A Review of Elder Abuse and Neglect Prevention Services in New Zealand

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Executive Summary

This report presents findings from a review of the Elder Abuse and Neglect Prevention Services Programme currently administered and part-funded by the Department of Child Youth and Family Services (Child Youth and Family). The overall aim of the Elder Abuse and Neglect Prevention Services Programme is to reduce the incidence of elder abuse or neglect. The programme provides an assessment and referral service to elder abuse intervention and follow-up services. It also provides education to carers and other people working with older people and community awareness initiatives. Services are provided through the employment of an elder abuse and neglect prevention (EANP) service co-ordinator.

The review

The review examined the service delivery programme model focusing on the 19 service sites adopting a generic approach to service delivery. It did not specifically address the three sites adopting Māori, Pacific and bicultural service models. This review also examined national co-ordination needs and contracting arrangements, and the development of a funding allocation framework for the contracting of services across all of the 22 sites.

This work involved a review of literature to identify trends in international trends and practices. An understanding of how services were provided was gained from workshops with service representatives, interviews with service providers and agencies for four case study sites, a survey of service co-ordinators, and administrative data analysis. National co-ordination needs and contracting arrangements were reviewed through a policy analysis approach. Finally, an analysis of 2001 population census data was undertaken and factors for consideration highlighted in terms of the development of a framework for allocation of funding.

The EANP Service model

The EANP service model is based on a multi-disciplinary co-ordinated team approach which aims to:

- meet the multiple needs of clients
- improve service co-ordination
- avoid service overlap
- clearly define roles for service providers.

There are four components to the model as shown below. These relate to the EANP services, intervention professionals and specialists, an Advisory Group and National Co-ordination.
### Component One: The Local Elder Abuse and Neglect Prevention Services

- Provides client co-ordination and referral by
  - Responding to all queries made by individuals, professionals or agencies regarding the provision of general information and/or information about assistance and services available.
  - Providing an initial assessment of individuals reported as experiencing abuse and/or neglect.
  - Referring of individuals to appropriate intervention services.
  - Monitoring the delivery and effectiveness of intervention services for individuals.
  - Collecting data and report on the number of inquiries, referrals and collect statistics on individual cases of Elder Abuse and Neglect.
- Develops and provides training and education to carers and people who work with older people
- Develops and provides public awareness programmes
- Develops and implements evaluation tools to measure the effectiveness of the service
- Establishes and maintains an Advisory Group
- Develops and maintains close working relationships with providers of elder abuse and neglect prevention intervention services and community groups such as local iwi/Māori, Pacific people, other ethnic groups, voluntary/community organisations and local authorities
- Provides staff support, supervision and training

### Component Two: Intervention Professionals and Specialists (Case Worker)

- provides the intervention and are experienced professionals working directly with clients to provide appropriate care and services.
  This group includes geriatricians, social workers, nurses and financial advisers.

### Component Three: Advisory Group

- Provides support and advice to the local elder abuse and neglect prevention service.
  Members of this group have professional interest, knowledge and skill in the area of elder abuse and neglect. This group may include case workers, representatives from Work and Income NZ, Police, hospital and health services, public and community agencies, local iwi/Māori, and Pacific peoples

### Component Four: National Co-ordination.

- involves development and review of service standards, monitoring of standards across service providers, provision of ongoing advice on the effectiveness of the service model, data collection, analysis and reporting.

### Requests, referrals and case characteristics

EANP services received general requests for information and advice, requests for general information about elder abuse and neglect and contact from people regarding specific elder abuse and/or neglect situations.
Contact about specific elder and/or neglect situations was mainly from professionals, partners, relatives, and by the person who may be experiencing abuse and/or neglect themselves. The reason for contacting the EANP ServicesIncluded:

- having someone to talk to about the situation
- information and advice about where to go to for help, what could be done, and confirmation of next steps that could be taken
- someone to investigate what is happening
- seeking an advocate or support person for the older person who may be experiencing abuse and/or neglect
- direct assistance in taking some actions about the situation
- reporting of abuse and neglect situations that have been dealt with for statistics.

Agencies also made referrals to EANP Services. Whether they made a referral was influenced by whether the person was a client of the agency, they had the skills and capacity to deal with the case ‘in-house’ and whether they had the consent from their client to do so. Cases referred onto EANP services included those where:

- the services were outside the scope of the agency
- the cases were complex
- an independent assessment or support person was needed (eg resthome complaint).
- agencies lacked confidence in their own ability to deal with situation.

Analysis of administrative data suggests that the majority of clients are female, New Zealand/European and aged between 70 to 84 years. The main abuse types experienced are psychological abuse (36% of clients) and material or financial abuse (28% of clients). Clients may experience more than one abuse type.

**Service provision**

Key guiding principles in the actions taken by the sites are ensuring that they do no further harm, empowerment and self determination, and ensuring the safety of the older person. Gaining agreement and consent to the actions that will be taken by the service from the older person who may be experiencing abuse or neglect is a key element of responding to cases. An over-riding factor in the requirement for consent for action is when there are concerns for the safety of the person who may be experiencing abuse or neglect. Consent from the older person who may be experienced elder abuse and/or neglect is sought at different stages of a case.

**General steps**

In general, all of the services:

- established rapport and trust with the client
- clarified what EANP Services provided
- clarified client’s rights to self determination
- checked the context in terms of doing no further harm
gathered information and investigated about the situation with the client, and others already involved in the situation (concerned others, family, professionals and agencies) including finding out about the:
- general circumstances
- family structure and situation
- competency and mental health issues
- other professionals, social services and agencies involved
- support available to the client (eg other family members)

identified and assessed of the problems including urgency and on-going risk
sought advice from the Advisory Group and other professionals and agencies as required about how to progress the case
undertook case planning with the client
referred onto other professionals or agencies where appropriate

Some but not all sites also provided intervention assistance, undertook case management and monitored the effectiveness and delivery of services. Whether these additional aspects were also undertaken depended upon the approach of the services, the other services available to the site, and resource limitations such as personnel time and travel costs.

Networking and liaison with the community was a key element of successful service provision in terms of providing comprehensive information and advice and about the options available to clients and what was required to access social service agencies.

**Visiting clients**

The extent that client visits were undertaken ranged from sites who only occasionally visited clients to one site who mentioned always visiting referral clients. However, most sites tended to visit the person who may be experiencing abuse and/or neglect with their consent. Prior to a first visit to a client, potential risk to safety in visiting was assessed through gaining information from the client or referrer (if not the client) on the phone and/or contacting other professionals who had knowledge of the client or situation.
Ways in which services addressed safety risks in visiting clients included:

- not visiting on their own
- ensuring that somebody knew where they were
- sometimes cueing the police
- having a cellphone
- having a “buddy” in the car with a cellphone.

**Investigation and assessment**

There was a variety of approaches adopted to gathering information and assessing the situation of the client. There was no standard approach adopted across the services. Experience based judgement was a key element. Some sites referred to basing their information gathering approach on the Child Youth and Family requirements for data collection or the Age Concern guidelines.

Experience-based judgement was a key part of assessing a situation. Some coordinators had also developed assessment checklists (tools) as part of their approach and this was often based on information from the Age Concern guidelines. Other information used was from the United Kingdom and the States.

The timing of the use of checklists varied across the sites. This ranged from the use of a checklist or tool at first contact with the client, during follow-up contact or as a guide towards the end of an investigation phase to ensure that the investigation had been comprehensive. Some sites referred to using a structured assessment sheet process, whereas others referred to semi-structured approaches or none.

In general, urgency and safety issues were assessed based on experience based judgement focusing on aspects such as how distressed the person was and how safe the older person, or in some cases - the person concerned about an older person considered the situation to be. All services generally documented their cases in writing and developed case plans with clients as part of their role.

**Referrals**

Referrals are made to a range of agencies with key agencies appearing to be those in the health service, Police, and advocacy and support services. Rest home complaints may be referred to the Health and Disability Commissioner or Advocate. Not all referrals are made to outside agencies. Referral on will also mean referral to agency field workers or other case workers identified to assist generally with EANP service provision in some sites.

Situations in which sites may have not referred on include:

- consent not given by the client
- client does not meet the criteria for referral to any of the available agencies (for example in terms of severity of mental health condition)
- lack of intervention service provider in that area
- lack of confidence in the intervention service provider
EANP Service can provide intervention without placing additional stress on the client with whom rapport and trust has been established.

Some cases involve a delayed referral to intervention agencies following a period of advocacy and support from the EANP Service until the client is prepared to be referred on to intervention service providers.

Not all cases are referred to intervention agencies and in some EANP Services intervention assistance is provided. The level of assistance provided by EANP services varies across sites. This is due to factors such as differences in the skills of EANP service personnel, accessibility of intervention services by the client, and availability of support and advocacy services. One site noted that they did not often provide intervention assistance and referred to the wide health service brief in the region and the availability of services to refer onto.

**Monitoring**

Monitoring the delivery and effectiveness of intervention services for individuals also varied across sites and was related to case management while a case was open. Case closure may have included ascertaining that the client was satisfied with the steps that had been taken and debriefing clients and others involved in the case. Follow-up of cases that had been closed differed across the sites.

**Education and public awareness**

EANP Services provide training to a wide range of professionals and providers on a wide range of topics across the sites. Training resources are developed independently by each site with different materials developed to meet the needs of the target audience.

A key element of the training role for many sites was the provision of elder abuse and neglect training to rest home staff as part of the requirements for gaining certification. Rest home staff are required to attend training on this topic annually and certification is required by all resthomes by October 2004. Not all resthome providers used the EANP Services to provide this training.

Sites differed in how pro-active they were in undertaking public awareness activities. There is a link between increasing public awareness and a resultant increase in demand for services. For some sites, with little (if any) capacity for significant increases in workload, this meant that they adopted a reactive approach to public awareness activities. Presentations and seminars were provided on request but not promoted. The development of promotional materials such as brochures and postures is undertaken separately by each of the sites. In addition, promotion of the services is often included in publicity for the organisation which the EANP Services are based within.

Management oversight and understanding of the services provided by the EANP Service co-ordinators varied across the sites. Regional peer meetings across sites were held by some areas where there was capacity to do so.
Comparison with international trends

At a theoretical level, the general approach of the EANP Service programme model is consistent with the direction in which elder abuse and neglect prevention is approached internationally. The model adopts a multi-disciplinary approach, espouses a commitment to elder abuse and neglect prevention as a priority and focuses on the development of responses at a community level. The service practice approach taken by EANP services is substantially validated by the comparison with international practice trends. In most areas, the practice directions indicated by the review of literature were also part of EANP service delivery.

Conclusions

The effectiveness of the present service model

The effectiveness of the present model is hampered by a lack of specificity at the practice level. Current service approaches vary across EANP Services and this is in part related to the different skill base across the different service co-ordinators, regional variations in the availability of services and co-ordinator perspectives. Even so, there is a clear commitment across all sites to elder abuse and neglect prevention and an empowerment philosophy to the provision of services. Key areas of difference across sites appear to be the extent that case management and monitoring is undertaken, how a multi-disciplinary approach is used, and the balance across casework, training provision and community awareness activities.

Services that are related to elder abuse but are outside the services contracted for by Child Youth and Family

Referrals for self-neglect are received by EANP Services. These cases are fundamentally different from elder abuse and neglect cases and although the EANP Services should have the appropriate linkages to refer these cases on, we do not envisage that they should become a formal part of the EANP Service provision role.

If the service provider has the capacity to appropriately intervene, assistance is provided by some EANP Services when clients do not consent to referral, referring the case is likely to place unnecessary stress on the client, or there are gaps in service provision. However, the priority across all sites was to refer clients to appropriate referral agencies when they could.

Gaps in services and other measures or actions that could improve effectiveness or efficiency of services

National Consistency

There is a need for increased national consistency across the services. An agreed standard use of terminology across the services and a more specific statement of service expectations is required. This includes approaches to the development of interagency protocols for service provision and information sharing. This is to ensure that there is clarity amongst local EANP Services about their role and to ensure that there is clarity about the roles and responsibilities of their services in relation to other intervention services provided at the local level.
More national level resources would be useful for the services. This includes the development of standard nationally endorsed templates such as consent and complaint forms, assessment checklists or guides, education and community awareness materials and evaluation forms. Nationally standardised forms are a way of ensuring that these resources are designed as well as possible. More nationally based resources and information sharing across the sites about service approaches, education provision, community awareness activities and approaches to evaluate effectiveness would be useful.

There is a need for national meetings across the services (at least annually) and regional meetings (at least quarterly) as a way of addressing the isolation of sites, to co-ordinate across the sites, share ideas and information, and provide peer support to each other.

Increased clarity of data definitions and national statistics that reflect information across all of the provider sites is required.

A national level community awareness/prevention strategy (potentially combined with family violence prevention more broadly) and which links in with local level activities should be undertaken. However, any national campaign should not be undertaken until it is generally established that there are resources in place to meet the increased demand that are likely to result.

Service gaps, capacity and funding

Service gaps that were identified which increased the time and assistance required with cases included situations where mental health issues were not severe enough to be referred to other services, cases where there were financial and legal issues to be addressed, and transport for clients to access services. An additional service gap identified was the increasing difficulty in recruiting suitably skilled volunteer case workers to refer cases to for assessment and case work.

The need for increased training opportunities and funding was widely emphasised.

Full or increased funding rather than partial funding of services should be considered to enable secure medium and longer term planning to be undertaken by sites.

National co-ordination

The absence of national co-ordination has left a leadership void in elder abuse and neglect services. Feedback from interviews, workshops and the literature review provide strong support for enhanced national co-ordination. Funding should be sought for a national co-ordination contract. At least $200,000 is estimated to be required to cover co-ordination, training and resource development needs. Responsibility for national co-ordination should be allocated to a non-government provider through a competitive contract process. Core responsibilities would be defined in the contract.

A reference group should be established. It should comprise key government agency representatives and service provider representatives (including Māori and Pacific peoples providers) and would meet, quarterly initially, to consider and review national co-ordination work programme priorities, and to agree the contribution which individual agencies might make to specific projects. The reference group would be guided by input from annual elder abuse and neglect prevention conferences. Specific technical and
professional expertise and input would be sought from across the sector on an as needed, project by project basis.

Co-ordination across elder abuse and neglect prevention services at a regional level should be formally recognised as an integral component of the overall elder abuse and neglect prevention model.

At the local level, elder abuse and neglect services should continue to work across agencies to co-ordinate service provision.

**Comprehensive data collection and analysis systems**

A co-ordinated approach to data collection for established cases of elder abuse and neglect is an essential requirement for Government and service providers to monitor trends, establish and monitor priorities for awareness raising and gain understanding about the nature of elder abuse and neglect in New Zealand. The agency responsible for managing elder abuse and neglect prevention services should co-ordinate the collection and analysis of consistent and comprehensive data on the nature and incidence of reported elder abuse and neglect, and that appropriate funding should be allocated to this function.

Consultation on data requirements should include the proposed reference group on elder abuse and neglect prevention services.

**Contracting arrangements**

Following the recent CYF Baseline review, Child Youth and Family, Treasury and MSD will be providing advice to Government on the future location of responsibility for managing a number of Child Youth and Family services including Elder Abuse and Neglect Prevention Services. In developing this advice, consideration should be given to the conclusion of this review that the health sector is the preferred location. This is primarily because of the significant interface between vulnerable older people and health and disability support services. Child Youth and Family, Treasury and MSD should consult with the Ministry of Health on the feasibility of operating a co-ordinated Elder Abuse and Neglect Prevention Service from Vote: Health.

This should include a strategy (including appropriate new funding) for phasing in comprehensive national coverage of elder abuse and neglect prevention services.

Child Youth and Family, Treasury and MSD should also note the second preferred alternative location of responsibility is with the Ministry of Social Development’s new Family Services group. This is less preferred because the primary focus of Family Services is expected to be on families with children, and because a focus on elder abuse and neglect in a family context would not cover abuse and neglect in institutional settings.

**Funding arrangements**

Although EANP sites are located nation-wide, there are areas where the ability to provide adequate services is problematic due to practical constraints such as travel. Service boundaries for existing service sites need to be clarified to better understand the size and nature of the client group that each service caters to.
An analysis of population census data on the distribution of older people across territorial authority areas based on general site boundary descriptions indicates a potential gap in service provision in the central North Island (Taupo – Waitomo – Rotorua). It also showed higher proportions of older people in the Christchurch and Wellington service areas. Auckland (non-Māori and non-Pacific) and Waikato proportions of older people are also relatively fairly high. These areas, therefore, have responsibility for a relatively larger proportion of the overall EANP services client base than other services. However, this information needs to be considered alongside other site characteristics such as geographical distance, travel needs, and availability of, and access to, intervention services.

**Recommendations**

In the short term, it is recommended that a national reference group be formed who develop a programme of action that includes short, medium and long term strategies to consolidate services, improve information, to promote consistency and role clarity, and to promote best practice. It is proposed that this plan of action includes the following:

- National co-ordination for the services
- Regional meetings that are supported and explicitly funded
- Training needs including identifying international or external expertise for training at a regional or national level
- Consistency across services and information sharing particularly in terms of clarification of terms and approaches
- Developing a clear statement of expectations in terms of the model

In the medium term (two to three year time frame), it is recommended that consideration be given to:

- Developing a national publicity awareness campaign which links in with campaigns at a local level and is accompanied by resources and increased funding to deal with increased demand
- Shifting partial funding to full funding to enable services to increase their planning horizons
- Increasing overall funding for service provision taking into account potential site differences in the allocation of that funding
- Funding for a central region North Island site
- Establishing regional co-ordinator roles with strong education provision and publicity skills who could also provide case work back-up support if required. This person could be based at one of the sites, focus on the development of regional and site specific materials for each service and also provide some peer support across sites
- Develop/up-dating national resources and guidelines
- Developing clear data collection guidelines, and analyse and disseminate national EANP Service statistics
• Establishing systems to collect and analyse national sector statistics. Data could be gathered from across the sector to provide a more comprehensive understanding about elder abuse and neglect in New Zealand.
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1 Introduction

This report presents findings from a review of the Elder Abuse and Neglect Prevention Services Programme currently administered and funded by the Department of Child Youth and Family Services (Child Youth and Family). The overall aim of the Elder Abuse and Neglect Prevention (EANP) services programme is to reduce the incidence of elder abuse or neglect. The programme provides an assessment and referral service to elder abuse and neglect intervention and follow-up services.

The review examined the service delivery programme model. As the review focused on service providers adopting a generic approach to service delivery, it does not specifically address Māori, Pacific and bicultural service models. This review also examined contracting arrangements and national co-ordination needs, and information that can contribute to the development of a funding framework for the contracting of services.

The structure of the report

This chapter of the report describes the population of older people in New Zealand, elder abuse and neglect and the contracted services, and the aims and scope of the review. The next chapter details the approach and methods used in the review. Chapters Three and Four present international models and key directions in international practice based on a review of international literature, and Chapters Five to Eight describe the way services in New Zealand operate. The contracted service model and service practice are compared with trends in international approaches in Chapter Nine. This is followed by consideration of national co-ordination needs and how these can best be met (Chapter Ten). Chapter Eleven considers contracting arrangements and provides information that should be considered in relation to a funding framework for services. The final chapter of the report provides conclusions and recommendations from the review.

1.1 Setting the scene

Older people in New Zealand

It is estimated that there was a total New Zealand resident population of 4,009,000 people in 2003. As shown in Table 1 below, older people² comprise about 11.9% of the total New Zealand population.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male (000)</th>
<th>%</th>
<th>Female (000)</th>
<th>%</th>
<th>Total (000)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>1,761</td>
<td>89.3</td>
<td>1,771</td>
<td>86.8</td>
<td>3,531</td>
<td>88.3</td>
</tr>
<tr>
<td>65 and over</td>
<td>211</td>
<td>10.7</td>
<td>267</td>
<td>13.1</td>
<td>478</td>
<td>11.9</td>
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<tr>
<td>Total</td>
<td>1,971</td>
<td>100.0</td>
<td>2,038</td>
<td>100.0</td>
<td>4,009</td>
<td>100.0</td>
</tr>
</tbody>
</table>

New Zealand has an aging population with the number of people aged 65 years and over is increasing over time. From 1993 to 2003, people aged 65 years and over

¹ The information presented in this section is from Statistics New Zealand (2003) *Demographic Trends 2003* Wellington
² The term “older people” refers to people aged 65 years and over in this report.
increased by 17.2 percent from 407,780 to 477,790. The percentage increases by sub-groups were:

- 65-74 years increased by 5.8%
- 75-84 years increased by 28.9%
- 85 years and over increased by 52.6%

While the number of older people in New Zealand is growing, the proportion of the New Zealand population aged 65 years and over has not changed markedly over the period 1993 to 2003. Older people make up around 11-12% of the population.

**Ethnicity**

It is estimated that in 2003 around 4.6% of the total population of older people were Māori. The proportion of Māori in the older population decreases with increasing age. A key reason for the small proportion of Māori in the older age ranges is the shorter life expectancy for Māori compared with non-Māori. Table 1-2 below presents the proportion of older Māori within the estimated Māori population in 2003.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. (000)</td>
<td>%</td>
<td>No. (000)</td>
<td>%</td>
</tr>
<tr>
<td>Under 65</td>
<td>291.05</td>
<td>96.6</td>
<td>296.57</td>
</tr>
<tr>
<td>65 and over</td>
<td>9.60</td>
<td>3.3</td>
<td>11.47</td>
</tr>
<tr>
<td>Total</td>
<td>301.00</td>
<td>100.0</td>
<td>308.70</td>
</tr>
</tbody>
</table>

There were around 9000 older Pacific peoples in 2001 who made up three percent of the total Pacific population.

**Gender**

Women significantly outnumber men in the older age groups. There are four women for every three in the 65 and over age group and nearly twice as many women as men among those aged 80 years and over.

**Future projections**

The following projections are based on a medium projection series3 for the 16 regional council and 74 territorial authority areas of New Zealand.

By 2021 it is expected that the population aged 65 years and over will increase by about 50 percent or more in all New Zealand regions and make up 18 percent of the population. Areas projected to have a high proportion of older people include: Central Otago (34%); Waitaki District (31%); Thames Coromandel District (29%); South Wairarapa District (28%).

It is projected that the proportion of older people will be relatively low at about 13% in Auckland, Wellington, Manukau and Porirua cities.

Looking ahead further still, by 2051 it is projected that older people will number 1.22 million and account for about a quarter of the New Zealand population.

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3 At the time of publication of Demographic Trends 2003 – this series was considered the most suitable for assessing future population changes.
Although the Māori population will also age over the next 50 years, it will remain a relatively young population. By 2051, the median age for the Māori population is expected to be 32 years, compared with 45 years for the total New Zealand population.

By 2051, Māori in the 65 and over age group are expected to make up 13% of the total older population.

The Pacific population is projected to grow at a faster rate than the total population. Although the Pacific population will become older, it will continue to have a much younger age structure than the total New Zealand population because of higher Pacific birth rates. The number of Pacific people aged 65 years and over is projected to reach 25,000 by 2021, almost three times the 2001 population. This will represent about six percent of the total Pacific population.

1.2 Elder Abuse and Neglect Prevention Services

1.2.1 Elder Abuse and Neglect

Definition of elder abuse and neglect

Elder abuse and neglect is used as an umbrella term referring to a range of diverse harms that may occur singly, or in combination, and may take place in a variety of settings, including people’s own homes, day centres and nursing homes and hospitals. It can occur in various forms including: physical, psychological/emotional, sexual, financial abuse or simply reflect intentional or unintentional neglect.

There is no single, internationally accepted definition of elder abuse and neglect. However an approach that has gained ground over the last 20 years is the definition adopted by The Toronto Declaration on the Global Prevention of Elder Abuse:

Elder abuse is 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.5

The definition and categories of abuse identified by Age Concern New Zealand in their resource kit about elder abuse and neglect are consistent with the Toronto Declaration definition.7 These definitions are used as the basis for the Child Youth and Family contracted elder abuse and neglect prevention services.8

Elder abuse and neglect is defined as:

when a person aged 65 or more experiences harmful, physical, psychological, sexual, material or social effects caused by the behaviour of another person with who they have a relationship implying trust.

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7 Age Concern New Zealand Inc. (1992) Promoting the rights and well-being of older people and those who care for them: A resource kit about elder abuse and neglect. p.3.2. – 3.4
8 The Department of Child Youth and Family funding agreement template for the provision of Elder abuse and neglect prevention and co-ordination of intervention services 1 July 2002 to 30 June 2003
Four major categories of abuse are identified. These are:

- **Physical abuse**
  Infliction of physical pain, injury or force

- **Psychological abuse**
  Behaviour that causes mental or emotional anguish or fear

- **Sexual abuse**
  Sexually abusive and exploitative behaviours involving threats, force or inability of the person to give consent

- **Material/financial abuse**
  The illegal or improper exploitation and/or use of funds and other resources.

Two categories of elder neglect are also identified. These are:

- **Active neglect**
  Conscious and intentional deprivation, by a carer, of basic necessities, resulting in harmful physical, psychological or material and/or social effects

- **Passive neglect**
  Refusal or failure of a carer, because of inadequate knowledge, infirmity or disputing the value of the prescribed service, to provide basic necessities resulting in harmful effects.

It has generally been estimated that between 2-5% of the older population experience some form of elder abuse. However, a 2002 report from the United Nations Secretary General based on studies conducted in the past 20 years found that in developed settings (such as Australia, Canada and the United Kingdom) the proportion of older persons reported as abused ranged from 3-10%.

Based on an estimated older population of 478,000, using the estimated range of 2-5% would suggest that in the range of 9,560-23,900 older people may be experiencing abuse in New Zealand in 2003.

The United Nations, report of the Secretary General states that:

> Although poorly understood, the direct and indirect financial and human costs and consequences of abuse of older persons are estimated to be considerable.

The direct costs include those associated with prevention and intervention such as provision of services, institutional care, criminal and justice procedures and education and research programmes. The indirect and human costs include such aspects as a diminished quality of life, emotional pain and suffering, distrust and loss of self-esteem, disability and premature death.

### 1.2.2 The Elder abuse and neglect prevention services

Elder abuse and/or neglect prevention services have been operating for the last ten years. Age Concern New Zealand have been a key catalyst in the development and expansion of elder and neglect prevention services in New Zealand. Age Concern is a not for profit organisation with a National Office and 30 independent councils throughout New Zealand.

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A brief overview of the history of the development of the elder abuse and neglect prevention service programme is presented below.

Table 1-3: Overview of the development of the elder abuse and neglect prevention services in New Zealand

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>National workshop organised by Age Concern to address professional and public demand for intervention and prevention strategies to combat elder abuse and neglect</td>
</tr>
<tr>
<td>1992</td>
<td>Age Concern publish a resource kit about elder abuse and neglect. This was developed as a consequence of the 1989 workshop and used a broad based working party and reference group with funding from a range of public and private philanthropic sources</td>
</tr>
<tr>
<td>1994</td>
<td>Lottery Grant funding provided part-funding to establish: Five Age Concern based elder abuse and neglect prevention pilot schemes A National advisory group with a programme oversight role and to provide a national perspective on the development of strategies for the care and protection of older people. A national co-ordinator position within Age Concern’s national office.</td>
</tr>
<tr>
<td>1997</td>
<td>The number of Age Concern based pilot schemes had increased to seven. Part-funding of the seven pilot schemes shifted to Child Youth and Family Funding for Age Concern national co-ordinator position continued by Child, Youth and Family.</td>
</tr>
<tr>
<td>1998</td>
<td>Evaluation undertaken by independent researchers to provide information to guide future funding decisions.10</td>
</tr>
<tr>
<td>1999</td>
<td>Number of services expanded to 17 – with services no longer exclusively provided by Age Concern. The national advisory group overseeing the pilots ceases to operate. National co-ordination role within Age Concern ended and additional funding redistributed across service areas.</td>
</tr>
<tr>
<td>2000</td>
<td>Four additional services funded to provide national geographical coverage and South Auckland service funded to provide services focusing on Pacific peoples. Total of 22 part-funded services nation-wide.</td>
</tr>
</tbody>
</table>

1.2.3 Current status

There are six different provider groups who operate the 22 contracted elder abuse and neglect prevention service sites around New Zealand. A generic approach to the service delivery model is provided by 19 of these sites. Three sites provide services

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which adopt approaches with a greater emphasis on Māori or Pacific peoples cultural paradigms. The sites are listed below.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Concern New Zealand</td>
<td>Whangarei, North Shore, Auckland, Counties-Manukau, Waikato, Tairawhiti, Hawkes Bay, Wanganui, Manawatu, Kapiti, Wellington, Nelson, Christchurch, and Invercargill</td>
</tr>
<tr>
<td>Presbyterian Support Services</td>
<td>Tauranga, Wairarapa, South Canterbury, Dunedin</td>
</tr>
<tr>
<td>Buller REAP</td>
<td>West Coast/Buller</td>
</tr>
<tr>
<td>Tui Ora Ltd</td>
<td>Taranaki (Bicultural focus)</td>
</tr>
<tr>
<td>Huakina Development Trust</td>
<td>Auckland (Māori focus)</td>
</tr>
<tr>
<td>TOA Pacific/Methodist Mission</td>
<td>South Auckland (Pacific peoples focus)</td>
</tr>
</tbody>
</table>

The services are contracted by Child Youth and Family though nine funding agreements (contracts). There is one contract with Age Concern national office for all 14 service sites, and a separate contract for each of the remaining eight service sites.

The objectives of the service are that they will:

- ensure older people are safe from abuse and other harm
- achieve well being for older people
- prevent elder abuse and neglect
- increase public awareness of elder abuse and neglect.

The definition of elder abuse and neglect and its forms proposed by Age Concern is used for the provision of services. These definitions exclude self-neglect which is not included in the contracts.

The contract states that service provision is to older people who are aged 65 years and over unless there are circumstances where the provision of services to people under the age of 65 years is justified.

### 1.2.4 The service delivery programme model

The service delivery programme model for the elder abuse neglect and prevention services was developed by Age Concern and is based on the use of a multi-disciplinary co-ordinated team approach. The objectives of the multidisciplinary approach are to:

- meet the multiple needs of clients
- improve service co-ordination
- avoid service overlap
- clearly define roles for service providers.

The four components and related roles and responsibilities are presented on Table 1-4 on the next page.

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11 Ibid
Table 1-4: The Four components of the Elder Abuse and Neglect Prevention (EANP) Services Programme model

<table>
<thead>
<tr>
<th>Role</th>
<th>Relationship to CYF contracted EANP Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Component One: The Local Elder Abuse and Neglect Prevention Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Provides client co-ordination and referral by</td>
<td>CYF contract for programme services</td>
</tr>
<tr>
<td>- Responding to all queries made by individuals, professionals or agencies regarding the provision of general information and/or information about assistance and services available.</td>
<td></td>
</tr>
<tr>
<td>- Providing an initial assessment of individuals reported as experiencing abuse and/or neglect.</td>
<td></td>
</tr>
<tr>
<td>- Referring of individuals to appropriate intervention services.</td>
<td></td>
</tr>
<tr>
<td>- Monitoring the delivery and effectiveness of intervention services for individuals.</td>
<td></td>
</tr>
<tr>
<td>- Collecting data and report on the number of inquiries, referrals and collect statistics on individual cases of Elder Abuse and Neglect.</td>
<td></td>
</tr>
<tr>
<td>• Develops and provides training and education to carers and people who work with older people</td>
<td></td>
</tr>
<tr>
<td>• Develops and provides public awareness programmes</td>
<td></td>
</tr>
<tr>
<td>• Develops and implements evaluation tools to measure the effectiveness of the service</td>
<td></td>
</tr>
<tr>
<td>• Establishes and maintains an Advisory Group</td>
<td></td>
</tr>
<tr>
<td>• Develops and maintains close working relationships with providers of elder abuse and neglect prevention intervention services and community groups such as local iwi/Māori, Pacific people, other ethnic groups, voluntary/community organisations and local authorities</td>
<td></td>
</tr>
<tr>
<td>• Provides staff support, supervision and training by</td>
<td></td>
</tr>
<tr>
<td>- Ensuring staff employed receive ongoing support, Professional Supervision (general and cultural) and training which should involve:</td>
<td></td>
</tr>
<tr>
<td>- regular Professional Supervision</td>
<td></td>
</tr>
<tr>
<td>- access to and sharing of educational resources</td>
<td></td>
</tr>
<tr>
<td>- development of training resources (as required)</td>
<td></td>
</tr>
<tr>
<td>- attendance at training courses/conferences</td>
<td></td>
</tr>
<tr>
<td>- linkage and collaboration with other Elder Abuse and Neglect Prevention and Co-ordination of Intervention Services.</td>
<td></td>
</tr>
<tr>
<td>- Peer review and practice review calls</td>
<td></td>
</tr>
</tbody>
</table>
### Table 1-4: continues

<table>
<thead>
<tr>
<th>Role</th>
<th>Relationship to CYF contracted EANP Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Component Two: Intervention Professionals and Specialists (Case Worker)</strong></td>
<td></td>
</tr>
<tr>
<td>• provides the intervention and are experienced professionals working directly with clients to provide appropriate care and services. This group includes geriatricians, social workers, nurses and financial advisers.</td>
<td>Intervention case workers are not funded by the programme but provide their services as part of their paid employment or voluntary community-based service.</td>
</tr>
<tr>
<td><strong>Component Three: Advisory Group</strong></td>
<td></td>
</tr>
<tr>
<td>• Provides support and advice to the local elder abuse and neglect prevention service. Members of this group have professional interest, knowledge and skill in the area of elder abuse and neglect. This group may include case workers, representatives from Work and Income NZ, Police, hospital and health services, public and community agencies, local iwi/Māori, and Pacific peoples</td>
<td>Advisory group members are not funded by the programme but provide their services as part of their paid employment or voluntary community-based service.</td>
</tr>
<tr>
<td><strong>Component Four: National Co-ordination.</strong></td>
<td></td>
</tr>
</tbody>
</table>
| • involves development and review of service standards, monitoring of standards across service providers, provision of ongoing advice on the effectiveness of the service model, data collection, analysis and reporting. | This role is undertaken through CYF’s contracting and management process. Contracted EANP Services are required to:  
- have appropriate experience, training and supervision  
- meet the established Standards for Approval of Elder Abuse and Neglect Prevention and Co-ordination of Intervention Services  
- comply with CYF’s Key Operating Processes, Policies and Systems (KOPPS) document. |

Note 1: This model description is based on information from the following documents: Child Youth and Family (2000) Elder abuse and neglect prevention and co-ordination of intervention services – Part 1: Invitation to submit a proposal. Wellington  
The Department of Child Youth and Family funding agreement template for the provision of Elder abuse and neglect prevention and co-ordination of intervention services 1 July 2002 to 30 June 2003
Other aspects of service provision for EANP Services include:

- support or arranging support to victims and, where appropriate, their family and carers
- identification and/or establishment of emergency safe beds.\textsuperscript{12}

\section*{1.2.6 Funding}

Child Youth and Family currently fund elder abuse and neglect prevention services to the value of $842,000 per year. This funding is distributed across the 22 contracted local services and is contractually described as a \textit{funding contribution} towards the delivery of services.

The contractual service requirements and level of funding provided to each service has remained the same since 1998. However, the difference between funding and the actual cost of services being provided has incrementally increased over time. Service providers have needed to cover this increase themselves.\textsuperscript{13}

\section*{1.3 The review}

This review was commissioned by the Office for Senior Citizens in June 2003. The review focuses on the appropriateness of the EANP Service model and not on the quality of individual services.

The overall goal of the review was to ensure:

1. The maximum effectiveness of the elder abuse and neglect prevention services in achieving positive outcomes for people suffering elder abuse and neglect;
2. The appropriateness or otherwise of the model adopted in the operation of elder abuse and neglect prevention services;
3. Effective linkages in the intervention and follow-up services; and
4. Increased public and professional awareness of elder abuse issues.

The specific objectives of the review were to:

1. Provide a framework for the evaluation of services, collection of data and information on the activities of services and the examination of the effectiveness of the present service model;
2. Collect data and information on current services, ensuring appropriate coverage of services and their activities in respect of geographic and cultural factors and taking into account all forms and levels of abuse, consistent with the contract with Child Youth and Family;
3. Collect information on the activities of these services that are related to elder abuse but are outside the services contracted for by Child Youth and Family;
4. Analyse the potential contribution that current systems and processes make towards achieving positive outcomes;
5. Identify any gaps in services and other measures or actions that could improve effectiveness or efficiency of services including national co-ordination and contracting issues; and

\textsuperscript{12} as noted in the Office for Senior Citizens (2002) \textit{Briefing to the Incoming Minister for Senior Citizens: Towards lifelong participation and independence.} Ministry of Social Development, Wellington, NZ

\textsuperscript{13} Ibid
6. Examine the equitability and appropriateness of the funding arrangements for services, relative to population numbers and cultural and other characteristics.

A review programme was developed to provide the framework for an evaluation of services, collection of data and information on the activities of services and the examination of the effectiveness of the present service model (Objective One). This programme focused on examining the activities of the 19 service providers who adopted a generic approach to service delivery and did not include three service providers who used approaches with a greater emphasis on Māori or Pacific peoples cultural paradigms. Approval of the review programme was gained by the Child Youth and Family Research Access Committee prior to the review proceeding and prior to the report being finalised.

The review comprises four components: A) Review of literature; B) Describing provider site service delivery C) National co-ordination and contracting issues; and D) Provider site area profiles. Separate contracts were established for each of these components of work. The methods used in each of these four components is described in the next chapter.

14 Scoping of a review approach in relation to these three sites has been undertaken separately as the basis for a future exercise which focuses on these providers.
2 Review approach and methods

2.1 Introduction

This chapter presents the four review components and describes the methods that were used.

Component A

This component involved a review of literature to identify ‘good practice’ in the area of elder abuse assessment and referral procedures. This information was used to inform the assessment of the New Zealand service delivery model and how it operated. This component was undertaken by Fleur Keys (Leniston Keys Ltd) and is available as a separate review working paper from the Office for Senior Citizens.

Component B

This element focused on describing how service delivery across the sites operated including services contracted by Child Youth and Family as well as services relating to elder abuse and neglect that were not specifically contracted. Gaps in services and ways in which the effectiveness and efficiency of services could be improved were also examined.

Information about service delivery across the sites was based on analysis across a range of review methods and information sources. These were:

- survey of all EANP Service site co-ordinators,
- workshops held with EANP Service representatives,
- an interview with the Age Concern National Office co-ordinator for EANP Services Age Concern sites,
- case study site interviews, and
- case reporting data from Child Youth and Family and Age Concern New Zealand for a sample of EANP Services for the July 2002 to June 2003 year.

It is noted that:

- comprehensive case reporting data across all of the sites was not available for the review. The data available provides general information about referrers, case characteristics and service activities.
- the workshops highlighted the different ways in which services use terminology (for example definitions of the terms general enquiry, referral, case) and the different ways service delivery is approached and viewed. This diversity presented challenges in describing how services operate and at times interpretation of what services specifically meant by their comments. To address these issues in the reporting of results, differences in the ways terms were used and interpretation difficulties are noted and presentation has focused at times on the request characteristics and context rather than use of the term referrals or cases per se.
- The information gathered in this review was not intended to provide a comprehensive description of how each of the sites operated but to generally describe the approach adopted by sites and highlight ways in which they may differ. This was to gain an understanding about sites’ service delivery in relation to the theoretical model of service delivery for EANP Services.
Component C
This component involved a policy analysis of national co-ordination and contracting options and issues. This included the location of responsibility for contract management; a model to enhance national co-ordination; and the establishment of a national database. This work was undertaken by a policy consultant, Peter Leniston (Leniston Keys Ltd).

Approaches included:
- Review of relevant documentation
- Consultation/meetings with key central government and other stakeholders including officials from Child Youth and Family, Ministry of Health, Ministry of Social Development, Police, Age Concern National Office, EANP Service providers with a specifically Māori, Pacific peoples or bicultural focus
- A workshop session with provider site representatives and other key stakeholders
- Involvement in case study site interviews with EANP service personnel and stakeholders.

Component D
This work involved an analysis of 2001 Statistics New Zealand population census information and data to develop a funding framework (as was feasible) to consider the equitability and appropriateness of the funding arrangements for services, relative to population numbers and cultural and other characteristics. Current provider site area descriptions were obtained using the Survey of EANP Service Co-ordinators.

Further description of the review methods is presented in the next section.

2.2 The review of literature

Literature for the review was identified by the Ministry of Social Development’s Information Centre. The Centre conducted a literature search in two parts:

- part one focused on the databases that the Centre has access to, these include Index New Zealand (produced by the National Library of New Zealand) and a number of social science and social work focused databases. The databases span international literature, in particular sources from Australia, the United States, the United Kingdom and Canada.
- part two consisted of a search of international clearing houses and national institutes.

In addition, an extensive search of the World Wide Web was undertaken, centred on international journals, government sites and specialist sites focused on elder abuse and neglect, gerontology, aging and family violence.

The literature presented in the review is largely from the United States, Canada, England and Wales, with lesser input from Australian and New Zealand sources. This reflected the availability of literature on the subject. In the New Zealand context, the key document drawn from was the elder abuse and neglect resource kit developed by Age Concern New Zealand (1992)15. While other New Zealand sourced material was considered, most of it provided contextual information and was not directly relevant to this review.

2.3 Case study interviews

Case study interviews were conducted at four EANP Service sites to gain an understanding of the way services are provided by different sites. Four sites were chosen based on a consideration of the need to represent the different provider organisations, different demographic characteristics of older people in the site areas, population size, and urban and rural areas.

Semi-structured face to face interviews were conducted with EANP Service personnel in each of the four sites and a mixture of face to face and phone interviews were conducted with Advisory Group members, and professional and specialist intervention provider representatives. It is noted that Advisory Group members were also was a professional and/or specialist intervention providers in many instances.

The interview schedules

Different interview schedules were developed for interviews with EANP Service co-ordinators/caseworkers; managers; Advisory Group members; and Intervention providers. A copy of the interview questions relating to these schedules is provided in Appendix A.

The sample

A total of 39 case study interviews were conducted.

EANP Service personnel

All EANP Service personnel at the four sites were interviewed:
Managers (3)
Co-ordinators (5)
Caseworkers (1)
Five co-ordinators were interviewed because one site operated as an umbrella service for two local areas, each with their own EANP Service co-ordinator. (Therefore two co-ordinators were interviewed at this site.)

Advisory Group

Co-ordinators at the four sites were asked for lists of their advisory group members so that they could be approached for interviews. The information provided and number of interviews conducted at each site area is provided below.

Site A:
The Advisory Group list was not provided because of its confidentiality to the services. The co-ordinator sent information and a letter seeking their involvement in the review to the group members asking for feedback about who wished to be involved. Three names were provided with whom face to face interviews were conducted.

Site B:
The co-ordinator provided a list of the Advisory Group and also approached them about their willingness and ability to be interviewed for the review. Three members of the group indicated they could be involved in face to face interviews for the review.
Site C:
A list of the Advisory Group was provided and the co-ordinator indicated three members who had spent time on the group and were more actively involved. Face to face interviews were conducted with these three members and phone interviews were conducted with the other seven members of the Advisory Group.

Site D:
The co-ordinator for this site had only recently taken up the position and provided a list of members who were to be included in the Advisory Group. Face to face interviews were conducted with three of these advisory group members and phone interviews with the remaining four. Due to the recency with which the Advisory Group was being established, seven phone interviews were also conducted with a list of intervention providers provided by the site co-ordinator.

Interviews were conducted with the following Advisory Group members and professionals and specialists:

- Police
- Victim Support
- Hospital Mental Health Social Workers
- Elder Mental Health Social Workers
- Rest home managers
- Needs Assessment Service Coordinator (NASC)
- Community-based services
- Women's refuge
- Community safer councils
- Lawyers
- Geriatrician
- Psycho-geriatric social worker
- Addictions Service
- Accredited Visiting Service Age Concern
- Older Person community services
- Community support services

Data collection
The 9 interviews with EANP Service personnel ranged from about 60 to 90 minutes in length. A total of 30 interviews were conducted with Advisory Group members and intervention providers. The interviews ranged from about 20 to 60 minutes in length. The interviews were conducted in two phases – the first series of interviews was conducted in October 2003 and the second in February – March 2004.

Apart from one interview, all of the face to face interviews were taped as well as written notes taken of the key points raised. Taping the interviews was considered appropriate in order to capture the ‘essence’ of concepts and issues raised by interviewees and to ensure accuracy. The concept of taping the interviews was discussed with each interviewee and permission was always sought prior to taping the interview.

Informed consent was gained from all participants, including their rights to: confidentiality and anonymity where desired; the right to not answer questions; or to withdraw from the research if they wished. Following the face to face interviews, all interviewees signed a consent form.
Data analysis

Information from the interviews was collated and analysed for common themes and key points relevant to the review objectives.

2.4 One day workshops

One day workshops were held on 17 and 19 November 2003 with EANP service representatives to gain information about how the services operated nation-wide. Sessions in the workshops included:
- Service aims
- How services are provided: mapping exercise in groups of three or four from initial contact through to closure (group facilitators were the note takers in each group)
- Education provision and community awareness
- Training and statistics
- Wrap up discussion

2.5 Survey of EANP service co-ordinators

A survey of the 20 EANP service co-ordinators was undertaken in November 2003 to gain consistent information across all the sites about how they operate. Responses were received from all 20 co-ordinators.

Questions areas included:
- length of time employed as the co-ordinator
- tertiary qualifications and background experience
- hours per week employed as the co-ordinator
- regional geographical service boundaries
- proportion of time spent on public enquiries, abuse notifications and referrals; education provision; and community awareness activities
- how often they visit, refer the caller, provide direct assistance to clients
- training undertaken
- training needs for the future
- other comments.

The survey data was input into a database with random checking processes utilised to ensure its accuracy. Analysis and reporting of the data was undertaken using Microsoft Excel software.

2.6 Administrative data analysis

Data was collected from the Child Youth and Family contract specialists and aggregate data regarding Age Concern-based sites was provided by Age Concern New Zealand. As there was only partial data available from the contract specialists, not all of the sites that are the focus of this review were able to be included in the administrative data analysis. In addition, the Age Concern information was provided in aggregate form and included cases from non-Child Youth and Family sites that could not be separated out.

The analysis of data was based upon cases closed in the July 2002 to June 2003 year and used aggregate data for 15 Child Youth and Family (CYF) part-funded Age
Concern sites (including Waitakere) and two non CYF funded Age Concern sites and data from three CYF part-funded Presbyterian Support Service sites.

2.7 2001 Population Census analysis

Data from the 2001 Population Census was accessed from the Statistics New Zealand website: www.snz.govt.nz using Table Builder which provides access to published data tables and allows these to be manipulated to meet the needs of the user. Tables were then downloaded and further analysed using Microsoft Excel software.
3 International models and emerging themes

International practice in responding to reports of elder abuse and neglect is varied. This chapter provides a brief overview of the approaches adopted in England, Wales, the United States of America, Canada and Australia and presents the emerging international trends identified in the review of literature.

England

In England elder abuse and neglect prevention and intervention services are addressed under a broader strategy focused on the protection of vulnerable adults. A vulnerable adult is defined as a person 18 years or over:

“who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or is unable to protect him or herself against significant harm or exploitation.”

A broad definition of community care services is adopted, incorporating all care services provided in any setting or context. The definition covers adults living in both the community and in residential settings.

The Department of Health has taken the lead role in the government sector, issuing guidelines on the development and implementation of multi-agency policies and procedures to protect vulnerable adults from abuse. The guidelines, published in 2000, offer “a structure and content for the development of local interagency policies, procedures and joint protocols which will draw on good practice nationally and locally.”

An emphasis is placed on a collaborative approach, in which responsible statutory, voluntary and private sector agencies work together to ensure that a coherent policy for the protection of vulnerable adults is in place, and that service delivery responses are consistent and effective. The primary focus is on the prevention of abuse where possible but, “..if the preventive strategy fails, agencies should ensure that robust procedures are in place for dealing with incidents of abuse.”

While the guidelines were issued at a national level, the emphasis is on the development of local policies and procedures. Legislative provision, in the form of the Local Authority Social Services Act 1970, requires all local authorities to comply with the guidelines unless “local circumstances indicate exceptional reasons which justify a variation.” Responsibility for the co-ordination of the development of codes of practice rests with each local authority social service department. All local authorities were to have multi-agency policies, procedures and practices in place by October 2001.

18 Ibid p.6
19 Ibid p.7
Wales

The Welsh response to the provision of elder abuse and neglect services is very similar to that of the England. The National Assembly of Wales has issued comparable guidelines\textsuperscript{20} for adult protection procedures in Wales, utilising the same definition of ‘vulnerable adults’.

United States of America

All 50 United States have specific adult protection legislation within which issues related to elder abuse and neglect are addressed. This approach is influenced by child welfare models, and is characterised by legal powers of investigation, intervention and mandatory reporting.\textsuperscript{21} Goodrich (1997) notes “in the absence of federal mandates, the states have had the opportunity to develop their own response to reports of adult abuse, neglect and exploitation.”\textsuperscript{22} Consequently, there is a large degree of variability in terms of definitions of elder abuse and neglect, agency responsibility, reporting mechanisms, and financial commitment.

Canada

The Canadian response to elder abuse and neglect intervention services is driven primarily at the provincial level, with a wide variety in approaches evident. McDonald and Collins (2000) characterise Canada as having developed four major kinds of programmes in response to elder abuse and neglect:

- statutory adult protection service programmes
- programmes based on a domestic violence model that respond to notifications of elder abuse and neglect as part of a continuum of family violence issues
- advocacy programmes for seniors
- an integrated model which brings together a number of agencies/individuals to form a multi-disciplinary team..

Australia

In Australia responses to the issue of elder abuse and neglect have been developed at the State and Territorial government level. Government responses differ from jurisdiction to jurisdiction reflecting, in part, differences in when and how policy responses were developed. However, the overarching principles underpinning responses are based in “…empowerment, valuing families and informal supports, preservation of rights, and the dignity and safety of older people.”\textsuperscript{23}

State approaches have generally favoured using existing community and health and social service providers to address elder abuse and neglect. While there is no legislation in Australia directed specifically towards the prevention of elder abuse and neglect, remedies may be found in criminal law, through the health system, and in utilising guardianship legislation that exists in all States and Territories for the protection of decision-impaired older people.\textsuperscript{24}

\textsuperscript{20} National Assembly for Wales (2000) In Safe Hands: Implementing adult protection procedures in Wales
\textsuperscript{21} McDonald, L. and Collins, A. (2000) p.43
\textsuperscript{23} Department of Families (2003) Evaluation of the Elder Abuse Prevention Unit, Queensland Government, Australia.
Emerging themes

While the literature reviewed provides useful insights into the practices adopted by a range of countries, it is not possible to talk definitively about ‘best practice’ or ‘good practice’ as the paucity of research and evaluations in this area mean that there is not an empirical base from which conclusions can be drawn. However, it is possible to identify common themes and emerging approaches.

Three major themes that have emerged from the literature:

1. a multidisciplinary approach to the management of elder abuse and neglect
2. a commitment to the prevention of elder abuse and neglect
3. local/community level responses

Theme One: A Multi-disciplinary approach

The literature suggests that a multi-disciplinary approach to elder abuse and neglect is the preferred model. Such an approach is promoted by central government in England and Wales; is favoured in Australia and New Zealand; and is occurring with increasing frequency in the United States and Canada, despite the existence of specialist adult protection services in those jurisdictions.

Arguments in favour of such an approach are premised on an understanding that elder abuse and neglect is a diverse and complex phenomenon, requiring a range of interventions and responses. Professionals ranging from physicians to police officers are likely to encounter abuse or neglect and are in key positions to offer assistance. However, the diversity of experience of victims of elder abuse or neglect means that it is unlikely that any single agency will have the necessary expertise and resources to respond effectively to all cases.25

Wolf (1994) presented the multi-disciplinary/consortium model as ‘best practice’, arguing that it has five key advantages: “(a) the avoidance of situations in which there are either too many or too few agencies involved; (b) the family systems approach is made viable; (c) service providers become familiar with one another; (d) resources are made available simultaneously; and (e) a comprehensive case plan can be developed.”26

The elder abuse and neglect resource kit developed by Age Concern New Zealand notes that: “Adopting a multi-agency/multi-disciplinary approach to planning and service delivery means that resources are used efficiently and effectively. This approach also provides support for service providers and an opportunity to share knowledge, experience and skills which enable new approaches to be tried and tested.”27

While there is very little in the way of evaluations of multi-disciplinary approaches in the field of elder abuse and neglect, there appears to be general agreement in the literature that such approaches are increasingly favoured.28 Good practice in this area

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25 National Committee for the Prevention of Elder Abuse www.preventelderabuse.org
27 Age Concern New Zealand Inc (1992) p.10.3
may, as in the case of England and Wales, draw from a broader research base on collaborative approaches and joint working generally. In England, in particular, the government has placed a strong emphasis on ‘joined up’ government, in which public, private and voluntary sector bodies are encouraged to work across organisation boundaries towards a common goal.

While the literature in general is supportive of a multi-disciplinary approach, some authors have noted constraints. Drawing on experience in the development of inter-agency protocols in New South Wales, Sadler and Sorenson (2000) suggest a number of weaknesses including: “…difficulties gaining participation by all key agencies…reliance on busy service providers to carry the process through to formal ratification and, in some areas, an incomplete service infrastructure.” However, as the authors themselves acknowledge: many clients experiencing abuse are already clients of the key service providers; interagency policies to respond to abuse need to be seen as part of a longer term strategy to prevent abuse (and ultimately reduce the costs of intervention services); and the further development of assessment tools and specialist training may help to address concerns about competing priorities and available resources.

**Key components of a multi-disciplinary approach**

While multi-disciplinary approaches can take a variety of forms, a review of the models espoused in England and Wales, and to a lesser extent North America, Australia and New Zealand, suggests the following are key components of such a framework:

- a. identification of key players
- b. shared definitions of elder abuse and neglect
- c. shared values and principles
- d. a comprehensive framework for interagency co-ordination
- e. procedures for responding to individual cases
- f. information sharing protocols
- g. training at all levels.

**a. Identification of key players**

The literature suggests that the first step in the process of establishing a multi-disciplinary framework is to identify all of the responsible and relevant agencies. It is recommended that consideration be given to a wide range of agencies, including those operating in the state, voluntary and private sectors.

The models highlighted in the literature tend to advocate agency identification at both the national and local levels. At a national level, key agencies need to be identified and included in the development of a high-level policy framework and approach. Agencies involved at a local level should reflect the needs, interests and service responses of the particular locale.

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29 The English guidelines refer to other Department of Health publications on joint working. The Department has also established a “Health and Social Care Joint Unit”, which works on issues at the interface of health and social care. The 1999 Health Act Partnership Arrangements also allow for closer working between health and local authorities.


b. **Shared definitions of elder abuse and neglect and scope of issues to be addressed**

A shared definition of abuse and neglect assists agencies to recognise such situations, develop consistent responses, and gather coherent data. Joint agreement on definitions and the scope of issues to be addressed may be particularly important where there is no clear legislative or policy framework to refer to. Shawcross (1999) notes the complexities of developing a shared approach in the absence of guidance from central government and contrasts this with the field of child abuse.  

c. **Shared values and principles**

The identification of a shared approach to responding to reports of elder abuse and neglect is another common theme. Shawcross (1999) suggests that, "For the purpose of interagency co-ordination it is important that agreements on philosophy and values are fundamental to the formulation of policy. This, while separate from procedural matters, provides the framework to underpin joint guidelines."

The literature suggests that the current approaches to responding to elder abuse and neglect are grounded predominately in an empowerment model. Empowerment is about assisting individuals to take control over their lives and to make decisions in their own best interests - it is about how assistance is offered rather than what is done. McCreadie (2002) states: "Research has indicated categorically that people need to be asked wherever possible about the kind of help they want, and their strengths in managing these situations need to be identified."

The empowerment approach is evident in responses developed in North America, the United Kingdom, Australia and New Zealand, and is consistent with the United Nations Principles for Older Persons (1991).

The principles underpinning the English guidelines for the protection of vulnerable adults recommend that agencies inter alia:

- “actively promote the empowerment and well-being of vulnerable adults through the services they provide;
- act in a way that supports the rights of the individual to lead an independent life based on self determination and personal choice;
- recognise people who are unable to make their own decision and/or to protect themselves, their assets and their bodily integrity;
- recognise that the right to self-determination can involve risk and ensure that such risk is recognised and understood by all concerned, and minimised wherever possible.”

The resource kit developed by Age Concern New Zealand promotes the involvement of older people in decision-making and suggests that all decisions must consider whether the rights of the older person and carer have been taken into account, as well as adherence to principles of least restrictive and disruptive interventions and the prevention of further harm.

While recognising and promoting the right of older people to make decisions, all of the guidelines reviewed suggest the need to balance independence with safety concerns.
The Canadian guidelines state that intervention is necessary when “…the abuse or neglect is life threatening, or the older person is clearly not capable of decision making in order to protect him or herself. Constructive dialogue among service providers and common sense are important if the interests of older adults are to be met.”

**d. A comprehensive framework for interagency co-ordination**

Co-ordination between agencies is fundamental to a multi-agency approach. Co-ordination may be supported in a number of ways: including the development of shared policy objectives and outcomes; joint management and governance arrangements; the use of interagency protocols and memoranda of understanding; the establishment of multi-disciplinary teams; and cross-disciplinary education and training processes.

McCreadie (2001) suggests that ‘good practice’ in the development of multi-agency policies in the prevention and management of elder abuse incorporates the following features (amongst others):

- all staff are familiar with policies and guidelines;
- links are made between abuse/protection policy and other relevant policies;
- policies are consistent, contributing to awareness of abuse and link to abuse/prevention policy and national care standards;
- policies are widely disseminated;
- users, carers and general public have information about abuse policy;
- contracts and service provision take into account abuse prevention; and
- a multi-agency implementation group meets every three months to monitor and oversee the implementation of the abuse policy.

She also notes that among the factors that promote joint working are a strong management lead, clearly defined geographical areas of responsibility, personal contacts, and a clear referral point.

The guidelines produced in England and Wales provide the most comprehensive examples of frameworks to support inter-agency working. While it is stated that the guidelines have been developed from best practice nationally and locally, they do not provide references to the source material.

The guidelines produced in England promote a four level framework as illustrated below:

<table>
<thead>
<tr>
<th>Level</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level One: Inter-Agency Policy</strong>&lt;br&gt;The policy sets the context for the development of detailed procedures.</td>
<td></td>
</tr>
</tbody>
</table>
- scope of problems being addressed  
- structures for planning and decision-making  
- principles to be upheld  
- definition of abuse  
- definition of ‘vulnerable adults’ |

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38 National Clearinghouse on Family Violence (2001) p.31  
40 Ibid p.28
The guidelines recommend the establishment of a multi-agency management committee with a clearly defined remit and lines of accountability. The role of the committee is to determine policy, co-ordinate activity between agencies, facilitate joint training, and monitor and review progress.  It is also noted that an effective response requires not only effective inter-agency and inter-professional collaboration, but also similar collaboration at all levels within agencies. Hence operational staff, supervisors, senior managers and chief executives must have a shared understanding of both the role their particular agency has to play within the framework; and of the role that each of them plays in relation to their counterparts in other agencies.

**e. Procedures for responding to individual cases**

Procedures for handling individual notifications of abuse and neglect are at the core of interagency frameworks. All agencies must be aware of, and committed to, an agreed process for managing cases from the point of referral, through an appropriate form of investigation/assessment, case planning and the provision of intervention strategies and services. It is also important that agencies have a shared approach to the ongoing monitoring of cases.

**f. Information sharing**

It is important that agencies have the ability to share information about individual cases if they are to work effectively towards the prevention and management of elder abuse and neglect. McCreadie (1996) notes that information sharing may be vital in piecing together a picture of abuse, but that this may conflict with codes of confidentiality.

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41 Department of Health (2000) p.15
42 Ibid p.16
within which many workers operate.\textsuperscript{43} It is therefore important that some guidance is provided on the circumstances in which information disclosure is warranted.

Both the English and Welsh guidelines address the need for information sharing between agencies. In each case the guidelines make reference to the following principles:

- information will be shared on a ‘need to know’ basis when it is in the best interests of the service user
- confidentiality must not be confused with secrecy
- informed consent should be obtained, but if this is not possible and other vulnerable adults are at risk, it may be necessary to override the requirement
- it is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those cases where there may be other vulnerable adults at risk.\textsuperscript{44}

The Welsh guidelines suggest that the development of protocols setting out local information sharing procedures should aim to support professional decision-making in individual cases; promote consistency in practice; and reduce the risk of individual decisions being challenged.\textsuperscript{45}

\textbf{g. Training}

The provision of appropriate training and education to a wide range of professionals and others in contact with older people is an important component of a multi-disciplinary approach to the prevention and management of elder abuse and neglect. McCreadie (2001) notes that training may be viewed as “…an essential adjunct to joint policy development in helping people towards greater understanding and awareness of (1) the problem of abuse; (2) policies and procedures and confidence in using them; and (3) appropriate professional and service responses.”\textsuperscript{46}

McCreadie goes on to suggest that interagency training should take place wherever policies cross agencies and require joint working. She notes that a multi-disciplinary approach to training may also contribute the building of good relationships between different groups and professionals.\textsuperscript{47}

The guidelines produced in England recommend that agencies provide training for staff and volunteers on the policy, procedures and professional practices that are in place locally, reflecting their responsibilities in the adult protection process. It is suggested the training should include:

- basic induction training to raise awareness that abuse can place and the professional duty to report it
- more detailed awareness training, including the recognition of abuse and responsibilities to follow procedures in their particular agency
- specialist training for investigators
- specialist training for managers.\textsuperscript{48}

\textsuperscript{43} McCreadie, C. (1996) p.7.8
\textsuperscript{44} These principles have been drawn from a broader English Department of Health report: Report on the review of patient-identifiable information (1997)
\textsuperscript{45} National Assembly for Wales (2000) p.27
\textsuperscript{46} McCreadie (2001) p.27
\textsuperscript{47} ibid p.27
\textsuperscript{48} Department of Health (2000) p.23
The Queensland Government’s *Strategic Plan for the Prevention of Elder Abuse* includes a key result area on education and training, targeted at professionals (including lawyers, medical practitioners, social workers, allied health professionals and community nurses, Aged Care Assessment Team members and indigenous health workers); informed intermediaries; consumer and carer groups; and educational institutes. The strategy suggests that educational programmes need to address ethical dilemmas, issues related to authority, established protocols for the identification and prevention of abuse, and referral networks.\(^{49}\)

In the New Zealand context, the Age Concern resource kit also stresses the importance of training on an ongoing basis. It is noted that successful interventions may require the development of new techniques and skills, rather than the transfer of those used in other areas.\(^{50}\)

Finally, the literature also suggests that training for professionals should address workers’ fears and potential denial of elder abuse and neglect. McDonald and Collins (2000) note that the strong feelings that both victims and abusers may arouse in professionals need to be dealt with in training and supervision.\(^{51}\)

**Theme Two: Commitment to prevention**

Education and public awareness raising are considered to be critical elements in a comprehensive approach to elder abuse and neglect. McDonald and Collins (2000) note that education is not just about learning new information, it is also about changing attitudes, behaviours and values. As such, education is a fundamental preventative strategy.\(^{52}\) In a similar vein, McCreadie (2002) states that the guidelines put in place by the government in England are necessary, but that “…research indicates that they are hardly sufficient on their own to tackle the problem of abuse. Prevention, as the government has recognised, should be the priority of policy.”\(^{53}\)

A commitment to prevention strategies underpins the multi-disciplinary approaches developed in England and Wales, the work of Health Canada, the resource kit prepared by Age Concern New Zealand, and some Australian models, particularly the work of the Queensland Elder Abuse Prevention Unit.\(^{54}\)

Prevention strategies can take many forms including: empowering older people through education and support; educating and training caregivers (especially in reducing and managing stress); training specific to professionals (to identify abuse and neglect and to intervene constructively); and campaigns targeted at the general public (to promote general awareness of the issues and responses).

The Queensland Government’s *Strategic Plan for the Prevention of Elder Abuse in Queensland* provides a useful example of a multi-sectoral, community centred strategic plan for preventing and responding to elder abuse. The plan includes key result areas on: raising community awareness about elder abuse; implementing

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\(^{49}\) Department of Families (2001) p.17  
\(^{50}\) Age Concern New Zealand Inc (1992) p.10.10  
\(^{51}\) McDonald and Collins (2000) p.55  
\(^{52}\) McDonald and Collins (2000) p.53  
\(^{54}\) The Queensland Government’s *Strategic Plan for the Prevention of Elder Abuse in Queensland* includes a commitment to research the most effective community awareness raising initiatives. This work may be a useful resource in the New Zealand context.
community response models and the most effective practice for elder abuse prevention; and professional education and training.

Theme Three: Local/community level responses

Several of the models examined in the literature promote a community or local level response to the prevention and management of elder abuse and neglect. As noted in section three, both the English and Welsh models devolve responsibility for the protection of vulnerable adults to local government, albeit within a broad framework developed by central government. This approach is not only consistent with the general provision of social services and health services within these jurisdictions, but also acknowledges that different localities may differ in both their needs (e.g. different age and ethnic structures within the local population) and their capability to respond (e.g. different mix of social service providers). While the responsibility for service provision is devolved to local authorities, monitoring is coordinated at a national level.

The Queensland Government provides an example of a community-based approach to the prevention and management of elder abuse and neglect. The Government’s Strategic Plan for the Prevention of Elder Abuse in Queensland includes a commitment to implement community response models and the most effective practice for elder abuse prevention. The plan notes that:

“…there is growing evidence that elder abuse is most effectively addressed when local communities take ownership of the issue and the responsibility for prevention and intervention. This involves effective collaboration between different service sectors in the community and the development of strong, supportive networks in the community that actively link with families and individuals. A community response model is congruent with healthy aging initiatives which include a focus on positive images of aging, inclusiveness and participation.”

The Canadian National Clearinghouse on Family Violence has developed a guide for the development of community approaches to addressing elder abuse and neglect. The guide frames the prevention of elder abuse and neglect as a community issue that requires “…a co-ordinated effort to create an environment which reaffirms the rights of older adults to self-determination, respect and dignity.

55 Department of Families (2001) p.15
4 Best practice in service provision

This chapter examines practices at key stages of the elder abuse and neglect prevention process: notifications and case intake; investigation and assessment; case planning and case management; and case monitoring. These stages and the process approaches that can generally be taken are summarised in the Figure 4-1 on the next page.

While the lack of research and evaluation in the field of elder abuse and neglect makes it difficult to identify ‘good practice’ per se, it is possible to highlight the direction that practice is moving through a review of guidelines and other commentaries.

The analysis draws heavily from a review of Social Services Inspectorate (SSI) reports undertaken for the Department of Health in England by researcher Claudine McCreadie (2001)\textsuperscript{56}. The study examines inspection reports produced in the period 1994 to 2000, and analyses examples of good practice by local authorities in their response to elder abuse. The study is the most definitive discussion of ‘good practice’ in elder abuse and neglect assessment and referral practices identified in the literature.

4.1 Case intake

Reports of suspected elder abuse or neglect may take a variety of forms and originate from a number of sources including the older person him/herself, family members, friends and neighbours, professionals and community groups. It is important that all of the players operating under a multi-disciplinary model have a clear understanding of how such reports should be handled. Equally, it is essential that members of the public know whom they should notify if they suspect elder abuse or neglect is occurring.

Ideally notification procedures should be simple and non-threatening to the notifier. It is also vital that those making reports have confidence that appropriate action will be taken.

An analysis of the literature suggests three key ‘practice directions’ at the point of notification and referral:

- the adoption of a single point of referral for notifications
- an initial screening process
- an assessment of case urgency

Figure 4-1: Generic Elder Abuse and Neglect Prevention Process

**Case intake**

**Objective:**
To identify those notifications that meet an agreed definition of elder abuse and neglect; and to screen out those calls that do not.

**Process:**
Could involve the use of high level screening tools such as questionnaires or checklists to obtain information to assist decision-making.

May include initial assessment of urgency of the situation and possible immediate referral (e.g. to Police or ambulance service) in an emergency.

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**Investigation & Assessment**

**Objective:**
To substantiate whether or not abuse has occurred, or is occurring; and to assess the risk of future abuse or neglect and the need for intervention.

**Process:**
Investigation and assessment may be seen as twin processes that often occur simultaneously.

The investigation process involves information gathering to document the nature and extent of the abuse or neglect, including identification of the perpetrator. It is likely to involve interviews with the victim and their family members.

The assessment process is focused on identifying where assistance might be provided to an older person. It is likely to build on the investigation interviews.

A variety of professionals might also take part in the process, each of whom may use assessment tools specific to their profession (e.g. doctors, mental health workers and social workers).

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**Case planning / Case management**

**Objective:**
To develop a comprehensive, coordinated and realistic case plan that addresses the harm experienced by the older person and minimizes the risk of such harm reoccurring. Some models may also address the needs of the carer and/or perpetrator of abuse or neglect.

**Process:**
Case planning involves consideration of the information obtained through the investigation/assessment processes and making decisions about appropriate interventions.

Case planning may be undertaken collaboratively with a range of professionals and/or service providers (e.g. in a case conference forum).

Alternatively, a series of meetings may be held with individual service providers to discuss appropriate interventions.

A case manager may be appointed to ensure that the recommended interventions take place, and that they are provided in a coordinated and timely way.

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**Intervention**

**Objective:**
To assist the older person to address the causes and impact of the abuse or neglect experienced and to minimize the risk of abuse or neglect occurring again.

**Process:**
Intervention refers to the actual services and/or strategies put in place to protect the interests of the older person e.g. community support services (home visiting, home nursing, transportation services); crisis intervention (such as an acute hospital bed); and legal assistance.

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**Monitoring**

**Objective:**
To assess the effectiveness of the services/strategies put in place and to consider the need for alternative services or approaches.

**Process:**
Case plans may be formally reviewed by a case manager or team at a date set in the original plan.

The monitoring process is likely to include talking to the older person and their carer.
Single point of referral

McCreadie (2001) suggests that having a single point of referral for reports of suspected elder abuse or neglect is good practice. While noting that the English guidelines on the protection of vulnerable adults appear to be ambiguous about whether there should be a single referral point for adult protection, she states that “….it would appear that this facilitates strong joint working.” McCreadie goes on to recommend that, within the English system, a special post within social services be developed as a focal point for referrals from general practitioners and other professionals.  

Initial screening

Background information is generally recorded at the time a notification of suspected elder abuse or neglect is made. Information may include the details of the person making the request, the details of the person requiring assistance, questions about the urgency of the situation, the involvement of service providers (e.g. health and social services) and whether permission has been given to act.

Under some models the collation of such information forms the initial stage of an investigation procedure, with all requests for assistance being followed up by further action (for example a home visit).

Alternatively, the information may be used as the basis of an initial screening procedure that determines whether or not a case is formally ‘accepted’. Screening questions are most commonly used to determine whether the request for assistance meets the criteria of the service provider (e.g. demographic criteria), and that the request seems genuine and there is sound basis for concern.

Assessment of urgency

Most of the models reviewed refer to the necessity of assessing the urgency of a situation at the point of notification. Services may be put in place immediately if the physical safety of the older person is in danger. The English guidelines note the importance of ensuring the safety of the vulnerable adult, and recommend early referral or consultation with the Police, especially if the matter appears to be very serious. Similarly, Age Concern New Zealand’s resource kit discusses the importance of assessing the urgency of the situation and arranging for immediate intervention as appropriate.

4.2 Investigation and Assessment

Investigation and assessment processes are often undertaken jointly. The guidelines developed by the Welsh government define investigation and assessment as “twin processes” that seek to establish matters of fact, the needs of vulnerable adult(s) involved, the responsibility and/or culpability of the person(s) against whom allegations have been made and the management of the service. The guide states: “The person co-ordinating the investigation will try to come to a view about what has happened as

57 McCreadie (2001) p.31
58 Age Concern New Zealand’s resource kit suggests that following the recording of background information, the case should be followed up by a member of the elder abuse team or a trained person. It is suggested that in most cases it will be necessary to make an appointment to visit the older person, their carer or others to gather more information and to assess what action, if any, is required.
59 Department of Health (2000) p.28
the basis of protective action even if they cannot amass evidence that allows legal action to be taken.\textsuperscript{60}

**Investigation procedures**

Investigative procedures are focused on substantiating abuse and neglect. Investigations may result in police involvement in cases and, if warranted, prosecution of the perpetrators of abuse or neglect. Several of the guidelines examined recommend early police involvement if serious abuse is suspected.\textsuperscript{61}

**Joint investigations**

The English guidelines for the protection of vulnerable adults make reference to an explicit investigation procedure to follow the receipt of allegations of abuse. The guidelines acknowledge that several agencies may have an interest in the investigation (e.g. police, social services, care providers) and recommend that investigations should be undertaken jointly by the appropriate agencies. The joint approach “...will ensure that evidence is shared, repeated interviewing is avoided and will cause less distress for the person who may have suffered abuse. Good coordination will also take into account the different methods of gathering and presenting evidence and the different requirements with regard to standard of proof.”\textsuperscript{62}

The guidelines also suggest that agencies receiving a complaint or allegation of abuse should inform other interested agencies of the nature of the complaint or allegation and the action being taken. It is further recommended that the lead agency should undertake a co-ordination and monitoring role, and ensure that the other agencies receive updates on the progress of the investigation unless it is unsafe to do so.\textsuperscript{63}

**Assessment procedures**

Once the facts of a case have been established through the investigative process, an assessment may be undertaken to determine the risk of future abuse or neglect to the older person and to identify the needs of the older person. The distinction between risk assessment and needs assessment is not always clear in the literature. However, the objectives of each process are different, as are the tools that may be used.

**A) Risk assessment**

Risk assessment procedures aim to identify older people who may be ‘at risk’ of abuse or neglect by virtue of their circumstances. The literature suggests that while a wide range of tools and protocols exist, very few have been validated and can be relied upon.\textsuperscript{64} McDonald and Collins (2000) note that most screening devices focus on the characteristics of the older person, the characteristics of the caregiver and, depending on the theoretical stance of the writer, the characteristics of the family system. The authors suggest that most of these instruments rely heavily on the subjective impressions of health and social service staff and/or verbal reports from informants and abused elders, and most fail to address issues related to the sensitivity and specificity of the measures.\textsuperscript{65}

\textsuperscript{60} National Assembly for Wales (2000) p.23
\textsuperscript{61} See the guidelines for the protection of vulnerable adults produced by the English and Welsh Governments and Age Concern New Zealand’s resource kit.
\textsuperscript{62} Department of Health (2000) p.29
\textsuperscript{63} Ibid p.29
\textsuperscript{64} Anetzberger (2001), Wolfe (2000), McCreadie (1996), Slater et al. (1999)
\textsuperscript{65} McDonald and Collins (2000) p.38
B) Needs assessment

Needs assessments are the basis upon which intervention strategies are generally identified and developed. The assessment process may incorporate interviews with the victims of abuse or neglect, their family members, and professionals or other service providers who have contact with them. A range of professionals can be involved in the assessment process, and specific tools may be used to assist decision-making.

It is evident from the literature that while a number of needs assessment tools have been developed by professionals, the majority of these have not been rigorously tested and have limited application. The majority of tools appear to have been developed by health professionals, with a focus on physical abuse and neglect.66

Good practice

Following a study of social services inspectorate reports in England, McCreadie (2001) notes that assessment has tended to be undervalued as an analytical and evaluative tool. She suggests the following ‘good practice’ principles in relation to needs assessments:

- assessments should be multi-disciplinary in nature (and supported by formal agreements and systems)
- ‘holistic’ assessments are needed that refer to the whole person, including their personal history, their household circumstances and their social network
- risk factors should be included in needs assessments
- the assessment of mental capacity is a significant element in risk assessment
- specialist skills and knowledge in the care of mentally ill older people are important for assessment
- carer needs should be separately assessed in all cases, preferably jointly between health and social services.

These good practice guidelines are premised on an evidence-base that suggests that “…many cases, particularly those involving physical and psychological abuse or multiple abuses will have behind them human relationships of particular complexity involving dependencies and pathologies. Therefore an assessment needs to examine the history and nature of relationships within the household, as well as the characteristics of both abuser and abused.”67

McCreadie also notes the need to reconcile the different assessment cultures that may exist across the health and social services professions, and the necessity of promoting a shared understanding of each other’s competencies. This view is endorsed by the English guidelines, which promote a needs assessment entailing joint discussion, decision-making and planning for the person’s future.68 Similarly, Age Concern New Zealand’s resource kit recommends a co-ordinated approach to assessment and clarification of the roles of key players.69

66 See for example, the Elder Assessment Instrument (EAI) developed for use in clinical settings. www.hartfordign.org
67 McCreadie (1996) p.7.5
68 Department of Health (2000) p.30
69 Age Concern New Zealand Inc (1992) p.12.4
While assessment tools may assist practitioners to identify client needs in a systematic way, the value of the tools in assessing situations is dependent on the practitioners’ skills in applying them. Nagpaul (2001) suggests that: “The practitioner needs to have skills in obtaining accurate information and in interpreting its meaning to the client. The practitioner needs to use clinical judgment throughout the assessment process to evaluate the client’s readiness for services and the appropriate referral based on situation dynamics.”

**Cultural appropriateness**

Finally, it is important to note the almost complete lack of research into the cultural appropriateness of risk and needs assessment tools in the field of elder abuse and neglect. While several authors acknowledge the need to recognise cultural differences, it is apparent from the literature that very little work has been undertaken in this area. One notable exception is the work of Brownwell (1997), who discusses the application of a “culturagram” to the assessment, detection and development of intervention strategies for addressing elder abuse as it affects immigrant older people and their families. The author notes that: “…understanding the risk factors for elder abuse in specific cultures is critical for practitioners working with immigrant families who may not want to admit the presence of elder abuse or mistreatment out of shame or fear of consequences.”

### 4.3 Case planning / case management

The outcomes of assessment procedures inform case planning. Assessment and planning may not always be distinct stages, as service providers involved in assessment processes are likely to begin to consider what can and cannot be changed to address the needs of the older person.

Where a multidisciplinary approach to risk and needs assessment has been adopted, it is likely that a number of agencies will also be involved in the case planning process. Such an approach allows for complex and diverse issues to be addressed by those with the appropriate skills, and for the full range of available services to be considered.

The involvement of multiple agencies may necessitate the appointment of a case manager responsible for the co-ordination of services. McCreadie (1996) suggests that a case manager may be located in a variety of settings, in either the statutory or voluntary sectors: “…The choice of setting may be particularly important in relation to elder abuse cases where people may have fears about statutory interventions, in particular of separation and institutional placements.”

The Welsh guidelines for the protection of vulnerable adults suggest that case conferences should focus on assuring proper risk management, protective and therapeutic interventions, redress, service provision and action against culpable individuals or service agencies. The guidelines recommend that an individual protection plan may be used to document the commitments made for individual service users. It is also suggested that the case conference should specify arrangements for the review of the case and, “…where further risk is a possibility, the protection plan should specify indicators which signal that the case conference should be immediately re-convened.”

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72 Age Concern New Zealand Inc (1992) p.13.1
73 McCreadie (1996) p. 7.5
Age Concern New Zealand’s resource kit notes the importance of involving the older person and their carer in the development of a case plan. The kit also recommends that consideration be given to cultural needs, financial needs and the care arrangements for the older person.\textsuperscript{75}

Finally, McCreadie (2001) suggests that good practice in case planning and management includes: clear statements on risk; the management of financial affairs; decisions about restraint; the availability of advocacy services for users; and the availability of proper legal advice to care managers and other professionals.\textsuperscript{76}

4.4 Monitoring

While the literature reviewed revealed very little about monitoring processes, it is nevertheless acknowledged as an important part of the management of elder abuse and neglect cases.

Age Concern New Zealand’s guidelines note the importance of ongoing monitoring of the implementation of case plans to ensure that services provided are fulfilling the intended function. It is noted that services may have to be changed or adjusted before a workable solution is found. The guidelines suggest that the case plan be formally reviewed at a date set in the original plan.\textsuperscript{77}

At a macro-level, the monitoring of elder abuse and neglect cases may contribute the knowledge base, and assist service providers to identify interventions that work. Shawcross (1999) notes that “…far too little is known about the success or otherwise of interventions; interagency guidelines should, at the least, have sections on how to monitor and review the outcomes of local strategies.”\textsuperscript{78}

The final step in the management of elder abuse and neglect cases is the closure of the case. Again, the literature is very light on this action. The Welsh guidelines acknowledge that there may not be a clear point of case ‘resolution’, suggesting that outcomes may combine elements of additional support and closer supervision, risk management, removal of one or both parties, therapeutic support, redress and compensation.\textsuperscript{79}

Age Concern New Zealand’s guidelines also note the difficulties around case closure, especially in situations where an older person may continue to become more dependent as a result of failing physical health. However, they recommend that service providers set limits once services are established.\textsuperscript{80}

\textsuperscript{75} Age Concern New Zealand Inc (1992) p.13.2 – 13.8
\textsuperscript{76} McCreadie (2001) p. 34
\textsuperscript{77} Age Concern New Zealand Inc (1992) p.13.10
\textsuperscript{78} Shawcross, C. (1999) p.69
\textsuperscript{79} National Assembly for Wales (2000) p.25
\textsuperscript{80} Age Concern New Zealand Inc (1992) p.13.10
5 EANP Service personnel

This chapter describes service co-ordinators and personnel involved in EANP Service provision. The characteristics of the co-ordinators and the extent that other people were described as being involved in EANP Service provision varied across the sites.

EANP Services are contracted to provide client co-ordination and referral for individuals reported as experiencing abuse and/or neglect including initial assessments, referral of individuals to appropriate intervention services and monitoring of the delivery and effectiveness of those services. EANP Services are also required to develop and provide training and education to carers and people who work with older people, and to develop and provide public awareness programmes.

5.1 Service co-ordinators

Although 19 sites are contracted by Child Youth and Family, there are 20 co-ordinators involved in the delivery of services. This is because one of sites operates by having a combined approach with two co-ordinators who deliver services to neighbouring urban areas. Child Youth and Family and the Ministry of Health jointly fund this site.81

The length of time that people had been employed as the EANP Service Co-ordinator varied greatly across the services. Just over half of the service co-ordinators had two years or less experience in the role and about a third had been in their positions for a year or less with about two thirds being tertiary qualified (Table 5-1).

Table 5-1: Time as EANP Service co-ordinator and whether tertiary qualifications held

<table>
<thead>
<tr>
<th>Time as co-ordinator</th>
<th>No Tertiary Qualification</th>
<th>Tertiary Qualification</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>From 3 to 6 months</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>From 6 to 12 months</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>From 1 to 2 years</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>From 2 to 5 years</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>5 years or more</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

TOTAL 7 13 20

Source: Survey of EANP Service co-ordinators

Of those with tertiary qualifications, just over half (7) were in the social work area. The remaining six co-ordinators held tertiary qualifications relating to the areas of education, nursing, psychology, anthropology and counseling.

Of those that did not have tertiary qualifications, one held the NZASW competency certificate and two had over ten years experience as social workers. Other areas of previous work experience included:

- Community health and nursing
- Counselling
- Working with older people (resthomes, alzheimer)
- Teaching

81 Site management interpretation of the funding is that case work is primarily associated with the Child Youth and Family funding and education and public awareness aspects of the service are primarily associated with the Ministry of Health funding.
• Social services managerial roles
• Care-giver
• Self employed business person.

5.2 Other EANP Service personnel

The EANP Service survey asked co-ordinators whether other personnel worked with them to provide EANP Services and hours worked per week. More than half of the EANP Services (13) were operated by co-ordinators in a sole position (Table 5-2). Two to three people provided services at other sites.

Table 5-2: Number of people who provide the EANP services at each site including the co-ordinator

<table>
<thead>
<tr>
<th>Number of people</th>
<th>Number of sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>13</td>
</tr>
<tr>
<td>Two</td>
<td>2</td>
</tr>
<tr>
<td>Three</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>19</td>
</tr>
</tbody>
</table>

Source: Survey of EANP Service co-ordinators
1: Includes Auckland/Waitakere site with two co-ordinators and one case worker
2: One site reported 4 personnel included word-processing time of 1 hour per week – as other sites did not include administrative support time, this person was not included in the reporting of people for this site in this table.

The hours that co-ordinators were employed to work is presented in Table 5-3. All of the 13 sole position co-ordinators worked at least half time (20 hours/week) with most working from 20-30 hours per week.

Table 5-3: Hours employed to work by co-ordinators

<table>
<thead>
<tr>
<th>Hours</th>
<th>Sole position</th>
<th>More than one person</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>20</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>25</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>26</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>30</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>35</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>37.5</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>40</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>13</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: Survey of EANP Service co-ordinators

Of those services involving more than one person, the total hours of personnel time ranged from 40 to 80 hours per week. Other people involved were mainly community or field workers. Two sites also specified manager involvement in the provision of services. In one site, the co-ordinator role was undertaken by the Services Manager of the agency who worked with two community health case workers who dealt with most of the case work.
The way in which field or case workers were viewed in terms of involvement in EANP Service provision needs to be taken into account when interpreting this information. In some sites, co-ordinators mentioned in-house agency or volunteer field/case workers who became involved in cases in terms of a referral onto a case worker to work with the client or as work undertaken as part of broader agency activities rather than as part of the EANP Services.

A field worker does not do elder abuse but her work serves as a prevention. This includes transport needs, form filling, referral for needs assessment.

(Service provider)

if I’ve got a referral in that area – and I think that she would be able to do the [follow-up] assessment – I refer it to her and we’ve got a process where we keep in touch with each other about all the details and we’ll work it out.

(Service provider)

The involvement of managers in the provision of EANP Services varied across the sites with most managers generally only having managerial involvement. Other managers were more actively involved to varying degrees in promoting public awareness, education provision, and/or service planning and a few were involved in case service provision.

### 5.3 Case study examples

The EANP Service personnel for the four case study sites is presented below. All of the five co-ordinators had backgrounds in the social work and/or mental health area. They had been in the co-ordinator role for varying lengths of time. Two co-ordinators having been employed as co-ordinators for six months or less and three had been employed from four to six years.

<table>
<thead>
<tr>
<th>EANP Service personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site A:</td>
</tr>
<tr>
<td>One Co-ordinator – recent appointment</td>
</tr>
<tr>
<td>Management oversight</td>
</tr>
<tr>
<td>Site B:</td>
</tr>
<tr>
<td>Umbrella location for 2 site areas (B1 and B2) with</td>
</tr>
<tr>
<td>• two area co-ordinators</td>
</tr>
<tr>
<td>• one case worker (employee)</td>
</tr>
<tr>
<td>Management oversight</td>
</tr>
<tr>
<td>Site C:</td>
</tr>
<tr>
<td>One Co-ordinator</td>
</tr>
<tr>
<td>Management oversight and involvement in public awareness and education provision</td>
</tr>
<tr>
<td>Site D:</td>
</tr>
<tr>
<td>One Co-ordinator</td>
</tr>
<tr>
<td>Management oversight</td>
</tr>
</tbody>
</table>

The co-ordinator at Site A had recently taken up the role in a sole EANP Service position in the agency. The agency manager had also recently taken up the management role and endeavoured to meet weekly with the co-ordinator to provide oversight support. However agency circumstances meant that this did not always occur.
Site B operates a combined approach with two co-ordinators who deliver services to neighbouring urban areas. The caseworker and Site B2 co-ordinator report to the Site B1 co-ordinator in terms of the day to day work of the services. Management involvement was generally in terms of service oversight, gaining additional funding for the services, and financial planning assistance.

At Site C, the manager was involved in service oversight and some presentations and public awareness activities but had no involvement in case work. At site D, the manager had a minimal role in relation to the EANP Service.

5.4 Issues raised

Issues raised in the review regarding EANP Service personnel were:

- the diverse professional skills required to provide the services required
- a lack of time available to provide services
- lack of available back-up support and the isolation of the role

The diverse professional skills required to provide the services required

EANP service provision includes case-based work with individuals reported as experiencing abuse and/or neglect; liaison and networking across a range of agencies and professionals; developing and presenting education to carers, and professionals; and developing and implementing community awareness initiatives.

Workshop participants and some interviewees mentioned the diverse skills that were needed by EANP Service personnel to optimally provide services. Two key areas identified were client based skills and education and promotional skills.

I think one of the things is the tension between the skill to be a trainer and education person and the pro-activeness versus the other aspects of the delivery which is the co-ordination of services and referrals etc. And you have to be pretty switched on in terms of planning and time management and also be a pretty multi-skilled person.

(Service provider)

Potential responses to address this issue were additional training across the skills required (particularly in the area of education and promotional skills) or the employment of different personnel to focus primarily on each of these two different service aspects.

Lack of back-up support available for sole position co-ordinators.

An issue that was discussed in the case study interviews was the isolation of the role and what would happen if the co-ordinator was unable to work for a period of time. In the sites where co-ordinators worked on their own, sometimes managers and others were able to take on the work if they had the appropriate skills. In other sites, it was either unclear how this issue would be managed or, service provision would generally stop.

If I'm sick everything stops – just a message saying I'm away and if it's urgent call the Police.

(Service provider)
The impact on the EAN services if the co-ordinator resigned or has become ill - that we would have to look around at management in the interim – which is quite difficult because you have cases in action – you have referrals being received – you have advice to be given – and we don’t have a specialist person that can step into that gap. At the best – my secretary and myself can only give general advice based upon the principles and we have to make a decision very quickly for me or a member of the executive committee to fill the gap.

(Service provider)

A lack of time available to provide services

A recurrent theme in the review was the lack of time available to provide services and the need to have strong time management skills. This was related both to the number of requests received as well as the travel time required for visiting and providing assistance in some sites.
6 Advisory Groups

6.1 Advisory Group composition

Nineteen of the 20 services had established Advisory Groups. The types of representatives or specialists who were members of EANP Service Advisory Groups is presented in Table 6-1. The size of advisory groups ranged from three to 13 representatives with about half of the services (10) having 8 members or less and half (9) having from nine to 13 representatives on their Advisory Groups.

Two sites also mentioned response teams which they gained advice from in terms of a team of nurses, social workers, clinical psychologists, psycho-geriatrician; and the hospital primary response team. Access to expertise to assist with cases was not solely restricted to the Advisory Groups. Co-ordinators also sought additional advice when necessary from other agencies and professionals. Some co-ordinators referred to specific consultants that they might use.

I have needed to use an accountant on numerous occasions as a consultant due to EPA concerns, family disputes, trust problems.

(Service provider)

I’ve [also] got a group of consultants who – we don’t meet as a group but I’ve got about four people – including a lawyer, a geriatrician, a Minister of religion… don’t use them very often but their expertise is always there and they’ve offered their services to provide me advice.

(Service provider)

Table 6-1: Representation on EANP Service Advisory Groups

<table>
<thead>
<tr>
<th>Advisory Group representatives</th>
<th>Number of EANP Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lawyer</td>
<td>19</td>
</tr>
<tr>
<td>Hospital social worker</td>
<td>17</td>
</tr>
<tr>
<td>Police</td>
<td>17</td>
</tr>
<tr>
<td>Mental health services</td>
<td>16</td>
</tr>
<tr>
<td>Geriatrician</td>
<td>14</td>
</tr>
<tr>
<td>Respite or Rest home care</td>
<td>13</td>
</tr>
<tr>
<td>Needs assessment service</td>
<td>12</td>
</tr>
<tr>
<td>Alzheimers Group</td>
<td>10</td>
</tr>
<tr>
<td>Family Violence Service/Group</td>
<td>9</td>
</tr>
<tr>
<td>Disabilities Service</td>
<td>5</td>
</tr>
<tr>
<td>Māori representative/service provider</td>
<td>4</td>
</tr>
<tr>
<td>Community worker with older people</td>
<td>3</td>
</tr>
<tr>
<td>Work and Income NZ</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: Survey of EANP Service co-ordinators

Note 1: Other representatives reported only by one site were: Child Youth and Family supervisor; older person’s health; pharmacist; addictions service; retired general practitioner; Salvation Army; safer community councils; Returned Services Association; Stroke Association; Pacific service provider; social work and psychology academics.

Note 2: These services assess needs, identify support options and facilitate access to support services such as home help for people with disabilities and full-time carers.
6.2 Advisory Group role

A key purpose of the Advisory Group across all of the service sites was to provide case based expert advice, support and feedback to the EANP Service. All of the sites with Advisory Groups contacted group members on a one to one basis as needed by phone and 16 of the 19 co-ordinators with Advisory Groups also held face to face meetings with group members. Other one to one contact approaches included email and fax. Feedback and advice was provided to services based on the expertise of the Advisory Group members but also in terms of additional expertise and resources that they were able to access or refer services to.

… it could well be Mum has agreed to talk with us and her son has mental health issues – she might describe to me what is happening for her son – so I take that information back – with her consent – take that information back and talk with one of the advisors in mental health. She then – may take that to her team as well – you know to gain their expertise and ask for their input and advice. So they are always available to us.

(Service provider)

Feedback and advice was also gained by some co-ordinators through regular meetings with the Advisory Group where cases could be discussed. However, not all members of Advisory Groups were able to attend these meetings due to a lack of availability. About two-thirds of the co-ordinators held group meetings at least three monthly (Table 6-2). Some sites also provided monthly reports to their Advisory Groups detailing the activities that had been undertaken that month.

Table 6-2: Frequency of Advisory Group meetings

<table>
<thead>
<tr>
<th>Frequency of Advisory Group meetings</th>
<th>Number of EANP sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular monthly meetings</td>
<td>8</td>
</tr>
<tr>
<td>Regular bimonthly meetings</td>
<td>1</td>
</tr>
<tr>
<td>Regular three monthly meetings</td>
<td>4</td>
</tr>
<tr>
<td>Regular six monthly meetings</td>
<td>1</td>
</tr>
<tr>
<td>Occasional group or team meetings</td>
<td>4</td>
</tr>
<tr>
<td>Group meetings not held</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
</tr>
</tbody>
</table>

Source: Survey of EANP Service co-ordinators

In addition to specific EANP Service case based advice, support and feedback, Advisory Groups were also used in other ways. These included:

- refining EANP Service policy and protocols including general referral approaches/pathways for dealing with different types of cases
- developing prevention strategies
- reviewing the development of educational and public awareness resources
- information sharing and networking across agencies
- as a resource for all agencies to bring elder abuse and/or neglect cases for discussion.
6.3 Case study examples

Information from the Advisory Group case study interviews suggests that the use of an Advisory Group in the provision of EANP Services worked well across the case study sites. Key elements to the ability for the group to successfully provide advice, support and feedback were the inclusion of a broad range of professionals and areas of expertise; and having members who were able to link into additional expertise when they themselves were not able to respond to queries or requests.

<table>
<thead>
<tr>
<th>Site</th>
<th>Advisory Group composition and role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site A</td>
<td>Contact as expertise required</td>
</tr>
<tr>
<td></td>
<td>Three monthly meetings recently begun</td>
</tr>
<tr>
<td></td>
<td>Terms of reference being established and role clarified</td>
</tr>
<tr>
<td>Site B</td>
<td>Contact as expertise required</td>
</tr>
<tr>
<td></td>
<td>Monthly meetings – as a resource for case discussion for all agencies</td>
</tr>
<tr>
<td>Site C</td>
<td>Rostered AG member to provide assistance and review case actions weekly</td>
</tr>
<tr>
<td></td>
<td>Contact as expertise required</td>
</tr>
<tr>
<td></td>
<td>Monthly report provided</td>
</tr>
<tr>
<td></td>
<td>Three monthly meetings</td>
</tr>
<tr>
<td>Site D</td>
<td>Contact as expertise required</td>
</tr>
<tr>
<td></td>
<td>Reports sent on a regular basis</td>
</tr>
</tbody>
</table>

The way in which the sites used their Advisory Groups and involved them in the work of the services varied across the case study sites. All sites contacted Advisory Group members on a one to one basis to gain information, advice and feedback in relation to cases they were working with. The primary role of the Advisory Groups was to provide support to the service co-ordinator in undertaking their work.

Site A had recently established her Advisory Group and initial meetings had involved clarifying their role and the composition of the group. The Advisory Group were one of the key resources that the recently appointed co-ordinator was using to gain advice and feedback and establish protocols, practices and standards in the way that the service operated. This is further discussed in section 8.2.1.

Site B held monthly meetings with the Advisory Group to discuss EANP Service cases, share information and for networking purposes. Advisory Group members also brought elder abuse and/or neglect related cases to Advisory Group meetings for discussion and input from members of the group. Although not seen as the primary purpose, use of the Advisory Group in this way was seen as a beneficial aspect of involvement in the group.

*It’s a meeting place where if we have difficult cases where we have come to the end of our tether – it’s good to be able to bandy them around – you know we don’t give out names or anything like that but we go through the individual cases that each person brings to the meeting and um – it’s really good – because we have got [a range of professionals and agencies] right across the board – so it is really good to get their input - something that we might have overlooked or missed.*

(Agency)
to be able to take cases along that we’re kind of may be a bit stuck with or whoever in the team – and you get quite a few opinions of what people think and other ideas of what we could do – and um also just a good source of information as well – people just come up with stuff – a good kind of networking and offering a perspective for other people’s cases – obviously that is seen as part of the role.

(Agency)

Site C had developed an Advisory Group process which provided daily support in her work as well as specific feedback to cases from the Advisory Group generally. All Advisory Group members were available as needed to provide expert advice and feedback. In addition, one member of the Advisory Group was rostered each week as a support contact for the co-ordinator to discuss general case issues. This group member might also be used where the co-ordinator had concerns about safety in visiting, where she would inform them of where she was going and when she would be expected to return. The rostered member received a weekly summary of service activity at the end of the week to review and comment on. Monthly reports of service activity including the type and location area of referrals were provided to all Advisory Group members and three monthly meetings were held to discuss case issues and service activities.

I’m part of the roster so if anything comes up during that particular period then [the coordinator] will ring me or email me or whatever and we will talk through a few cases – curly ones and there are a few that will specifically impact on the [us] – maybe the [we] should be involved and she will usually ring me and I’ll discuss whether we should – how we should and perhaps who as well.

(Agency)

Site D operated on the basis of contacting Advisory Group members as required and meetings were not held. Although efforts had been made previously to have Advisory Group meetings, they had not been thought to be necessary by group members. Information about service activities was provided to group members from time to time. Advisory Group members were positive about the work of the service and the role of the group to support the co-ordinator. Some of the Advisory Group members also mentioned that getting regular information about service activities and having on-going knowledge of the other members of the Advisory Group would be useful.

We used to meet regularly – now when you get a group of people such as [the co-ordinator] had got together – and from all different aspects … it is very difficult to get them on a continual basis and there didn’t appear to be the continuity.

(Agency)

### 6.3.1 Issues raised

A recurrent issue that was raised in the interviews and also reported from the workshops was the time and availability that Advisory Group members had for EAN Service work. This impacted mainly on the ability for members to attend meetings rather than on an ability to respond to one to one requests for information or advice.

… attending advisory group meetings when I can – I probably get to one in three if I’m lucky … the whole idea of resourcing in the community field really – um elder abuse is one of those problems that’s there – but it is not as visible as a lot of other problems of abuse – therefore it often doesn’t get the resources. It’s one of those areas – probably where if
you started digging down – you would find it a lot bigger than you anticipated. So um yeah unfortunately – so particularly from my department there are other priorities. And my involvement is probably it is more personal than as a departmental response really.

(Agency)
7 Types of requests and case characteristics

7.1 Initial contact

Initial contact with the EANP Services was through phone, face to face (street traffic, at presentations or meetings) or in writing (email, fax, letter). Approaches by the public was mainly by phone. Initial contact for some services was sometimes through foot traffic and this was related to the visibility and location of the site (for example, if located on a central city road frontage). Agency contact with services was often in writing or by phone with a follow-up request in writing.

7.2 Types of requests

Sites received a wide range of requests. These included general requests for information and assistance; information relating to elder abuse and neglect prevention and situations relating to suspected elder abuse and/or neglect. These can be grouped into general requests; requests about elder abuse and neglect issues generally, and contact regarding specific elder abuse and/or neglect situations.

General requests

Requests are made for information and advice about social services generally and concerns such as the location of doctors, lawyers, trust information, and dealing with health professionals and concerns. Services are also approached for practical help with aspects such as form filling, transport, and getting their basic needs met (food, housing).

Requests about elder abuse and neglect issues generally

A range of people seek information relating more specifically to the services that are provided and elder abuse and neglect. They include the general public (Enduring Power of Attorney information was mentioned as a key request topic by some sites and not others), training institutions (for example students), community groups and people working with older people. Media requests are also sometimes received in relation to current issues and information for articles.

Contact regarding specific elder abuse and/or neglect situations

Contact regarding specific elder abuse and/or neglect situations is made by the older person themselves, agencies, and concerned individuals such as professionals, relatives and friends. Anonymous calls are also made to services. Situations include where there is concern that elder abuse and/or neglect might occur as well as those where it may be occurring, or have occurred. Addressing concerns of increasing risk of elder abuse and/or neglect occurring in the future was viewed by those who mentioned it as relating to the service prevention role. Contact may also be about abuse situations that have been addressed which have remaining issues that need to be resolved. Work involving cases other than those where the issue was suspected abuse and/or neglect could also take appreciable time and effort.

We work a lot with carer stress. We acknowledge that that is a huge part of some abuse cases. And if we can support the carer to make things better for them – the flow on effect will hopefully be a positive one. So it’s what I consider to be preventative work…

…It could well be that a daughter phones and she is not managing well with Mum. You know – her memory has failed her um – she is doing
the oddest things – she’s awake all hours. So we would then talk with them – about contacting their GP, contacting the mental health foundation, it could well be that Mum’s had a stroke – well OK contact the Stroke Foundation – are you aware that they exist. It’s really putting people together with services that are out there in the community.

(Service provider)

…one is the situation where the lady’s husband had been physically abused prior to his death – um – she has now become our client because she is still stressed out by the trauma that everybody in their family experienced at that time. A verbal complaint was made at the time but they were not satisfied with the response that they got from the service providing agency – so there is an element of abuse there – the abuse happened to her husband who has now passed away but she is not being abused now – she is traumatised by the abuse that happened to her husband – so I can’t record that as an actual case of abuse so I am recording that as a case of consultation. Because of the hours that I work and it has taken quite a bit of time to refer her on …

(Service provider)

The reason for contacting the EANP Services about a situation varied and assistance may be sought in terms of one or more of the following:

- having someone to talk to about the situation
- information and advice about where to go to for help, what could be done, and confirmation of next steps that could be taken
- someone to investigate what is happening
- seeking an advocate or support person for the older person who may be experiencing abuse and/or neglect
- direct assistance in taking some actions about the situation
- reporting of abuse and neglect situations that have been dealt with for statistics.

### 7.3 Referrals and case characteristics

Information about referrals to the services and case characteristics about those involved in the case and type of abuse are presented in this section based on administrative data from a sample of EANP services.

As aggregate information was provided about Age Concern-based sites, this information includes two services (total of 14 cases) who were not Child Youth and Family funded. The data also includes cases indicated of self-neglect (either experienced on its own or in combination with other types of abuse and/or neglect as it was not possible to separate out cases of where self-neglect was the only type of abuse and/or neglect experienced. In addition, only partial information was available from Child Youth and Family of the five non Age Concern-based Child Youth and Family part-funded services and therefore not all services could be included in this analysis. However, there are some clear patterns in the data that are likely to be indicative of characteristics of all cases generally. It is also noted that the characteristics of referrer types and cases may vary at a site level.

Service sites provide information about their services in terms of the numbers of general enquiries and case referrals that they have dealt with. However, the way in
which these terms are viewed and which situations are coded as general enquiries or case referrals differs across sites. Whereas one site will code contact by a person who may be experiencing elder abuse and/or neglect who does not want to take further action as a referral, another site would code this as a general enquiry. These differences need to be kept in mind in terms of the information provided about the characteristics of referrals and cases.

7.3.1. Who refers cases to Elder Abuse and Neglect Prevention Services

Table 7-1 presents aggregate information about referrers for cases closed by a sample of EANP services in July 2002 to June 2003 year. Referrals to the EANP services were mainly made by professionals, self-referrals, partners, relatives and to a lesser extent agencies. Around three in ten referrals were made by professionals and just under two in ten are self referrals. Partners and relatives made a third of the referrals (33%).

Table 7-1: Referrer types for EANP Service cases closed in July 2002 to June 2003

<table>
<thead>
<tr>
<th>Who referred case</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>203</td>
<td>29%</td>
</tr>
<tr>
<td>Self</td>
<td>128</td>
<td>18%</td>
</tr>
<tr>
<td>Husband/wife/partner</td>
<td>112</td>
<td>16%</td>
</tr>
<tr>
<td>Relative</td>
<td>124</td>
<td>17%</td>
</tr>
<tr>
<td>Agency</td>
<td>80</td>
<td>11%</td>
</tr>
<tr>
<td>Friend or neighbour</td>
<td>48</td>
<td>7%</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>1%</td>
</tr>
<tr>
<td>Missing</td>
<td>6</td>
<td>1%</td>
</tr>
<tr>
<td>Total</td>
<td>710</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note 1: Based on aggregate data of 613 cases for 15 Child Youth and Family (CYF) funded Age Concern sites (including Waitakere) and 14 cases from 2 non CYF-funded Age Concern sites and reporting of 83 cases from 3 CYF funded Presbyterian Support Service sites.

Just over one in ten referrals were made by an agency. However, this should not be interpreted as the number of elder abuse and neglect situations that agencies come across. Not all situations of suspected elder abuse and/or neglect are referred to EANP services. The main reasons identified in the case study interviews for non-referral of cases by agencies aware of the services were when:

- the person was already a client of the agency and they have the skills and capacity to deal with the case “in-house”
- consent was not given by the client.

Cases referred on to EANP Services included those where:

- the services were outside the scope of the agency
- the cases were complex
- an independent assessment or support person was needed (eg resthome complaint)
- agencies lacked confidence in their own ability to deal with the situation
7.4 Case clients

The majority of EANP service clients were female, New Zealand/European and aged between 70 and 84 years old and related to the abuser. Sixty-nine percent of clients are female and 60 percent are aged between 70 and 84 years. The age of clients is presented in Figure 7-1. In nearly a quarter of the cases the client was aged from 80 to 84 years old and in just over 60 percent of cases the client was aged from 70 to 84 years.

Table 7-2: Reported ethnicity of EANP Service\(^1\) clients\(^2\) for cases closed in July 2002 to June 2003 for

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealander/European</td>
<td>574</td>
<td>78%</td>
</tr>
<tr>
<td>Māori</td>
<td>56</td>
<td>8%</td>
</tr>
<tr>
<td>Pacific peoples</td>
<td>6</td>
<td>1%</td>
</tr>
<tr>
<td>Asian</td>
<td>7</td>
<td>1%</td>
</tr>
<tr>
<td>Other European</td>
<td>36</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>2%</td>
</tr>
<tr>
<td>Unknown</td>
<td>44</td>
<td>6%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>740</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note 1: Based on aggregate data of 613 cases for 15 Child Youth and Family (CYF) funded Age Concern sites (including Waitakere) and 14 cases from 2 non CYF-funded Age Concern sites and reporting of 83 cases from 3 CYF funded Presbyterian Support Service sites.

Note 2: A case may involve more than one client.

Figure 7-1: Age of 740 EANP Service\(^1\) clients\(^2\) for cases closed in July 2002 to June 2003

Note 1: Based on aggregate data of 613 cases for 15 Child Youth and Family (CYF) funded Age Concern sites (including Waitakere) and 14 cases from 2 non CYF-funded Age Concern sites and reporting of 83 cases from 3 CYF funded Presbyterian Support Service sites.

Note 2: A case may involve more than one client.
Table 7.3: Abuser relation to EANP Service clients for cases closed in July 2002 to June 2003

<table>
<thead>
<tr>
<th>Abuser relationship to client</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>son/daughter</td>
<td>204</td>
<td>39%</td>
</tr>
<tr>
<td>Husband/wife/partner</td>
<td>82</td>
<td>16%</td>
</tr>
<tr>
<td>Other</td>
<td>64</td>
<td>12%</td>
</tr>
<tr>
<td>Other relative</td>
<td>52</td>
<td>10%</td>
</tr>
<tr>
<td>Friend</td>
<td>37</td>
<td>7%</td>
</tr>
<tr>
<td>Neighbour</td>
<td>32</td>
<td>6%</td>
</tr>
<tr>
<td>Tradesman/sales person</td>
<td>17</td>
<td>3%</td>
</tr>
<tr>
<td>Son-in-law/daughter-in-law</td>
<td>15</td>
<td>3%</td>
</tr>
<tr>
<td>Unknown</td>
<td>10</td>
<td>2%</td>
</tr>
<tr>
<td>Brother or sister</td>
<td>7</td>
<td>1%</td>
</tr>
<tr>
<td>Boarder</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>525</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note 1: Based on aggregate data of 613 cases for 15 Child Youth and Family (CYF) funded Age Concern sites (including Waitakere) and 14 cases from 2 non CYF-funded Age Concern sites and reporting of 19 cases from 1 CYF funded Presbyterian Support Service sites.

Note 2: A case may involve more than one client

7.5 Types of cases

Figure 7-2 below presents the abuse types experienced by clients for cases closed in the July 2002 to June 2003 year. These figures refer to all of the abuses that may have been experienced and more than one abuse type may have been indicated for a client. The main abuse types are clearly psychological abuse and material/financial abuse.

Figure 7-2: Types of abuse and neglect experienced for EANP Service cases closed in July 2002 to June 2003

- Sexual abuse: 2%
- Passive neglect: 2%
- Neglect: 2%
- Active neglect: 5%
- Self neglect: 11%
- Physical abuse: 14%
- Material or financial abuse: 28%
- Psychological abuse: 36%

Note 1: A case may involve more than one type of abuse (Total abuses experienced = 1127)

Note 2: Based on aggregate data of 613 cases for 15 Child Youth and Family (CYF) funded Age Concern sites (including Waitakere) and 14 cases from 2 non CYF-funded Age Concern sites and reporting of 83 cases from 3 CYF funded Presbyterian Support Service sites.
Self neglect was experienced by 11% of the clients. Self-neglect differs from elder abuse and neglect cases dealt with by the services because it does not occur within a relationship of trust. Although this is not a neglect area that services are specifically contracted for, this is an area that they receive referrals about and include in their case work. In some situations this is because the self-neglect is part of a larger number of abuse and/or neglect types experienced.
8 Service provision

This chapter presents the way in which services deliver their services. The review found that although there were core considerations in terms of working with suspected cases of older abuse and/or neglect, there was a wide variety in the way that services perceived their role and conducted their services. To some extent difference in service delivery was due to regional context such as whether the area is mainly rural or urban, and the services available for them to refer onto.

8.1 Consent to act

Key guiding principles in the actions taken by the sites are those of ensuring that they do no further harm, empowerment and self determination, and ensuring the safety of the older person. Gaining agreement and consent to the actions that will be taken by the service from the older person who may be experiencing abuse or neglect is a key element of responding to cases. An over-riding factor in the requirement for consent for action is when there are concerns for the safety of the person who may be experiencing abuse or neglect.

8.1.1 When contact is by a concerned individual or agency

In situations where the contact is made by a concerned individual or agency about an older person, the response by the service will differ depending on whether the older person is aware that contact with an EANP Service is being made. In situations where the person of concern is not aware that the services are being contacted, some sites proceed with further information gathering and others do not.

Some services may proceed with gathering further information by contacting professionals or agencies that are working with the person of concern and may visit the older person of concern representing the broader community group they are part of rather than specifically in terms of their EANP Service position to find out more about the situation. Proceeding in this situation may be based on the assessed reliability of the contact source and gaining adequate identifying information from them. Other sites generally do not proceed with further action if the older person of concern is not aware of the contact. They will respond by listening, providing information and advice as appropriate, expressing concern, and may also:

- suggest that the person speak to the older person about their concerns
- send out some information about elder abuse and neglect the EANP Service
- extend an invitation to re-contact the service.

Case study interview comments include:

You need to talk to the referrer before you can go to see the client, it just depends on whether there’s consent – um let me think of an example – if someone rang up about say their neighbour – who they thought was being abused say. I would ask them – has the matter been spoken about – is your neighbour aware that you are ringing us and if they said no – then you probably need to go and get their consent before we can – we can go any further. Um – if there’s a situation of considerable emergency or danger – we take the risk and go without that consent - but we do work mainly on that consent basis though.

(Service provider)
It could be a phone call that we receive from a neighbour – they’ve heard yells – screams coming from next door and Mum’s living there with her son – the two of them. We get a lot of those cases. We will ask the neighbour if they have spoken with Mum (I’ll call her Mum) and if it is OK for us to make contact. If she hasn’t spoken with Mum – we can send out some information to her – and maybe when she is talking with Mum she can pass on this information about [us] and what we have to offer.

(Service provider)

8.1.2 Consent from the older person who may be experiencing abuse and/or neglect

Consent from the older person who may be experienced elder abuse and/or neglect is sought at different stages of a case. This includes consent from the older person to:

- visit them
- visit or involve others (such as family members)
- contact service agencies on behalf of the client (for example, banks, Work and Income New Zealand)
- refer the client to a professional (eg lawyer) or agency (mental health services)
- document the case.

Sites have different approaches to whether consent is obtained verbally or in writing. However it appears that many sites gain written consent to refer clients to other agencies.

8.2 Steps taken to progress cases

This section outlines the steps taken to progress cases where there were elder abuse and/or neglect concerns.

8.2.1 General steps

In general, all of the services undertook the following:

A. established rapport and trust with the client
B. clarified what EANP Services provided
C. clarified client’s rights to self determination
D. checked the context in terms of doing no further harm
E. Information gathering and investigation about the situation with the client, and others already involved in the situation (concerned others, family, professionals and agencies) including finding out about the:
   - general circumstances
   - family structure and situation
   - competency and mental health issues
   - other professionals, social services and agencies involved
   - support available to the client (eg other family members)
F. identification and assessment of the problems including urgency and on-going risk
G. seeking advice from the Advisory Group and other professionals and agencies as required about how to progress the case
H. case planning with the client
I. referral onto other professionals or agencies where appropriate

There was a wide variation in the way that sites provided intervention assistance, undertook case management and monitored the effectiveness and delivery of services. Whether these additional aspects were also undertaken depended upon the approach of the services, the other services available to the site, and resource limitations such as personnel time and travel costs.

Networking and liaison with the community was a key element of successful service provision in terms of providing comprehensive information and advice and about the options available to clients and what was required to access social service agencies. An example of the way in which networking facilitated the work of the services is provided below.

*I think it also depends on the networks you build up – I mean they’ve got to trust you as much as you’ve got to trust them – and with the referrals – until you build up a base of networks … your face there at those [family violence] meetings and raising issues about older people um – you know – it brings it out of the closet – and just recently we have had a number of referrals from [that] area and I attribute all of that to actually being present at those meetings…*

*And I guess by being there, by participating, they trust us now – they trust us to make a referral and yeah – and I know that we’ve been able to do the same – yeah – pass on a couple of referrals to them as well.*

(Service provider)

Knowledge and networks with providers of other cultural groups was also considered important. This enabled service providers to offer a choice when contacted for assistance from the service and, if they proceeded with a case, to have access to appropriate assistance with the case work.

*Most of our clients are European – we do work with other clients – Samoan, Somali, Asian, Māori Pacific Island – but there are other services also available. They can chose to contact them otherwise we are quite happy to work with them.*

*… they are always available if I need help – in fact the Pacific Island help services and I have done joint assessments … because there is often a language problem. And we just accept that now – it’s something that we want.*

As mentioned previously, the extent to which action was undertaken by services was determined by the decisions of the client.

*But if we have got consent to visit – we will normally phone and make a time to go and visit. Um if it’s not safe to visit her at home – we can go to visit her at the neighbours or wherever she feels comfortable. We will outline to her the services that we offer – um – highlighting that it is indeed a – we follow her direction – you know we’ll talk to her about what the issues are – but at the end of the day it’s her choice – and we are there to support that choice – whatever that might be. Um so yeah – as you can appreciate every case is very individual – I would suggest that many of them where it is Mum and son – um – no action really gets taken – which is really very hard.*
Comments from case study interviewees suggest that quite often clients may be reluctant to take further action. Key reasons appeared to relate to not wanting to disrupt their living situation (for example in a resthome or with a family carer) or family dynamics.

Lots of reasons but it could well be that um – he’s her youngest – everybody else has flown the coup – he’s still my baby. He may well have mental health issues – and/or drug issues – um “he can’t cope on his own – he’s never lived on his own” um “he’s got nobody else to support him” – “he’s not too bad really”.

8.2.2 Whether clients are visited as part of case work

Whether case related work was done by EANP Services was through phone or also involved visiting them once or many times depended on the approach adopted by the site, the skills of the EANP personnel, how case or field workers were used, the complexity of the case and whether there was client consent to visit. The extent that client visits were undertaken ranged from sites who only occasionally visited clients to one site who mentioned always visiting referral clients. However, most sites tended to visit the person who may be experiencing abuse and/or neglect with their consent (see Table 5-E).

<table>
<thead>
<tr>
<th>Table 8-1: Extent that providers visited the person who may be experiencing abuse and/or neglect (with their consent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
</tr>
<tr>
<td>Occasionally</td>
</tr>
<tr>
<td>Sometimes</td>
</tr>
<tr>
<td>Quite Often</td>
</tr>
<tr>
<td>Always or almost always</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

Source: Survey of EANP Service co-ordinators

Prior to a first visit to a client, potential risk to safety in visiting was assessed through gaining information from the client or referrer (if not the client) on the phone and/or contacting other professionals who had knowledge of the client or situation.

Ways in which services addressed safety risks in visiting clients included:

- not visiting on their own
- ensuring that somebody knew where they were
- sometimes cueing the police
- having a cellphone
- having a “buddy” in the car with a cellphone.

Some services had made general arrangements with others (for example field officers, health consumer advocate, or needs assessment service field officer) to go with them on visits when there were safety concerns. However other sites often made visits on their own.
8.2.3 Not using the EANP Service name

EANP Service providers did not always use the service name when working with clients and other family members. This approach was taken when clients were unaware of contact with the service by a concerned other person and also sometimes when the person themselves had contacted the service so as not to jeopardise gaining the trust of the client and to minimise the potential of creating family tensions. Many sites referred to adopting this low level general approach, especially in the early stages, to avoid alienation and to facilitate information gathering and on-going involvement of the client and others (such as family members).

And I don’t want to be underhanded about it um but I think it’s kind of you know – you have a stranger showing up at your door and saying – I am here from elder abuse – it’s not a very good start – whereas if it saying we’re about support and it’s for people to know about what services are out there for them – it doesn’t have to be a really nasty thing and I do find when people hear that I’m from elder abuse services that they do get defensive right away.

(Service provider)

Some Age Concern-based sites used the Age Concern branding where as others had separate cards with titles such as Community Elderly Services to use when taking a general service approach.

8.2.4 Assessment of the situation

There was a variety of approaches adopted to gathering information and assessing the situation of the client. There was no standard approach adopted across the services and experience based judgement was a key element. Some sites referred to basing their information gathering approach on the Child Youth and Family requirements for data collection or the Age Concern guidelines.

Experience-based judgement was a key part of assessing a situation. Some co-ordinators had also developed assessment checklists (tools) as part of their approach and this was often based on information from the Age Concern guidelines. Other information used was from the United Kingdom and the States.

There is very very little that I can find in the way of screening and assessment tools. Particularly for older people – and while this is not something we would sit there with the client and tick the boxes – we are aware of what some of the issues are – what are some of the risk factors in regard to elder abuse. It gives us the cues .. Previous to that – all of our forms basically – had just been – the form that we used had just been pulled together from everything everyone else was using – you know – that looks good – and that looks good – to put it together.

(Service provider)

The timing of the use of checklists varied across the sites. This ranged from the use of a checklist or tool at first contact with the client, during follow-up contact or as a guide towards the end of an investigation phase to ensure that the investigation had been comprehensive. Some sites referred to using a structured assessment sheet process, whereas others referred to semi-structured approaches or none.

Two of the workshop participants listed areas that they considered in making experience-based judgements about the situation. These are presented below.
Experienced based assessment about:  safety-home alone; personal care; meal preparation – cooking and food; home situation/context – warmth etc; when saw doctor last; support services; bouncing off referrers comments/concerns.

Set areas of life that want to cover:
- other agencies involved
- finances
- family
- issues concerning them
- values
- state of house
- cognitive ability
- mobility/access

Situations of urgency and safety concerns for the client

In general, urgency and safety issues were assessed based on experience based judgement focusing on aspects such as how distressed the person was and how safe the older person, or in some cases - the person concerned about an older person considered the situation to be.

8.2.5 Case planning

All services generally documented their cases in writing and developed case plans with clients as part of their role. It was noted by some sites that case planning was a contractual requirement (Child Youth and Family Key Operating Policy and Practices) which they were audited against by Child Youth and Family.

Case planning involved identification of the issues and the goals of the client, providing information and advice about the options that were available and working with the client to develop and agree on a plan. The development of case plans might also involve family members, support people and other professionals and agencies already working with the client. It may include actions to be undertaken by the client themselves, others involved in the situation and/or EANP Services. Some workshop participants also indicated that plans relating to the (alleged) abuser were sometimes developed. Situations where this might occur included when the abuser was the partner, close family member, or living with the client.

8.2.6 Referring the case on

Cases were asked to indicate the extent that providers referred the case onto other services varied across the sites (Table 8-2). However interpretation of this table needs to include consideration of the way in which the term referral is viewed. It appears that some sites may use this term in relation to needing no on-going involvement with the client whereas other services may interpret referral on as involving other professionals and agencies to provide significant intervention services and also retain some involvement in the case.

Examples of this difference from the workshops include the following workshop notes:

Refer on usually – will act in a consultative role (although the case is considered closed)

Ask is there another agency involved? If so work with them – case is still open

Some aspects referred on – but have on-going involvement
Referral on will also mean referral to agency field workers or other case workers identified to assist generally with EANP service provision in some sites.

Situations in which sites may have not referred on include:
- consent not given by the client
- client does not meet the criteria for referral to any of the available agencies (for example in terms of severity of mental health condition)
- lack of intervention service provider in that area
- lack of confidence in the intervention service provider
- EANP Service can provide intervention without placing additional stress on the client with whom rapport and trust has been established

Some cases involve a delayed referral to intervention agencies following a period of advocacy and support from the EANP Service until the client is prepared to be referred on to intervention service providers.

**Table 8-2: Extent that providers refer the caller or person who may be experiencing abuse on to other services**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>1</td>
</tr>
<tr>
<td>Occasionally</td>
<td>2</td>
</tr>
<tr>
<td>Sometimes</td>
<td>5</td>
</tr>
<tr>
<td>Quite Often</td>
<td>8</td>
</tr>
<tr>
<td>Always or almost always</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: Survey of EANP Service co-ordinators

One service provider reported in the survey never referring cases on and noted that this was because:

I am often let down by services referred on to and am left having to “clean up” a much bigger mess.

A key factor in referral to other agencies is whether there are other agencies already involved in the situation who could provide support or assistance. In these situations, there is likely to be a referral back/on to the support agency to deal with the issue.

Referrals are made to a range of agencies with key agencies appearing to be those in the health service, Police, and advocacy and support services. Rest home complaints may be referred to the Health and Disability Commissioner or Advocate.

Case study comments about who key referrals were to include:

*probably the assessment service would be one of them – the health – GPs – Police – they’ve got a good community constable – if it’s a case of financial abuse – it’s a really good win win situation because we dealt with a person who was far to frail to lay charges and go through the process – so I worked with her and the resthome to put safety things in place and the community constable worked in terms of the abuser and put things in place for them. We’ve had um – Pacific Health – um WINZ – we’ve got a good rapport with WINZ, Occupational therapists –*
resthome managers, um [DHB] – lawyers – psychogeriatricians – quite a lot end up in the health service really – I guess.

(Service provider)

...could be legal services – particularly if financial abuse - - family court – um mental health services – it could be very practical issues – things to do with – it could be that we are helping someone to move from an unsafe environment to a safe environment – we will work with [Sarah] in regards to housing. A lot of resthomes that we will refer to also the Needs Assessment Service at the hospital – the services ... at Age Concern – the Accredited Visiting Service. For so many people who are being abused – isolation is a key issue – if they are quite happy to have a visitor to come and visit them once a week – also if they are being financially abused by family members – we also [refer to] a financial management service – which actually removes that pressure from the family and their money can be managed.

(Service provider)

### 8.2.7 Intervention assistance provided by EANP Services

Not all cases are referred to intervention agencies and in some situations intervention assistance is provided. The level of assistance provided by EANP services varies across sites. This is due to factors such as differences in the skills of EANP service personnel, accessibility of intervention services by the client, and availability of support and advocacy services. One site noted that they did not generally provide intervention assistance and referred to the wide health service brief in the region and the availability of services to refer onto.

In some Age Concern-based sites, the EANP Service involved an Age Concern case worker (not employed by the EANP Services) early in the case and this case worker provided support and advocacy services for the client.

Intervention assistance provided included:

- advocacy and support through the process (eg visiting lawyers)
- making appointments (doctors, lawyers, agencies)
- intervening with families – eg providing some ideas on who might be helpful such as support and/or cultural services and groups
- providing transport to access services
- assisting with filling in forms and making applications
- carer relief placement and arranging respite case
- home visit monitoring
- getting them involved in group functions (eg Accredited Visiting Service)
- assisting with bank account details and changes
- undertaking casework.

The main factors that were mentioned that determine whether or not intervention assistance is provided are the availability of services to provide the intervention, the availability of family members to assist, and whether assistance is needed to access those services (service gaps).
Notes from the workshop participants included:

_Casework when nobody else to do it – other agencies are not prepared to do it or do not have the skills_

_Where direct and no-one else to do it – will look for volunteer ultimately_

_Eg practical stuff: support with application, arranging transport to lawyers etc, photocopying/letter writing/logistical support. Note conscious of need to empower not undermine independence or to provide services which others can/should provide._

_Will only do if no-one else to refer to:_
Support in Court; support in family conference; advocacy role in family meetings / meeting with public trust/banks re financial matters – setting up EPAs [Enduring Power of Attorney]

_Will offer in emergencies, try to involve family – only if no-one else_

Two key service gap areas mentioned by interviewees were mental health issues and assistance in working with cases of financial abuse. These were in terms of insufficient severity in the mental health conditions for cases to be worked with by mental health services and practical assistance in terms of putting in place changes (eg changing bank accounts) in situation of financial abuse. Service provider comments included:

_Mostly financial and mental health to a point. Um – for me personally I find the mental health criteria quite tight for them accepting cases – personality disorders, we’re talking major mental health disorders here – so the personality disorders kind of fall through the cracks – that’s an issue. Also – how under resourced mental health services are – and that they can’t assess clients sometimes – you know._

_A couple that I’ve dealt with recently have been with financial abuse where people have been in resthomes but they have been abused by their families outside – where we’ve actually done the groundwork to help them change bank accounts, change pin numbers – arrange with WINZ to get their money paid to them at the resthome – I mean I don’t know who else to refer this to in the community so we are actually doing the work ourselves._

_Definite gaps in terms of financial – and legal support for older people_

Transport issues was a key service gap area for some sites and not others. The extent of intervention assistance was required depended on the regional context of the site (urban or local) and the availability of other services. One site noted that regional council vouchers could be used, when a person was eligible, to assist with transport issues in their area.

Another service gap area mentioned was advocacy and support through the family court process.

_There is a huge gap of people or services who will take on the role of applicant in the Family Court because people are frightened of court processes. And you have to have a lot of information together for the courts to decide whether it is a case for them to look into. And a lot of_
families will not do this – all the information, defended hearing and costs etc – huge issues….

Cases mentioned as being particularly time consuming when there were no other services available were those relating to self neglect and where there were serious problems in family relationships (dysfunctional families). The extent to which there is a lack of services to work with cases of self-neglect across the sites is unclear. Some sites referred these types of cases onto other agency based or volunteer field workers.

one of the women… she works very closely with cases of self-neglect so we are able to refer onto her the majority of the cases that we work with – which is just as well because they are very timely – they take a lot of time – a lot of resource – to work with people in these situations.

Emergency safe beds

The survey of EANP co-ordinators asked co-ordinators whether they had identified or established emergency safe beds and the number of times emergency safe beds had been used in the past 12 months (Table 8-3). Out of the 20 EANP Service providers, 16 had identified or established emergency safe beds, one had not, and one co-ordinator did not respond. One respondent noted that although emergency safe beds may not have been actively identified, there would be no problem in getting one organised if this was required.

Table 8-3: Number of times the use of emergency safe beds has been required in the past 12 months

<table>
<thead>
<tr>
<th>Times used</th>
<th>Number of EANP Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not needed</td>
<td>11</td>
</tr>
<tr>
<td>Once</td>
<td>2</td>
</tr>
<tr>
<td>Twice</td>
<td>4</td>
</tr>
<tr>
<td>Three times</td>
<td>2</td>
</tr>
<tr>
<td>Not known</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: Survey of EANP Service co-ordinators

8.2.8 Case management

The extent that case management was seen as part of the role of EANP services ranged from one site that did not generally see case management as part of the role, to others that managed cases to the point of referral to another agency and those that managed cases past referral until the issues had been dealt with to the clients satisfaction. Two sites referred to their roles as primarily information brokerage rather than case management. One site had specifically had case management software developed for EANP Service provision.

In general, it appears that most sites provided some level of case management in their services and stayed involved in cases to facilitate their progress and co-ordinate service across multiple agencies if this was required. Some sites referred to the level
of case management depending on their level of confidence in the agency they were referring to.

8.2.9 Monitoring the effectiveness and delivery of services

Monitoring the delivery and effectiveness of intervention services for individuals also varied across sites and was related to case management while a case was open. Case closure may have included ascertaining that the client was satisfied with the steps that had been taken and debriefing clients and others involved in the case. Follow-up of cases that had been closed differed across the sites. A constraint on service providers in their capacity to monitor and follow up on cases is the time available they have for their work. Workshop examples include:

Monitoring once a month while case still open – involvement until plan complete

Once case closed follow up can be three, six, nine, twelve months as depends on type of case and community (aim of three months but this can stretch).

…ring client in couple of weeks - may have informal follow-up with agencies through networks, case closed if client indicates they are satisfied (phone or visit)

Don’t have formal on-going monitoring role but keep an ear to the ground. NB – might follow-up with phone call if outcome not concluded to my satisfaction.

8.2.10 Training and education to carers and people who work with older people

EANP Services provide training to a wide range of professionals and providers on a wide range of topics across the sites. Training resources are developed independently by each site with different materials developed to meet the needs of the target audience.

A key element of the training role for many sites was the provision of elder abuse and neglect training to rest home staff as part of the requirements for gaining certification. Rest home staff are required to attend training on this topic annually and certification is required by all resthomes by October 2004. Not all resthome providers used the EANP Services to provide this training.

Sites varied in the extent to which they promoted their training services to carers and others. For some sites, workload pressures meant that they provided training on request rather than actively seeking opportunities for training provision. Co-ordinators did not necessarily provide all education sessions, and sometimes managers or other specialists presented sessions. Some sites charged for training and other site did not. The fees charged were generally to lower the direct cost of education provision in terms of travel, time and materials. The types of groups, range of topics, resources used and approaches that worked well are presented in Table 8-4 below.
Groups

- Resthome staff and managers
- Caregivers and home help providers
- Tertiary students in social work, social services, nursing, and other areas
- Community organisations and groups generally such as CAB, Rotary, Iwi Social Services and St John’s staff.
- Hospital staff
- Government agencies including Work and Income New Zealand, Police, Victim support, Housing NZ managers, Public Trust
- Professionals including social workers, general practitioners, district nurses, pharmacy workers and lawyers
- Other agencies such as Stroke Foundation, Artificial Limb Board, and ADARDS (Alzheimers).

Topics

- Elder abuse and neglect prevention
  - EANP Services
  - Abuse and neglect – how and why
  - Characteristics of abusers/abused
  - Managing difficult/challenging behaviours
  - Carer stress; Use of restraints
  - Institutional abuse; Spiritual abuse; Caregiver abuse
- Safety for older people
  - Safe with age – driving
  - Safety in your community; Safe and secure alarms
  - Keeping older people safe
- Financial issues for older people
  - Enduring power of attorney
  - Retirement; Financial planning
  - Wills; Family trusts
  - Work and Income NZ and gifting policy
  - Gifting tax laws
  - Residential care subsidy
- Older peoples’ rights
  - Rights and responsibilities
  - Valuing older people
  - Assertion for older people
- Services in the community
  - Age Concern services
  - Social services criteria
  - Home help – home services, formal carers and informal carers
- Other topics: Cultural awareness; Respect and differences; Sexuality and intimacy.

Resources used

- Age Concern EA Kit
- NSW ‘Aussie’ kit – health and disability
- Videos – Age Concern – What’s age got to do with it
- Behind Closed Doors video
- Promoting rights and wellbeing of older people
- UN Declaration of Rights of Older Persons
- Abuse Matters – UK Video Kit
- Age Concern (NZ) resource library
- Posters
- Brochures
- Case studies
- EPA brochures
- Bookmarks
- Certificates of attendance
- Evaluation forms

What worked well

- Group exercises
- Case studies – life experience
- Tailoring the situation to the needs of each group
- Statistics
- Certificates
- Handouts
- Taking field officer for larger groups
- Video – good case scenarios
- Evaluation forms
- Two workers presenting
- ‘Keep it simple’
- Attendance certificates
- Language/culturally appropriate approach
- Having a presentation with prepared workbook style form for participants to follow and fill in
- Innovation, creativity and energy to present well
- Credibility and experience of presentation – having worked in the area.
8.2.11 Community awareness programmes

Sites differed in how pro-active they were in undertaking public awareness activities. There is a between increasing public awareness and a resultant increase in demand for services. For some sites, with little (if any) capacity for significant increases in workload, this meant that they adopted a reactive approach to public awareness activities. Presentations and seminars were provided on request but not promoted.

The development of promotional materials such as brochures and postures is undertaken separately by each of the sites. In addition, promotion of the services is often included in publicity for the organisation which the EANP Services are based within.

The purposes of community awareness activities were to:

- increase awareness about EANP services, elder abuse and neglect generally, and how to get help and assistance
- Promote the rights of older people and a positive attitude towards ageing and older people
- empower people by providing them with information
- prevent elder abuse and neglect by encouraging people to plan for older years.

Table 8-5 on the next page shows the community awareness activities that had been undertaken, the materials that were used and what workshop participants thought worked well.
Table 8.5: Community awareness activities

<table>
<thead>
<tr>
<th>Community awareness activities</th>
<th>Community awareness materials</th>
<th>What works well</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Telephone directory listings</td>
<td>• Posters (variety) – self-published</td>
<td>• Wide distribution is essential – people don’t notice much until they are in a position of requiring the service</td>
</tr>
<tr>
<td>• A&amp;P show</td>
<td>• Pamphlets – self-published</td>
<td>• Word of mouth is a very reliable form of public awareness (from previous clients)</td>
</tr>
<tr>
<td>• Community magazines and other local publications – DHB publications, small community papers, local newspaper articles (reports of abuse and neglect, advertising of service)</td>
<td>• Booklet – self-published</td>
<td>• Visual and verbal presentations</td>
</tr>
<tr>
<td>• Day long forum</td>
<td>• Reprint of journal articles</td>
<td>• 1 hour sessions</td>
</tr>
<tr>
<td>• Displays – banks, supermarkets, medical centres, libraries, shop windows, hairdressors, hospital display boards malls and info desk</td>
<td>• Videos</td>
<td>• Use humour and sense of fun – goes a long way</td>
</tr>
<tr>
<td>• Talks – church groups</td>
<td></td>
<td>• Encourage interaction and questions</td>
</tr>
<tr>
<td>• Radio and tv interviews</td>
<td></td>
<td>• Short sharp sessions</td>
</tr>
<tr>
<td>• Information day</td>
<td></td>
<td>• Be passionate about your topic</td>
</tr>
<tr>
<td>• Mobility wise – life tubes</td>
<td></td>
<td>• Be relevant – latest NZ stats</td>
</tr>
<tr>
<td>• Networking with community services and other groups</td>
<td></td>
<td>• Be user friendly</td>
</tr>
<tr>
<td>• Street float</td>
<td></td>
<td>• Be practical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Be yourself</td>
</tr>
</tbody>
</table>
8.2.12 Staff support, supervision and training

Management oversight and understanding of the services provided by the EANP Service co-ordinators varied across the sites. Regional peer meetings across sites were held by some areas where there was capacity to do so.

All of the site co-ordinators received professional/clinical supervision for their EANP Service role. The frequency of supervision ranged from weekly to monthly.

Fourteen of the 20 co-ordinators surveyed had undertaken training in the past 12 months. Most training related to seminars, forums or conferences that had been attended. The training that had been undertaken included:

Elder abuse and neglect
- On the job training
- Elder abuse standards – contract requirements
- Elder Abuse

Financial and legal
- Enduring Power of Attorney
- Alzheimers conference
- Elder Law Conference
- Competency and PPPR Act
- Community Law Centre 12 week course

Violence and safety
- Domestic violence and the law
- Family violence seminar
- Dementia and depression violence intervention link forum
- Assessing dangerousness and planning for safety

Personal
- Workshop on self-care
- Intimacy and sexuality for older people

Professional skills
- Strength-based approach
- Strengthening families facilitation
- Crisis intervention

Other
- Governance and management
- Neuro semantics and neuro linguistic programming
- “Human Rights’ forum
- Addictions and families seminar.

Fifteen EANP co-ordinators also indicated that they had specific training needs for the future. The training needs identified included:

Financial and legal
- Wills – family trusts
- Services to deal with legal issues
- Enduring Power of Attorney
- Legal aspects in relation to NZ legal systems
- Family court procedure
Mental health
- Dementia training
- Psycho-geriatric and mental health services
- Mental health issues for older people
- Impact of mental health issues of younger family members on the older person

Communication
- Guidance with addressing community groups regarding elder abuse and neglect
- “Using the media” training
- Adult education training

Social work practice
- Social work conferences (general training on social work)
- Social work – Comm. and family studies

Other
- General training provided by Child Youth and Family
- Working with family violence

8.2.13 Data collection and statistics

All services collect data and report on the number of enquiries, referrals and individual cases of Elder Abuse and Neglect as part of their contractual requirements. However, there was some evidence of differences in interpretation and statistical reporting in terms of what was considered to constitute a case and when a case was considered to be closed.

Age Concern-based sites provide their statistical reports to the New Zealand National Office which then collates this information and provides it to Child Youth and Family. Age Concern New Zealand had also published reports based on the information gathered from Age Concern sites. EANP Services considered this information was a valuable resource for education and community awareness activities. No national collation and reporting of service provision and cases across all of the Child Youth and Family part-funded sites had been undertaken.

8.3 Case study examples

Table 8-6 on the following page outlines the approaches taken by the four service sites and highlights commonalities and differences. The co-ordinator at Site A had recently taken up the role as a sole EANP Service position. This example provides some insight into the experience of and the issues that a new person in a sole position might face. Sites B to D are examples of services with more established personnel and the different ways in which service delivery was approached. These differences were to some extent a reflection of the skills of the EANP Service personnel, the regional contexts and availability of other services in these areas.

In all of the case study sites, the interviewees considered the services that were provided were important and the viewed co-ordinators positively.
| Table 8-6: Case study service approaches to responding to elder abuse and/or neglect situations |
|----------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| **Site A**                       | **Site B1**                     | **Site C**                      | **Site D**                      |
| Consent to act                   | May contact under a general guise to assess the situation if client is unaware of referral to service | Consent required regardless of referrer unless safety concerns | Consent required regardless of referrer unless safety concerns | Consent required regardless of referrer unless safety concerns |
| Consent issue protocols being developed with Advisory Group (AG) | | | | |
| Assessing the situation         | Phone and visits                | Phone, and visits               | Phone and visit                 | Phone-based and visits          |
|                                 | Currently predominantly experience and judgement based | Predominantly experience and judgement based - use of academic research based risk assessment checklist as cues | Predominantly experience and judgement based - assessment forms based on Age Concern guidelines to ensure comprehensiveness | Use of short checklist based on Age Concern guidelines. |
|                                 | Assessment tool protocol being developed with AG | | May do initial assessment and refer to designated volunteer case workers for follow-up assessments | |
| Case planning and management    | Case planning undertaken        | Case planning and management undertaken | Case planning and management undertaken | Case planning undertaken Viewed as information brokerage, case management role when necessary (case not referred) |
|                                 | Case management approach being developed | | | |
| Intervention assistance         | Case intervention as required   | Case intervention as required   | Case intervention as required   | Intervention assistance provided as required |
|                                 | Intervention boundaries protocol being developed with AG | | | |
| Education to Professionals      | Letters sent and networking     | Reactive                        | Reactive                        | Active                          |
|                                 |                                 |                                 |                                 | |
| Community awareness             | Active                          | Reactive                        | Reactive                        | Active                          |
8.3.1 Site A

The Site A co-ordinator had recently taken up her role and provided services in a predominantly rural setting.

Learning about the role

Learning about the role to date had been mainly experience based. Management of the agency had recently changed and the agency was undergoing a period of organisational review, which had resulted in a lack of management availability and institutional knowledge of what the role entailed. The manager endeavoured to meet weekly with the co-ordinator to provide oversight support for the position, and had arranged for the previous incumbent to be available for support and advice for the new co-ordinator. The site co-ordinator commented that although some support was gained through contact with the previous incumbent, this had limited usefulness because of the newness and complexities of the role.

They said that she was available – and I was welcome to call her. But then when she would come – we would often get – sitting and not going out and doing – because I haven’t set it up and I didn’t know what I was supposed to set up – it’s hard to direct that yourself – when you don’t know exactly what your needs are.

(Service provider)

A key support in understanding and developing the site co-ordinator’s role was through contact with other regional EANP Service co-ordinators in discussing and finding out about their approaches. Another key source of information was through the Age Concern elder abuse and neglect prevention guidelines and the Child Youth and Family Key Operating Policy and Practice documentation.

The co-ordinator noted that specific training would probably have been useful and that being in a stand alone position meant that you had to be motivated to seek things out and make things happen. However as a person new to the role it took time to orient yourself as you have to have an idea of where you actually go to look for these things.

Referrals and cases to date had been mainly through others rather than self-referrals with many cases relating to family issues. Key aspects of the role that were arising were working in isolation, consent issues, and the extent to which intervention assistance should, or needed to, be provided.

When referrals had been received, the general approach, where consent had been given, was to follow up by visiting to assess the situation. In some situations the case would be referred for further medical/cognitive assessment. In other circumstances where cognitive competence was not assessed to be an issue, the co-ordinator would work together with the client to look at what supports there were or steps that could be taken, ensuring that the client was the decision-maker. Cases ranged from those which were short term to those that appeared likely to require long-term assistance.

I have had a couple that have been really short term – where I have seen them twice and referred them on – or just brought the family in and let them know what was going on and the family picked things up. And I’ve been in contact once since then just to see how things are going – yeah.

…like this fellow with financial abuse - he’s gonna be long term – … because the family are that dysfunctional and aggressive – yeah they just push their way in – and he is deteriorating cognitively – and then
may be it won't be – because my next step with him is to talk to him about enduring power of attorney and may be he can put some of those kinds of things in place and I will be able to back out a lot – a lot more – like right now I see him every one to two weeks. Which is a lot, but the family is just like – there's time I can go without seeing him for three weeks – and then all of a sudden everyone is phoning me … fighting with each other and making reports — you see they're reporting each other to me and so – you can't just not go and see him – I have to go and make sure that he is coping all right.

(Service provider)

Working in isolation

Initially, much of the co-ordinator's work was done on her own with experience based decisions about not entering situations that looked potentially dangerous. Subsequently linkages were made with an in-house agency social worker who provided peer support and was able to accompany her on some visits.

_Some of the problems with assessment is that I am going into somebody's home and I have been wary of going into somebody's home when I don't know who I am going to be seeing really. So that can be a problem – you are in a rural area like this and you don't have transport – somebody can't be expected to come up here all the time – so that – sometimes I may take [the agency social worker] with me just so that I'm not on my own._

(Service provider)

As additional networks and contacts were established, the co-ordinator was able to gain peer support through the local needs assessment service. This was seen to have advantages for both services.

_It also helps particularly with that role because it is quite – they work in isolation and so I felt it was important to bring [the co-ordinator] into the [field officers'] group so that she could at least have some support – um but also for our field officers to know that she is there and she can support them as well – if they have any concerns around any abuse._

(Agency)

The co-ordinator also established relationships with other services to facilitate joint assessment visits and casework.

Consent issues

Consent issues were a key aspect of the role that the co-ordinator was working through and was to discuss with the Advisory Group. Situations where referrals had been made without the consent of the person being referred raised the question of whether it was appropriate to visit and under what guise to visit. At the time of the interview, the co-ordinator had made visits under the broader agency banner in these situations to assess what was happening and provide support. Other consent issues that arose included whether it was appropriate to gather information from other agencies such as Police about the situation prior to having met with the referred person.

Intervention assistance

Intervention assistance was provided when there was no service that the person could be referred to or who could offer the support required. A key area of assistance was in providing transport to access services.
Because [the rural service area] is such a huge area and you get services that are available in [one place] but you can’t in [another place] and you can’t get down there – there are a lot of transport issues for clients that are not able to access services so well.  

(Service provider)

Other service gaps included situations where there were disabilities or mental health issues which were not sufficiently major to meet the requirements of other agencies to refer onto. Intervention assistance had included helping someone to ensure their business remained viable (in relation to financial abuse that had occurred), and ongoing weekly to fortnightly visits in response to on-going reports by ‘dysfunctional’ family members. The co-ordinator was working through the issue of service delivery boundaries and mentioned that one of the potential benefits of the Advisory Group was:

Being able to work through things like that – you know – maybe having somebody who says – that’s probably all that you can do – realistically you can’t do everything for people. Um – but sometimes you need someone to help you to sort things out.  

(Service provider)

**Professional education**

Contact had been made with various groups, GPs and resthomes with pamphlets and offers to present education sessions. There had been a mixed response to these approaches with some invitations to provide sessions. Resources for the sessions was developed from the Age Concern elder abuse and neglect guidelines and from resource material used by her predecessor which she had adapted to her own style of presentation including additional exercises. Two rest home talks had been given with different reactions to the session from each:

I have given two talks – the first one the rest home was fabulous – they were so onto it… And the second one was really different – they didn’t really have any concept of what abuse was – yeah it was really interesting. And exercises that I gave in the first home – they were like wow this is so neat – and the second home – they didn’t get it.  

(Service provider)

**Community awareness**

It appears that the EANP Service had had a relatively low community profile previously. The co-ordinator was actively attending community network meetings and relevant forums to establish contacts, increase awareness of the service and get to know others in the community.

I must emphasise that I don’t think their role is well developed yet… in our region the service is becoming more active – more pro-active – getting out there explaining what they do – and I definitely see potential for it developing.

**8.3.2 Site B**

Site B involved a combined approach to delivering services with two co-ordinators based at the same site (B1) and providing services to two neighbouring urban site areas (B1 and B2). Separate service contact numbers and Advisory Groups had been established for these areas. Both co-ordinators adopted the same general approach
to service delivery. The main focus of the case study presentation in this sub-section is the service delivery approach by Site B1.

Site B EANPS personnel valued the peer support that working in the combined team approach allowed and the ability to assist each other in times of increased workload, share information and ideas and provide back-up support for the other person in circumstances when they were unable to work.

Consent to act
Site B1 gained consent from clients prior to visiting regardless of who the referrer was unless there were safety concerns.

Assessing the situation
Information gathering and assessment of the client’s situation was usually undertaken through visiting the client (with their consent) to understand the situation and consider options for developing the case plan. Assessment predominantly involved experience based judgement with the use of a risk assessment sheet based on the US Journal of Elder Abuse and Neglect. Joint assessments were also undertaken.

We need to be fairly sure before we refer on – you know – we need to know what the incidents have been, how they have tried to manage that, because generally speaking – most cases of elder abuse have been happening for some time before we get to hear about it – what steps they have put in place to help manage the situation and it is only then that we are able to say – well you know have you thought about – this or considered contacting these people.

Intervention assistance
Intervention assistance was provided when no services were available for referral. Key areas where service was lacking included when mental health issues were not severe enough to refer on to mental health services, and in the area of financial abuse. Cases of self-neglect were received and these were referred to an intervention service which worked with these types of cases.

Education to professionals
The reactive approach to providing education sessions was adopted because of lack of capacity to respond should there be a significant increase in requests. Thirty-seven education sessions were delivered or scheduled to be delivered in 2003. Most of these sessions were to resthome personnel. Education sessions were undertaken jointly for sessions with groups of six or more because of the sensitivity of the topic and safety reasons. This site had been pro-active in developing new resources to ensure that their sessions delivered to resthomes were relevant and effective. The site team had recently completed a revised education approach which included a workbook for attendees to complete. The development of this resource had taken appreciable time and was reported by the interviewees to be working well.

We’ve just in the last two months – sat down and put together a new education package for staff in their resthomes. One of the resources available down in Wellington is a training module “Abuse Matters” that has come from the UK – a really really good tool – and we have taken the video and played around with that a bit. And so we have put together a new education pack um – and it’s a workbook that they get to own – you know – because we wanted some buy in from the staff – because a lot of the staff are just there because they are told to be
there and it gives them an hour break from being on their feet. So we wanted some buy in from them – so there’s three stories that we work our way through and the stories are actually based in care facilities – whereas we haven’t really had that as a resource before – you know a video that is actually in a care facility. We are finding it really good – we only just started using it in the last three weeks maybe – but we have had some good feedback from it and we have evaluation sheets that we hand out to everyone to complete.

Community awareness
A reactive approach was also adopted to community awareness activities because of service capacity. A previous community awareness exercise involving display and provision of brochures at a shopping centre had resulted in a significant jump in demand which it had been difficult to meet.

We went to [the] shopping centre and went to all the shops … – Police, CAB, library – even the little book shops, chemists etc. We asked if we could put a few of our brochures out – and everyone was very supportive yeah… and we were just inundated and we just can’t do that. As much as we would love to – because we are not just into running down to the bottom of the cliff with stretchers um – but we just don’t have the capacity to meet the demand.

(Service provider)

8.3.3 Site C
Consent to act
Site C gained consent from clients prior to visiting regardless of who the referrer was unless there were safety concerns.

Assessing the situation
Information gathering and assessment of the client’s situation was usually undertaken through visiting the client (with their consent). Initial assessment on the phone was sometimes undertaken by the co-ordinator and the case referred onto volunteer case workers to conduct a follow-up assessment and undertake any casework. Volunteer case workers were experienced health or social service professionals or non-government agency workers who worked directly with clients. They were required to be directly affiliated with an organisation with an understanding of older people. There was an orientation process for new case workers and the co-ordinator completed client follow up processes with initial clients of the case worker.

… If I’ve got a referral in that area [location] – and I think that she [the volunteer case worker] would be able to do the assessment – I refer it to her and we’ve got a process where we keep in touch with each other about all the details and we’ll work it out.

A concern expressed by the co-ordinator was a lack of availability of people with the appropriate skills and experience to take on the case worker role.

… when we first started – we had a number of individuals volunteer as case workers – professional people - social workers and things like that and in those days you could ring up a hospital social worker and get them involved… but their jobs have been so narrowed down, um - that doesn’t happen and I’ve only got three people that are case workers that can share the assessment process with me.
Intervention assistance

Intervention assistance was provided generally when no services were available for referral and also in situations where assistance could be readily provided.

So I go out and do the home visit and if it’s something that I felt confident that I could assist in, in any way – I mean our main role is to assess the situation and refer onto an appropriate agency – we are not really there to re-invent the wheel – but in some situations the worst thing you can do for an older person that you are dealing with is to refer them on to another agency because that’s just another trauma that they’re having to go through.

Key service gaps were mentioned related to assisting the client when their was financial abuse and in the area of self-neglect.

– that’s definitely one of the gaps and um we do referrals for self-neglect if we can – because there’s nobody else out there responding as well … we haven’t had any referred to us in some time … – unfortunately it takes a long time because um – it’s a matter of winning their trust and rapport and quite often there is just nowhere to refer those people onto – so you – you know – you follow them through.

Education to professionals

As with Site B, a reactive approach to providing education sessions was adopted because of lack of capacity to respond should there be a significant increase in requests. Sessions had mainly been to resthomes and resources had been developed mainly from information from the Age Concern Guidelines.

Community awareness

Similarly to Site B, a reactive approach was adopted to community awareness activities because of service capacity. This site had also previously undertaken a community awareness initiative which had resulted in a significant jump in demand which it had been difficult to meet.

8.3.4 Site D

The Site D co-ordinator approached service delivery in terms of being a brokerage model in terms of providing assistance in resolving the situation.

Consent to act

A referral was only progressed when the client was aware that the service had been approached. Most client contact was by phone.

Assessing the situation

Information gathering and assessment of the client’s situation was also usually undertaken over the phone. This involved gaining information through the use of a checklist based on the Age Concern guidelines. Case planning was undertaken through identifying issues and goals, and working through the options and steps that could be taken to reach these aims. Advisory Group assistance and advice was sought on a one to one basis as required and referral was made based on the information available and after seeking input from an Advisory Group member or members.
**Intervention assistance**

Intervention assistance was provided when cases were not able to be referred. The coordinator mentioned that there was a broad health service brief for providing intervention services in the community and that there were strong social services available to deal with cases that arose. An agency interviewee also noted that:

*Yes. In [this area] we are really quite fortunate – there are a lot of services available.*

**Education to professionals**

This was a primary focus of the work undertaken at Site D with the resthomes as the main group that education was provided to. Around 40 educational sessions had been or were to be presented in total in the year.

**Community awareness**

A range of community awareness activities had been undertaken with varying success. Community awareness activities included newspaper and radio, public meetings and distribution of pamphlets.

### 8.4 Overall service provision

All sites respond to queries, provide initial assessments of individuals reported as experiencing abuse and/or neglect and refer individuals on to appropriate services where they can. However, the way this is undertaken differs across services. These differences in practice have evolved over time as each of the services has developed approaches to service that best suit their own skills and capacities and take into account the geographical spread, needs, and services available, in each area.

There are also differences across the sites in the estimated proportion of time spent on public enquiries and cases; education to professionals; and increasing community awareness activities by the service co-ordinators (Figure 8-1).
Just over half (11) of the co-ordinators spent most time on enquiries and cases whereas for others the majority of time was spent on education provision and/or community awareness. Possible reasons for this difference include the service approach, accessibility of the service by older people, and availability of intervention services for referral.

8.5 Issues raised

This section presents the issues that were raised in the workshops and case study interviews regarding the provision of services. Discussion of these issues in relation to the model of service delivery, emerging international trends and practice directions is presented in Chapter Nine.

8.5.1 Clarity and specificity regarding the services to be provided

A recurrent issue from the workshops and the interviews was the need for greater specificity about what the services are expected to provide and role boundaries. Areas of focus included:

- Information brokerage versus case management emphasis
- Skills and professional status required of service providers
- Level of intervention assistance provided
- The focus of education provision in terms of groups and topics
- Activity definitions for statistical recording
- Geographical service boundaries

Clarity on most of these areas is inter-linked. For example, clarity about the emphasis of service delivery on information brokerage or case management will shed light on the skills and professional status required of service providers and the level of intervention assistance that might be expected. A related issue that was raised by an agency was...
the need for contractual specificity regarding the services to ensure that funding was focused on elder abuse and neglect rather than broader issues for older people.

8.5.2 National consistency, resources, and information sharing

National consistency across the services was raised as an issue in the workshops and by case study interviewees. Individual sites developed many of their own resources for day to day work. This included the development of standard forms such as consent and complaint forms, assessment checklists or guides, education and community awareness materials and evaluation forms. Nationally standardised forms were seen as a way of ensuring that these resources were optimally designed.

There was also a need identified for more nationally based resources and information sharing across the sites about service approaches, education provision, community awareness raising activities and approaches to evaluate effectiveness. More information sharing was also sought about government policies. All of the services thought that it was essential that there be national meetings across the services (at least annually) and regional meetings (at least quarterly) as a way of addressing the isolation of sites, to co-ordinate across the sites, share ideas and information, and provide peer support to each other.

Other resources that it was suggested were more up to date information on New Zealand research, national purchase/sharing of Elder Abuse USA Quarterly, updating of current resource materials (such as the Age Concern video), and the development of an education kit.

8.5.3 Statistics and data collection

The workshops and case study interviews identified a clear need for national statistics that reflected information across all of the provider sites rather than only the Age Concern-based services. A concern was also raised about the amount of information required, and the need to revise the current template, and to have consistent definitions across the sites for reporting of cases.

8.5.4 Prioritising education and prevention

A recurrent theme of the workshops and the interviews was the on-going hidden nature of elder abuse and neglect and the need for community awareness strategies to bring the issue out in the open. There was a strong call for a national level strategy (potentially linked in with family violence prevention more broadly) which linked in with local level activities.

A clear consequence of increased community awareness identified by the sites was increased demand on services. Some sites mainly adopted a reactive approach to education and increased community awareness because of a lack of capacity to handle the increased workload that would result. Therefore, it would be essential that any national campaign was accompanied by increased resources to ensure that services would be able to meet the increased demand that would result.

8.5.5 Provision of education to professionals

Workshop participants raised the issue of the skill requirements needed to provide education sessions and to address the different topics that education sessions covered. The role of the services in providing these sessions was raised in terms of whether other providers (for example, community law centres) could provide some of the education.
8.5.6 Funding, service capacity and planning

The need for increased funding and service capacity was a recurrent theme in the review work and was raised by all of the service providers, agencies and professionals involved in the review. Recognition of the costs of travel, time, and materials used was also raised.

The inability to undertake medium to long term planning due to the partial funding approach was raised as a difficulty. Where funding was successfully sought to augment the Child Youth and Family funding, this tended to be short term and its security could not be relied on for future planning. It was also suggested that having some central government funding could be a barrier to gaining additional funding from other sources because of an expectation that additional funding should be sought from government rather than elsewhere.

Workshop participants noted that planning needed to take into account the uneven workload pattern with case clusters and less referrals over the Christmas period.

Service gaps that were identified which increased the time and assistance required with cases included situations where mental health issues were not severe enough to be referred to other services, cases where there were financial and legal issues to be addressed and providing transport to clients. An additional service gap identified was the increasing difficulty in recruiting suitably skilled volunteer case workers to refer cases onto for assessment and case work.

Although some services may not have been actively promoting awareness of elder abuse and neglect issues themselves because of service capacity issues, the area of elder abuse and neglect is gaining a higher profile over time. This is evidenced by the requirement for annual training on elder abuse and neglect for resthome certification and training requirements in this area in the intervention guidelines being developed by the Ministry of Health. Concerns were raised about the ability to meet the likely increase in demand in education provision over time.

8.5.7 Sector location of the service

An issue that was raised and discussed by many of the interview participants was the sector location of the service in a community agency. The current arrangement was related to the increased accessibility and approachability of a community group in comparison with a government organisation, and the close linkage with other community in-house services.

_The reason it was put here was that older people would feel more comfortable and their family members feel more comfortable in actually coming to a community organisation to talk about this really delicate issue._

(Service provider)

This approach was balanced against a perceived lack of mandate to act in elder abuse and/or neglect situations when the older person being abused did not want to proceed with any action.

_… for me I see a dilemma sometimes with promoting people’s rights and on the other hand making sure that they are safe. We cannot sometimes do both – we just can’t um. And at the end of the day older people are adults and are entitled to make the decisions they do make – so sometimes I feel there is a bit of a conflict of interest._

(Service provider)
Other potential sector agencies that were suggested could potentially house the services included dedicated elder abuse and neglect prevention personnel as part of a Needs Assessment and Service Co-ordination team, or as part of an Elder Mental Health service. However, in general there was strong support for the location of the services within the community sector.

8.5.8 Training and induction

A lack of training was a major issue identified by many service providers. This was in terms of both funding to attend training and an absence of training opportunities that were directly relevant to the work. Increased (ring-fenced) funding for training, and information sharing about training opportunities was often suggested.

Training for new co-ordinators was limited and mainly based on “learning on the job”. It was suggested that an orientation handbook could be developed.
9 The model, practice directions and service delivery

In this chapter, the contracted service model is related to emerging trends in international approaches. This is followed by a comparison of international practice trends and EANP service delivery.

9.1 Consistency of model with international approaches

At a theoretical level, the general approach of the EANP Service programme model is consistent with the direction in which elder abuse and neglect prevention is approached internationally (see below).

<table>
<thead>
<tr>
<th>Major themes in international approaches emerging from the literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. a multidisciplinary approach to the management of elder abuse and neglect;</td>
</tr>
<tr>
<td>2. a commitment to the prevention of elder abuse and neglect; and</td>
</tr>
<tr>
<td>3. local/community level responses.</td>
</tr>
</tbody>
</table>

These approaches are underpinned by:

- identification of key players
- shared definitions of elder abuse and neglect
- shared values and principles including a commitment to an empowerment model, in which older people are assisted to take control of their own lives
- a comprehensive framework for interagency co-ordination with interagency protocols and procedures clarifying agency responsibilities and accountabilities
- procedures for responding to individual cases
- information sharing protocols
- effective ongoing training at all levels, both within and across relevant agencies.

The EANP Service model adopts a multi-disciplinary approach, espouses a commitment to elder abuse and neglect prevention as a priority and focuses on the development of responses at a community level. The approach is an empowerment model that emphasises self-determination. The stated objectives of the multidisciplinary approach of the EANP Service model are to:

- meet the multiple needs of clients
- improve service co-ordination
- avoid service overlap
- clearly define roles for service providers.

Key elements of the service provision model include responding to individual cases; developing and maintaining close working relationships with providers of elder abuse and neglect prevention intervention services and community groups; and training carers and others working with older people.
9.2 Service delivery consistency with international trends and directions

This section compares current service delivery practices with the key elements that underpin emerging themes in international approaches (Table 9-1) and practice directions at key stages of the elder abuse and neglect prevention process: notifications and case intake; investigation and assessment; case planning and case management; and case monitoring with EANP service delivery (Table 9-2).

Table 9-1: Key elements of international trends and EANP service provision

<table>
<thead>
<tr>
<th>Key elements of international trends</th>
<th>EANP service provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of key players</td>
<td>Element included</td>
</tr>
<tr>
<td>Shared definitions of elder abuse and neglect</td>
<td>Element included</td>
</tr>
<tr>
<td>Shared values and principles including a commitment to an empowerment model, in which older people are assisted to take control of their own lives</td>
<td>Element included</td>
</tr>
<tr>
<td>A comprehensive framework for interagency co-ordination with interagency protocols and procedures clarifying agency responsibilities and accountabilities</td>
<td>Element included to some extent</td>
</tr>
<tr>
<td>Procedures for responding to individual cases</td>
<td>Element included to some extent</td>
</tr>
<tr>
<td>Information sharing protocols</td>
<td>Element included to some extent</td>
</tr>
<tr>
<td>Effective ongoing training at all levels, both within and across relevant agencies.</td>
<td>Element included to some extent</td>
</tr>
</tbody>
</table>

As shown in Table 9-1 EANP service provision includes all of the key elements of international practice trends, at least to some extent. The findings regarding EANP service delivery in the previous chapter suggests that increased specificity about the function of the services and the development of national resources such as standard protocols and forms would help to ensure that these key features of practice are in place.

The need for on-going training as a key element of practice reinforces the importance of addressing the training gap identified by service providers. It also highlights the importance of the training role that the services have in the area of elder abuse and neglect. Increased and improved training resources such as those identified by the review participants would help to ensure that training was effectively provided by the service. This was a key area of discussion regarding the potential benefits of national co-ordination and is discussed further in Section 10.2: The Case for national co-ordination.
The service practice approach taken by EANP services is substantially validated by the comparison with international practice trends. In most areas, the practice directions indicated by the review of literature were also part of EANP service delivery.

**Table 9-2: International practice directions and EANP Service provision**

<table>
<thead>
<tr>
<th>Case Intake</th>
<th>EANP service provision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective:</strong> To identify those notifications that meet an agreed definition of elder abuse and neglect; and to screen out those calls that do not.</td>
<td></td>
</tr>
<tr>
<td><strong>Practice directions:</strong></td>
<td>EANP service provision</td>
</tr>
<tr>
<td>A single point of referral for reports of suspected elder abuse and neglect to promote a coordinated response</td>
<td>Provided by service</td>
</tr>
<tr>
<td>A simple high-level screening process at the point of notification to assess the likelihood of elder abuse or neglect having occurred (as per an agreed definition) and the appropriateness of further intervention</td>
<td>Screening processes are undertaken in varying ways across the services</td>
</tr>
<tr>
<td>An immediate assessment of urgency and referral as appropriate</td>
<td>Provided by service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Investigation and Assessment</th>
<th>EANP service provision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective:</strong> To substantiate whether or not abuse has occurred, or is occurring; and to assess the risk of future abuse or neglect and the need for intervention.</td>
<td></td>
</tr>
<tr>
<td><strong>Practice directions:</strong></td>
<td>EANP service provision</td>
</tr>
<tr>
<td>Joint investigation to avoid repeated interviewing and ensure that evidence is shared</td>
<td>Provided by service</td>
</tr>
<tr>
<td>Distinct risk and needs assessment processes, undertaken (as appropriate) by multidisciplinary teams</td>
<td>Provided by service</td>
</tr>
<tr>
<td>Holistic assessments</td>
<td>Provided by service</td>
</tr>
<tr>
<td>A focus on the mental capacity of the older person</td>
<td>Provided by service</td>
</tr>
<tr>
<td>A separate assessment for carers</td>
<td>Provided by service</td>
</tr>
<tr>
<td>Acknowledgement and sensitivity to cultural differences</td>
<td>Provided by service</td>
</tr>
</tbody>
</table>
### Case planning/case management

**Objective:** To develop a comprehensive, co-ordinated and realistic case plan that addresses the harm experienced by the older person and minimises the risk of such harm reoccurring. Some models may also address the needs of the carer and/or perpetrator of abuse or neglect.

### Practice directions:

<table>
<thead>
<tr>
<th>Practice directions</th>
<th>EANP service provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusion of the appropriate range of agencies in case planning</td>
<td>Provided by service</td>
</tr>
<tr>
<td>Involvement of the older person and their carer in case planning</td>
<td>Provided by service</td>
</tr>
<tr>
<td>Appointment of a case manager to co-ordinate and monitor the implementation of case plans</td>
<td>Not currently (explicitly) provided by service</td>
</tr>
</tbody>
</table>

### Monitoring

**Objective:** To assess the effectiveness of the services/strategies put in place and to consider the need for alternative services or approaches.

### Practice directions:

<table>
<thead>
<tr>
<th>Practice directions</th>
<th>EANP service provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing monitoring to ensure the case plan is followed through and is working as intended</td>
<td>Sometimes provided by service</td>
</tr>
<tr>
<td>The collation of data from the monitoring process to contribute to an understanding of ‘what works’ in terms of practice interventions</td>
<td>Not currently provided by service</td>
</tr>
</tbody>
</table>

The main area of difference between international practice directions and the EANP services relates to case management and monitoring. While case management was a feature of the way in which many of the services operated, for others the main emphasis of service provision appeared to be viewed as information brokering. A clear statement of the role of services in terms of case management and monitoring and a shared understanding of what this means operationally would help to ensure consistency in service practice.

The one international practice which was not generally being undertaken was collection and collation of data to understand “what works” in terms of practice interventions. Although this was undertaken by some service personnel in an informal way, international practice trends suggest that a more formal approach to monitoring across the services should be adopted.

Overall, the comparison of EANP services with international trends indicates that the approach taken in New Zealand is well founded. The EANP service approach substantially adopts practices suggested by the review of literature. However, there is some need for increased consistency and shared understanding across service providers of practice directions. An approach that can facilitate this, is increased national co-ordination. This is discussed in the next chapter.
10 National co-ordination

10.1 Overview

This chapter draws on relevant documents, discussions with key stakeholders, input from provider site interviews and workshop discussions to recommend a model for national co-ordination of EANP services.

Under the proposed system:

- Responsibility for national co-ordination would be allocated by the funding agency to a non-government provider through a competitive contract process;
- A reference group comprising key government agency representatives and service provider representatives (including Māori and Pacific peoples providers) would meet, quarterly initially, to consider and review national co-ordination work programme priorities, and to discuss the contribution which individual agencies might make to specific projects; and
- Co-ordination across elder abuse and neglect prevention services at a regional level would be formally recognised as an integral component of the overall elder abuse and neglect prevention model. At the local level, elder abuse and neglect services would continue to work across agencies to co-ordinate service provision.

A coordinated approach to data collection across all relevant agencies is also recommended.

Following a national workshop held in 1989, to address professional and public demand for intervention and prevention strategies to combat elder abuse and neglect, Age Concern:

- developed a resource kit on elder abuse and neglect using a broad based working party and reference group and funding from a range of public and private philanthropic sources; and
- established seven pilot elder abuse and neglect programmes, funded by the Lottery Grants Board.

Historically, some national co-ordination was provided by the national advisory group which oversaw the original elder abuse and neglect prevention pilots. The group monitored and maintained an overview of the pilot programmes and provided a national perspective on the development of strategies for the care and protection of older people. The group comprised representatives from Age Concern New Zealand, the Senior Citizens Unit of the then Department of Social Welfare, Police, the Advisory Council for Senior Citizens, the Māori Women’s Welfare League, the Pacific peoples community, the NZ Gerontology Association and the Alzheimers Society.

The original Lottery Grant funding for the pilots also included a component for national co-ordination. This funded the establishment of a position within Age Concern’s national office. The national coordinator’s tasks included “maintaining an overview on issues relating to elder abuse; dissemination of information to pilot programmes and to other areas working to establish programmes; development of resources and training materials including standards and protocols for programmes; collection and analysis of data; monitoring of trends and new initiatives for intervention and prevention; and maintenance of links between each of the pilots and the national advisory group.”

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82 Elder Abuse and Neglect in New Zealand: A report prepared by the National Advisory Group on Elder Abuse and Neglect, September 1995
From 1997, the NZ Community Funding Agency (NZCFA) assumed funding responsibility for the original pilots and their extension to seven other areas, as they were the only agency with the appropriate contracting capacity at the time. NZCFA also had a broad focus on community welfare which has not necessarily carried over into the current Department of Child, Youth and Family Services. NZCFA initially provided funding to Age Concern for national co-ordination ($50,000pa), but this was phased out in 1999, with the extension of the programme to a range of other providers and locations. The national advisory group overseeing the pilots also ceased to operate. Although the Senior Citizens Unit withdrew from the National Advisory Group in 1999, four further meetings were held in 2000. Age Concern advise that they had since attempted, unsuccessfully, to resurrect a National Advisory Group.

Child, Youth and Family has not assumed any national service development role. Nor has Child Youth and Family conducted any analysis of data collected from providers, other than for direct contract management purposes.

In practice, Age Concern has continued to provide a minimal level of national co-ordination, primarily, but not exclusively, for its own sites. This co-ordination is provided by the Age Concern’s National Development and Support Coordinator. This role is partly subsidised through its single contract covering provision across 14 areas. The coordinator’s tasks, as they relate to elder abuse and neglect prevention include:

- Collecting service data and meeting Child, Youth and Family reporting requirements;
- Monitoring issues which impact on policy and service delivery;
- Negotiating funding contracts;
- Standards development and management advice to individual services;
- Input to broader policy and service development (eg input to Te Rito, supporting the development of a bicultural service in Taranaki);
- Resource development – including identifying funding (eg enduring power of attorney information and training resources, promoting elder abuse and neglect guideline development in Health, conducting an evaluation of elder abuse and neglect resources);
- Training needs assessment and delivery (although the last national training was conducted in 2000); and
- Networking with key stakeholders, other providers and internationally.

### 10.2 The case for national co-ordination

Several consistent themes highlighting the need for enhanced national co-ordination emerged from provider site interviews with coordinators, managers and advisory group members. These were reinforced in the workshop discussions:

- Resources produced in the past by the National Office of Age Concern were highly valued, and were well utilised, but individual sites were often producing basic materials (eg forms, education and public awareness material, complaints procedures etc) at a local level, that could have been developed and promulgated at a national level;
- Many interviewees expressed significant concern about the lack of elder abuse and neglect prevention training opportunities, induction training, and the lack of
opportunities for coordinators to get together at a national level (until the recent workshop, the last such opportunity was in 2000);

- Coordinators often expressed a strong sense of isolation;
- Some interviewees were concerned at the lack of comprehensive national data.

“\textit{I’d like to see a lot more communication between elder abuse and neglect services – We have to have a national meeting at least once a year – I’ve been here five years and I’ve had two.}”

“In Auckland we have the regional meeting – that’s neat – what if all New Zealand got together, say once a year”

 “[\textit{We need]} some form of national training to say this is what’s available this year- rather than us having to source our own training”

“[\textit{There’s a}] definite need for workforce development and education – many elder abuse and neglect coordinators work on their own”

“Every service coordinator should get properly trained – they’re put in blind. Expertise is developed on the job”

“[\textit{elder abuse and neglect needs}] a champion at the national level”

“\textit{If Child, Youth and Family want consistency they need a co-ordination body involving Presbyterian Support, Tui Ora etc}”

“We need some clear guidelines – we hear about people working one way and us another and that takes a lot of energy”

“I would see a lot of value in these things [workbook, handouts etc] being provided nationally”

“[\textit{The local coordinator}] put together a needs assessment form – that could be made better with outside input – there definitely would be value in one standard approach, which is what’s happening in Health”.

“No national statistics –that’s crazy –we’re not getting the best value from our data”

“I find the Age Concern overview report useful…I think it would add strength if we had national data”

“[\textit{We need}] national guidelines and protocols. There should be a national [education and awareness] campaign”

“I think there should be a national advisory group to support the national coordinator”

“National co-ordination is so important. It’s just not happening now”
From both the interviews and workshops there was general support for enhanced national co-ordination. The review of literature, conducted as part of the wider review also reinforces the value of national co-ordination (eg to facilitate interagency protocols and procedures clarifying agency responsibilities and accountabilities and developing information sharing protocols.) Possible national co-ordination functions identified in discussions included:

- Resource development;
- Training;
- Data collection and analysis;
- Sharing best practice and research knowledge;
- Establishing a research strategy;
- Professional leadership and support;
- Facilitating networking and peer support (including annual national conference);
- Advocacy;
- Developing consistent application of a national model of service delivery;
- Negotiating funding;
- Undertaking national initiatives (eg awareness raising, 0800 number);
- Standardisation of policies and procedures (eg mileage rates and audit procedures);
- Facilitating intersectoral co-ordination;
- Providing a conduit for input to, and information on, wider government policies and initiatives; and
- Raising the profile of elder abuse and neglect services.

Several of these ideas were reinforced by a recent evaluation of Age Concern New Zealand elder abuse and neglect training resources conducted by the New Zealand Institute for Research on Ageing\textsuperscript{83} that recommended, amongst other things, the development of a new national elder abuse and neglect prevention training resource (which could be accompanied by a new New Zealand video), revised standardised guidelines, national training days, seminars and conferences and the development of a national website containing statistics, information, fact sheets, research, references to relevant documents etc.

The absence of national co-ordination has left a leadership void in elder abuse and neglect services. To some extent this has been mitigated by regional co-ordination initiatives. The services are also continuing to rely on the legacy of past co-ordination (eg resources developed some years ago). There is a high degree of variability in ways of operating, not all of which can be attributed to differing local needs. Development of services to, and for, Māori and Pacific peoples has been ad hoc (ie no analysis of need, priority areas etc has been conducted at a national level). Elder abuse and neglect service quality is surviving on the skills, goodwill and commitment of many individuals, but it is not operating effectively as an efficient integrated system. The current duplication of effort in resource development, for example, is wasteful and not conducive to developing the best quality resources. There is no consistent method

\textsuperscript{83} Evaluation Report: Age Concern New Zealand Elder Abuse and Neglect Training Resources, NZ Institute for Research on Ageing, Victoria University of Wellington, January 2004
of identifying and sharing good practice. Because of the range of providers, some parts of the system have greater, or lesser, degrees of connection to others. The case for national co-ordination is strong.

If national co-ordination is to be enhanced, it will be important to ensure there is a practical focus on identified areas of need, such as training, a national conference and identification and development of priority resources for coordinators.

Two important messages emerged from both the interviews and the workshops which must inform the approach to national co-ordination:

- The need to strike a balance between national consistency and local/regional flexibility and to recognise diversity; and
- The importance of regional co-ordination as a cost efficient way of providing more regular peer support.

This is particularly important for Māori, Pacific peoples and bi-cultural based services. These providers generally saw value in enhanced national co-ordination, qualified in one instance by concerns about committing limited available time to national initiatives such as training or hui/conferences.

These messages were reinforced by the observation that effective national co-ordination would depend upon “buy-in” from individual services. It is important that national co-ordination is delivered in a way that facilitates cooperation and input from both Government agencies and providers.

One workshop group suggested responsibility for national co-ordination needed to be shared by a range of agencies. Another suggested national co-ordination should be the responsibility of the Office for Senior Citizens because of Ministry of Health resistance to seeing elder abuse and neglect being “lumped in health”. Some saw a role for a national advisory group to provide governance and leadership.

A key question is whether a national co-ordination function should simply become the responsibility of an existing organisation (eg the contracting department), or be established as a separately contracted function.

Factors to be considered in designing the approach to national co-ordination, and determining which agency should provide national co-ordination, include:

- Independence from specific provider interests;
- “Buy-in” from individual services;
- Independence to advocate for services;
- Mandate; and
- Access to resources (eg data analysis expertise).
- Signals about the way elder abuse and neglect prevention services are viewed (eg rights, health or welfare)
- Fit with the multidisciplinary service model
- Government’s preference to bring policy, funding and operations together.

If a government agency is to provide national co-ordination, it would be logical for this to be the same agency that is managing service provider contracts. The key advantages in a government agency providing national co-ordination services would
be the mandate to reflect co-ordination priorities in contracts with providers, direct input into government decision making and resource allocation processes, the ability to influence other departments and agencies through formal relationships and processes and access to resources and technical expertise in areas such as communications or data analysis. A government agency may, however, have less independence to advocate for the sector than a non-government agency.

If a non-government agency is to provide national co-ordination the key advantages are independence from specific government agency interests, signaling effects (eg the services are about older people’s rights and interests rather than a specific sector dimension) and a sound understanding of working in a non-government setting and, potentially, greater “buy-in” from other providers. Ultimately the expertise and interests of the agency selected would be the key determinants. There may be disadvantages in particular agencies providing national co-ordination such as perceived conflicts of interest.

It is, however, possible to design a “hybrid” system which draws on the benefits of both options. This could be achieved by establishing a contract for national co-ordination by competitive tender, but establishing a governance and leadership regime which allows individual providers and government agencies, together, to develop and monitor the national co-ordination work programme and priorities. Ultimately, of course accountability for effective national co-ordination would lie with the contracting agency.

Under such a system, responsibility for national co-ordination could be allocated to a non-government provider through a competitive contract process. Core responsibilities would be defined in the contract (eg to organise an annual elder abuse and neglect conference, organise national training initiatives and develop common resources).

A reference group comprising key government agency representatives and service provider representatives (including Māori and Pacific peoples providers) would meet, quarterly initially, to consider and review national co-ordination work programme priorities, and to agree the contribution which individual agencies might make to specific projects. The reference group would, in turn, be guided by input from annual elder abuse and neglect prevention conferences. Specific technical and professional expertise and input would be sought from across the sector on an as needed, project by project basis.

Co-ordination across elder abuse and neglect prevention services at a regional level would be formally recognised as an integral component of the overall elder abuse and neglect prevention model. At the local level, elder abuse and neglect services would continue to work across agencies to coordinate service provision.

This proposed system is represented diagrammatically below:
At a minimum, the funding allocation for national co-ordination should provide for one full time position ($85,000pa including direct administrative overheads, travel, photocopying etc). Approximately $60,000 - $100,000pa should be allocated for resource development including a specified national/regional training component, approximately $25,000pa for a national conference and around $10,000pa to administer and fund travel costs for the National Reference Group. Additional administrative costs (including administrative assistance, management and supervision) and support for regional co-ordination imply an overall funding allocation for national co-ordination of at least $200,000pa.

10.3 National co-ordination recommendations

Funding should be sought for a national co-ordination contract. Responsibility for national co-ordination should be allocated to a non-government provider through a competitive contract process. Core responsibilities would be defined in the contract.

A reference group comprising key government agency representatives and service provider representatives (including Māori and Pacific peoples providers) would meet, quarterly initially, to consider and review national co-ordination work programme priorities, and to agree the contribution which individual agencies might make to specific projects. The reference group would be guided by input from annual elder abuse and neglect prevention conferences. Specific technical and professional expertise and input would be sought from across the sector on an as needed, project by project basis.
Co-ordination across elder abuse and neglect prevention services at a regional level should be formally recognised as an integral component of the overall elder abuse and neglect prevention model.

At the local level, elder abuse and neglect services should continue to work across agencies to co-ordinate service provision.

10.4 Establishment of a system of comprehensive data collection and analysis

Current elder abuse and neglect datasets are very limited in that they cover only referrals to and from elder abuse and neglect prevention services. Further, the only significant collation and analysis of data for service development purposes has been conducted by Age Concern NZ. Age Concern’s data collation and analysis has provided a detailed and thorough understanding of the activities of a limited set of elder abuse and neglect providers, but it can provide no more than a partial, and highly qualified, insight into a sector of elder abuse and neglect in New Zealand.

It would be relatively straightforward to improve the co-ordination and analysis of data across all elder abuse and neglect prevention services. However, this would be insufficient to develop a useful dataset because it only covers a limited set of providers.

A co-ordinated approach to data collection on established cases of elder abuse and neglect across all relevant agencies is a prerequisite to an understanding of the reported incidence of elder abuse and neglect. This is because elder abuse and neglect prevention services only deal with an unknown proportion of reported cases of elder abuse and neglect. Health providers, police and other agencies will often deal directly with cases that come to their attention. Further, elder abuse and neglect prevention services do not have national coverage.

Comprehensive data on the reported incidence of elder abuse and neglect is an essential requirement for the government and service providers to monitor trends, establish and monitor priorities for awareness raising and education and so on. The review of literature conducted as part of the overall review of EANP services highlighted the importance of:

- Shared definitions of what constitutes elder abuse and neglect; and
- The collation of data from the monitoring process to contribute to an understanding of ‘what works’ in terms of practice interventions.

The proposed national co-ordination model enhances the capacity for coordinated data collection across the full range of agencies involved. Although data collation in respect of elder abuse and neglect prevention services could be managed through the national coordinating body, ultimate responsibility for the collation and analysis of data must rest with the contracting agency for two key reasons:

- The contracting agency is responsible for ensuring data is available to monitor the provision of contracted services and providing related advice to government.
- The national coordinating body should not be responsible for interpreting data that could reflect on their own performance.

Locating the contracting function with the Ministry of Health would enhance the potential for comprehensive high quality data collection and analysis, because much of the additional data required will be from within the health sector, and because of the strong linkages which the Ministry has with other government agencies. If the
contracting function is located with the Ministry of Social Development, these linkages would be weaker. Nevertheless, the Ministry of Social Development has a strong data collection and analysis capability. No funding has been allocated to this function. The current funding appropriated to Child Youth and Family only covers contract management services. Initial set-up and design costs are likely to be significant, in part because the elder abuse and neglect prevention sector is not yet well defined.

10.5 Data collection and analysis recommendations

- The agency responsible for managing elder abuse and neglect prevention services should coordinate the collection and analysis of consistent and comprehensive data on the nature and incidence of reported elder abuse and neglect, and that appropriate funding should be allocated to this function.

- Consultation on data requirements should include the proposed reference group on elder abuse and neglect prevention services.
11 Contracting and funding arrangements

11.1 Overview

This chapter draws on relevant documents, discussions with key stakeholders, input from provider site interviews and workshop discussions to make specific recommendations on the proposed location of responsibility for contract management.

It concludes that the responsibility for managing Elder Abuse and Neglect contracting would sit best with the health sector, but acknowledges there will be a number of funding and management issues to consider if a comprehensive elder abuse and neglect service is to be delivered through the health sector. A less practical alternative would be to locate responsibility for Elder Abuse and Neglect Prevention Services within the Ministry of Social Development's new Family Services group.

Since this review was initiated, the Chief Executives of Child, Youth and Family and the Ministry of Social Development, and senior Treasury and State Services Commission officials have conducted a first principles review of the Department of Child Youth and Family Services. They concluded that "the location of funding programmes in Child Youth and Family which are not focused on children and young people and/or families should be reviewed with a view to transfer to a government department more closely aligned to the purpose of the funding programme". 84

As recommended in the review, the Government has directed Child Youth and Family, in consultation with MSD and Treasury to:

- review its NDOCS 85 by October 2004 and make recommendations on.... which NDOCS are used primarily for services to adults as individuals and/or for general welfare programmes available to the general public (such as Budget Advice Service, Elder Abuse, Emergency Housing) and provide advice on the feasibility and implications of transferring these to government agencies where there is a closer match between the service focus of the funding and the business of those agencies. 86

This establishes an appropriate formal process to determine the issue of responsibility for managing EANP services. Any advice the report might include on the future location of responsibility for elder abuse and neglect prevention services will be dependent on an officials’ process involving the Ministry of Health and other relevant Government departments. The paper, therefore, does not necessarily reflect the views of the Ministries and Departments that will contribute to that advice. It does, however, provide an independent perspective which should be considered in the development of that advice.

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85 the term “NDOC” refers to the non-departmental operating class of expenditure – ie expenditure relating to services which the department contract from other providers, as opposed to expenditure on services which the department is responsible for delivering.
86 ibid p100
11.2 Possible locations for EANP services contract management

A number of departments have interests and responsibilities relating to older people’s interests and or experience in contracting for social services which should be considered in identifying where contract management responsibility for elder abuse and neglect services is best located in the future.

11.2.1 Child Youth and Family

The Department of Child Youth and Family Services is currently responsible for management of elder abuse and neglect prevention service contracts. Child, Youth and Family has, in practice, focused primarily on its contract management responsibilities, such as the development of specific standards of approval for EANP services, undertaking approval assessments on a regular basis, and developing specific service types and measures for elder abuse and neglect.

The merger of NZCFA and the Children Young Persons and their Families Service in 1999 created a tension between the functions of the two agencies. The department has tried to resolve this but has come under increasing pressure to focus on what was the core business of the previous Children Young Persons and their Families Service. Funded services that are peripheral to that business were arguably somewhat sidelined as a result.

Child, Youth and Family has not focused on service development needs or data analysis beyond contract monitoring. There was never, however, an explicit expectation that Child Youth and Family would collect and analyse higher level data. Nor has Child, Youth and Family explicitly funded a national co-ordination function since 1999. The decision to no longer fund a national co-ordination role was taken in conjunction with the, then, Senior Citizen’s Unit. This decision appears to been based on the judgement that, with a wider pool of providers becoming involved in delivering EANP services, it became impractical for a single provider to fulfill that role.

In 2003 a review of Child Youth and Family’s baseline funding was conducted by Treasury, the Ministry of Social Development and Child Youth and Family. This comprehensive review looked at the organisation itself, its service issues and the resources it needs to operate effectively.

The reviewers recommended that Child, Youth and Family’s outcome focus be on the safety and security of children and young people, rather than general wellbeing, and that as a priority it focus on preventing the recurrence of harm (abuse, neglect, insecurity of care) and on preventing child and youth reoffending. Child, Youth and Family’s role in a broader set of family services could then be driven by this interest. It would include an emphasis on strong partnerships with providers and strong engagement in local services planning and co-ordination of services aimed at keeping children safe. Child, Youth and Family should not be expected to be a broadly focused family support service or to lead community development.87

The reviewers also proposed that Child, Youth and Family’s community funding responsibilities be better aligned with the outcomes proposed by the review and with Child, Youth and Family’s core functions.

87 Report of the Department of Child Youth and Family Services First Principles Baseline Review, September 2003 (MSD, Treasury, CYF) p.4
The reviewers noted that an accompanying report proposed that the Ministry of Social Development provide leadership and carry out co-ordination functions for broad based family services. They supported its proposal that a priority focus for this work be on services that support improved outcomes for Child, Youth and Family clients, or support families whose children and young people are at greatest risk of becoming Child, Youth and Family clients. Specifically, they recommended Ministers “Note that MSD has proposed that it set up a family support services operational group at national and regional levels and recommended that one of the first priorities of any new operational group will be to work with and strengthen family support services which support Child Youth and Family work.”

The Minister for Social Development and Employment subsequently announced (October 2003) that, as part of the Government’s response to the Baseline Review, Child, Youth and Family will focus on its primary role of keeping children safe and preventing youth re-offending. Child, Youth and Family will continue to purchase community services that support keeping children safe. This work will be supported and complemented by Ministry of Social Development’s new role in coordinating broad based family support services across government. Family Support Services will be established within the Ministry of Social Development from July 2004.

In considering Child, Youth and Family’s outcomes, the review concluded that Child, Youth and Family’s funding programmes (NDOCs) are currently not well aligned with its core activities. They proposed that further reviews of aspects of Child, Youth and Family administered NDOCs are needed to better align Child, Youth and Family’s NDOC funding responsibilities with the proposed outcomes. The location of funding programmes in Child, Youth and Family which are not focused on children and young people and/or families should be reviewed with a view to transfer to a government department more closely aligned to the purpose of the funding programme (although they did not expect this to result in a significant shift in responsibilities between agencies).

Specifically, the report recommended that Ministers “direct Child, Youth and Family, in consultation with MSD and Treasury, to review its NDOCs by October 2004 and make recommendations on …[amongst other things]…which NDOCs are used primarily for services to adults as individuals and/ or for general welfare programmes available to the general public (such as Budget Advice Service, Elder Abuse, Emergency Housing) and provide advice on the feasibility and implications of transferring these to government agencies with responsibilities more closely aligned to the objective of the funding.”

Ministers have since endorsed the recommendation to review NDOC funding.

11.2.2 Ministry of Health

There is a significant interface between vulnerable older people and providers of health and disability support services. In addition to primary health care, there is direct or indirect contact through, for example, home-based support services and residential care. Although the provision of Government Superannuation through the Work and Income Service of the Ministry of Social Development is an almost universal link between older people and government–funded service providers, the interface with the
health sector is on a more personal level which is more likely to expose issues of elder abuse and neglect.

The Health of Older People Strategy, published in April 2002, sets out a clear vision for the health sector:

**Older people participate to their fullest ability in decisions about their health and wellbeing and in family, whanau and community life. They are supported in this by co-ordinated and responsive health and disability support programmes**

Principles include:
1. A holistic, person-centred approach that promotes wellness and participation;
2. Providing information to enable older people, carers, family and/or whanau to make informed choices about their health and wellbeing; and
3. Supporting carers in ways that strengthen the older person’s family, whanau and informal support networks.

Specific actions include:

- Working to improve information on service availability for older people, their family, whanau or caregivers and service providers and health professionals (Key Step 1.1.1);
- Supporting the development of protocols and promoting training for health providers in recognising and responding to family violence and abuse (Key Step 1.3.2); and
- Working collaboratively with elder abuse and neglect prevention services and other relevant community agencies to:
  - strengthen the community supports available to older people at risk of abuse
  - increase community awareness through education to minimize the potential for elder abuse
  - promote coordinated, timely and culturally effective responses by agencies when there is abuse
  - encourage older people and their families to use the provisions of the Protection of Personal Property Rights Act to protect older people and to determine advance directives and proxies (Key Step 1.3.3).

The Ministry is currently developing new elder abuse guidelines, including a specific focus on the needs of Māori and Pacific peoples.

The Ministry of Health provides advice to District Health Boards on how best to address the government’s goals and priorities. It also acts as the Minister’s agent and monitors the performance of District Health Boards and other Crown entities. The Ministry plans and funds those services that District Health Boards are not responsible for, including public health and disability support services for people aged under 65 years. Responsibility for disability support services for older people (aged 65 years and over) was devolved to District Health Boards on 1 October 2003.

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93 Health of Older People Strategy: Health Sector Action to 2010 to Support Positive Ageing, Hon Ruth Dyson, Associate Minister of Health and Minister for Disability Issues, April 2002. p1
Much of the responsibility for implementing key aspects of the government’s health strategy lies with District Health Boards. They have both a funding role (planning and funding the health services for their populations) and a provider role (delivering hospital and related services). District Health Boards are responsible for assessing local needs and providing appropriate and effective services to their communities.

District Health Boards are required to comply with Operational Policy Frameworks endorsed by the Minister of Health. These are given effect through the Crown Funding Agreements between the Minister and each District Health Board. The current framework, for example, requires each District Health Board to safeguard consumers, staff and visitors from abuse, including physical, mental, emotional, financial and sexual maltreatment or neglect as far as is reasonably practicable. District Health Boards are expected to have policies and procedures on preventing, detecting and removing abuse and/or neglect. These must include definitions of abuse and neglect and clearly outline the responsibilities of all staff that suspect actual or potential abuse, including immediate action, reporting, monitoring and corrective action.94

The District Health Boards system is not particularly conducive to delivering a national, coordinated service delivery programme. Nevertheless, the Accredited Visiting Service provides one example of central co-ordination of a service delivered across New Zealand. In this case, Capital and Coast Health have responsibility for managing a national contract for services on behalf of all relevant District Health Boards. However the Ministry of Health is not sure that this is a sound model to build on as it may not sit well with all District Health Boards. The Ministry and Capital and Coast intend to undertake an evaluation of befriending services, including the Accredited Visiting Service, to identify the effectiveness of such services and to make recommendations to District Health Boards about the purchasing of such services.

11.2.3 Ministry of Social Development

The Ministry of Social Development provides strategic social policy advice to government and provides a range of social services including income support, employment services, NZ superannuation, student allowances and loans and services to rural clients through Heartland Services. It is also responsible for the Ministry of Youth Development, the Office for Disability Issues, the Office for the Community and Voluntary Sector and the Office for Senior Citizens. It has responsibility for the establishment of the Families Commission and is currently developing a Family Services role, as discussed earlier.

The Office for Senior Citizens provides policy advice on legislative, policy and operational issues that affect senior citizens. The Office’s role includes:

- Supporting the Minister for Senior Citizens in representing the interests of older people in policy making;
- Maintaining a broad involvement across the wide range of programmes, policies and services that impact on older people;
- Monitoring changes that affect older people and advising other departments; and
- Promoting positive ageing concepts to government departments and local communities.

11.2.4 Other agencies
The Police also have a role in elder abuse and neglect prevention, although Police advise that, to date, their primary focus has been on partner and child abuse, through their Family Violence Coordinators and frontline strategies. Police have indicated it is now appropriate to extend their focus to addressing elder abuse and neglect prevention.

The Department of Internal Affairs administers some community funding including Lotteries General Grants, Lotteries Seniors Grants, Lotteries Health Research and the Communities Grants Scheme.

11.3 Options for the future
Most feedback favoured removing the contract management responsibility from Child, Youth and Family. The alternative most commonly suggested was to fund the services through the health sector, although some concerns were expressed about the feasibility of operating the current system within the health funding and accountability model. Comments included those listed below.

<table>
<thead>
<tr>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Funding should not sit with Child, Youth and Family… I would like to see it sit with Health Services – we get really good statistics from that”</td>
</tr>
<tr>
<td>“If it was with health it would have a useful dialogue with home-based services”</td>
</tr>
<tr>
<td>“I was interested it was with Child, Youth and Family. Its only an adjunct – the focus is not there, the funding doesn’t match”</td>
</tr>
<tr>
<td>“When you think of Child, Youth and Family you think of children”</td>
</tr>
<tr>
<td>“[The contracting arrangement] seems unusual – to give it to a department whose focus is young people and families. To me it’s more about health and wellbeing (also an education focus)”</td>
</tr>
<tr>
<td>“. . . I don’t think you can combine elder abuse and neglect with [Child, Youth and Family’s] definition of family ….. but if it devolves to 22 District Health Boards that’s courting disaster. If it did we’d have to…lobby to get funding”</td>
</tr>
<tr>
<td>“If funding went to health it would get sucked into [District Health Boards’ general expenditure.] [Funding would need to be] kept in a national framework. I think in the longer term it should be with Family Services.”</td>
</tr>
</tbody>
</table>

The following table identifies a range of possible contract management agencies and the advantages and disadvantages associated with each.
Table 11-1: Possible EANP Services contract management agencies and the advantages and disadvantages

<table>
<thead>
<tr>
<th>Contracting Agency</th>
<th>Advantages</th>
<th>Disadvantages</th>
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<tbody>
<tr>
<td>Child Youth and Family</td>
<td>Experience in administration of elder abuse and neglect contracts. Regional contracting and monitoring networks. Child Youth and Family has significant funding responsibilities for family violence prevention programmes. There are important linkages between elder abuse and neglect and wider violence within the families.</td>
<td>Baseline Review promotes narrower focus on child protection and youth re-offending – and review of location of services to adults. Has not focused on service development, data analysis and national co-ordination.</td>
</tr>
<tr>
<td>Ministry of Health</td>
<td>Vulnerable older people are high users of health and disability support services. There is a broad range of linkages including residential care, home-based support and mental health services. District Health Boards are well connected to the range of other primary care providers. The District Health Board structure provides comprehensive national coverage (broadly) defined by territorial local authority boundaries. The health sector operates within a multi-disciplinary model. The health sector has a clear strategy for services for older people and has shown commitment to developing resources for elder abuse and neglect prevention.</td>
<td>Devolution to District Health Boards may not be conducive to enhanced national co-ordination – national protocols are less influential in the health sector. Concerns about the ability to “ring-fence” elder abuse and neglect funding. Current elder abuse and neglect prevention services are not organised along District Health Board boundaries (although there is a “good fit” in most areas). Location in health would imply some rationalisation/ extension of services over time. The health sector has no general mandate to deal with material or financial abuse (other than through its residential care responsibilities).</td>
</tr>
<tr>
<td>Contracting Agency</td>
<td>Advantages</td>
<td>Disadvantages</td>
</tr>
<tr>
<td>--------------------</td>
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<td>---------------</td>
</tr>
</tbody>
</table>
| Ministry of Social Development – Family Services | Independent from sector interests – broad social development focus  
The Ministry of Social Development (Work and Income) manages national superannuation provision  
Extensive institutional experience in service delivery, policy, research and data collection and analysis  
Likely to have a strong focus on reducing family violence. | Principal focus, initially, will be on family services as they relate to families at risk of poor outcomes – supporting Child, Youth and Family objectives with more broadly based and preventative services to families  
A focus on elder abuse and neglect in a family context would not cover abuse and neglect in institutional care settings  
No experience or infrastructure for contract management as Family Services is yet to be established. |
| Ministry of Social Development – Office for Senior Citizens | Strong focus on needs of elderly and awareness of elder abuse and neglect issues  
The Office has responsibility for promoting and monitoring the Positive Ageing Strategy. | Conflicts with advocacy function  
No contract management role or experience. |
| Police | Police have significant regional networks and a strong commitment to preventing and responding effectively to all forms of family violence. | Police’s interest is narrower than health  
Inappropriate to frame elder abuse and neglect as primarily a policing matter. |
| Internal Affairs | Significant contract management experience. | Limited focus on older people. |
Through its response to the Baseline Review of Child Youth and Family the Government has effectively endorsed the view of the Chief Executives of Child, Youth and Family and the Ministry of Social Development, and senior Treasury and State Services Commission officials that the location of EANP services, amongst others should be reviewed with a view to transfer to a government department more closely aligned to the purpose of the funding programme.

The proposed focus of the new Family Services function within the Ministry of Social Development is on supporting improved outcomes for Child Youth and Family clients, or families whose children and young people are at greatest risk of becoming Child Youth and Family clients. Although it would be feasible to locate the contracting function within the Ministry of Social Development, this would fail to resolve some of the key concerns arising from contracting through Child Youth and Family, namely the predominant focus on families with children.

On balance, there is a stronger case for locating the contracting function within the health sector. Health is the main provider of services to vulnerable older people. The sector has demonstrated a commitment to elder abuse and neglect prevention and has the linkages to, and responsibilities for, care and protection of older people.

Location within the health sector raises a number of significant issues. The current elder abuse and neglect prevention services do not all fit neatly into the District Health Boards geographical structure. The District Health Boards structure does not lend itself to operating a national service delivery programme (However, the review acknowledges the need for variation in service delivery to reflect local environment. This concern would also be mitigated by the establishment of a national co-ordination function, discussed below). Further, current funding levels are not sufficient to fund programmes to their current level in all District Health Boards.

These issues would all need to be worked through with the Ministry of Health, as part of the work by officials in developing advice for government on future funding and management options for elder abuse and neglect prevention services. However, from a practical point of view, vulnerable older people are significant users of health and disability support services and may be in frequent contact with health and support providers. Even financial abuse, which is arguably not a health issue (unless it arises in residential care settings), is possibly more likely to come to the attention of health workers than other agencies of state.

As noted earlier, Child Youth and Family has been directed, in consultation with Treasury and Ministry of Social Development, to provide advice, by October 2004, on the feasibility and implications of transferring a number of programmes, including EANP services, to government agencies more closely aligned to the objective of the funding. This is an appropriate vehicle for providing formal advice to Government on the future location of responsibility for contract management of elder abuse and neglect prevention services. (This advice would also be expected to address the appropriate timeframes for any transfer of responsibility).

### 11.4 Contract management recommendations

In developing advice to Government on the future location of responsibility for managing Elder Abuse and Neglect Prevention Services, Child Youth and Family,
Treasury and MSD should note this review’s conclusion that the health sector is the preferred location, primarily because of the significant interface between vulnerable older people and health and disability support services. Child Youth and Family, Treasury and MSD should consult with the Ministry of Health on the feasibility of operating a co-ordinated Elder Abuse and Neglect Prevention Service from Vote: Health.

This should include a strategy (including appropriate new funding) for phasing in comprehensive national coverage of elder abuse and neglect prevention services.

Child Youth and Family, Treasury and MSD should also note the second preferred alternative location of responsibility is with the Ministry of Social Development’s new Family Services group. This is less preferred because the primary focus of Family Services is expected to be on families with children, and because a focus on elder abuse and neglect in a family context would not cover abuse and neglect in institutional settings.

### 11.5 Funding arrangements

An component of the review was to conduct an analysis of 2001 Statistics New Zealand population census data to develop a funding framework. This framework was to consider the equitability and appropriateness of the funding arrangements for services, relative to population numbers and cultural and other characteristics. It is noted that the focus of this exercise was not on funding level requirements but rather on the potential relative allocation of funds across services.

#### 11.5.1 Area definitions

Definition of site areas was based on descriptions provided by co-ordinators in the EANP co-ordinator survey. These definitions were then mapped against Statistics New Zealand Territorial Authority (TA) areas as the basis for the analysis. Mapping of the descriptions to TA areas was not always obvious and this was because of overlaps in the service site areas described, a lack of service clarity about service boundaries, and differences in how the site area and TA area boundaries were defined. In some instances, a personal judgement was made about where a TA was allocated. For these reasons, the information provided is only indicative. Further work on boundary definitions in the future would enable a more robust analysis to be made. The allocation of TA areas is presented in Appendix B.

Although sites are allocated nationally, the mapping of services identified nine areas not being covered by Child Youth and Family part-funded services. One of these areas was Rodney which has EANP services funded by the Ministry of Health. The other areas were:

- Papakura District
- Franklin District
- Rotorua District
- Otorohanga District
- Waitomo District
- Taupo District
• Western Bay of Plenty District
• Chatham Islands District.

It is noted that this suggests there may be a lack of service coverage over the central North Island in terms of Rotorua, Otorohanga, Waitomo and Taupo.

11.5.2 Analysis and indicative findings

The framework is based on an analysis of the number of people aged 65 years and over covered by a service area in relation to the total population of people aged 65 years and over across all TA areas covered by Child Youth and Family funding. Additional analysis was undertaken in terms of the Huakina Development Trust Māori focused service and the TOA Pacific/Methodist Mission Pacific Peoples focused service based in Auckland. This was of the Māori and Pacific peoples populations and non-Māori and non-Pacific populations of people aged 65 years and over in Auckland, Waitakere, Manukau, and Northshore. The underlying assumption that this rests upon is that non-Maori and non-Pacific older people form the main client group for these services. The analysis tables are provided in Appendix B.

Table 11-2 below presents the overall proportions of older people in each of the service areas. The table shows higher proportions of older people in the Christchurch and Wellington service areas. Auckland (non-Māori and non-Pacific) and Waikato proportions of older people are also relatively fairly high. These areas, therefore, have responsibility for a relatively larger proportion of the overall EANP services client base than other services.

Table 11-2: Proportion of older people in service site area out of total funded site areas.

<table>
<thead>
<tr>
<th>EANP Service</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland (non-Māori, non-Pacific)</td>
<td>8.6</td>
</tr>
<tr>
<td>Christchurch</td>
<td>11.8</td>
</tr>
<tr>
<td>Dunedin</td>
<td>4.9</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>4.2</td>
</tr>
<tr>
<td>Invercargill</td>
<td>3.2</td>
</tr>
<tr>
<td>Kapiti</td>
<td>2.1</td>
</tr>
<tr>
<td>Manawatu</td>
<td>3.4</td>
</tr>
<tr>
<td>Manukau (non-Māori, non-Pacific)</td>
<td>4.9</td>
</tr>
<tr>
<td>Nelson</td>
<td>3.7</td>
</tr>
<tr>
<td>North Shore (non-Māori, non-Pacific)</td>
<td>5.0</td>
</tr>
<tr>
<td>South Canterbury</td>
<td>2.3</td>
</tr>
<tr>
<td>Tairawhitia</td>
<td>1.3</td>
</tr>
<tr>
<td>Taranaki</td>
<td>3.1</td>
</tr>
<tr>
<td>Tauranga</td>
<td>4.2</td>
</tr>
<tr>
<td>Waikato</td>
<td>8.6</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>1.7</td>
</tr>
</tbody>
</table>
In terms of the Huakina Development Trust Maori focused service, the combined proportion of older Māori in the Auckland, Waitakere, Northshore and Manukau sites was 3.2%. In relation to the TOA Pacific/Methodist Mission Pacific Peoples focused service, the combined proportion of older Pacific peoples in Auckland, Waitakere, Northshore and Manukau was 4.4%. There is a limited relevance in including these services in a comparison across sites because of the different approach taken to service delivery.

Other ways in which this data can be looked at across sites is in terms of the 70 to 85 year age sub-groupings and the proportions of older women in each area as statistics show that these sub-groups are more likely to be clients of EANP Services.

Overall, the analysis provides partial information for considering funding allocation. However, it should be kept in mind that the number of older people in a service area is only one of the factors that impacts on service delivery requirements. Other factors include the availability of agencies to provide services, travel time over geographically spread service areas, and regional culture in terms of the likelihood of people to contact EANP Services.
12 Conclusions and recommendations

Conclusions are presented in terms of each of the review aims. This is followed by short, medium and long term recommendations for next steps that could be taken.

12.1 Conclusions

The effectiveness of the present service model

At a theoretical level, the general approach of the EANP Service programme model is consistent with the direction in which elder abuse and neglect prevention is approached internationally. The model adopts a multi-disciplinary approach, espouses a commitment to elder abuse and neglect prevention as a priority and focuses on the development of responses at a community level.

The effectiveness of the present model is hampered by a lack of specificity at the practice level. Current service approaches vary across EANP Services. This is in part related to the different skill base across the different service co-ordinators, regional variations in the availability of services and co-ordinator perspectives. Even so, there is a clear commitment across all sites to elder abuse and neglect prevention and an empowerment philosophy to the provision of services. Key areas of difference across sites appear to be the extent that case management and monitoring is undertaken, how a multi-disciplinary approach is used, and the balance across casework, training provision and community awareness activities.

Services that are related to elder abuse but are outside the services contracted for by Child Youth and Family

Referrals for self-neglect are received by EANP Services. These cases are fundamentally different from elder abuse and neglect cases and although the EANP Services should have the appropriate linkages to refer these cases on, we do not consider that they should become a formal part of the EANP Service provision role.

If the service provider has the capacity to appropriately intervene, assistance is provided by some EANP Services when clients do not consent to referral, when referring the case is likely to place unnecessary stress on the client, or when there are gaps in service provision. However, the priority across all sites was to refer clients to appropriate referral agencies whenever they could.

Gaps in services and other measures or actions that could improve effectiveness or efficiency of services

National consistency

There is a need for increased national consistency across the services. An agreed standard use of terminology across the services and a more specific statement of service expectations are required. This includes approaches to the development of interagency protocols for service provision and information sharing. This is to ensure that there is clarity amongst local EANP Services about their role and to ensure that there is clarity about the roles and responsibilities of their services in relation to other intervention services provided at the local level.
More national level resources would be useful for the services. This includes the development of standard nationally endorsed templates such as consent and complaint forms, assessment checklists or guides, education and community awareness materials and evaluation forms. Nationally standardised forms are a way of ensuring that these resources are designed as well as possible. More nationally based resources and information sharing across the sites about service approaches, education provision, community awareness activities and approaches to evaluate effectiveness would be useful.

There is a need for national meetings across the services (at least annually) and regional meetings (at least quarterly) as a way of addressing the isolation of sites, to co-ordinate across the sites, share ideas and information, and provide peer support to each other.

Increased clarity of data definitions and national statistics that reflect information across all of the provider sites is required.

A national level community awareness/prevention strategy (potentially combined with family violence prevention more broadly) and which links in with local level activities should be undertaken. However, it would be essential that any national campaign is not undertaken until it is generally established that there are resources in place to meet the increased demand that is likely to result.

Service gaps, capacity and funding

Service gaps that were identified which increased the time and assistance required with cases included situations where mental health issues were not severe enough to be referred to other services, cases where there were financial and legal issues to be addressed, and transport for clients to access services. An additional service gap identified was the increasing difficulty in recruiting suitably skilled volunteer case workers to refer cases to for assessment and case work.

The need for increased training opportunities and funding was widely emphasised. Full or increased funding rather than partial funding of services should be considered to enable secure medium and longer term planning to be undertaken by sites.

National co-ordination

The absence of national co-ordination has left a leadership void in elder abuse and neglect services. Feedback from interviews, workshops and the literature review provide strong support for enhanced national co-ordination. Funding should be sought for a national co-ordination contract. At least $200,000 is estimated to be required to cover co-ordination, training and resource development needs. Responsibility for national co-ordination should be allocated to a non-government provider through a competitive contract process. Core responsibilities would be defined in the contract.

A reference group should be established. It should comprise key government agency representatives and service provider representatives (including Māori and Pacific peoples providers) and would meet, quarterly initially, to consider and review national co-ordination work programme priorities, and to discuss the contribution which individual agencies might make to specific projects. The reference group would be guided by input from annual elder abuse and neglect prevention conferences. Specific
technical and professional expertise and input would be sought from across the sector on an as needed, project by project basis.

Co-ordination across elder abuse and neglect prevention services at a regional level should be formally recognised as an integral component of the overall elder abuse and neglect prevention model.

At the local level, elder abuse and neglect services should continue to work across agencies to co-ordinate service provision.

**Comprehensive data collection and analysis systems**

A co-ordinated approach to data collection for established cases of elder abuse and neglect is an essential requirement for Government and service providers to monitor trends, establish and monitor priorities for awareness raising and gain understanding about the nature of elder abuse and neglect in New Zealand. The agency responsible for managing elder abuse and neglect prevention services should co-ordinate the collection and analysis of consistent and comprehensive data on the nature and incidence of reported elder abuse and neglect. Appropriate funding should be allocated to this function.

Consultation on data requirements should include the proposed reference group on elder abuse and neglect prevention services.

**Contracting arrangements**

In developing advice to Government on the future location of responsibility for managing Elder Abuse and Neglect Prevention Services, Child Youth and Family, Treasury and MSD should note this review’s conclusion that the health sector is the preferred location, primarily because of the significant interface between vulnerable older people and health and disability support services. Child Youth and Family, Treasury and MSD should consult with the Ministry of Health on the feasibility of operating a co-ordinated Elder Abuse and Neglect Prevention Service from Vote: Health.

This should include a strategy (including appropriate new funding) for phasing in comprehensive national coverage of elder abuse and neglect prevention services.

Child Youth and Family, Treasury and MSD should also note the second preferred alternative location of responsibility is with the Ministry of Social Development’s new Family Services group. This is less preferred because the primary focus of Family Services is expected to be on families with children, and because a focus on elder abuse and neglect in a family context would not cover abuse and neglect in institutional settings.

**Funding arrangements**

Although EANP sites are located nation-wide, there are areas where the ability to provide adequate services is problematic due to practical constraints such as travel. Service boundaries for existing service sites need to be clarified to better understand the size and nature of the client group that each service caters to.
An analysis of population census data on the distribution of older people across territorial authority areas based on general site boundary descriptions indicates a potential gap in service provision in the central North Island (Rotorua, Otorohanga, Waitomo and Taupo).

The population census analysis shows higher proportions of older people in the Christchurch and Wellington service areas. Auckland (non-Māori and non-Pacific) and Waikato proportions of older people are also relatively fairly high. These areas, therefore, have responsibility for a relatively larger proportion of the overall EANP services client base than other services. However, this information needs to be considered alongside other site characteristics such as geographical distance, travel needs, and availability of, and access to, intervention services.
12.2 Recommendations

The recommendations suggested below have been presented in terms of short, and medium term steps that should be taken towards an effective full service delivery model.

Short term

In the short term,

it is recommended that a national reference group be formed who develop a programme of action that includes short, medium and long term strategies to consolidate services, improve information, to promote consistency and role clarity, and to promote best practice. It is proposed that this plan of action includes the following:

- National co-ordination for the services
- Regional meetings that are supported and explicitly funded
- Training needs including identifying international or external expertise for training at a regional or national level
- Consistency across services and information sharing particularly in terms of clarification of terms and approaches
- Developing a clear statement of expectations in terms of the model

Medium term

In the medium term (two to three year time frame), it is recommended that consideration be given to:

- developing a national publicity awareness campaign which links in with campaigns at a local level and is accompanied by resources and increased funding to deal with increased demand
- Shifting partial funding to full funding to enable services to increase their planning horizons
- Increasing overall funding for service provision taking into account potential site differences in the allocation of that funding
- Funding for a central region North Island site
- establishing regional co-ordinator roles with strong education provision and publicity skills who could also provide case work back-up support if required. This person could be based at one of the sites, focus on the development of regional and site specific materials for each service and also provide some peer support across sites
- Develop/up-dating national resources and guidelines
• Developing clear data collection guidelines, and analyse and disseminate national EANP Service statistics

• Establishing systems to collect and analyse national sector statistics. Data could be gathered from across the sector to provide a more comprehensive understanding about elder abuse and neglect in New Zealand.
APPENDIX A

Interview schedules

The schedule for the EANP service co-ordinator interview and a generic interview schedule is presented in this appendix.

EANP Service co-ordinator questions

1. Firstly can you tell me about the area that your service covers and the types of cases that are dealt with?

2. How are initial referral and assessments of reported incidents of elder abuse and neglect undertaken?

3. How does the coordination of, and referral to, professional services operate?

4. How do you provide support or arrange support to victims and, where appropriate, their family and carers?

5. Have you identified and/or established emergency safe beds?

6. What process do you have for the monitoring and review of individual cases?

7. What have you done in terms of provision of education to a range of professionals about elder abuse and neglect prevention, detection, intervention and treatment in the past year?

8. What have you done in terms of raising of community awareness of elder abuse and neglect in the past year?

9. What statistical data on the services do you provide and do you think this is useful?

10. How is national coordination of services provided?

11. What training and service standards/documentation is or has been available and does this meet your needs?

12. Aside from what has already been discussed, are there any gaps in services and other measures or actions that could improve effectiveness or efficiency of services?

13. To what extent do service providers contribute financially or otherwise to the cost of running services? Are you expected or required to?

14. Any other comments you would like to make?
Generic interview questions

1. Firstly can you tell me about how you became involved in the area of the Abuse and Neglect Prevention Services

2. How would you describe your role in relation to the Elder Abuse and Neglect Prevention Services?

3. What does your role involve?

4. What would you say works well in the provision of Elder Abuse and Neglect Prevention Services?

5. What would you say does not work very well – could be further developed in the provision of Elder Abuse and Neglect Prevention Services?

6. Apart from those you have already mentioned, are you involved in any way in these other areas of service provision?
   A. initial assessment of reported incidents of elder abuse and neglect;
   B. co-ordination of, and referral to, professional services
   C. support or arranging support to victims and, where appropriate, their family and carers;
   D. identification and/or establishment of emergency safe beds;
   E. monitoring and review of individual cases;
   F. provision of education to a range of professionals;
   G. raising of community awareness; and
   H. statistical data on the services provided.

7. Overall, what is your view of the services that are provided by the Elder Abuse and Neglect Prevention Services?

8. Aside from what has already been discussed, are there any gaps in services and other measures or actions that could improve effectiveness or efficiency of services?

9. Any other comments you would like to make?
APPENDIX B

Territorial authority areas and data tables for the funding framework analysis

Table B-1 and the charts on the figure on the following page show the Territorial Authority areas that were allocated to the different service delivery areas. Tables B-2 and B-3 present framework data for considering the proportion of older people in each of the service delivery areas. It is noted that this data only provides indicative information because of lack of certainty about service boundary areas. Other factors that should be taken into account when considering funding allocation across the sites are geographical spread, service availability and regional culture.

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Review of Elder Neglect and Prevention Services

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116
Table B-3: Number and proportion of older Māori and Pacific people in EANP service delivery areas by age group and gender

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| % of funded | 1.68% | 2.06% | 1.88% | 1.40% | 1.61% | 1.51% | 1.01% | 1.10% | 1.06% | 0.82% | 0.85% | 0.84% | 0.57% | 0.54% | 0.55% | 4.41% | 4.44% | 4.43% |

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