older person first on an individual basis can be important (NZGG, 2003b), to allow disclosure of anything that cannot be discussed in front of the whānau or carers and to ascertain who the older person wishes to involve. Significant processes include education and restoration of the mana, and respect for elders. This is worked towards over time through a series of whānau meetings (K Dawson and Te Oranga Kaumātua Kuia, personal communications, 2003 and 2004).

Reducing inequalities in health status

The Government is working to address the health needs of Māori, including inequalities in health status. Health services should benefit the health of all peoples. Health care providers are encouraged to contribute to ensuring that Māori are able to enjoy the same level of health as non-Māori by:

- taking account of Māori health needs and perspectives
- developing culturally appropriate practices and procedures
- engaging with whānau, hapū and iwi
- developing partnerships with Māori providers
- recruiting and supporting Māori personnel/health workers.

Māori health holistic model and quality framework

There are several Māori health models and frameworks that illustrate Māori holistic approaches to health and wellbeing. The most well known of these is Te Whare Tapa Wha, which represents the aspects of health and wellbeing for Māori (Dawson, 2002b; Durie, 1994). Health care providers are encouraged to familiarise themselves with Te Whare Tapa Wha, or other Māori health models, such as Te Wheke (Pere, 1997), and Jones' Five Cornerstones of Healing (Jones, 2000), and use the framework in their interaction with Māori.

However, health care providers should be mindful that these models are simplified expressions of Māori wellbeing. Where possible, service providers should engage with local hapū and iwi so that unique hapū perspectives can inform services in an ongoing way.

A second area of focus for health providers is to improve their service delivery to Māori, as indicated in *He Taura Tieke* and *He Korowai Oranga. He Taura Tieke* (Ministry of Health, 1995) provides a quality framework and detailed checklist for providers to plan, develop and manage effective health services for Māori. *He Korowai Oranga: The Māori Health Strategy* (Minister of Health, 2002) provides a framework for the public sector to take responsibility for the part it plays in supporting the health status of Māori and their whānau. *He Korowai Oranga* has a strong focus on whānau ora (whānau health and wellbeing).

Principles for action

Health care providers should ensure the service they provide is safe and respectful of Māori beliefs and practices. The following whakataukī highlights the importance of respectful practice in optimising the effectiveness of health care providers and their actions:*

E tāu hīkoi i runga i āku whāriki
E tāu noho i toku whare
E hau kina ai tāku tatau tāku matapihi

Your steps on my whāriki (mat), your respect for my home,
Opens my doors and windows.

*(Barnes, 2000)

The hallmarks of a culturally competent system require health care providers to demonstrate:

- accessibility of their service to victims of family violence
- recognition of the diversity of Māori in their culture and their experience of violence
- knowledge and understanding of Māori holistic frameworks of health
- knowledge and development of responsive services for Māori
- accountability
- partnerships with iwi, hapū and Māori that are sustained
- that the context of the whānau and the community are incorporated within the delivery of services.

The delivery of a culturally safe and competent service that responds to Māori who have been abused should be underpinned by the following principles (K Dawson and Te Oranga Kaumātua Kuia, personal communications, 2004 and 2003; Fanslow, 2002; Leahy, 1999).

(1) Safety and protection must be paramount

Maintaining the safety of koroua and kuia must be paramount. Any practices or interventions that health care providers engage in should not further endanger or disadvantage the older person.

Actions and behaviours to ensure safety and protection for older Māori

- Do not assume that the whānau should be involved – offer plans of action the older person can take (these may or may not include whānau).
- Affirm the elder's right to a safe, non-violent environment.
- Offer referral to Māori or mainstream elder abuse and neglect services.
- Have Māori staff available. This may include kaumātua who can provide support.
- Your communication style is important. Use language that is easily understood, a tone that conveys respect, and a non-judgmental attitude.
- Manage risk factors.

(2) The provision of a Māori-friendly environment

Health care providers should ensure that they provide an environment, including physical, attitudinal and behavioural factors, that will contribute to older Māori feeling comfortable and at ease.

Actions and behaviours that can contribute to older Māori feeling comfortable in the environment

- Provide a welcoming, relaxing environment, for example incorporating Māori images and te reo Māori in design, signage and greetings.
- Have Māori staff available.
- Convey a genuine attitude that is gentle, welcoming, caring, non-judgmental and respectful.
- Do not rush – leave the person time to think about and respond to questions.
- Ask open-ended questions.
- Offer resources and holistic support.

(3) The provision of culturally safe and competent interactions

Health care providers responding to older Māori who have experienced abuse should have an understanding of the application of the Treaty of Waitangi and its principles in a health context. Health care providers are encouraged to seek training to develop their cultural safety and competence in working with Māori.

Health professionals should be aware of their own culture, values and beliefs, as well as Māori culture and beliefs. Understanding the dynamics of abuse and neglect for Māori involves understanding the effects of both the colonisation process and socioeconomic disadvantage on many Māori.

Actions and behaviours that contribute to the development of culturally safe and competent interactions

- Explore your own cultural values and beliefs and develop an understanding of the value of other people's culture.
- Familiarise yourself with Te Whare Tapa Wha and apply the model in your personal practice with Māori.
- Engage with local hapū to provide ongoing feedback on the cultural appropriateness of your services.
- Apply the quality framework He Taura Tieke to ensure that your services are effective for Māori.
- Engage kaumātua to provide cultural guidance.
- Develop knowledge and understanding about the dynamics of elder abuse for older Māori.

(4) A collaborative community approach to elder abuse

The implementation of interventions for older Māori should occur in collaboration with other agencies or sectors to ensure the needs of those experiencing abuse are adequately responded to. Sectors working in isolation may result in Māori elders being forced into taking options that are less than desirable. Interventions may include support with affordable care, transportation, housing and income.

The development of local community knowledge and collaboration in responding to people experiencing abuse is vital. Health care providers can be important participants in intersectoral community networks for family violence.

Actions and behaviours that contribute to a collaborative intersectoral approach

- Develop knowledge of appropriate referral agencies for koroua and kuia who experience abuse or neglect.
- Become involved in intersectoral and community violence prevention networks.
- Take the time to know your local community and elder abuse referral agencies. Where possible, offer referral to Māori advocates with expertise in elder abuse.
- Recognise that for solutions to be meaningful to older Māori, other sectors may need to be involved.

Te Oranga Kaumātua Kuia Service Trust provides a service for older Māori and their whānau who may be affected by elder abuse. See Appendix D, p.57, for contact details.

Pacific

Pacific peoples and elder abuse

The aim of this section is to enable Pacific and non-Pacific health care providers to have an understanding of some of the complex issues that face older Pacific peoples and their families.

Background

Pacific peoples currently make up 6.5% of the total population in New Zealand, with about two-thirds of Pacific people living in Auckland. The seven Pacific ethnicities that are significantly represented in New Zealand are: Tuvalu, Tokelau, Fiji, Tonga, Niue, the Cook Islands and Samoa.

The number of Pacific people aged 65 years and older in New Zealand is expected to increase by more than 400% by 2051 (Ministry of Health, 2002),[4] with increasing numbers living to 85 years or older (Statistics New Zealand, 2002). Based on current trends, this population growth will bring a corresponding increase in the number of older Pacific people living with and being cared for by their families. Currently about half of all older Pacific people live in extended family households (Ministry of Social Development, 2002).

Older Pacific people's income is low compared to the rest of the population. This is particularly so for those who were born overseas, many of whom do not meet the residential criteria for New Zealand Superannuation. Ability to access New Zealand citizenship can limit income and can affect property ownership, living arrangements and the level of independence of older Pacific people. In addition, Pacific families need to stretch scarce resources to meet the demands of everyday living, as well as customary obligations.

The majority of older Pacific people currently residing in New Zealand were born overseas, and for many, English is their second language. The provision of information in Pacific languages and by oral means, such as radio programmes, can be a more effective method for ensuring access to services and information, including information on the rights of health consumers.

Pacific context

In many Pacific families the role and place of Pacific older people or elders continues to be significant and critical to the physical, mental, and spiritual wellbeing of the nuclear and extended family. Any approaches towards understanding issues of elder abuse in Pacific communities require an appreciation of the role of Pacific older people within families, and the family's obligation to provide care to their older people.

A predominant Pacific world view is that conduct that is disrespectful towards older people is a violation and breach of the protocol and etiquette that governs relationships. Within Pacific cultures, there are protocols and etiquette that govern all human relationships. The degree of complexity of protocols varies between Pacific ethnic groups, but there are two primary concepts that define appropriate behaviour and language that are common to most Pacific peoples:

- Piri'anga Tau Teta'i ki Teta'i, Fekau'aki, Fehagaiaga, Na veiwekani, Va Fealoaloa'i, Va fakafeagai
- Fa'aaloalo, Vaerua 'Akangateitei, Feveitokai'aki, Fakalilifuaga, Na veirokorokovi se veidokai, Fakaaloalo.

Simple translations of these concepts are, respectively:

- interpersonal and interdependent relationships
- respect.

[4] There will be considerable regional differences. By 2021, for example, it is projected that the proportion of Pacific people aged 65 years and older will be 8.5% in Counties-Manukau, 6.5% in Auckland, and 4.9% in the Capital and Coast area.

The definition of elder abuse in Pacific families therefore includes any action and behaviour that does not respect the older person as well as the family. In most Pacific cultures, abusive behaviour may incur severe consequences.

What do we know about Pacific peoples and elder abuse?

Research on elder abuse within Pacific families in New Zealand is limited. An elder abuse and neglect prevention programme for older Pacific people is provided by TOA Pacific (Treasured Older Adults) in Auckland (see Appendix D, p.57, for contact details). The following section draws largely from their experience in elder abuse intervention with Pacific people.

Pacific older people living in extended family households, and in particular women and those with chronic illness, may be at greater risk of being abused. One possible reason for this is the long-term stress on families caring for their older people without the benefit of additional support from health services.

Stress factors that can contribute to abuse are often symptoms of wider social, cultural, and environmental influences. Potential factors that may be present include poor health status, inadequate or overcrowded housing conditions, low income, and cultural differences between generations or between Island-born and New Zealand-born family members (Fanslow, 2002). Migration and the introduction of Western societal and religious values and beliefs has brought about social change, influencing traditional social structures, lifestyles and support systems.

> *Research points to the breakdown of family structure when people migrate. People moving to a new country often attempt to hold on to the more familiar ways of being and doing but these ways are not always successful in the new environment. Perhaps one of the most significant points about migration for Pacific families is the break in kinship ties and the loss of collective support.* (Child, Youth and Family Services, 2002)

Intergenerational tensions can arise in Pacific families when the culturally based attitudes and values of Pacific-born family members differ from those of their New Zealand-born children or grandchildren. Misunderstandings or disagreements can occur, for example, over budget management, child-rearing practices, respect for elders and cultural protocols and practices.

Traditionally, older family members have been cared for by their family and within the extended family structure. Caring is seen as a responsibility and a duty and can result in a reluctance to ask for help, which in some Pacific cultures can be viewed as something that is to be offered rather than requested (Huakau and Bray, 2000). Anecdotal information suggests that Pacific people can be especially reluctant to report abuse or injury (M Hamani and TOA Pacific, personal communications, 2004 and 2003). Occurrences of abuse are unlikely to be spoken of or referred to in literal or direct terms. An older person may instead say, for example, that he or she is unhappy. Embarrassment and shame, fear of community scrutiny or extended family distress are common reasons why abuse of older people is kept private and therefore unreported.

These factors pose a barrier to Pacific families seeking and receiving support from health services. Perceptions and attitudes when approaching health care providers will likely include fear that family information will be revealed. Many Pacific families live within relatively small and tight-knit communities, and personal interactions (whether through family, village, island, church or social connections) play a large part in the way that information is communicated. The development of trust and the gaining and maintaining of community confidence are therefore prerequisites to effectively addressing elder abuse within Pacific communities.

Financial abuse or neglect and emotional abuse are more frequently observed categories than physical abuse or sexual abuse, which is rarely identified (M Hamani and TOA Pacific, personal communications, 2004 and 2003). An issue in financial neglect is the cultural emphasis on giving to others, which can result in older people habitually giving beyond their means. A further issue occurs where influential family members over-ride an older individual's decisions relating to property or finance.

The Pacific elder abuse intervention service provider has responded with advocacy on older people's rights to 'independence, participation, care, self-fulfilment, and dignity', and programmes that aim to empower older Pacific people to develop their own solutions and support.

Principles for action

The hallmarks of a culturally competent system require health care providers to demonstrate:*

- accessibility of their service for persons experiencing abuse
- recognition of the diversity of Pacific peoples in their culture and their experience of violence
- knowledge of referral services for Pacific peoples.

*(Fanslow, 2002)

Health care providers should ensure the service they provide is safe and respectful of older Pacific peoples, underpinned by the following principles (M Hamani and TOA Pacific, personal communications, 2004 and 2003; Fanslow 2002).

(1) Safety and protection of the older person must be paramount

The safety of the older person experiencing abuse must be paramount. Any practices or interventions that health care providers engage in should not further endanger or disadvantage the older person.

Actions and behaviours to ensure safety and protection

- Your communication style is important. Your language and tone should convey respect and a non-judgmental attitude. Preferably communicate in the language of the older person.
- Have staff or qualified interpreters who speak Pacific languages available.
- Affirm the older person's right to a safe, non-violent home.
- Offer options for plans of action for the older person.
- Do not assume that the family should be involved – ask the older person what plan of action they want (it may or may not include the family).
- Offer referral to specialist Pacific or mainstream elder abuse and neglect services.
- Manage risk factors.

(2) The provision of a Pacific-friendly environment

Health care providers should ensure that they provide a Pacific-friendly environment, including attention to the physical environment and the behaviour and attitudes of the health care providers. An appropriately trained person with, where possible, the same ethnicity as the person experiencing abuse is likely to be the best person to assess or follow up cases of abuse. The first point of contact is important in building trust, together with a non-judgmental atmosphere that conveys openness and caring.

Actions and behaviours that contribute to older Pacific people feeling comfortable

- Provide a welcoming, relaxing environment.
- Ensure actions and behaviours convey a caring, non-judgmental and respectful attitude, from the first contact.
- Do not rush – leave time to think about and respond to questions.
- Ask open-ended questions and provide explanations of what is happening.
- Ensure that the confidentiality of your discussions is understood.
- Offer resources and support that meet the ethnic-specific needs of the older person.

(3) The provision of culturally safe and competent interactions

Health care providers responding to Pacific people who experience abuse should have an understanding of specific cultural needs. Health care providers are encouraged to seek training to develop their cultural safety and competence in working with Pacific peoples. The training should focus on exploring their own culture, values and beliefs, as well as the dynamics of abuse for Pacific peoples.

Actions and behaviours that contribute to the development of culturally safe and competent interactions

- Explore your own cultural values and beliefs and develop an understanding of Pacific people's culture.
- Develop knowledge of the effects of migration on Pacific peoples.
- Develop knowledge of the effects of hardship experienced by many Pacific peoples.
- Demonstrate knowledge and understanding of relationships within Pacific families and communities.
- Demonstrate knowledge and understanding of factors contributing to elder abuse and appropriate solutions for older Pacific persons and their families.
- Identify and remove barriers for older Pacific people accessing health care services.
- Develop knowledge of referral agencies appropriate for older Pacific people experiencing abuse.

(4) A collaborative community approach to elder abuse should be taken

Interventions for elder abuse should occur in collaboration with other agencies or sectors. Sectors working in isolation may result in older people being forced into taking options that are less than desirable. Interventions may include support with affordable care, transportation, housing and income.

The development of local community knowledge and collaboration in responding to persons experiencing abuse is vital to support individuals to become free of violence. Health care providers can be important participants in intersectoral community networks for elder abuse.

Actions and behaviours that contribute to a collaborative intersectoral approach to elder abuse

- Recognise that for solutions to be meaningful to older Pacific people, other sectors may need to be involved.
- Take the time to know your local community and elder abuse referral agencies. Where possible, offer referral to Pacific advocates with expertise in elder abuse.
- Do not assume that the family or church should be involved in supporting the older person – ask what plan of action the older person wants (it may or may not include the family or church).

Ethnic

Ethnic communities and elder abuse

> *An ethnic group is one that has a sense of peoplehood or belonging based on shared culture, values, beliefs, religion, or symbols such as language, food or dress.* (Ministry of Social Development, 2001)

There are more than 200 ethnic groups identified in New Zealand census data. The largest source of new migrants to New Zealand is Asia, including South Korea, China, Taiwan, Hong Kong and Malaysia. Other significant ethnic groups are Dutch, German, Italian and Eastern European.

There is limited information on the needs of older ethnic people in New Zealand. International research indicates that the traditional ethnic family is characterised by extended family systems with an emphasis on interdependence of family members, continuity between generations and familial duty. Older people in traditional 'age-honouring' cultures hold a position of prestige within the family, and obligation to older members is emphasised. Ethnic families often prefer to care for older family members at home (Ministry of Social Development, 2002). It is important to acknowledge, however, that generalisations across cultures are risky and issues for ethnic communities are complex.

Increased numbers of nuclear ethnic families and higher participation by women in the workforce can compromise traditional care-giving practices and may contribute to intergenerational conflict. Inadequate resettlement processes can prevent participation within the individual's own ethnic group and limit integration into the wider community. Support networks can therefore be limited and the responsibilities of carers can be greater.

There can be cultural, structural and economic barriers to using mainstream services, as well as language barriers, which can contribute to social isolation and inactivity. A study of older Chinese in New Zealand found that difficulties of language, acculturation, low social support and low access to health services were all factors associated with depressive symptoms (Altikaya and Omundsen, 1999). Differences in beliefs about health and illness and stigma attached to the use of particular health services are additional factors for some ethnic groups.

Research indicates that a range of flexible, culturally appropriate services are required to meet the needs of ethnic older people and their families. The use of interpreting services, translated materials and multilingual staff are features of culturally appropriate services. Addressing structural and economic barriers to access and raising cultural awareness of service providers will also be required (Ministry of Social Development, 2002; Brownell, 1997; Kosberg and Garcia, 1995; Charlesworth, 1986).

Some ethnic communities provide services to support older ethnic people in New Zealand. Examples include the Asian Health Support Service, Chinese New Settlers Services Trust, Shakti Ethnic Women's Development Project, the Anglican Chinese Centre Honour Elders Club, the Friendly Support Network for Dutch people, the Wellington Jewish Care of the Aged residential facility, and the Shanti Niwas Centre for Indian Senior Citizens.

> *When working with older people from another culture, it is essential that advice and assistance is sought from that culture. Wherever possible, it is preferable that services be provided by people from the same culture as the older person. Be mindful that people from other cultures are likely to have ways of addressing elder abuse and neglect that are consistent with their own culture.* (Age Concern New Zealand, 1999)

Notes

Identifying & Responding

Section B: Prerequisites for identifying and responding to elder abuse and neglect

Guiding principles

The following principles should apply to the prevention and response to elder abuse and neglect.

(1) The safety of the older person is paramount.

(2) Any action taken should not cause more harm than the abuse or neglect, nor undermine the rights of the older person or their carer.

(3) The safety of those working with elder abuse should be protected. Do not work in isolation.

(4) Actions that are supportive and empowering assist older persons experiencing abuse to make choices and take control over their lives.

(5) Each older adult has distinctive family/whānau, cultural and other values that should be respected and appropriately addressed.

(6) A collaborative and intersectoral approach enables solutions to be found that are meaningful to the older person and provides support for those working with elder abuse and neglect.

Training of health care providers

Health care providers involved in elder abuse assessment or intervention should receive appropriate training on how to ask older people about abuse, and how to respond when it is identified. In addition, it is expected that health care providers should have demonstrated competency in the following as part of clinical training:

- cultural competency
- ensuring the safety and autonomy of abused or neglected older adults
- empowering approaches when working with older people and their carers
- issues of consent and assessment relating to abused elders who do not have mental capacity.

In the event that an individual provider does not have these skills, assistance should be sought from a more experienced colleague and the provider should take active steps to acquire the necessary knowledge and skills.

Development of policies and/or protocols

Best practice will be achieved in settings where there is sufficient organisational support for addressing abuse as a critical health care issue, and where health care providers work in partnership with community-based providers of services for those who have experienced abuse. A multi-agency/multidisciplinary approach to the planning and delivery of services is recommended to ensure a range of support, skills and experience is available. This approach is likely to include the following elements:*

- *inter-agency protocols* with established working relationships with local elder abuse services and other relevant agencies, and referral pathways
- *a key service provider or case manager* – person(s) with responsibility for co-ordinating the assessment and intervention in each situation of elder abuse (this person is likely to be a member of, or be appointed by, the multidisciplinary elder abuse and neglect team; see Appendix I, p.68, for an outline of the key service provider/case manager's role)
- *a multidisciplinary elder abuse and neglect team* – to identify and support the key service provider with the co-ordination of intervention, assessment of situations involving abuse, development of case plans and monitoring of progress
- *an elder abuse and neglect network* – to act as a resource to agencies and service providers working with older people, including providing advice on service planning; to provide information updates; and to review the effectiveness of services.

*(Age Concern New Zealand, 1992)

Conditions for interviews relating to elder abuse

People experiencing abuse are likely to be physically, emotionally and spiritually vulnerable. The first point of contact is important in building trust, together with an atmosphere that conveys openness, caring and a non-judgmental attitude. It is important to provide sufficient time to respond and explore options. A positive encounter for the person includes being asked what plan of action they would like to take and being offered resources, support and guidance.

The following conditions should apply to interviews relating to elder abuse:

- Assessment and intervention should take place as part of a face-to-face health care encounter.
- Use open-ended and non-judgmental questions (see Section C 1.4, p.35).
- Professional interpreters should always be used where required, rather than a person's friend or family member.
- The interview should take place in private. Unless the older person specifically requests the presence of a friend or family member for support, the person should be interviewed away from relatives or caregivers.
- If there is suspicion of abuse or neglect, the person's caregivers may also need to be interviewed, but separately from the care receiver, and only if it safe to do so (see Section C 1.5, p.36).
- Where cognitive impairment is suspected, a comprehensive assessment of the individual's mental and physical state must be undertaken by an experienced health professional, with referral for assessment of mental capacity as indicated (see Appendix H, p.66).
- Where the person does not have mental capacity, contact with their appointed welfare guardian or person holding enduring power of attorney will be required. Where there is no appointed guardian or attorney, application to the Family Court may be required.

See also section C 1.2, p.33, for issues to consider when asking about abuse.

Gaining consent

Informed consent is required prior to assessment. Legislation concerning informed consent is governed by the Code of Health and Disability Services Consumers Rights (New Zealand Health and Disability Commissioner, 1996).

The process of consent needs to be carried out in a manner consistent with the needs and culture of the older person. For older Māori the involvement of whānau is likely to be integral to assessment. Where the older person wishes for whānau to be involved, and providing it is safe to do so, it is important for whānau members to be proactively involved in decision-making concerning consent (New Zealand Health and Disability Commissioner, 1999). In Pacific families consent is a dynamic process rather than a single event, so consent will need to be revisited periodically.

Where a person has been assessed as lacking capacity to give consent, it is important to establish whether they have another person authorised to give consent on their behalf. A person appointed by the Court as a welfare guardian, or who holds enduring power of attorney (EPA) for care and welfare of the older person, may give informed consent on their behalf (see Appendix H, p.66).

Maintaining confidentiality

Information is protected by privacy legislation, and confidentiality of health information must be maintained in accordance with the Health Information Privacy Code (Office of the Privacy Commissioner, 1994). There are situations where a health care provider will need to pass on information, and this may include a situation of abuse or suspected abuse. Limitations of confidentiality include the following two situations.

- There is a legal and ethical obligation to take action if serious harm is likely to arise through not doing so.
- A court may order disclosure of transaction details whether they have been recorded or not, although this rarely occurs.

Older people and their caregivers should be told of the confidentiality of the conversation and the limits of that confidentiality, including the limits of confidentiality of medical records (see also Appendix L, p.71).

Elder abuse or neglect: assessment and response

The six-step approach

(1) Identify – Section C 1

- Include general questions during an assessment to help identify alert features.
- Direct elder abuse questions should be used for all older adults who present with alert features or signs and symptoms of elder abuse, and
- may be used where risk indicators suggest there is the potential for elder abuse.

(2) Provide emotional support – Section C 2

- Listen to the person's story.
- Acknowledge what they tell you.
- Validate their experience.

(3) Assess risk – Section C 3

- Determine the level and urgency of safety concerns.
- Identify risk that is life threatening, including risk of homicide.
- Identify risk of suicide or self-harm.

(4) Plan safety – Section C 4

- If the older person is at risk of serious harm or death, advise the older person of concerns and contact the police if required. Contact EAN services and/or relevant agencies such as social workers, mental health services for older people, or an emergency safe bed facility.
- For all other safety concerns, seek consent to refer and discuss a safety plan and referral options.
- Educate and support the person whatever their choices, and provide contact information for services.

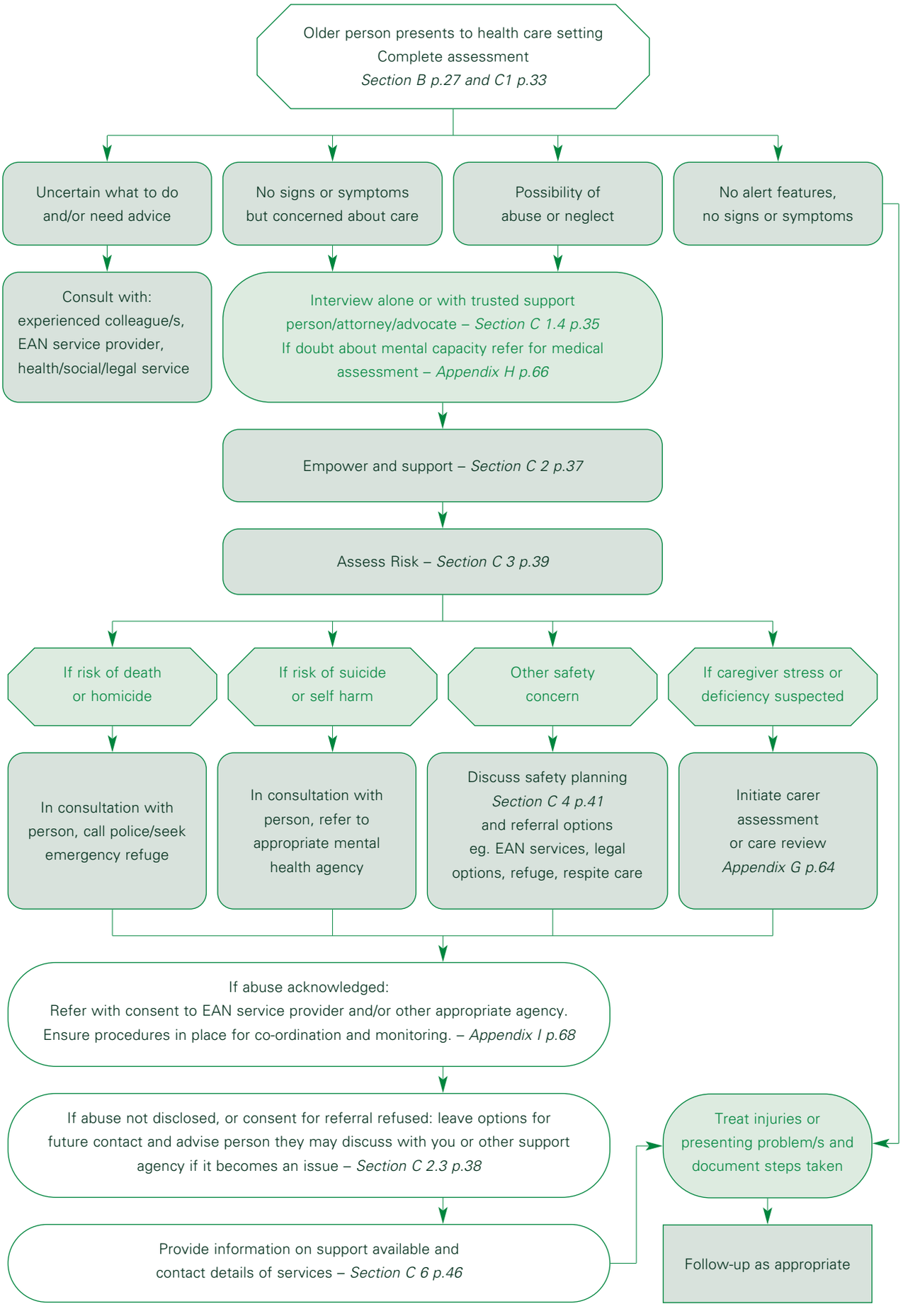
(5) Document – Section C 5

- Record the action taken and document any current or past injuries.

(6) Refer – Section C 6

- Complete appropriate referrals, such as to EAN service providers, health, social and/or legal services.
- Ensure procedures are in place for the co-ordination and monitoring of intervention, and follow up as required.

Elder abuse or neglect: assessment and response – summary flowchart



Notes

The Six-Step Approach

Section C: The 6 step approach

1. Identify

1.1 Best practice guidelines

Health care providers working with older people should always be alert for features that may indicate the possibility of abuse, because most abuse goes undetected. Alert features of abuse or neglect are outlined in section C 1.3, and signs and risk factors are listed in Appendices A and B.

Questioning for elder abuse is recommended when alert features or signs and symptoms of abuse or neglect are present.[5] Routine screening of all older people in the absence of signs and symptoms is currently not recommended, due to a lack of validated abuse screening methods where the safety and benefits have been evaluated. However, health care providers should remain vigilant and may choose to question older adults about abuse in the absence of alert features or signs and symptoms, when concern is raised by the presence of a number of high risk factors (see Appendix B) (McDonald and Collins, 2000; Thompson and Atkins, 1996; Patterson, 1994; Bouquin and Johnson, nd).

Because it is common for more than one type of elder abuse to be taking place, be alert for signs and symptoms for all types of abuse and neglect.

1.2 Issues to consider when asking about possible abuse and/or neglect

The health care provider's ability to engage the older person in the questioning process is a critical factor for obtaining accurate and relevant information (Nagpaul, 2001). Consider the following.

- Might the presence of others affect disclosure? Privacy is important.
- Does the older person have sensory deficits? Ensure glasses and hearing aids are used and eliminate background noises. Ensure the area is well lit. Arrange seating face-to-face, use familiar words and repeat questions.
- Are reactions slowed? Allow extra time for responding and pace questions. Where English is a second language offer the use of professional interpreters. Ensure that you speak clearly and avoid jargon.
- Is it feasible to talk to the person in their own home? Most older people feel safer in familiar surroundings, and the living situation can also be observed.

It is common for people who have been abused to deny that abuse has taken place (Age Concern New Zealand, 1992). Talking about abuse can be very difficult. Maintaining privacy about what goes on in the home can be highly valued, while a sense of duty or desire to protect their carer or family members can deter the person from speaking out against their abuser. The abused person may feel ashamed, frightened or intimidated, or may fear being placed into care or being labelled with dementia. The person being abused may be resigned to or accepting of long-standing abuse and may blame themselves or feel it is their duty not to complain and to accept what life deals out. There may also be a concern that revealing the abuse could result in losing contact with an abuser who is a vital source of social contact or care.

[5] Older women in intimate relationships may also be at risk from partner abuse. Health care practitioners should maintain a heightened index of suspicion, in particular if an older woman presents with unexplained injuries, has a delay in seeking care, has multiple vague medical issues, if they or their partner abuse alcohol, or if a partner seems overly protective or controlling. (From NMCADV Information for Health Care Providers). Refer to Ministry of Health Family Violence Intervention Guidelines for Child and Partner Abuse (2002) for information on partner abuse.

Each older adult will have distinctive family and other values and differences that must be respected. When working with older people from another culture, be mindful that there may be cultural differences in definitions and ways of addressing abuse. Cultural differences in communication style also need to be considered.

Always aim to ensure that any action does not cause more harm and does not undermine the rights of the older person and their caregiver.

The first point of contact influences the degree of trust older Māori may have in the health care provider

- Provide an environment that promotes whānau ora and contributes to older Māori feeling comfortable.
- Use a non-judgmental and respectful communication style, tone and language.
- Have Māori staff available. This may include kaumātua for advice and support.
- Offer and support whānau participation as indicated by the older person.
- Recognise that relationship building is a process that takes time.
- Undertake training and a process of reflecting on how your personal beliefs and attitudes about both Māori and abuse may affect your professional practice and interaction with Māori.

Providing a service that is safe and respectful for older Pacific people and older people from ethnic communities

- Offer resources and support that meet the ethnic-specific needs of the older person.
- Recognise that relationship building is a process that takes time.
- Ensure a non-judgmental and respectful communication style, tone and language.
- Identify and remove barriers for older people from Pacific and other cultures accessing health care services
- Develop knowledge of Pacific and ethnic referral agencies and community representatives.
- Have available persons who can speak the same language as the older person.
- Undertake training and a process of reflecting on how your own cultural values and beliefs may affect your professional practice.
- Develop your knowledge and understanding of the dynamics of abuse in Pacific and other cultures.

1.3 Alert features

The following features should alert health care providers to the possibility of abuse, and the need to expand history taking and assessment procedures.*

- There is incongruity between observations and information from the older person, or a discrepancy in perceptions of the older person and the suspected abuser.
- There is any discrepancy between an injury and the history, unexplained injuries, conflicting stories, vague or bizarre explanations, or denial.
- There are frequent requests for care or treatment for comparatively minor conditions.
- There is a delay in seeking care or reporting an injury.
- The older person is described as ‘accident prone’ or has a history of injury, untreated injuries and multiple injuries, especially at various stages of healing.

- There are repeated accident or emergency attendances of the older people from the same care setting.
- There are manifestations of inadequate care, including poor hygiene or nutritional status, poorly controlled medical conditions, frequent falls and confusion.
- A relative or carer appears overly protective or controlling, or the older person displays unexplained anger or fear towards the carer or relative.
- There is an apparent inability to afford food, clothing, housing or social activities, or questionable use of the older person's possessions/property/funds.

*(Levine, 2003; Community Care Access Centre of Waterloo Region, 2001; Bennett, 1994; Cochran and Petrone, 1987; New Mexico Coalition Against Domestic Violence, nd).

1.4 Questions for older people who may be at risk of abuse

Asking the older person to describe their situation in a general way may be an effective way to open discussion. More direct verbal questions are appropriate if indicated by earlier responses and as the interview progresses, when trust and rapport have been established and when there is a high degree of suspicion that elder abuse exists. Gentle probing and supportive statements made by the health care practitioner can reduce defensiveness (Nagpaul, 2001).

Open-ended, non-judgmental questions that commence with an enquiry about a typical day are recommended (Quinn and Tomita, 1986). Questioning should naturally progress to an assessment of activities and enquiries about levels of dependency, care giving and family relationships.

General questions to assist identification of alert features.

Older adults may be asked:

- How are things going at home/in residential care?
- How are you spending your days?
- How are you feeling about the amount of help you are getting at home/in residential care?
- How do you feel your [husband/daughter/other caregiver] is managing?
- Do you have everything you need to take care of yourself?

When comprehensive assessment is undertaken, questions should explore the older person's expectations of care, previous family history, information on recent crises and illness in the family, and the level of social network and support. Where possible, this should include questions about resources and finances, feelings of loneliness, and stress, depression and anxiety in the person being assessed and (where relevant) their carer. Exploration of alcohol problems, drug use/abuse, possible enforced isolation or confinement, what happens when people disagree, and behaviour problems among household or family members can follow.

Only relevant and pertinent information should be collected and information may not be able to be gathered all at once. A social assessment may require interviews over a period of time, and discussion of private concerns often requires an established relationship of trust (Campbell and Browne, 2001; Bennett, 1994).

If there is any doubt about the person's mental capacity, a comprehensive assessment should occur prior to detailed questioning, but do not delay any immediate action required to ensure the person's safety. Explanations for the need for such an assessment need to be given and consent obtained. Note that persons are presumed to have capacity to make decisions for themselves unless proved otherwise (see Appendix H, p.66).

Where a combination of alert features are apparent or where signs and symptoms of abuse are identified, direct questioning for elder abuse should follow (see also Appendix C, p.56).

Direct questions for use when the presence of alert features or signs and symptoms indicate possible elder abuse.

- Has anyone at home ever hurt you?
- Has anyone ever taken anything that was yours without your consent?
- Has anyone ever made you do things you didn't want to?
- Has anyone ever touched you without consent?
- Has anyone ever scolded or threatened you?
- Have you ever signed any documents that you didn't understand?
- Are you afraid of anyone at home?
- Are you alone a lot?
- Has anyone ever failed to help you to take care of yourself when you needed help?[6]

1.5 Questions for the caregiver

DO NOT discuss concerns or actions with a caregiver:

- if it will place either the older person being abused, or you the health care provider, in danger
- if the family/whānau may close ranks and reduce the possibility of being able to help an older person
- if an investigation by police is under way.

If you have any doubts or are uncomfortable about discussing concerns about possible abuse with the older person's caregivers, you should first consult with senior staff and/or with elder abuse services where available (see Appendix D, p.57). Measures to ensure your own safety include having a second staff member present during the interview (see section C 4.7, p.43, on worker safety).

Where interview of the caregiver is appropriate and safe

Use open-ended, non-judgmental questions about care giving, level of dependency, family and home environment, concerns, stress indicators and support networks (see also section C 2.2 p.38). For example:

- How is [the older person receiving care] getting on?
- How has life changed for you since becoming a caregiver?
- Have you been able to talk with someone about these changes?
- How has having [the older adult] dependent on you affected your relationship?
- Do you know what practical help is available to assist you?

If you suspect the caregiver may be the abuser

The caregiver may be under stress and frightened about what will happen. Putting them at ease while trying to find the facts is not easy but will be the most productive way of checking the seriousness of the situation and assessing what needs to be done. In most cases asking the caregiver to describe what is involved in the day-to-day care of the older person will open up the discussion and enable the health care provider to check for stress, financial difficulties, health and other problems, as well as the caregiver's ability to manage the care. For example:

- What kinds of things do you have to do now as part of caring for [the older person]?
- Are you able to get a break or have enough time for yourself?
- Do you ever worry that [the person being cared for] is not safe?
- Are you ever worried that you might hurt your [relative/person being cared for]?

[6] Source: American Medical Association, Diagnostic and Treatment Guidelines on Elder Abuse and Neglect, www.ama-assn.org/ama1/pub/upload/mm/386/elderabuse.pdf

2. Support/empower persons experiencing abuse

Disclosure of abuse is a difficult step. Many victims feel shame and guilt, and have been told by the abuser that they are responsible for the abuse they experience. Clear messages are needed that support and reassure those experiencing abuse that they are not at fault, and that help is available. Hearing these messages from health care providers is one of the most powerful interventions that health care professionals provide.

Ensuring older Māori are not only supported but also empowered

- Provide support that is based on an understanding of the context for Māori and elder abuse.
- Recognise the diversity of Māori.
- Ask the older person what plan they want.
- Offer referral to Māori advocates with expertise in elder abuse.

Ensuring older people from Pacific and ethnic communities are not only supported but also empowered

- Start with some general conversation. Avoid an overly clinical/business-like approach.
- Respond with sensitivity to gender, and the dynamics of status in ethnic communities.
- Select interpreters with care and ensure the role of the interpreter is clearly defined and confidentiality is assured. Never use a child as interpreter.
- Provide support based on an understanding of the context for older persons from Pacific and other ethnic communities, including the effects of migration, refugee resettlement, and religious or cultural conditioning.
- Recognise that for solutions to be meaningful to older persons from Pacific and ethnic communities, other sectors may need to be involved.
- Provide advice on the resources available and legal protection and prevention systems.
- Offer referral to ethnic-specific agencies.

2.1 Supporting the older person being abused

Listen to the person's story. *Acknowledge* what they have told you. Be empathic, non-judgmental and non-blaming:

- That must have been terrifying. You are a strong person to have survived that.

Validate:

- You are not alone – others experience abuse in their home/rest home/hospital.
- You are not to blame for the abuse.
- You did not deserve or provoke the abuse. It is never justified.
- Your reactions are a normal response to trauma.

Inform:

- I can seek help for you and your family/caregiver.
- You have the right to live free of fear and abuse.
- What they are doing is also a crime. It is not just a family or private matter.

2.2 Support for the older person's caregiver(s)

If circumstances permit you to discuss concerns or actions to be taken with a person's caregiver, follow these principles (see also Appendix G, p.64).

- Broach the topic sensitively.
- Help the caregiver feel supported and able to share any concerns they have with you.
- Help them understand that you want to help keep the older person safe, and support them in their care of the person.
- Where options exist, support the caregivers to make their own decisions.
- Involve extended family/whānau and other people who are important to them.
- Be sensitive to, and discuss, the older person's or caregiver's fears about approaching other agencies such as elder abuse and neglect services, police, social services, hospital staff, and other agencies.
- However, be clear that your role is to keep the older person safe.

2.3 Persons who deny abuse or refuse support

If elder abuse is suspected, but the individual does not acknowledge that it is a problem:

- leave the door open for further contact and state that if abuse does become a concern, you are available to discuss it with them if they would like to
- provide them with the means of contacting appropriate support agencies
- look for further indicators at the next consultation
- undertake danger assessment (see section C 3.1).

If the person acknowledges abuse but refuses support

The older person's willingness to accept help, make choices and handle change will affect assessment and intervention options. Older persons (and/or their abuser) may need a particular service but choose not to accept it, and reasons for this may need to be explored. Barriers to accepting intervention can include fear, lack of initiative or motivation, or practical issues such as lack of transport or mobility issues. The person may fear having to leave their home or may misunderstand the impact of service provision. Assistance to overcome barriers or the support of an advocate can be offered as appropriate.

If the older person is competent and informed of the options and facts but still refuses to accept services, this must be respected. Leaving the door open for future contact and providing information on available support and contact numbers is important.

Practitioners working with persons experiencing abuse can face ethical and clinical dilemmas, including situations where there are no good solutions for the older person and/or their family/whānau or carer. It is important that the practitioner has support available and that supervisory and interdisciplinary assistance is provided to support decision-making when ethical and clinical dilemmas are involved (Nagpaul, 2001).

3. Assess Risk

This section outlines some of the primary risks associated with abuse that need to be considered, and suggests initial referral options. (See also section C 6, p.46, concerning referrals, and Appendix D, p.57).

Health care professionals are responsible for conducting a preliminary risk assessment with persons experiencing abuse in order to ascertain the likely level of immediate risk for the older person leaving the health care setting, and to determine appropriate referral options. Where ongoing safety concerns are identified, referral to persons or agencies experienced in elder abuse is recommended, both for follow-up assessment of the circumstances of suspected or actual elder abuse and neglect, and for case planning and co-ordinated intervention.

Telephone advice from elder abuse services may be helpful during preliminary risk assessment and can assist with referral decision-making.

Note: *injuries or other evidence of abuse are not required for referral.*

Assessment for older Māori

- Reassure koroua and kuia that there are support networks in place to assist them.
- Apply Te Whare Tapa Wha model to your assessment, and maintain respect for whānau processes and tikanga.
- Invite whānau involvement as guided by the koroua or kuia – do not assume involvement is the preferred approach.
- Where possible, offer referral to and involve Māori advocates with expertise in elder abuse (see section C 6 and Appendix D).

Assessment for Pacific and other ethnic elders

- Offer reassurance to elders from Pacific or ethnic communities that there are services that can help, and offer referral (see section C 6 and Appendix D).
- Recognise the diversity of definitions and experiences of violence, and the barriers to asking for and receiving support.

3.1 Danger assessment

The purpose of risk assessment is to identify where immediate help is needed, make appropriate and timely referral, and lay the foundations for working with the older person and the caregiver so that solutions can be found that will help reduce the risk of elder abuse. The safety, wellbeing and rights of the older person must always be the main focus.

The level of immediate risk and need for urgent referral will depend on the type and severity of abuse and the immediate situation of the person experiencing abuse. Assessment of the following factors can assist in danger assessment.

Immediate safety risk

- Is there evidence of life-threatening injuries or danger of significant harm, death or homicide?
- Is there a risk of suicide or significant self-harm?

High danger risk

- Is the abuser present?
- Is the person afraid to go home or to be left alone?
- Is the person unable to defend or care for themselves if left alone?
- Has a threat to kill or threat with a weapon been made?
- Has there been physical abuse increasing in severity?
- Has the abuser access to weapons, particularly firearms?

Other factors to consider

- Have threats of suicide or homicide been made?
- Is alcohol or substance abuse involved?

3.2 Risk of suicide or self-harm

Health care providers need to consider assessing the possible suicidality of persons experiencing abuse. Studies into links between elder abuse and suicide are lacking, but a history of abuse is recognised as one factor contributing to suicide risk. Practitioners need also to be aware that older men are a group at greater risk of suicide. Any older person expressing suicidal ideas should be treated very seriously. A suitably trained mental health clinician should be contacted to assist anyone who has expressed suicidal thoughts, or following any act of attempted suicide or deliberate self-harm.

Signs associated with high risk of suicide include:*

- previous suicide attempts
- stated desire/attempt to kill oneself
- a well-developed, concrete suicide plan
- access to the method to implement the plan
- planning for suicide (eg, putting affairs in order).

*(Rives, 1999)

Other factors frequently associated with the risk of suicide or self-harm may also be symptoms of the abuse. These include depression, extreme anxiety, agitation or enraged behaviour, and excessive drug and/or alcohol use.

For guidelines on assessing risk of suicide, refer to the New Zealand Guidelines Group 2003 publication *Assessment and Management of People at Risk of Suicide*. Initial assessment should aim to determine:

- whether a person's injury was caused by self-harm
- how serious the deliberate self-harm was (including the seriousness of intent)
- the key precipitants to self-harm/ideation
- the current level of risk
- the urgency for assessment by mental health services
- the best way to keep the person safe and supported until further assessed.

Any person expressing suicidal ideation should be assessed by a mental health clinician before they are discharged home (NZGG, 2003a).

Because of the abuse issues, joint referral to elder abuse services may also be warranted. The most helpful intervention to reduce suicide risk may be to assist the person to obtain safety from the abuser.

4. Plan Safety

If elder abuse and/or neglect is identified or suspected, then some level of safety planning needs to occur. This is best accomplished as part of a multidisciplinary team. Consult with an experienced colleague or person(s) with training in elder abuse response and intervention. Information from the risk assessment process described in the previous section will help to ensure that acute needs are identified and included in the safety plan.

4.1 Deciding what action to take

When deciding on the action to take, consider the following questions:

- What is the least disruptive option for the older person?
- Is immediate referral for treatment or specialist assessment required?
- Will the action being considered cause further harm?
- Have the rights of the older person, and their carer, been considered?
- What services are available?
- Who needs to be notified?
- What support is available to assist with action taking?

Remember that confidentiality and keeping the older person informed of your actions are essential. The older person has the absolute right to make an informed decision about what action is taken and when. The older person may refuse assistance. This can be extremely difficult for service providers. If there is a reasoned choice, the decision must be respected (see section C 2.3, p.38).

It is important to note that most cases of elder abuse and neglect are not crisis situations. Often the problems are long standing and complex and will take time to work through. There are often no immediate solutions.

Safety planning for older Māori

- Develop knowledge of Māori elder abuse advocates and services.
- Involve and offer referral to a Māori elder abuse advocate, where available.
- Do not assume that the whānau has the necessary skills and information to respond to the immediate or short-term needs

Safety planning for Pacific and ethnic elders

- Know your local community referral agencies with expertise in abuse.
- Offer the choice of a Pacific or ethnic-specific elder abuse advocate, where available.
- Do not assume the family, church or cultural community leaders should be involved – ask the older person what plan of action they want.

4.2 For the small proportion of persons with acute safety concerns

- Is the abuser present?
- Does the abused person have a safe place to go when leaving the consultation?
- Is emergency assistance required (eg, police, acute hospital admission or safe bed facility)?
- Is urgent referral to mental health services required?

Always remember the person's rights. Quick solutions may have adverse effects in the long term. For example, removing an older person from their home may cause them enormous stress and may have other repercussions. This is usually a last resort intervention. Relocation is sometimes necessary, but not always for the person being abused: sometimes it is the abuser who needs care or accommodation.

Decisions about reporting a suspected incident of abuse to the police should, except on rare occasions, be made in consultation with the abused person. Reporting an incident to the police without the person's consent can endanger their safety, as filing charges may enrage the abuser. On the rare occasion that a health care provider believes a person's life is in immediate danger, police may be notified without the person's permission. The Privacy Act 1993 is not breached if the health care provider has acted in good faith to protect a person from serious harm.

Local protocols for reporting to the police should be followed and EAN services involved where available.

4.3 For older persons with ongoing safety concerns

- If possible in your area, make contact during the consultation with EAN services.
- Where appropriate, suggest that the person consider obtaining a protection order through the Family Court. Social workers, Women's Refuge and other family violence prevention advocates can provide assistance with obtaining such orders.
- Identify an ongoing support system (eg, family, friends who may help).
- Ensure that the person has a list of contact numbers for specialist elder abuse services.
- Provide the person with information that will help them plan for safe exit from an abusive situation.
- Ensure they are aware of the legal support available to them and how to access it.
- In the case of neglect by self or others, as appropriate contact general practitioner, health, social or legal services.

See also section C 6, p.46, for information on referral options.

4.4 For all those experiencing abuse

- Advise the older person about the possibility of an increase in the frequency and severity of abuse without outside help.
- Support the person, irrespective of their choices. Understand that it is important for each person to make their own choices. Frequently the person may choose not to take any action at this time, but be aware that your support can make it easier for the person to seek further assistance when they are ready.
- Decide if you are going to make a referral now or defer making a referral.
- As appropriate to your role, identify a date for review or refer for follow-up. Periodic reassessment for all cases of suspected abuse is needed, regardless of whether evidence of abuse is conclusive.
- Leave the door open so they have a future point of contact.
- Getting safer is a process, not an act. Remember your role is to assist the older person to make themselves safer, not to 'rescue' them.

4.5 Legal options

There are legal powers available for the Court to intervene and to provide protection where appropriate. The Domestic Violence Act 1995 provides protection for victims of abuse through court protection orders. Psychological abuse is also treated as violence. Note that the abuser does not have to be a spouse or family member for the Domestic Violence Act to apply (see section C 6.4).

Abusers can be charged under section 151 of the Crimes Act 1992 for failing to provide 'necessities of life' for people who are unable to provide care for themselves (see section C 6.3).

The Protection of Personal and Property Rights Act 1988 allows for the appointment of an attorney (ordinary power of attorney or enduring power of attorney) or welfare guardian to act on behalf of another person. The Act also provides for overturning (revoking) an existing enduring power of attorney where the attorney is believed to be acting contrary to the best interests of the older person (see section C 6.4).

4.6 In a residential/institutional setting

Additional enquiries to consider include:

- Is the older person and their family aware of the concern and/or incident?
- Is the nurse manager or other people in the home/hospital aware of the incident(s)? If so, what action has been taken?
- Is there anyone else who is aware of the situation and has contact with the older person (eg, doctor, social worker, rest home/hospital visitor)?
- Who needs to be notified of concerns and/or incidents?
- What immediate and longer-term steps need to be taken to ensure the older person's safety?

In the case of a certified rest home or hospital, abuse can be reported to HealthCERT in the Ministry of Health, the local District Health Board, or to the Health and Disability Commissioner. Local elder abuse and neglect services can explore cases of suspected abuse and report cases to HealthCERT for further investigation. Additional points of contact are the New Zealand Private Hospitals Association, Residential Care New Zealand and Age Concern New Zealand (see also Appendix L, p.71).

4.7 Worker safety

Monitoring and protecting your own safety is important at all stages, and should include the following:

- Be aware of warning signs of aggression, including threatening comments to you or others, attempts to block your exit and increasing agitation or irritation.
- Do not discuss concerns or actions with a carer or family/whānau member if you are uncomfortable or concerned that doing so will place you or others in danger.
- Remove yourself promptly if you feel at risk.
- In a community setting, do not visit alone a home where you believe there may be violence occurring or the violent person may be present.
- Tell others of your visiting plan, park your car on the road where you will be able to drive away, lock your car and keep the keys under your control.
- Document concerns and notify incidents.

5. Document

In situations of identified or suspected physical or sexual elder abuse, a thorough physical examination is required, including appropriate laboratory tests and X-rays, to identify all current and past injuries. (This may or may not be relevant in cases of emotional or financial abuse.) A physical examination is important because people experiencing abuse frequently minimise or deny the extent of violence they have experienced, or they may have been prevented from receiving appropriate medical care. In addition, careful documentation of the results of the examination can assist those abused to obtain protection orders if required, either immediately or in the future.

Note: *confidentiality of abuse documentation* – care must be taken to ensure the privacy and confidentiality of any written information. Particular care is needed to avoid the possibility that the abuser finds out that abuse has been disclosed, in order to avoid a risk of retributive violence. Notes for each individual should be stored in separate files.

Working with older Māori

- Record ethnicity/iwi of the older person and your inclusion of cultural considerations (such as the offer of referral to Māori elder abuse advocates, or the involvement of a Māori member of staff).
- Where physical evidence and photographs are required, ensure that the procedures and their importance are explained so that the person can feel as comfortable as possible with the process.

Working with Pacific and ethnic elders

- Record the ethnicity and the primary language of the older person and your inclusion of cultural considerations.
- Where physical evidence and photographs are required, provide adequate support and explanation, and ensure that processes are sensitive to cultural considerations.

5.1 Documentation steps

- Specify which aspects you saw or heard, and which were reported or suspected. Use the person's own words as much as possible.
- If known, state the identified abuser's name or relationship to the older person.
- Note the stated or suspected cause of any injuries, and when they allegedly occurred.
- Note if any injury is consistent or inconsistent with the person's explanation.
- Mark the site(s) of old and new injuries on a body injury map (see Appendix E, p.60). Describe the estimated age of injuries, colour and size.
- Note any action taken, referral information offered, and follow-up care arranged.
- Include the date and time of your contact with the person experiencing abuse, when you wrote your notes (if different from the time of contact), and referral/support actions that were taken.
- Include a legible signature and staff designation.

5.2 Collection of physical evidence

If assault has occurred, collection of physical evidence may be required to assist in any legal proceedings the abused person or others choose(s) to initiate. To avoid loss of relevant information, it is best if examinations for this purpose are conducted by those with specific training in this area. In cases where this help is not available, with the person's permission collection of physical evidence associated with an assault can be undertaken. Ensure that procedures and processes are explained so the person can provide informed consent and feel as comfortable as possible with the process.

Steps for collection of evidence include the following:

- Place damaged clothing and other evidence in a sealed envelope or bag.
- Mark the envelope with the date, the abused person's name, and the name of the person who collected the items.
- Keep the envelope in a locked drawer until turned over to the police or the person's lawyer.

5.3 Photographs

Some health care settings may choose to develop a policy for photographing injuries from assault. Procedures for undertaking this step are outlined in Appendix F, p.63.

6. Referral

For effective use of these guidelines, referral relationships and inter-agency protocols need to be in place. The health care provider may wish to seek advice from elder abuse services, even if referral is not made. Note also that it is not necessary for an incident of abuse to be proven before making a referral.

The actual point at which to make a referral will be a matter of professional judgement, and will be influenced by:

- the level and urgency of safety concerns
- the readiness of the older person to disclose information on abuse and their willingness to accept referral
- the complexity of the older person's physical, social and mental health needs.

Referral to a range of agencies may be required, depending on the needs and wishes of the older person. Options are many and include referral for further assessment or treatment, referral for rehabilitation and support needs, provision of community support services, counselling, or respite care. Referral of the abuser may also be appropriate, such as to alcohol and drug services, or to respite care if the abuser has care needs. Referral for comprehensive assessment may be required where signs of cognitive impairment are present (see Appendix H, p.66).

Because a number of agencies are likely to be involved it is important to identify a key service provider or case manager to ensure co-ordinated and comprehensive services are provided to older persons who have been abused or neglected. This ensures consistency, reduces any duplication or service gaps, limits confusion for the older person, and enables ongoing support to be provided. In communities where there is a local EANP service, the EANP co-ordinator may undertake this role. Protocols for the identification of and responsibilities of a key service provider will be needed to ensure roles and responsibilities are clear (see Appendix I, p.68).

Referral for older Māori

It is vital that health care providers have knowledge of the people and groups within their local community who possess the necessary knowledge and skills for working with older Māori. This includes Māori elder abuse advocates and services.

Referral for Pacific and ethnic elders

Ensure contact details are available for people and community groups with the necessary knowledge and skills for working with older people from Pacific and ethnic communities.

6.1 Elder abuse and neglect prevention services

There are currently 26 community-based Elder Abuse and Neglect Prevention and Co-ordination of Intervention (EANP) services operating throughout New Zealand. EANP services use a co-ordinated, multidisciplinary approach, involving health professionals and a wide range of other individuals and organisations that can assist with situations involving abuse and neglect. Contact details are provided in Appendix D, p.57, (see also section C 6.7, p.49).

EANP services offer information, advice and support to the older person and have access to a wide range of professionals who specialise in providing services for older people. EANP co-ordinators assess cases, provide safety planning and referral and co-ordinate intervention. They also provide elder abuse prevention training and community awareness raising, and distribute information and advice on elder abuse issues.

6.2 Safe bed facilities

The availability of emergency accommodation will vary from community to community, but providers may include the National Collective of Independent Women's Refuge, or respite care short-stay beds in residential care facilities or hospitals. Health care providers need to be aware of options in their community and any inter-agency protocols for accessing these services.

6.3 Police

Elder abuse is considered a crime under the Domestic Violence Act 1995, and involvement of police in response to individual cases is likely to be appropriate where there are serious and urgent concerns for safety. Assault charges can be laid against the abuser if the older person wishes. These charges are heard in the Criminal Court. Adequate documentation of past and present injuries can assist this process.

Police may also be involved under section 151 of the Crimes Act where there is a failure to provide 'necessities of life' for people who are unable to care for themselves.

Police family violence co-ordinators and community constables are also usually involved with local elder abuse service teams/networks.

6.4 Family Court

Protection orders

Any person who has been injured or threatened can obtain a protection order through the Family Court under the terms of the Domestic Violence Act 1995. Temporary protection orders, valid for a period of three months, can be served without prior notice to the alleged abuser.

A person may apply for a protection order for themselves, with the assistance of legal aid or through a lawyer, or an application can be made on behalf of:

- a person who lacks the capacity to make decisions for him/herself
- a person who, because he/she may be physically incapable and/or frightened to make an application, is unable to apply for the protection order personally.

It is important for the abused person to be aware that obtaining a protection order may in some cases result in the abuser becoming more abusive, to punish the older person. For this reason it is important that the person understands what the protection order is intended to provide and that the police need to be contacted every time the abuser threatens or assaults them. Legal advisors and the police should be able to explain how to access and use the orders in the safest and most effective way.

Enduring power of attorney

An enduring power of attorney (EPA) is an authority given under Part IX of the Protection of Personal and Property Rights Act 1988 (also known as the PPPR, or 3PR, Act). A person ('the donor') gives authority to a person (or persons) or a trustee company (the 'attorney') to look after the donor's property and/or their personal care and welfare. Only one care and welfare attorney may be appointed, but the donor may appoint up to three property attorneys.

The donor can choose to put their property EPA into effect at any time, but otherwise property and/or care and welfare EPAs are effected when the donor is deemed mentally incapable. For the purposes of Part IX of the PPPR Act, the donor is deemed mentally incapable if:

- they are not wholly competent to manage their own affairs in relation to their property
- they lack, wholly or partly, the capacity to understand the nature, and foresee the consequences, of decisions in respect to their personal care and welfare, or
- they do have the capacity to understand and make decisions on their personal care and welfare but are wholly incapable of communicating these decisions.

Abuse can occur when an attorney exploits their powers and fails to operate in the best interests of the older person. In this situation the EPA may be revoked. If the donor is mentally competent they can revoke the EPA themselves, but if they are mentally incapable a third party can make an application for revocation to the Family Court on the donor's behalf

A Community Law Centre, legal advisor, or Age Concern New Zealand (www.ageconcern.org.nz) can provide more information on enduring powers of attorney.

Personal orders and welfare guardians

Under the Protection of Personal and Property Rights Act 1988, if a person does not have an EPA and becomes partly or fully incapable of managing their affairs (eg, through loss of mental capacity or ability to communicate decisions about their personal care or welfare) they, or someone on their behalf, can make an application to the Family Court to place them under a personal and/or property order. The Family Court has the power to review an order at any time and must review it after three years.

If a person has no EPA and is totally unable to communicate or understand decisions then the Family Court can appoint a welfare guardian. A new guardian can be appointed in place of an unsatisfactory guardian in an application for review.

A person's property manager or welfare guardian must act in that person's best interests.

6.5 Health and social support agencies

Establishing networks of people and agencies who can provide support to older persons experiencing elder abuse is crucial. The networks may include EANP services (see 6.1) and:

- health services that provide services for older people, including:
  GPs and primary health care services
  health of older people social workers, geriatricians, psycho-geriatricians
  mental health services for older people
  assessment, treatment and rehabilitation units (AT&R)
  needs assessment and support co-ordination agencies (NASC)
  disability support service providers
- DHB family violence co-ordinators
- Women's Refuge and other domestic violence prevention agencies
- Doctors for Sexual Abuse (DSAC)
- iwi/marae-based health services
- cultural and ethnic-specific support groups
- legal agencies, including Local Community Law Offices and Law Society
- support agencies and community groups such as:
  Age Concern New Zealand (www.ageconcern.org.nz)
  Presbyterian Support (www.ps.org.nz)
  Alzheimers New Zealand (www.alzheimers.org.nz)
  Arthritis New Zealand (www.arthritis.org.nz)
  Hearing Association (www.hearing.org.nz)
  Mental Health Foundation (www.mentalhealth.org.nz)
  Stroke Foundation (www.stroke.org.nz)
  Parkinsons New Zealand (www.parkinsons.org.nz)
  Victim Support (www.victimsupport.org.nz)
  Carers New Zealand (www.carers.net.nz)
  Hospice New Zealand (www.hospice.org.nz)
  Disabled Persons Assembly (www.dpa.org.nz)

HealthCare Providers New Zealand (www.healthcareproviders.org.nz)
Retirement Villages Association (www.retirementvillages.org.nz)
New Zealand Home Health Association (www.nzhha.org.nz)

- older persons advocacy groups, including Grey Power
- church groups and other community organisations
- Senior Citizens Centres
- alcohol and drug abuse services
- respite care and carer support services.

6.6 Services for abusers

- National Network of Stopping Violence Services (Inc) programmes are aimed at teaching men non-violent alternatives to abuse. Many programmes also offer a range of additional services, including support services for abused women. To find out who is providing Stopping Violence programmes in your area, contact the National Office: phone 04 802 5402 or fax 04 802 5403. The local Family Court will have information on approved programmes under the Domestic Violence Act.
- Relationship Services is a national provider of individual programmes for abusers (phone 0800 RELATE).

6.7 Services for Māori, Pacific and Ethnic communities

- Te Oranga Kaumātua Kuia Service Trust (see Appendix D, p.57, for contact details)
- TOA Pacific (see Appendix D for contact details)
- Tui Ora Ltd (www.tuiora.co.nz)
- Shakti Asian Women's Support Group (phone: 09 630 7728 or 0800 742584)
- New Zealand Federation of Ethnic Councils (nzfec@xtra.co.nz)
- RMS Refugee Resettlement Agency (Refugee and Migrant Service) (rms@actrix.gen.nz)

See also:

- Te Aka Kumara o Aotearoa – Takoa 2003 (www.takoa.co.nz)
- Health Sector – The NZ Directory (www.healthsector.co.nz)

Notes

Appendices

Appendix A

Signs and symptoms associated with elder abuse and neglect

Caution: these factors may raise suspicion of abuse but are not diagnostic. Avoid jumping to conclusions. The whole situation needs to be taken into account.

Behavioural signs

Behaviours that the older person may exhibit:

- shows signs of being afraid of a particular person/people
- appears worried and/or anxious for no obvious reason
- becomes irritable or easily upset
- appears depressed, withdrawn
- loses interest
- has sleep disturbances
- has changed eating habits
- has suicidal wishes
- has frequent shaking, trembling and/or crying attacks
- has rigid posture
- presents as helpless, hopeless, sad
- uses contradictory statements not resulting from mental confusion
- is reluctant or hesitant to talk openly; waiting for the caregiver to answer
- avoids physical, eye or verbal contact with caregiver or service provider.

Behaviours that the person inflicting abuse may exhibit:

- blaming the older person for his/her behaviour (eg, wandering, incontinence)
- not wanting the older person interviewed alone
- refusing treatment for the older person
- seeking medical attention from a variety of doctors/medical centres
- responding defensively, making excuses, being hostile or evasive
- excessively concerned or unconcerned
- minimal eye, physical or verbal contact (culturally relevant)
- treating the older person like a child
- using threats, insults, harassment
- taking control of the older person's money or other resources
- difficulty managing their own life.

Physical abuse

- abrasions
- bleeding
- burns
- dehydration
- dislocations
- grip marks
- internal injuries
- over-sedation
- punctures
- sprains
- welts
- bed sores
- bruises
- cuts/lacerations
- direct beatings
- fractures
- hypothermia
- malnutrition
- poisoning
- scalding
- swelling
- wounds.

Sexual abuse

- bruising or bleeding, pain or itching in the genital area
- sexually transmitted disease
- difficulty in walking or sitting
- recoiling from being touched
- fear of bathing or toileting.

Psychological abuse

- resignation
- fear
- shame
- depression
- mental confusion
- marked passivity
- anger
- insomnia.

Financial/material abuse

- failure to pay rent or other bills on behalf of the older person
- sale of property by an older person who seems confused about the reasons for the sale
- lack of money for necessities
- lack of money for social activities
- depletion of savings
- disappearance of possessions
- management of a seemingly competent older person's finances by another person
- signs of misuse of an enduring power of attorney, with control over an older person's property/financial affairs for personal gain and to the detriment of the older person's welfare
- signatures on documents/cheques not resembling the older person's signature
- reluctance to make a will or have budget advice.

Active/passive neglect

- malnourishment or dehydration
- hypothermia
- weight loss with no apparent medical cause
- pallor, sunken eyes, cheeks
- injuries that have not been properly cared for
- poor personal hygiene
- clothing in poor repair; inappropriate for season
- lack of safety precautions, supervision
- absence of appropriate dentures, glasses or hearing aids when these are needed
- abandoned or left unattended for long periods
- medicines not purchased or administered
- no social, cultural, intellectual or physical stimulation.

Self-neglect

- reclusive
- frugal
- shrewdness, fear, distrust
- inappropriate eating habits
- malnourished, dehydrated
- filthy and unhealthy living environments
- collecting and/or hoarding rubbish
- absence of basic hygiene and personal care
- inappropriate or unusual clothing
- menagerie of pets
- inability or refusal to pay bills
- fiercely guards independence and privacy.

Adapted from Age Concern New Zealand, 1992.

Appendix B

Risk factors for elder abuse and neglect

Important factors include the quality of the family and caring relationship, and the level of dependencies. In the absence of direct measures of these factors, proxy indicators include the elder's health status (physical and mental functioning) and household structure (ages and relationships).

Note: *the risk factors described below are not diagnostic of abuse. However, in certain situations, contexts and combinations they may raise the practitioner's suspicion of abuse.*

General risk factors

Elder abuse or neglect is more likely to occur when:

- the abused lives together with the abuser
- there is a history of family violence or partner abuse
- there is unresolved previous sexual abuse
- the level of emotional, social, physical or financial dependency (of the person being abused and/or the abuser) is increasing
- there is a lack of adequate support and relief for the caregiver
- following a recent change in living arrangements.

Factors that appear to increase vulnerability to abuse include:

- poor or failing health
- cognitive impairment
- lack of family, financial or community support.

Factors associated with those more likely to abuse:

- history of alcohol or substance abuse, or violence
- financial dependency on the older person
- poor health
- socially isolated.

Older people more likely to be abused or neglected are those:

- who are dependent on one person for all or part of their care
- with confusion or memory loss, or who exhibit difficult and/or inappropriate behaviour
- with whom communication is difficult or impossible
- with long-standing negative personality traits that may have become more pronounced
- who have feelings of low self-esteem
- with a background of family conflict and tension
- who have limited social contact and networks.

People more likely to inflict abuse and/or neglect are those:

- experiencing stress from their caring role or who have inadequate support, supervision and/or training
- experiencing stress in other areas such as unemployment, financial, health
- who may be dependent on the victim for money, housing, emotional support
- who have experienced previous family conflict and tension
- who have a background of alcohol or drug-related problems
- who have poor support and/or social networks
- who have difficulty controlling feelings of anger, frustration
- who have feelings of low self-esteem.

Adapted from Age Concern New Zealand, 1992.

Appendix C

Elder abuse screening recommendations

Health care settings

Screening for elder abuse is recommended when signs and symptoms or alert features are present. Routine screening of all older people whether signs and symptoms are present or not is not recommended for elder abuse. However, health care providers should always remain vigilant and be aware of risk factors and alert features. Proactive questioning about abuse may be indicated in the absence of signs and symptoms when multiple risk factors are present.

Health care providers need to be aware that older women may also be at risk of partner abuse and should maintain a high index of suspicion. (Refer to *Family Violence Intervention Guidelines: Child and Partner Abuse*, Ministry of Health, 2002.)

When should screening for elder abuse occur?

Primary care settings:

- when the older person presents with signs and symptoms indicative of abuse
- whenever alert features or signs and symptoms are identified
- where proactive or comprehensive health assessment[7] reveals alert features or signs and symptoms.

Emergency department/urgent care settings:

- at any emergency department visit when the older person presents with signs and symptoms indicative of abuse
- prior to discharge from an emergency department when proactive assessment identifies alert features or signs or symptoms.

Mental health settings:

- when the older person presents with signs and symptoms of abuse
- when comprehensive assessment identifies alert features or signs and symptoms.

In patient settings:

- when the older person presents with signs and symptoms of abuse
- prior to discharge when proactive assessment identifies alert features or signs or symptoms

Residential care settings:

- when the older person presents with signs and symptoms of abuse
- when comprehensive assessment identifies alert features or signs and symptoms

Screening for abuse may be indicated in the absence of signs and symptoms when there are multiple risk factors present, or may be initiated by a request from the older person or their carer/family/whānau support.

[7] Proactive and comprehensive assessment recommendations are outlined in Ministry of Health and NZGG *Guidelines on Assessment Processes for Older People* (2003).

Appendix D

Elder abuse and neglect prevention (EANP) services

An up-to-date list of contact details for all EANP Service Providers is available on the Age Concern NZ's website **http://www.ageconcern.org.nz**

Below are listed the addresses of providers as of January 2007.

National

Age Concern New Zealand
National Coordinator for EANP Services
and Professional Advisor EANP Services
PO Box 10-688
WELLINGTON
Ph: 04 801 9338
Fax: 04 801 9336
Email: national.office@ageconcern.org.nz
Web: http://www.ageconcern.org.nz

Whangarei

Age Concern Whangarei
EANP Coordinator
16 Manse Street
Regent
WHANGAREI
Ph: 09 438 8043
Fax: 09 438 8048
Email: ageconcern.whg@xtra.co.nz

Auckland

Age Concern Rodney
EANP Coordinator
PO Box 12
Red Beach
HIBISCUS COAST
Ph: 09 426 0916
Fax: 09 426 0917
Email: age_concern_rodney@xtra.co.nz

Age Concern Auckland
EANP Coordinator
PO Box 19 542,
Avondale,
AUCKLAND
Ph: 09 820 0184
Fax: 09 828 1660
Email: ageconcern@ageconak.org.nz

Age Concern North Shore
EANP Coordinator
177B Shakespeare Rd
Milford
NORTH SHORE
Ph: 09 489 4975
Fax: 09 486 2928
Email: ageconns@acns.co.nz

Age Concern Counties-Manukau
EANP Coordinator
PO Box 200 185
Papatoetoe
AUCKLAND
Ph: 09 279 4331
Fax: 09 279 4334
Email: ageconcern.manukau@clear.net.nz

Te Oranga Kaumatua Kuia Disability Support Services Trust (Maori Service)
EANP Project Coordinator
29 Alfriston Road
Manurewa
AUCKLAND
Ph: 09 268 0174
Mob: 025 971 017
Fax: 09 267 9219
Email: teorangakk@xtra.co.nz

TOA Pacific (Pacific People's Service)
EANP Project Coordinator
PO Box 22 754
Otahuhu
AUCKLAND
Ph: 09 276 4596
Fax: 09 276 4597
Email: maliah@toapacific.org.nz

Tauranga

Presbyterian Support Northern
Older Person's Advocacy and Liaison Services Coordinator
PO Box 10 050
MT MAUNGANUI
Ph: 07 575 9709
Fax: 07 575 9735
Email: wbop@northern.familyworks.org.nz

Waikato

Age Concern Hamilton
EANP Coordinator
30 Victoria St
HAMILTON
Ph: 07 838 2266
Fax: 07 838 2268
Email: postmaster@ageconcern.gen.nz

Taupo

Age Concern Taupo
EANP Coordinator
PO Box 595
TAUPO
Ph: 07 378 1199
Fax: 07 378 9712
Email: age@reap.org.nz

Tairawhiti

Age Concern Tairawhiti
EANP Coordinator
PO Box 496
GISBORNE
Ph: 06 867 6533
Fax: 06 867 5932
Email: tac.tai@xtra.co.nz

Hawke's Bay

Age Concern Hastings
EANP Coordinator
PO Box 185
HASTINGS
Ph: 06 870 9060
Fax: 06 870 9061
Email: ean.ageconhast@xtra.co.nz

Taranaki

Te Hauora Pou Heretanga
Elder Protection Service Advocate
PO Box 8128
NEW PLYMOUTH
Ph: 06 759 7303
Fax: 06 759 7302
Email: reception@thph.tuiora.co.nz

Wanganui

Age Concern Wanganui
EANP Coordinator
PO Box 703
WANGANUI
Ph: 06 347 7672
Fax: 06 345 1799
Email: ageconcernwgnean@xtra.co.nz

Manawatu

Age Concern Manawatu
EANP Coordinator
PO Box 5063
PALMERSTON NORTH
Ph: 06 355 2270
Fax: 06 355 1726
Email: ageconcernman@xtra.co.nz

Horowhenua

Age Concern Horowhenua
EANP Coordinator
PO Box 1080
LEVIN
Ph: 06 367 2181
Fax: 06 367 3322
Email: ageconcernhorowhenua@ihug.co.nz

Kapiti Coast

Age Concern Kapiti Coast
EANP Coordinator
PO Box 217
PARAPARAUMU
Ph: 04 298 8879
Fax: 04 298 6033
Email: ean@ageconcernkapiti.co.nz

Wairarapa

Presbyterian Support Central
EANP Coordinator
PO Box 80
FEATHERSTON
Ph: 06 308 8028
Fax: 06 308 9270
Email: turret@psc.org.nz

Wellington

Age Concern Wellington
EANP Coordinator
PO Box 35 187
Naenae
LOWER HUTT
Ph: 04 567 4998
Fax: 04 567 4998
Email: eanwgtn@acwellington.org.nz

EANP Training and Public Awareness
PO Box 57 164
Mana
PORIRUA
Ph: 04 233 9402
Fax: 04 233 9402
Email: avswgtn@acwellington.org.nz

Nelson

Age Concern Nelson
EANP Coordinator
PO Box 431
NELSON
Ph: 03 546 7682
Fax: 03 546 7067
Email: ageconcern.nelson@clear.net.nz

West Coast

REAP Buller
EANP Coordinator
PO Box 236
WESTPORT
Ph: 03 789 7659
Fax: 03 789 6335
Email: bullerreap@ts.co.nz

Christchurch

Age Concern Canterbury
EANP Coordinator
PO Box 2355
CHRISTCHURCH
Ph: 03 366 0903
Fax: 03 365 0639
Email: team@ageconcerncan.org.nz

Timaru

Presbyterian Support South Canterbury
Elder Protection Coordinator
PO Box 278
TIMARU
Ph: 03 688 1748
Fax: 03 688 8716
Email: admin@pssc.co.nz

Otago

Age Concern Otago
EANP Coordinator
PO Box 5355
DUNEDIN
Ph: 03 477 1040
Fax: 03 477 1040
Email: agecon@ageconcernotago.co.nz

Southland

Age Concern Southland
EANP Coordinator
PO Box 976
INVERCARGILL
Ph: 03 218 6351
Fax: 03 218 1211
Email: sandra@acinv.org.nz

Appendix E

Record of elder abuse assessment and referral

Client/Patient name _____

Date of birth _____

Ethnicity _____

NHI number/Client ID _____

Demographic Information

Living arrangement _____

Cultural information _____

Primary caregiver _____

Observed Indicators of Potential Abuse

Psychological Abuse

- ○ Forced institutionalisation
- ○ Reduced physical/mental activity
- ○ Abandonment (physical and emotional)
- ○ Withdrawn, passive, overly compliant
- ○ Forced to make decisions re property/finances
- ○ Anxious, fearful
- ○ Hopeless, helpless, sad
- ○ Verbal aggression, name calling, threats, intimidation
- ○ Restricted access to telephone, food, bathroom
- ○ Restricted access to family, friends, visitors, services

Neglect

- ○ Malnourished, dehydrated
- ○ Poor hygiene
- ○ Inappropriately clothed
- ○ Inadequate living environment
- ○ Inadequate attention to activity or health care needs

Financial/Material abuse

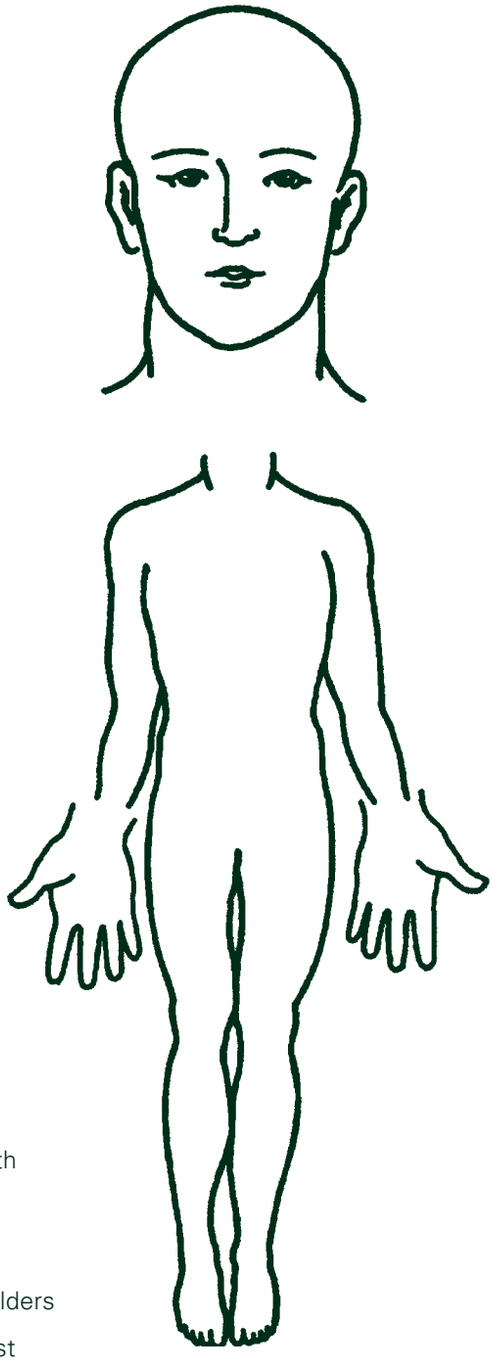
- ○ Questionable use of elder possessions/property/funds
- ○ Apparent inability to afford food, clothing, housing, social activities

Physical Abuse

- ○ Presence of physical injury (hair loss, bruises, unwanted sexual activity, swelling, etc)
- ○ Reports of falling
- ○ Physical or chemical restraint

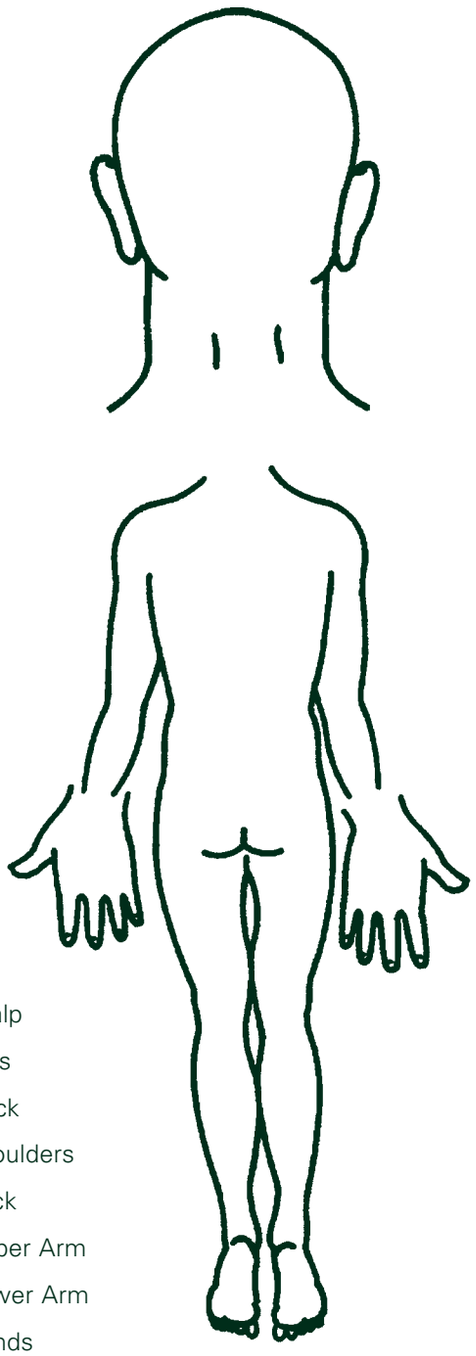
Injuries

Measure, describe and show abrasions, lacerations, areas of pain and tenderness:



FRONT

- ○ Face
- ○ Eyes
- ○ Nose
- ○ Mouth
- ○ Ears
- ○ Neck
- ○ Shoulders
- ○ Breast
- ○ Thorax
- ○ Upper Arm
- ○ Lower Arm
- ○ Hands
- ○ Abdomen
- ○ Upper Leg
- ○ Lower Leg
- ○ Feet



BACK

- ○ Scalp
- ○ Ears
- ○ Neck
- ○ Shoulders
- ○ Back
- ○ Upper Arm
- ○ Lower Arm
- ○ Hands
- ○ Buttocks
- ○ Upper Leg
- ○ Lower Leg
- ○ Feet

Incongruity

○ Client information differs from service provider observations

○ Discrepancies between client and caregiver perceptions

Assess Safety

Is abuser present?	○ Yes	○ No
Is the person afraid of their carer/relative?	○ Yes	○ No
Is the person afraid to go home?	○ Yes	○ No
Has physical violence increased in severity?	○ Yes	○ No
Threats of homicide?	○ Yes	○ No
Threats of suicide?	○ Yes	○ No
Is there a gun in the home?	○ Yes	○ No
Alcohol or substance abuse?	○ Yes	○ No
Has a safety plan been discussed?	○ Yes	○ No

Comments (Describe nature and source of risk to safety)

_____

_____

Referrals

○ Family violence referral agency number given

○ Police called

○ Legal referral made

○ Refuge number given

○ In-house referral made

○ Other referral made

Photographs

Consent to be photographed	○ Yes	○ No
Photographs taken	○ Yes	○ No

Attach photographs and consent form

Comments (Include names or contact details of who referred to)

_____

_____

_____

For Review by: _____

Review Date/Time frame: _____

Record completed by:

Signature: _____ Date: _____

Designation: _____

Modified from screening tools sourced from:
1. The Family Violence Prevention Fund and Educational Programs Associates Inc.
2. Community Care Access Centre of Waterloo Region.

Appendix F

Form to authorise photographing injuries

When offering to photograph for documentation of injury and/or assault, it is important to explain to the injured person that the photographs:

- will become part of their medical record
- may be released to the police, if requested
- will be very useful as evidence if they decide to prosecute the assailant.

The person's permission to photograph must be obtained on a signed consent form (see below).

If possible, the photographs should be taken by the person doing the interview and should be taken at close range to the specific injury. Ideally each picture should contain an identifiable feature, such as the face, or hand holding an identifying document.

The back of each photograph should be signed and dated by the photographer and injured person. The photograph should be put in a sealed envelope that can be attached securely to the person's record. The envelope should be marked with the date and the notation, 'photographs of injuries'. The release form should be kept next to the envelope.

Permission to photograph

The undersigned hereby authorises: _____

Name of Practice/Health Care Facility

and the attending physician to photograph or permit other persons in the employ of this practice to photograph: _____

Name of Patient

while under the care of this facility, and agrees that the negatives or prints be stored in the patient's medical record, sealed in a separate envelope. The undersigned authorises the following uses of these photographs.

Permission to use photographs

These photographs may be released to the patient's lawyer ○ Yes ○ No

These photographs may be used to assist with clinical diagnosis ○ Yes ○ No

These photographs may be used for teaching purposes ○ Yes ○ No

Date: _____

Patient's signature: _____

Witness's signature: _____

Appendix G

Working with carers in situations of elder abuse and neglect

Caring for the carer is one of the primary steps towards preventing abuse. Very often the unpaid time, energy and skills put into caring for an older person are not acknowledged. Many carers also work and carry out other family responsibilities while taking on the role of caring for an older person, often with no specific training.

Carers are expected to know how to carry out difficult tasks and understand complicated illnesses or disabilities with little or no training. They need to know how to work alone and also as part of a team (eg, with service providers that come into the home). Providing care for an older dependent person requires many skills and an understanding of the complexities of dependency and ageing.

The carer may undertake the responsibility of care because of his/her positive relationship with the older person or because of a sense of obligation, yet at the same time the carer may feel uncertain, resentful, angry or afraid about doing so. These more negative feelings are likely to be intensified in situations where the carer feels trapped in the caring role or if the relationship has been difficult and/or distant. If there is a history of family violence, these feelings may be especially strong.

Most older people are cared for at home by a single relative, often with very little support from other family members. Caring for an older dependent person, especially over an extended period, can be physically and emotionally exhausting and debilitating. The tasks involved in caring are often unscheduled, irregular and unpredictable. This makes it very difficult for carers to organise their own lives, respond to their own needs and interests and, at times, carry out basic household tasks.

The belief that families ought to be able to cope can make it difficult for people to acknowledge the problems they may be experiencing in caring for a dependent person. It can also mean that carers feel unable to let go of the caring role and jeopardise their own health and wellbeing. Stress that can be a part of caring is denied, or, if acknowledged, can be thought of as a failure on the part of the individual.

Recognising carer stress

Emotional indicators can include:

- loss of interest and motivation
- anxiety
- sudden mood changes
- anger at self as well as dependent person
- feelings of isolation
- low self-esteem.

Physical indicators can include:

- chronic exhaustion
- lethargy
- weight loss/gain
- frequent colds/infections
- backache/headache
- high blood pressure.

The reduction of stress

Asking for help is never easy. Carers may well feel there are actual or imagined constraints to adopting possible courses of action. Looking after oneself in order to better protect and care for someone else requires determination and courage.

The health service provider may need to make a referral for assessment or reassessment of the needs of the person being cared for. Needs assessment services determine the level of need according to set criteria and co-ordinate appropriate services to meet those needs.

The responsibilities of those who are helping carers are to:

- remain aware of constraints on the carer in asking for help
- enable carers to clarify their options and explore what services are available and acceptable to the carer
- ensure that the services offered are appropriate to the individual situation.

Working with carers to prevent elder abuse

Health service providers can play an important role in preventing abuse by carers. This includes:

- discussing dependency and the implications
- discussing the practical realities and demands of caring
- encouraging the carer to consider the personal adjustments that may be required
- providing the carer with information to assist them with access to practical help
- assisting the carer to identify and manage stress
- considering stress as a potential causal factor when making clinical assessments, and, where appropriate, monitoring stress levels
- providing information about and referring carers to appropriate community-based service providers and support groups such as Carers New Zealand, Alzheimers New Zealand, Stroke Foundation, Parkinsonism Society, Relationship Services, counselling providers, and carer support groups
- supporting training for carers, such as managing challenging behaviour.

Abuse of carers

In some situations the older person may abuse the person providing care. Contributing factors may include difficulty in accepting his/her reliance on the carer; psychiatric illness, dementia or other disorder that results in aggression or loss of judgement or insight; or continuation of past abusive behaviour.

Assistance available includes:

- carer support groups, often organised by the various health groups such as Alzheimers New Zealand, Parkinsonism Society, Stroke Foundation, etc.
- day care centres
- respite care
- sitter services
- information on residential/private hospital care and other alternatives to caring for an older person at home, which are available from community health services.

If a service is offered to a carer and it is refused, then it should be offered again a few weeks later. Often a carer does not recognise their own stress.

Appendix H

Cognitive impairment, dementia, and elder abuse and neglect

Assessments need to be thorough and may require more time when there is an indication of cognitive impairment, including mental confusion or dementia. Where cognitive impairment is suspected, a comprehensive assessment of the individual's mental and physical state must be undertaken by an experienced and appropriately qualified health professional with access to multidisciplinary specialist expertise.

Risks associated with cognitive impairment

The person with cognitive impairment is in a particularly vulnerable position. Abusers can take advantage of their inability to remember, or their lack of credibility with others.

People with dementia may be suffering from lowered self-esteem through the stigma associated with dementia. Dementia may not be disclosed to outsiders by either the person with dementia or their caregiver because of stigma and a wish to retain the person's dignity.

Working with people with dementia is a highly skilled and complex process. Professionals need an understanding of the condition, its likely effects on people and how to work with people with dementia. People with dementia may be skilled in covering their memory loss and confusion so that it is not readily apparent to health care providers. People with dementia may have limited mental capacity to think through alternatives in decision-making. This could also apply to a person with mild cognitive impairment who appears to be functioning appropriately.

Interviewing and responding to people with cognitive impairment

The gathering of valid and reliable information from persons who experience mental confusion presents special challenges to health care providers and others who may be responding to reports of abuse. People with significant cognitive impairment, such as those with advanced Alzheimer's disease, may be unable to provide clear responsive answers to interview questions, or may be unable to reveal their experiences/mistreatment through verbal or non-verbal means. As a result, abuse of persons with cognitive impairment from dementia or other neurological disorders may go undetected and untreated.

Health care providers responding to situations of suspected abuse of a person with cognitive impairment need to be especially vigilant for objective signs of abuse, given that subjective accounts may appear inaccurate. Non-verbal responses (such as withdrawing or recoiling from an abuser) may be a clue where there is cognitive impairment but intact emotional memory.

Where abuse is witnessed or suspected through medical or other evidence, additional sources of information are likely to be required to give further verification. Care is needed, however, to ensure that the person with dementia is not unintentionally excluded or denied an opportunity to speak for themselves by directing discussions towards the carer. Careful judgement on who to interview and how much information to reveal will be important to ensure the person is not endangered by sharing information with an abusive family member (or someone who colludes with them).

It is also important to protect the privacy of information and to ensure the person's sense of safety from suspected abusers; for example, by careful attention to the timing and location of the interview or assessments.

A diagnosis of dementia can evoke stereotypical images of non-competence. There is a risk that the person with dementia will not be believed, because their story of abuse may be confused or incomplete. Everyone with dementia is different, with varying capabilities. Some individuals suffering short-term memory loss and mild cognitive impairment can still accurately recall and relate experiences of abuse.

If people with dementia can proceed at their own pace without feeling pressured they will be able to contribute more effectively. Communications need to be clear and in an easily understood format. Information needs to be written, preferably in slightly larger font if typed, as well as verbal. Important points may need repeating. Be aware that apparent deafness may actually be an indication of difficulty processing information – pauses between words/phrases will allow time for processing.

Information provided by others and first-hand information from the abused person obtained in the rapport-building phase of an interview or consultation will help to establish the person's capacity to provide meaningful information.

In all cases, irrespective of a person's ability to communicate, comprehend or make a decision in relation to the abuse, it is important to:

- respect the person's view and treat the information they provide seriously
- maximise the control the person has over the abuse
- ensure that options provided are the least restrictive
- identify significant others who can support and assist the person.

Mental competence and legal capacity

If the person lacks mental capacity it will be important to determine whether they have a legally appointed representative to act on their behalf (such as a welfare guardian or person with enduring power of attorney). Where there is no appointed guardian or attorney, application to the Family Court for a personal order or appointment of a welfare guardian may be required, as set out under the Protection of Personal and Property Rights Act 1988 (see section C 6.4, p.47).

Note that everyone is presumed to have the capacity to make decisions for themselves unless proven otherwise. A personal order or appointment of a guardian cannot be invoked simply because a person makes decisions which may not seem reasonable to other people.

(For more information on enduring power of attorney and the Protection of Personal and Property Rights Act 1988 (3PR Act), see www.ageconcern.org.nz).

Appendix I

Outline of the key service provider/case manager's role[8]

In each situation of elder abuse or neglect, a critical task may be to appoint a professional service provider as key service provider/case manager. This will enable co-ordinated intervention and help to reduce the duplication of tasks and role confusion. If there is an existing key service provider/case manager, this person should be involved. In communities where there is an elder abuse and neglect (EANP) service, the EANP coordinator may undertake this role.

The role of the key service provider/case manager may include one or more of the following.

Advocate role:

- ensuring the older person (and carer) is aware of and understands the options and choices available
- supporting and assisting the older person (and carer) to take steps on their own behalf whenever possible
- supporting the carer/family/whānau or significant others in caring for the older person
- facilitating access to services and specialist advice (eg, legal, financial, etc) essential for the older person's and/or carer's wellbeing and quality of life.

Broker role:

- helping the older person (and carer) to clarify goals and set realistic objectives that will meet their needs
- matching these needs with the services available and arranging delivery
- working with the older person (and carer) and service providers to ensure roles and objectives are clearly stated and understood
- co-ordinating services
- regularly reviewing, evaluating and updating services.

A key service provider/case manager may find he/she needs to assume both the advocacy and broker roles from time to time. This can be confusing and demanding, as it may involve representing the older person's needs and obtaining services on their behalf while representing a system supplying services. It is therefore important for key service providers/case managers to be clear about their role and to have training, supervision and support.

In some situations it may be necessary for the older person and carer to have separate advocates to ensure their individual needs are met. In such cases it may not be appropriate for either of these advocates to act as key service provider/case manager.

[8] Adapted from Age Concern New Zealand 1992.

Appendix J

Checklist for health care providers[9]

Preventing elder abuse or neglect – what you can do

- Learn to recognise the signs and types of abuse and neglect, both obvious and hidden.
- Know how you should respond to cases of abuse. Find out your practice's or employing agency's policy and procedures on abuse.
- Collaborate with other professionals when responding to abuse. Identify the key professional or agency taking responsibility for the response.
- Develop your own policy and procedures in conjunction with local referral agencies.
- Listen to older persons, residents and colleagues and observe any unusual or sudden changes in behaviour or practice.
- Know how to ask older persons and carers appropriate questions.
- Support and encourage others to increase their knowledge about abuse.
- Support and encourage research into abuse and intervention techniques.

What to do if you come across, or suspect, elder abuse or neglect

- Don't ignore your feelings if you know or strongly suspect abuse is happening. Seek advice or guidance on how to proceed and what action to take.
- Always respect the needs and wishes of the older person who may be experiencing abuse, and be sensitive to their cultural background, values and beliefs.
- Always be sure that any action does not cause more harm than the abuse or neglect and does not undermine the rights of the older person and the carer.
- Be clear about policies on confidentiality, and never promise a level of confidentiality that policies do not support.
- Follow policies on reporting abuse or neglect. Take notes and record incidents.
- Always speak in private to a person who may be experiencing abuse. Unless the person wishes it, don't discuss the matter with them if others are present as they may be too afraid or ashamed to talk.
- Don't discuss your concerns with a possible abuser at an early stage of enquiry or if discussions may place either yourself or the person being abused at any risk.
- If responding to cases of abuse in the community, take action to ensure your own safety and make visits with a colleague.
- If the risk is serious and immediate action is required to ensure safety, you may need to involve the police. Be aware of your own agency's policies/guidelines on police involvement.
- If you suspect a colleague of abuse, don't cover up. Always report incidents.
- Seek advice from your professional body or union if you are involved in 'whistleblowing' (see Appendix L).
- If a resident or their relative wishes to report abuse, they may use complaints procedures and/or make contact with elder abuse services for support.
- Always check that action has been taken.

[9] Adapted from The Abuse of Older People in Hospital: Information for workers, Action on Elder Abuse, 1998.

Appendix K

Local referral agency contact information

Elder abuse or neglect referral agencies	**Contact**	**Notes**
Elder Abuse and Neglect Service		
Social Worker Services		
Health of Older People Services		
Assessment, Treatment and Rehabilitation Service		
Age Concern New Zealand		
Presbyterian Support		
Respite Care		
Safe/Emergency Bed		
Police		
Māori, Pacific and other social service agencies		
Māori Elder Abuse Prevention Services		
Māori Social Service Organisation		
Pacific Elder Abuse Prevention Services		
Pacific Social Service Organisation		
Asian Social Service Organisation		
Refugee and Migrant Social Service Organisation		
Family violence referral agencies		
Women's Refuges		
Family Violence Interagency Networks		
Family Violence Co-ordinator		
Women's Support Groups		
Stopping Violence Services		

Appendix L

Reporting incidents of abuse and 'whistleblowing'

If you suspect a colleague of abuse, don't ignore the situation or cover up. Always report and record incidents. If possible, go directly to the line manager responsible. If a manager takes no action or is the person you suspect of abuse, report this to another senior member of management in accordance with internal procedures. Keep a written record of your actions.

Reporting abusive colleagues can be extremely stressful and it is important to seek support. Do seek support from your professional body or union if you are involved in 'whistleblowing'. Be aware of issues of confidentiality and know or seek advice on the circumstances where disclosure of information is justifiable under the Health Information Privacy Code. The Privacy Act 1993 is not breached if the health care provider has acted in good faith to protect the patient from serious harm. (Note that there is a legal and ethical obligation to take action if serious harm is likely to arise through not doing so.)

People raising allegations of serious wrongdoing within their organisations are protected under the Protected Disclosures Act (commonly known as the whistleblowing legislation), which came into force on 1 January 2001. 'Serious wrongdoing' is defined in the Act and includes, for example, any act, omission or course of conduct that constitutes a serious risk to public health or public safety, or to the maintenance of the law, or that is improperly discriminatory, oppressive or grossly negligent.

Internal procedures for allegations of serious wrongdoing need to be followed first, unless there are reasonable grounds for not doing so (eg, if the head of the organisation is involved, or the matter is really urgent, or there are some other exceptional circumstances).

In the case of a certified rest home or hospital, abuse can be reported to HealthCERT in the Ministry of Health, the local District Health Board, or to the Health and Disability Commissioner. Local elder abuse services can explore suspected cases of abuse and report cases to HealthCERT on their behalf.

The Health and Disability Services (Safety) Act 2001 requires hospitals and residential care providers to become certified to operate, and the Health and Disability Sector Standards (NZS8134: 2001) includes criteria for complaints management, restraint minimisation and safe practice (NZS8141: 2001). Contact HealthCERT, Ministry of Health, for further information.

Additional points of contact for advice and support are the New Zealand Private Hospitals Association, Residential Care New Zealand, New Zealand Home Health Association, local EANP services and Age Concern New Zealand.

A person making disclosure is protected from discrimination under the Human Rights Act. If a person suffers retaliatory action from their employer as a result of disclosure, that person may have a personal grievance claim under the Employment Relations Act 2000.

Glossary

Elder abuse: '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.' Perceptions of what constitutes harm will vary between groups and across cultures. Four commonly recognised categories of abuse are:

- physical abuse – infliction of physical pain, injury or force, including medication abuse (deliberate or accidental misuse of medication and prescriptions that sedate or result in harm to the older person) and inappropriate use of restraint or confinement that causes pain or bodily harm
- sexual abuse – any forced, coerced or exploitive sexual behaviour or threats imposed on an individual, including sexual acts imposed on a person unable to give consent, or sexual activity an adult lacking mental capacity is unable to understand.
- psychological/emotional abuse – any behaviour that causes anguish, stress or fear, including verbal abuse, intimidation, harassment, damage to property, threats of physical or sexual abuse, and the removal of decision-making powers
- financial/material abuse – illegal or improper exploitation and/or use of funds or other resources, including financial abuse occurring when a person who has been given ordinary or enduring power of attorney abuses their powers and fails to operate in the best interests of the older person.

Other sub-types of abuse identified in the literature that can be grouped within, or may cut across, the above categories include:

- partner abuse – abuse or neglect within a life-long or recent partnership.
- institutional abuse – such as that occurring within residential care where a policy or practice results in abuse or neglect.
- abuse by discrimination, disrespect and ageist attitudes – including behaviour that is perceived by older people as dishonouring or insulting.
- structural/societal or systemic abuse – marginalisation of older persons such as by social or economic policies.

Elder neglect: is included in the above definition of elder abuse. It occurs when an older person experiences harmful effects as a result of another person failing to perform behaviours which are a reasonable obligation of their relationship to the older person, and are warranted by the older person's unmet needs and includes abandonment. The main categories of neglect are:

- active neglect – the conscious and intentional deprivation by a carer of basic necessities, resulting in harmful physical, psychological, material and/or social effects
- passive neglect – the refusal or failure by a carer, because of inadequate knowledge, infirmity, or disputing the value of a service, to provide basic necessities, resulting in harmful physical, psychological, material and/or social effects
- self neglect – an additional category of neglect that occurs when a person refuses to accept or fails to provide themselves with basic necessities, resulting in harmful physical, psychological, material and/or social effects.

Family violence: violence or abuse of any type, perpetrated by one family member against another family member. It includes child abuse, partner abuse and elder abuse.

Indicator-based screening: questioning based on the presence of signs and symptoms. This is the recommended approach for elder abuse. Practitioners may choose to screen in the absence of signs and symptoms when a number of high-risk indicators are present.

Older person: defined for the purposes of this document as a person aged 65 years and over. However, from a practical perspective, flexibility regarding the age of the person experiencing abuse is important. The main emphasis should be on providing protection and support. Persons aged 55-65 may experience life transitions and illness or disability that result in dependency on others. In such situations of abuse and neglect the use of 65 in the definition should not inhibit action.

Routine screening: a routine enquiry, either written or verbal, by health care providers to individuals about their personal history of abuse or neglect. Unlike indicator-based screening, routine screening means routinely questioning all individuals, or specified categories of individuals, about abuse. Routine screening for elder abuse is not recommended at this time.

Glossary of Māori terms

Aroha: love

Hapū: sub-tribe

Hinengaro: mind; conscience

Iwi: tribe

Kaumātua: respected elder

Koroua: older man/men

Kuia: older woman/women

Mana: integrity

Taha: side/context

Te reo Māori: the Māori language

Tikanga: custom; rule

Tinana: body; physical aspect

Wairua: spirit

Whakataukī: saying

Whānau: extended family

Whānau ora: health and wellbeing of the immediate and wider family.

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Signs and symptoms of possible elder abuse and neglect

Caution: These factors may raise suspicion of abuse but are not diagnostic.
Avoid jumping to conclusions. The whole situation needs to be taken into account.

Physical abuse

- multiple injuries, especially of different ages: eg, bruises, hair loss, fractures
- burns/scalding, especially in unusual places
- grip marks
- indication of physical assault
- over-sedation
- poisoning

Sexual abuse

- Sexually transmitted disease
- Difficulty walking or sitting
- Recoiling from being touched
- Bruising or bleeding, pain or itching in the genital area.
- Fear of bathing or toileting

Psychological abuse

- resignation
- fear
- shame
- depression
- mental confusion
- marked passivity
- anger
- insomnia
- restricted access to phone, food, visitors, social activities, services

Financial/material abuse

- failure to pay rent or other bills on behalf of the older person
- sale of property by an older person who seems confused about the reasons for the sale
- lack of money for necessities
- lack of money for social activities
- depletion of savings
- disappearance of possessions
- reluctance to make a will or have budget advice
- management of a seemingly competent older person's finances by another person
- management of an older person's property/ financial affairs for personal gain and to the detriment of the older person's welfare
- signatures on documents/cheques not resembling the older person's signature

Neglect

- malnourishment or dehydration
- hypothermia
- weight loss with no apparent medical cause
- pallor, sunken eyes, cheeks
- bedsores or injuries that have not been properly cared for
- poor personal hygiene
- clothing in poor repair; inappropriate for season
- lack of safety precautions, supervision
- absence of appropriate dentures, glasses or hearing aids
- abandoned or left unattended for long periods
- medicines not purchased or administered
- no social, cultural, intellectual or physical stimulation

Adapted from *Promoting the Rights and Well-being of Older People and Those who Care for Them: a resource kit about elder abuse and neglect*. Age Concern New Zealand 1992.

Guidelines Summary

Elder abuse and neglect: assessment and response

Principles

[1] The safety of the older person is paramount.

[2] Any action taken should not cause more harm than the abuse or neglect, nor undermine the rights of the older person or their carer.

[3] The safety of those working with elder abuse should be protected. Do not work in isolation.

[4] Actions that are supportive and empowering assist older persons experiencing abuse to make choices and take control over their lives.

[5] Each older adult has distinctive family/whanau, cultural and other values that should be respected and appropriately addressed.

[6] A collaborative and intersectoral approach enables solutions to be found that are meaningful to the older person and provides support for those working with elder abuse and neglect.

Key points

Be alert for features or signs and symptoms of abuse or neglect. It is recommended that open-ended, non-judgemental questions about care giving, family relationships and dependencies are included in an holistic health assessment. Progress to direct questioning as appropriate and as indicated.

Do not discuss concerns with a carer or family/whanau member who you suspect of being the abuser if it may place the older person or yourself in danger.

Direct questioning and intervention in situations of elder abuse or neglect requires specific skills and those involved should receive training in this area.

The dynamics of elder abuse are often complex so working with the support of a multi-disciplinary elder abuse and neglect team is recommended.

Have available a referral contact list of people and services.

Identify a key service provider/case manager to co-ordinate intervention and monitor progress.

If a service offered to an older person or their carer is refused, ensure they have an opportunity for future contact and provide information on safety options and support available.

Elder abuse or neglect: assessment and response

The six-step approach

(1) Identify – Section C 1

- Include general questions during an assessment to help identify alert features.
- Direct elder abuse questions should be used for all older adults who present with alert features or signs and symptoms of elder abuse, and
- may be used where risk indicators suggest there is the potential for elder abuse.

(2) Provide emotional support – Section C 2

- Listen to the person's story.
- Acknowledge what they tell you.
- Validate their experience.

(3) Assess risk – Section C 3

- Determine the level and urgency of safety concerns.
- Identify risk that is life threatening, including risk of homicide.
- Identify risk of suicide or self-harm.

(4) Plan safety – Section C 4

- If the older person is at risk of serious harm or death, advise the older person of concerns and contact the police if required. Contact EAN services and/or relevant agencies such as social workers, mental health services for older people, or an emergency safe bed facility.
- For all other safety concerns, seek consent to refer and discuss a safety plan and referral options.
- Educate and support the person whatever their choices, and provide contact information for services.

(5) Document – Section C 5

- Record the action taken and document any current or past injuries.

(6) Refer – Section C 6

- Complete appropriate referrals, such as to EAN service providers, health, social and/or legal services.
- Ensure procedures are in place for the co-ordination and monitoring of intervention, and follow up as required.

Alert features

The following features should alert health care providers to the possibility of abuse, and the need to expand history taking and assessment procedures.

- There is incongruity between observations and information from the older person, or a discrepancy in perceptions of the older person and the suspected abuser.
- There is any discrepancy between an injury and the history, unexplained injuries, conflicting stories, vague or bizarre explanations, or denial.
- There are frequent requests for care or treatment for comparatively minor conditions.
- There is a delay in seeking care or reporting an injury.
- The older person is described as 'accident prone' or has a history of injury, untreated injuries and multiple injuries, especially at various stages of healing.
- There are repeated accident or emergency attendances of the older people from the same care setting.
- There are manifestations of inadequate care, including poor hygiene or nutritional status, poorly controlled medical conditions, frequent falls and confusion.
- A relative or carer appears overly protective or controlling, or the older person displays unexplained anger or fear towards the carer or relative.
- There is an apparent inability to afford food, clothing, housing or social activities, or questionable use of the older person's possessions/property/funds.

Questions

General questions to assist identification of alert features:

Older adults may be asked:

- How are things going at home/in residential care?
- How are you spending your days?
- How are you feeling about the amount of help you are getting at home/in residential care?
- How do you feel your (husband/daughter/other caregiver) is managing?
- Do you have everything you need to take care of yourself?

Direct questions for use when presence of alert features or signs and symptoms indicate possible elder abuse:

- Has anyone at home ever hurt you?
- Has anyone ever taken anything that was yours without your consent?
- Has anyone ever made you do things you didn't want to?
- Has anyone ever touched you without consent?
- Has anyone ever scolded or threatened you?
- Have you ever signed any documents that you didn't understand
- Are you afraid of anyone at home?
- Are you alone a lot?
- Has anyone ever failed to help you to take care of yourself when you needed help?

Source: American Medical Association, *Diagnostic and Treatment Guidelines on Elder Abuse and Neglect*. www.ama-assn.org/ama1/pub/upload/mm/386/elderabuse.pdf