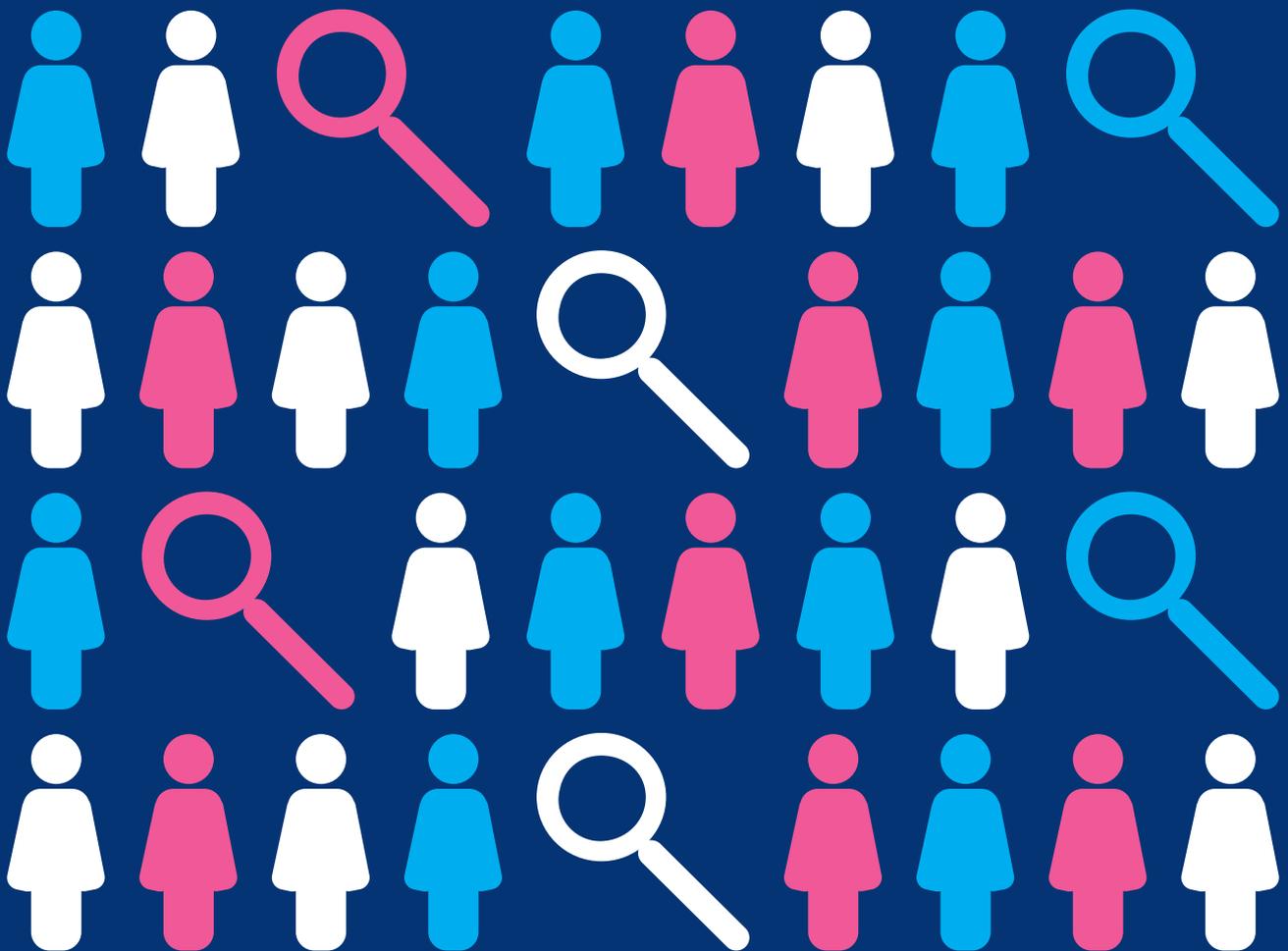


Safe Later Lives: Older people and domestic abuse





Acknowledgements

Thank you to Age UK for helping to shape this first Spotlights on older people and domestic abuse. Thanks are also due to all of the practitioners, victims and policy experts who contributed to this report. Finally, grateful thanks to Abigail Munroe for her work on drafting the final document.

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Background

Domestic abuse is a complex, wide reaching and largely hidden phenomenon. Each year, around 2.1 million people suffer from domestic abuse in England and Wales – 1.4 million women (8.5% of the population) and 700,000 men (4.5% of the population).¹ Crucially, 85% of victims made five attempts on average to get support from professionals in the year before they accessed effective help to stop the abuse.²

Whilst the impact of domestic abuse is grave on all victims, certain groups experience additional challenges and barriers. Many surveys and studies, such as the Crime Survey for England and Wales, have excluded consideration for victims aged 60 plus,³ and awareness raising campaigns have consistently focused on younger victims and perpetrators.⁴ This serves to reinforce the false assumption that abuse ceases to exist beyond a certain age. The limited pool of research which does exist on domestic abuse and older people suggests that “older women’s experiences of domestic abuse are markedly different from those in younger age groups and that these differences have not been adequately acknowledged or accounted for”.⁵

This report provides a focus on this historically ‘hidden’ group, which is essential to tailoring appropriate and effective services for victims (and perpetrators). The report is part of the SafeLives ‘Spotlights’ series, which will focus on hidden groups of domestic abuse victims throughout 2016 and 2017 and propose recommendations for both practitioners and policymakers. The first Spotlights has focused on older victims of abuse and involved a survey with 27 professionals, feedback from survivors, frontline practitioners and policymakers, as well as webinars and a social media Q&A.

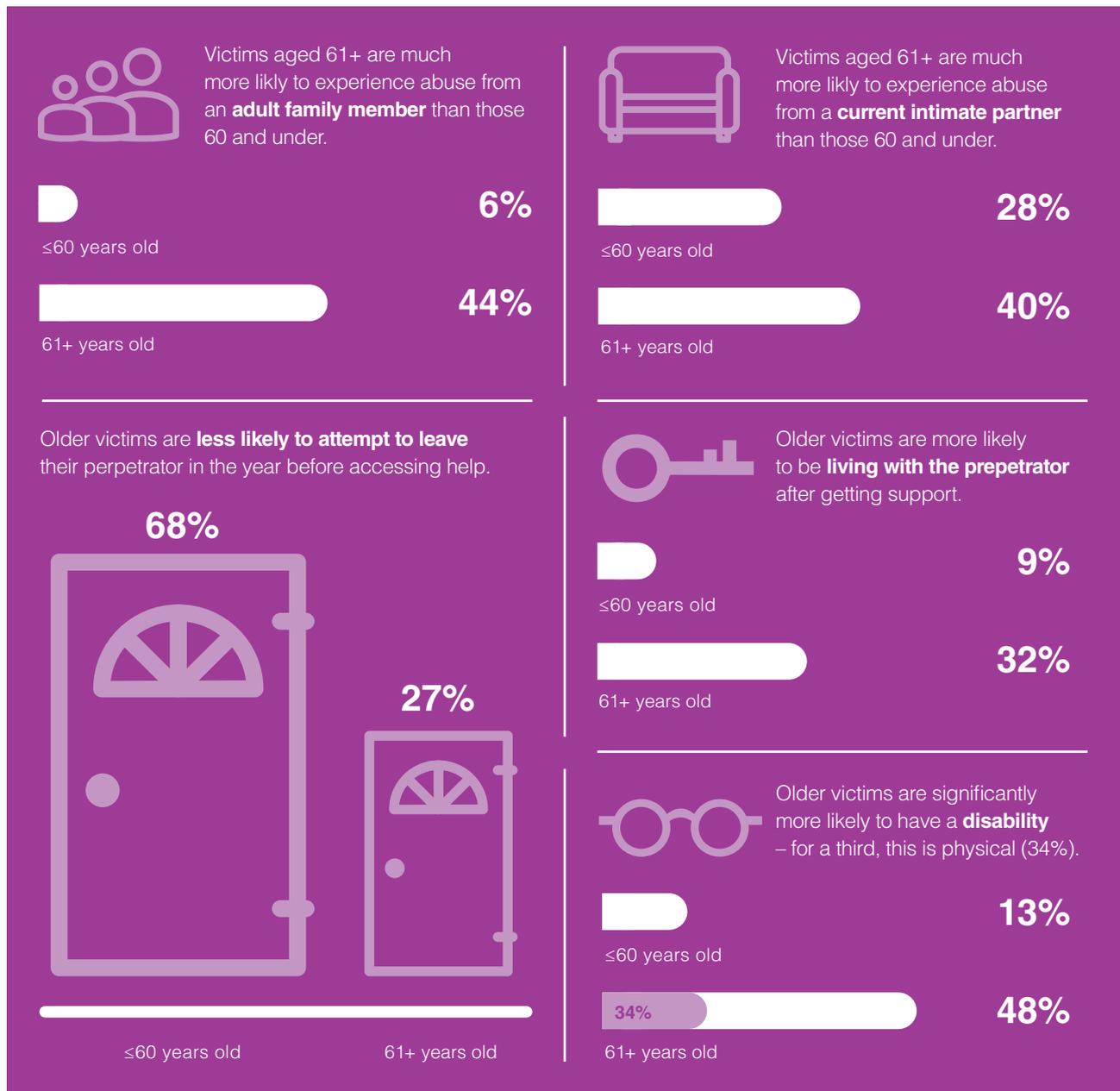
The scale of the problem

What do we know about older victims of domestic abuse?

Although there is no widely accepted prevalence data for this age group, we estimate that in the last year approximately 120,000 individuals aged 65+ have experienced at least one form of abuse (psychological, physical, sexual or financial).⁶ Although Marac (Multi-Agency Risk Assessment Conferences) data does not include this age bracket, figures show that only 3% of victims aged 60 or over are accessing **Idva** services supported by the Marac model.⁷

Profile of clients	60 and under	Over 60
Perpetrator is current partner	28%	40%
Male clients	4%	21%
Adult family member is the primary perpetrator	6%	44%
Multiple perpetrators	9%	7%
Attempted to leave the perpetrator	68%	27%
Average length of abuse	4 years	6.5 years
Physical health & mental health	6 & 7	6 & 6
Physical abuse	69%	69%
Sexual abuse	25%	10%
Harassment and stalking	73%	57%
Jealous and controlling behaviours	83%	73%

Spotlights: Older victims of domestic abuse



Policy and legislative context

To varying extents, domestic abuse has been included in policy since the mid-1970s. Due to its multi-faceted nature, public policy responses to domestic abuse feature within a number of areas. Provisions can be seen across housing, health, education, security and social services, as well as civil and criminal law. Consistently, older women do not benefit from generic policy provision, as they require more tailored responses to fit their needs and experiences. As is stated by the Government's 'Ending Violence Against Women and Girls' strategy (2016–2020) "there is no generic approach to providing services to victims of violence and abuse. Needs may be complex and may include, for example, housing provision,

assistance with debt or support for mental health problems. Provision should meet the needs of the diverse range of victims whether long term residents of that locality or victims who have moved in more recently”.⁸ In this strategy, older women are highlighted as a specific group whose needs must be assessed by the Transformation Fund after its launch in April 2017. They are described as forming a group that “experience multiple disadvantage”.⁹

Guidance issued by the Local Government Association (LGA) and association of directors of adult social services (Adass)¹⁰ sets out key UK legislation which provides the basis for safeguarding older people experiencing domestic abuse.

The Statutory Guidance issued under the Care Act, published in October 2014, states that adult safeguarding ‘means protecting an adult’s right to live in safety, free from abuse and neglect’ (Section 14.7). Safeguarding duties apply to an adult who:

- ‘has needs for care and support (whether or the not the authority is meeting any of those needs)
- is experiencing, or is at risk of, abuse or neglect
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect’. (Section 14.2)

The Care Act specifies that freedom from abuse and neglect is a key aspect of a person’s wellbeing. The guidance outlines that abuse takes many forms, and local authorities should not be constrained in their view of what constitutes abuse or neglect. It describes the following types of abuse, which include exploitation as a common theme:

- Physical abuse
- Domestic violence
- Sexual abuse
- Psychological abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse
- Organisational abuse
- Neglect and acts of omission
- Self-neglect

It also states that abuse and neglect can be caused deliberately or unintentionally. Domestic violence is a category of abuse which was added to the existing list of categories following consultation on the draft Care Act guidance.

Financial abuse has also been highlighted further in the Care Act guidance following consultation as the signs can present differently from other more physical signs of abuse. This needs to be considered in the context of domestic abuse within this guide. The guidance outlines that the aims of adult safeguarding are to:

- ‘Stop abuse or neglect wherever possible
- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- Safeguard adults in a way that supports them in making choices and having control about how they want to live
- Promote an approach that concentrates on improving life for the adults concerned
- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect
- Provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult
- Address what has caused the abuse or neglect.’ (Section 14.11)

There are no separate policy statements from national Government on the issue of older people and domestic abuse, though the Violence Against Women and Girls strategy (2016–2020) includes older people within the groups of victims who the Government will support through improved commissioning:

“We recognise that some sectors of society can experience multiple forms of discrimination and disadvantage or additional barriers to accessing support. These include women and girls from Black and Minority Ethnic (BME) communities, lesbian, gay, bisexual and transgender (LGB&T) women, older women and disabled women, adults who seek help for childhood sexual abuse, and the needs of female offenders who have also been victims of violence and abuse. Our support to promote effective local commissioning will focus on ensuring the needs of all victims are met.”¹¹

Wales

In Wales, the Government has launched a consultation on guidance for older people and domestic abuse.¹² The Welsh Government's National Adviser for Violence Against Women recently published an Annual Plan which recognised the need for greater understanding of the needs and the evidence base for interventions and models of support for older people.

Scotland

The Scottish Government has recently passed the Abusive Behaviour and Sexual Harm Bill.¹³ Among other measures, the Bill provides a new specific domestic abuse aggravator that identifies an aggravated offence if the crime involves abuse of the offender's partner or ex-partner. This followed the publication of the Government's Strategy for Preventing and Eradicating Violence Against Women and Girls in 2014.¹⁴ The strategy did not mention older victims specifically, but did cite figures which suggested younger adults were more likely to have experienced abuse by a partner in the last 12 months from the Scottish Crime and Justice Survey.

Key Findings

Many of the problems facing older victims are common to all of those experiencing domestic abuse. However, older victims' experiences are often exacerbated by social, cultural and physical factors that require a tailored response. Our Insights dataset shows that clients over 60 are less likely to have attempted to leave than those under (17% vs 29%). This report has identified the following six key findings from the Spotlights investigation (July and August 2016).

Finding 1

Systematic invisibility

Finding 2

Long term abuse and dependency issues

Finding 3

Generational attitudes about abuse may make it hard to identify

Finding 4

Increased risk of adult family abuse

Finding 5

Services are not effectively targeted at older victims, and do not always meet their needs

Finding 6

Need for more coordination between services

1. Systematic Invisibility

- Evidence gathered throughout the Spotlights consistently shows that older people are not being represented in domestic abuse services. Practitioners speaking to our researchers commented on the lack of older peoples' cases coming through to Maracs. One Idva stated, “when we look back over our records, we could see that once people hit fifty or sixty, there are hardly any Marac referrals”.¹⁵ Similarly, an adult social care representative estimated that “ninety percent of Marac cases are younger women and women with child protection issues, we have very few cases presented at Marac where they are older people.”¹⁶
- Our research suggests that as a consequence of so few older victims accessing domestic abuse services, professionals tend to believe that domestic abuse does not occur amongst older people. During our engagement with frontline practitioners, one adult social care representative stated: “people have the idea that domestic abuse affects younger women or women with young children, and that it doesn't really affect people over 65”.¹⁷ These assumptions may encourage health professionals to link injuries, confusion or depression to age related concerns rather than domestic abuse. An Idva with specialist experience in working with older victims emphasised that “sometimes professionals [social workers and doctors] only see medical conditions with older people and they're [...] not trained to see domestic abuse”.¹⁸ Margaret had worked with older women suffering from a range of medical issues that were directly linked to the physical and traumatic effects of domestic abuse – such as arthritis, diabetes, hearing loss and mental health concerns – but the link remained undetected by medical staff.¹⁹ This is reflected in our Insights data, where only 9% of older domestic abuse clients are referred through health routes, which is surprising when those aged 61+ are statistically more likely than younger victims to report poor physical health (11% compared with 3% of those under 61) and to have visited their GP in the past 12 months (53% compared to 46% of those under 61).
- This lack of recognition amongst some professionals is crucial given disclosure of abuse is more likely if victims are offered repeated opportunities to do so. This is particularly the case for older people who are less likely to access services through self-referral.²⁰ During our research, a hospital-based Idva explained that as a frontline practitioner, “you're often sowing the seeds and it's the next time or the next time after that [that the victim will disclose abuse and ask for help] // it's about people knowing that there is support out there, perhaps the next time that they come into hospital they will want to do something about it, or perhaps the next time the district

nurse sees something or tries to speak to them about it they will want to do something”.²¹ The same practitioner stated that she worked with an older woman who advised her to “keep on ringing me and eventually the time will come [where she will inform the police of the abuse and accept further support], but I’m not there yet”.²² Thus, the need for consistent dialogue with older people about their experiences and encouragement to accept help is highly necessary, but this cannot be done without increasing the recognition of older victims of abuse among professionals.

- Illustrating the devastating effects that lack of recognition has on older people, a Domestic Homicide Review for Mrs Y, a 79-year-old victim killed by her husband, found that professionals in a range of capacities did not consider her to be at risk of domestic abuse due in part to her age. As Age UK’s Head of Safeguarding wrote in an article on improving support for older victims, “had the potential signs of domestic abuse been recognised and explored, then it may have been prevented”.²³ Practitioners we surveyed for this Spotlights echoed the need to take steps to prevent services missing older people. For example, respondents suggested that services must ensure that their professionals has “an understanding that the dynamics of domestic abuse of older people is different” and knows “how to speak to people who are confused but still have capacity”.²⁴
- The current lack of training on the specific issues faced by older victims of domestic abuse may mean that practitioners lack the skills and knowledge to respond to it confidently. Our survey revealed a range of confidence levels among domestic abuse practitioners when responding to older victims. Out of those practitioners that said they work regularly with older clients, a small majority of 53% (8) said they felt very confident supporting them, with 40% (6) reporting average confidence and 7% (1) with low confidence. It has been suggested in a previous study that it would be appropriate and progressive to embed domestic abuse education regarding older women within general domestic abuse training for a range of professionals, in order to increase confident responses, recognition and suitable action.²⁵

2. Long term abuse and dependency issues

- Research shows that older victims of domestic abuse are likely to have lived with the abuse for prolonged periods before getting help.²⁶ For example, of the older adults that are visible to services, a quarter have lived with abuse for more than 20 years.²⁷ This can present issues in service uptake for this client group, who may feel additional pressures to stay with an abusive partner related to the length of time they have experienced the abuse. For example, they may feel increased anxiety about leaving behind a “lifetime of contributions to the family business, homes, and other assets”²⁸ such as pets or treasured possessions. This point was reflected in our service user interview, where it was said that with older victims of abuse, “there is more emotion involved as you are established and have a long history. There is just so much at stake”.²⁹ In addition, older victims may have increased fear over the change in long-term family dynamics that could occur³⁰ as a result of disclosure, and as one practitioner explains, adult children may put pressures on their parent to stay: “why are you doing this? You’ve been with Dad for X amount of years, why are you doing this all of a sudden? Poor Dad”.³¹ These issues may explain why older people are statistically less likely to self-refer (6% self-referrals aged 61+ compared with 14% for those under 61).³² This internalisation of abuse is likely to contribute to older people’s invisibility to services.
- An additional key barrier that can arise in this client group is the issue of dependency. Older people are statistically more likely to suffer from health problems, reduced mobility or other disabilities, which can exacerbate their vulnerability to harm.³³ Our Insights dataset showed that when asked to rate their physical health on a scale of 1 to 10 (1 being ‘very poor’ and 10 being ‘excellent’), 11% of victims aged 61+ reported a number between 1 and 3, compared with 3% of victims who were 60 and under.³⁴ When we spoke to older victims, they also reflected this theme. One person explained, “I became more physically dependent on my husband as my health deteriorated... I also become quite isolated”.³⁵ Problems with physical health and subsequent isolation can present barriers to victims being able to access community services, as they may be unable to easily leave their home.³⁶ During our research, an Idva emphasised that home visits are necessary for older clients.³⁷ However, this presents its own problems, as statistically, older clients are twice as likely to be living with the perpetrator of their abuse,³⁸ meaning the opportunity for services to speak to victims alone is significantly reduced. Hospital Idva Jane and adult social care representative Mel both discussed the issue of contact with older

clients in a podcast for this series. Mel spoke of it being “very difficult to even make a telephone call to somebody who is in that relationship because, more often than not, the perpetrator is there all the time”.³⁹ Jane reports that “it is impossible [to contact older victims] once they have gone home”,⁴⁰ and speaks of cases where perpetrators have disconnected landlines and removed mobile phones from victims.⁴¹ This creates a huge barrier to follow up work with older victims, even once domestic abuse is identified, and contributes to their continued isolation, preventing them from getting the help and support that they need.

- Another common barrier for older people with health and mobility issues is instances where the perpetrator of the abuse is also the carer. The Care Act (2014) defines a carer as someone who ‘provides or intends to provide care for another adult’.⁴² Research suggests that the potential for violence within a carer’s relationship increases when the carer is an intimate partner or close relative.⁴³ Similarly, another study revealed that one third of 220 family carer participants disclosed significant levels of abuse, and half reported some abusive behaviour.⁴⁴ Being cared for by an abuser raises a wealth of additional challenges and forms of abuse. For example, one of the practitioners speaking in our podcast series explained that there are “situations where perpetrators have withheld fluids because that means that [the victim] is going to the toilet less so it’s less mess, or where they have held medication back because medication affects the individual”.⁴⁵ Another practitioner in our series also described a case where food was withheld by the perpetrator who cared for the victim, to keep her weak. These less visible forms of abuse may be harder to detect by professionals, particularly as they can present under the guise of additional medical conditions as opposed to abuse, and suspicions from health staff may only arise when repeat incidences occur. For example, a hospital Idva described how they were only able to recognise an abusive caring relationship in one case when the victim “kept coming into hospital with urinary tract infections because she was so dehydrated”.⁴⁶ By this point, the abuse may have been sustained over a long period of time. This type of caring dynamic presents specific challenges to services, who have to tailor responses to fit this particular presentation of abuse, which, as one of the Idvas described, “is not as simple as the normal victim / perpetrator relationship because some of the work is about supporting the perpetrator to take some of the weight off them because they can become quite bitter about what has happened to their lives”.⁴⁷
- The caring dynamic can also present difficulties when the individual being cared for becomes the perpetrator, perhaps due to medical issues that can exacerbate aggression such as dementia. In these situations, the victim may feel a lot of guilt connected to any disclosure of the abuse, for example in one

study, an older woman stated: “and I still kept thinking, this man is ill and I can’t leave him”.⁴⁸ Similarly, when there are additional health issues present within an abusive relationship, it may lead to professionals not suspecting domestic abuse due to the perceived vulnerability of the perpetrator. An adult social care representative explained that this is particularly problematic for police “because they have to look at whether it’s in the public interest to remove people from houses or relationships where they have a diagnosis of dementia or Alzheimer’s, even though that perpetrator may have always been abusive.”⁴⁹

3. Generational attitudes about abuse may make it hard to identify

- It has been noted that “older women are far less likely to identify their situation as abuse”,⁵⁰ which acts as a barrier to the uptake of services and presents a challenge to outreach workers. Older victims are likely to have grown up in a time where the home was a private domain, and it would not have been deemed socially acceptable to discuss matters that occurred behind closed doors.⁵¹ This was reflected in our interview with an older victim of domestic abuse, where she revealed that she had experienced abuse for over 40 years, and felt as if she could not talk about it due to feelings of embarrassment.⁵² The internalisation of such experiences can lead to a ‘that’s just the way it’s always been’ attitude amongst the older generation. This is reflected in our Insights dataset which shows that 25% of older victims have lived with the abuse for 20+ years.⁵³ In another interview, a practitioner spoke of this generational attitude, stating that for many older women, “it was very much marriage for life until death do us part”. This is representative of the generational silence surrounding domestic abuse. This attitude is described as being exacerbated for older BAME women, particularly those from a religious background who may face additional personal and familial pressures to stay with an abusive partner. Practitioner Margaret Smith describes this as the ‘double struggle’.⁵⁴
- Evidence from the available literature and our Spotlights interviews shows that for older women there has been a lack of formal and informal networks of support, which leads to the perception that there is nothing they can do to better their situation, and thus they remain under the radar of services. For hospital based Idvas, this can be the biggest barrier.⁵⁵ Older victims are shown to be less aware of the existence of formal support services, due to the fact that far fewer domestic abuse services existed when they

were younger. Speaking in an interview for this Spotlights, an older survivor of domestic abuse revealed: “I was not aware I could get any help”.⁵⁶ Similarly, a number of survivors in a previous study spoke of a historical lack of domestic abuse services, for example one stating that, “It was behind doors a lot, you know what I mean, like mine was, and in them days, years ago, there was nothing at all for us to turn to, you know.”⁵⁷ In terms of informal networks of support, one practitioner in our podcast series spoke of her repeated work with older victims who had revealed abuse to friends or family many years ago,⁵⁸ only to be encouraged to remain silent. These networks often shared the same generational attitudes that many older women have internalised. It has also been found that where older women are aware of current services available, they feel that such services do not cater for older people, perhaps due to the fact that the majority of domestic abuse campaigns focus upon younger women with children (until recently). One very experienced Idva mentioned that many of the older women feel undeserving of such services and often state “I’m not sure if I should be here really. Maybe you’d be better off seeing the younger ladies with the kids”.⁵⁹ Similarly, in a webinar for this series, SafeLives Director of Practice, Jo Silver, shared a quote from an Idva who saw older victims feeling anxious about “wasting our time”.⁶⁰ This goes some way to explaining the lower self-referral rates to domestic abuse services amongst older women.⁶¹

4. Increased risk of adult family abuse

- According to our Insights dataset, 44% of respondents who were 60+ were experiencing abuse from an adult family member, compared to 6% of younger victims. This presents some challenges to service providers who may not be used to recognising or responding to this form of abuse.
- One of the practitioners in our podcast series explained that distinct issues can arise related to adult family abuse, for example, the adult child may be neglectful of their parent’s care needs in order to avoid costly care options that impact upon their inheritance. She explained that “care packages will be set up and then they’ll go home and the adult child will phone up the next week cancelling the care and stopping all those people from coming in, possibly saying the victim doesn’t want that care to happen, and the whole thing will stop just so that the money isn’t going out”.⁶² This process was described by the practitioner as a “constant battle”.⁶³ Equally, an older victim may fear disclosure to authorities of this type of abuse. They may want to maintain their relationship and avoid additional costs related to removing themselves from their adult child who may provide much

of their care needs.⁶⁴ In a webinar for this series, our Director of Practice, Jo Silver shared quotes from an health-based Idva: “We’ve had quite a few referrals made to us by nurses, but find these clients don’t often continue their engagement. Possibly because of the consequences of sharing information if they or others are thought to be at risk. The recent reasons have been that the perpetrator is often a relative, most commonly an adult child who is caring for them”.⁶⁵

- Adult familial abuse also presents challenges as “there seems to be a number of adult children who are experiencing some type of mental health issue including problematic alcohol and/or substance use, however, unless they are a risk to the community, services are not likely to intervene”.⁶⁶ This was the case for one of the older victim Domestic Homicide Reviews discussed in Episode 1 of our Spotlights podcast series. On the day leading up to the murder in 2014, both mother (victim) and son (perpetrator who suffered from significant mental health issues) were asking for [the adult son] to go into care and that wasn’t forthcoming. The urgency of that need was not recognised at the time. It was put down to their “volatile relationship”, so domestic abuse hadn’t been looked at in that context.⁶⁷ This suggests that services need to have more awareness of domestic abuse in relation to the adult child and parent dynamic, as older people are experiencing further invisibility within this form of abuse.

5. Services are not effectively targeted at older victims, and do not always meet their needs

- It is important that services respond to older victims in an appropriate and targeted way, however, this is shown to not consistently be the case.
- It is important that advertising campaigns are focused on older victims. A Safety Interventions Manager spoke of the impact that domestic abuse campaigns have on service uptake when referring to Camden Council’s ‘Know This Isn’t Love’ campaign which was aimed at young people through the production of short features for social media and cinemas. The campaign raised domestic abuse service referrals by 44% for people in the area aged 16–25.⁶⁸ However, the same outlets would not be appropriate in targeting older victims, who are less likely to regularly be accessing these spaces, and thus services must alter their methods for this client group. After speaking to older victims about access to campaigns, the same practitioner reported that they “were very keen on seeing

that information on our bus stops. They said that's something that speaks to them. And also in their local shopping areas, but the transport links were a really big point for them".⁶⁹ This finding is echoed by research conducted with older victims, which concluded that "there is a real need for information and resources to be targeted to areas where they are visible to older victims, for example GP surgeries or other public areas".⁷⁰

- Pressuring older women to leave their relationship when statistics show that they are less likely to do so than younger women, can lead to a sense that victims are not being listened to. Data also shows that older victims are more likely to still be living with the perpetrator of their abuse following support and intervention.⁷¹ Older victims of abuse spoke of the pressures that they have been exposed to by services that focus heavily on a victim leaving an abusive relationship. In an interview for this series, an older victim of domestic abuse revealed: "I felt pressured to leave my husband. I told them that this was my house and that I did not want to go into a council flat on the ground floor where I would not feel safe. I told them of my other physical issues but I did not feel listened to. They just wanted me to leave".⁷² The 2014 Care Act should improve practitioners' capacity to make adult safeguarding more personalised. Speaking of this development, one of the practitioners explained in a podcast that victims who "have the capacity to make decisions, even if it be unwise ones, have the support of us helping to make them as safe as they want to be, not necessarily rescuing them or removing them from situations but absolutely supporting them in the decision making process and supporting them to continue, even in a relationship that on the surface doesn't look very good for them".⁷³ Reflecting on the importance of this, an older victim in our study concluded: "listen, don't put pressure on us and let us make our own decisions".⁷⁴
- It has been noted that services are not always able to respond specifically to the needs of older victims due to shortages in appropriate referrals. For example, a 2007 Women's Aid report stated that, "from a care provision perspective, women's refuges and other domestic abuse services may not be appropriate for older women for a number of reasons such as lack of facilities for those with disability and mobility issues, and an absence of the specialised support that older women may need".⁷⁵ This was also reflected by a practitioner in one of the Spotlights podcasts, who spoke of her negative experiences when referring older women to refuges that "do not generally have the support available to cope with the kind of care needs that these victims tend to have. Or the social needs, because refuges generally have younger people".⁷⁶ Furthermore, when care needs or disability is involved, the barriers in providing safe and appropriate services are exacerbated. This is of particular relevance to older victims of abuse, as our Insights dataset shows that 48% of people over 60 in the survey reported some form of disability,

compared to 13% of younger victims.⁷⁷ A social care representative spoke of the realities of the lack of specialised services for victims with disability which forces them to stay in abusive relationships, with the only alternative option to specially adapted housing being residential care.⁷⁸

- There is evidence to suggest that services that are specifically targeted to the client group are successful. In an interview with an older victim that had accessed the Silver Project, a service run for older victims by Solace Women's Aid, the service user offered a wholly positive appraisal of her experience in accessing this targeted support: "their navigation steered me in the right direction legally, professionally and emotionally. They were listeners, they were helpful, they were available and most of all made you feel welcomed and very understood".⁷⁹ The service user also commented on the significance that one-to-one counselling sessions had in facilitating her emotional recovery from the years of abuse, and the essential nature of having one point of contact to build a rapport with, so that "you don't have to keep repeating the same story again".⁸⁰

6. Need for greater coordination between services

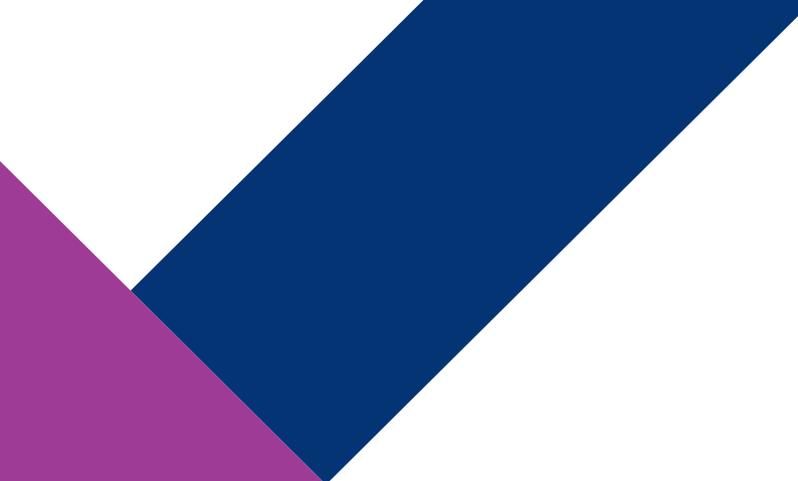
- One study describes the "ideological gulf" that exists between individuals providing domestic abuse services and those in older people's services.⁸¹ This is a theme that is often repeated, with domestic abuse practitioners recurrently speaking of the challenges faced when attempting to work with local agencies, particularly a lack of coordination between domestic abuse services and adult safeguarding services. For example, an adult social care representative we spoke to said: "people still aren't identifying that there are domestic abuse issues for older people, they are treating them rather as safeguarding".⁸² This was again stressed in a later comment that "we are very good as professionals at looking at safeguarding but not specifically at identifying the support that domestic abuse services can provide specifically".⁸³ This suggests that older victims of domestic abuse tend to get caught up under a wide remit, which will impact on the provision of specific and tailored responses. Crucially, in their DHR Case Analysis, Standing Together finds that "a significant proportion of adults who need safeguarding support do so because they will also be experiencing domestic violence. Yet despite the overlap, the two have developed as separate fields".⁸⁴ More positively, in speaking about the 'Know It's Not Too Late' campaign run by Camden Council to target older

people experiencing abuse, the council's safety interventions manager said that the campaign has resulted in a "huge rise in the number of adult safeguarding meetings that the Idvas are attending",⁸⁵ suggesting that there are ways for the two services to work more effectively together.

- There is also a need for greater coordination between health services and domestic abuse services. In our survey, one commenter said that agencies were "not recognising domestic abuse and therefore not referring to domestic abuse services or Marac"⁸⁶ in instances where health services were informed of domestic abuse by a patient but the appropriate referrals were not made. Illustrating the devastating but common effects of this, one of the practitioners involved in our research spoke of a Domestic Homicide Review that occurred in 2013 in Camden, in which both the victim and perpetrator had reported the abuse in their relationship to their GP before the victim's death, but this was not followed up.⁸⁷ When talking about the benefit of health based Idvas in affecting a culture change in different services, the practitioner remarked that health services "make a referral and expect a letter back from their referrer to say 'we've seen this patient', and that's quite different from the way an Idva works".⁸⁸ In one study it was found that all of the victims in their study "had tried to access help from numerous sources (doctors, psychiatrists, marriage counsellors, police), numerous times. All the interviewees talked about frustrating encounters with health care workers and fruitless attempts to get help from their GPs".⁸⁹ Standing Together identify the need for specific training for health professionals. They advise that "GPs should have adult safeguarding training as a requirement and would benefit from guidance and training on recording significant particulars about a patient's personal situation".⁹⁰ An older victim that was interviewed for this Spotlights stated: "I could talk to my doctor as I trust him and he knows most of the things that go on in my life... talking to my doctor really opened my eyes".⁹¹
- Lack of coordination is a concern surrounding what is done with information once it has been disclosed, and how quickly disclosures are responded to. An Idva speaking in one of our podcasts expresses her concern over this issue, stating that "there is a fear that if people do start to say that they want things to change and then [the perpetrator] gets sent home and then the cat is out of the bag and the perpetrator is going to have a field day with them when they get home".⁹² These concerns over the perpetrator's behaviour following allegations was raised in the Marac national scrutiny panel report which stated that information regarding the perpetrator's risk assessment should be considered and have an impact upon discharge decisions. In a previous study,⁹³ an older

victim revealed that following her eventual disclosure of abuse to police, her husband was released without charge to the home and subjected her to the “worst 24 hours of my life”. This is an issue for domestic abuse victims of all ages, but is of particular significance to older victims who are more likely to live with the perpetrator of their abuse.⁹⁴ Thus, information sharing between services to identify risk in these situations, the ability and capacity to respond appropriately, and the knowledge and confidence to make referrals are essential, to increase the safety of the victim.

- There are three examples in this Spotlights series of successful attempts to coordinate services. In 2013, Camden Clinical Commissioning Group introduced the Identification and Referral to Improve Safety project in GP surgeries and hospital based Idva services. Domestic abuse referrals from health professionals to the two main domestic abuse organisations in the borough – Camden Safety Net and Solace Women’s Aid – increased from three between them, to 800. A practitioner from the area elaborated: “that’s not a sudden surge of 800 people who have suddenly become victims of domestic abuse. That’s 800 people who weren’t being recognised and identified before; who, by simply being asked the question, have said ‘actually yes, and I would like to be referred onto services’”.⁹⁵ Another example of an effective attempt to increase coordination between services came from two other practitioners interviewed as part of this series. Both have been involved in amalgamating training from adult social care and domestic abuse for all professionals working in the relevant fields, including health staff, police, and adult social care staff. The practitioners describe the project as “less of a training session but more a discussion and identification session, allowing people to think a little more outside of the box when they are dealing with people”.⁹⁶ Ultimately, these examples illustrate how it is possible to make these essential connections between health and domestic abuse professionals, and facilitate effective and timely knowledge sharing. As Jo Silver explained in our webinar, our ‘One Front Door’ model, which is about to be piloted, has the goal of setting up a single hub that sits behind the various additional access points, such as substance misuse, children’s services, adult safeguarding. One Front Door is able to ask every agency to check their information on a particular address or individual at the initial point of concern. As Jo explains, information sharing between services remains restricted by legal frameworks, but the proposed model allows services to allocate a flag to an individual based on their knowledge and subsequent risk assessment. This can then be viewed by other agencies on a single system.



Policy and Practice Recommendations

1. Systematic Invisibility

- Provide training for health professionals so that they understand the dynamics of an abusive relationship involving an older victim, and how to provide a safe place for disclosure – this applies specifically to GPs and other medical professionals who regularly come into contact with older people.⁹⁷
- Domestic abuse governance boards to monitor referrals and engagement of older people with domestic abuse services and action plan accordingly.

2. Long term abuse and dependency issues

- A cultural understanding within professional services that older victims may need prolonged interventions due their abuse being sustained over a longer period.
- Specific training for those who deliver care to older people, so that they may be more equipped to recognise abuse.
- Physical and mental health services should work closely with domestic abuse services in acknowledgement that care and dependency issues are often intertwined. All relevant information

relating to current and historical support, relating to health concerns should be shared at Marac, including the development of new care plans if abuse is recognised as part of the caring relationship.

- Continued coordination between hospital Idvas and other services that offer care to older people, in order to ensure that effective and safe care plans are in place and maintained. This includes a sufficient investigation if a victim or family member cancels previously agreed care pathways.
- Increased support for older carers that are identified as being under pressure, as it has been discussed by practitioners that such pressures can act as triggers to abuse. Frequent and effective carers' assessments are crucial to this recommendation.
- Specific training for professionals on the incidences of abuse within a caring relationship, and/or where dementia or other mental/physical disabilities are present.

3. Generational attitudes about abuse may make it hard to identify

- Services must not assume that older people are aware of the services available to them. Domestic abuse governance boards and services should target older people with specific materials and messaging.
- Services must be aware that older people may be less likely to disclose, and must ensure they ask the appropriate questions and give victims the space and opportunity to talk.
- Services must be trained to help older victims identify their situation as abuse.
- Embed domestic abuse champions within adult services sector.

4. Increased risk of adult family abuse

- Ensure that domestic abuse is fully considered at adult safeguarding enquiries, through the implementation of training

to ensure practitioners are recognising the dynamics of abuse between intimate partners or from family members.

- Increase effective coordination between services that work with adult family members, such as mental health services. Ensure that service providers in these fields are trained in order to be able to identify the presence of domestic abuse within this dynamic, and make the appropriate referrals.
- Training for Idvas specifically on inter-family violence and the adult safeguarding concerns related to this.

5. Services are not effectively targeted at older victims, and do not always meet their needs

- Build upon drop-in and outreach services that specifically target older victims, and that are available at places where all older people feel comfortable, in the knowledge that older victims are more likely to live with their abuser – so the home may be an inappropriate place to screen for domestic abuse.
- Ensure advertising of services is accessible and relatable to older victims, and appears in places that they are more likely to see, for example GP surgeries, public transport and literature older people are more likely to read.
- Ensure that all relevant service providers and professionals are trained on the challenges and experiences of older victims, so that their response can be tailored appropriately. For example, formulating plans to keep victims safe that do not solely focus on the need for a victim to leave an abusive relationship, and knowing what social benefits / financial support are available specifically.
- Consider older women in service re-design, such as housing and refuge options.

6. Need for greater coordination between services

- Set up pathways for greater coordination between the full range of professionals that provide regular services with older people, and expand on those which have already been established, to ensure that domestic abuse concerns are not lost in the ‘umbrella’ term of safeguarding, and that services are effectively sharing information on a case by case basis. This should include a closer working relationship between adult safeguarding and Idva teams. Coordination should also ensure the possible implementation of joint visits to older victims with professionals who they already trust and feel comfortable with.
- Ensure Adult Social Services are embedded as a core Marac agency. This is due to the changes in the Care Act 2014 and the role adult social care plays in supporting vulnerable adults experiencing abuse. We hope this will increase the identification of older people as victims, in order to meet the duties as set out in the Care Act. It is important that the same representative attends on a consistent basis, and has the appropriate level of authority to be able to confidently make decisions and allocate resources on behalf of their organisation. They may also be the agency that takes the lead as a single point of contact, coordinating the care package and ensuring communication between the relevant agencies is managed appropriately. The adult social care assessment should take into account the discussion at Marac.
- Ensure that all Marac representatives have a working knowledge of the Care Act 2014 and/or Adult safeguarding and Domestic Abuse: a guide to support practitioners and managers.
- Set up a single point of contact with a trusted professional, who can support and represent the victim and facilitate information sharing between all other services who have contact with the victim. It is noted that this is usually the Idva but in older people’s cases it may be more appropriate for this role to be taken up by someone who is already working or has a trusting relationship with the victim, such as an adult social worker.
- Implement a multi-agency domestic abuse training programme.
- Ensure that services have coordinated information around a perpetrator in order to make safe and appropriate decisions surrounding discharge if the individual has been held in custody.

Notes

1. ONS (2015), Crime Survey England and Wales 2013–14. London: Office for National Statistics
2. SafeLives (2015), Insights Idva National Dataset 2013–14. Bristol: SafeLives
3. Women's Aid, 2007
4. It is welcome news that the Crime Survey for England and Wales will now be considering including people aged 60+ for the self-completion section of the survey in the future, which for the first time would provide a comparable prevalence rate of domestic abuse for older people
5. www.reducingtherisk.org.uk/cms/sites/reducingtherisk/files/folders/resources/victims/Domestic_abuse_and_older_women_McGarry_and_Simpson.pdf 'Domestic Abuse and older women: exploring the opportunities...' page 2
6. No prevalence estimates are currently available on individuals aged over 60 experiencing domestic abuse. We have used the findings from the <http://assets.comicrelief.com/cr09/docs/elderabuseprev.pdf> UK Study of Abuse and Neglect of Older People 2007 and excluded the proportion of abuse perpetrated by carers (12%) or close friends (5%) (Table 4.1, page 59). We also looked at the ONS findings from the <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/compendium/focusonviolentcrimeandsexualoffences/yearendingmarch2015/bulletintablesfocusonviolentcrimeandsexualoffencesyearendingmarch2015> Crime Survey for England and Wales for those aged 55 – 59 years. There was a considerably higher prevalence rate within this group; 5.4% women and 2% men had experienced any domestic abuse in the last year (2014/15 Crime Survey England and Wales, Appendix table 4.10)
7. SafeLives National Insights Dataset 2015–2016 (unpublished)
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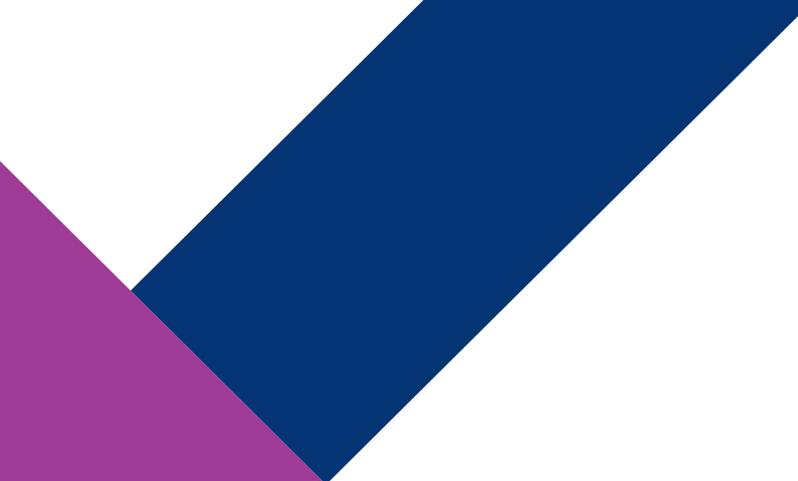
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21. http://safelives.org.uk/sites/default/files/resources/Spotlight%20episode%20%20podcast%20transcript_0.pdf
22. Ibid.
23. http://safelives.org.uk/practice_blog/older-people-and-domestic-abuse-completing-jigsaw
24. Spotlights older people survey responses (unpublished)
25. Naegle et al (2010)
26. http://safelives.org.uk/practice_blog/its-our-right-be-safe-any-age-how-can-we-make-it-easier-older-victims-get-help
27. SafeLives' National Insights Dataset 2015–2016 (unpublished) findings for clients aged 61+ and under 60
28. 'It's our right to be safe at any age. How can we make it easier for older victims to get help?' Monsura Mahmud blog, page 2

29. Spotlights older people survey responses (unpublished)
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57. Julie McGary and Christine Simpson 'domestic abuse and older women: exploring the opportunities for service development and care delivery' page 4. www.reducingtherisk.org.uk/cms/sites/reducingtherisk/files/folders/resources/victims/Domestic_abuse_and_older_women_McGarry_and_Simpson.pdf
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97. SafeLives has recommended that every hospital should have an Idva service. You can read the report 'A Cry for Health' here: <http://www.safelives.org.uk/node/935>



About SafeLives

SafeLives is a national charity dedicated to ending domestic abuse, for good.

We combine data, research and insight from services and survivors to find out what really works to make vulnerable people safe and well. Every year, over two million people experience domestic abuse; it is not acceptable or inevitable, and together we can make it stop.

Agencies must work together to provide people with wraparound and tailored support. Those at high risk of murder or serious injury should be given a dedicated Independent Domestic Abuse Advisor (Idva) who works on their behalf and is there at every step of the way.

We know that the safety of a victim and the safety and wellbeing of their children are inextricably linked; we need a 'whole-picture' approach to vulnerability.

People should not have to wait until they're in crisis before we pay attention.

We want long-term solutions, not short-term fixes. There needs to be a change in behaviour and culture, not just in structures and processes. The simple existence of a response to abuse is not enough.

Support for vulnerable people must be early, effective and consistent – wherever you live, whoever you are.



What we do

- Use our data, research and frontline expertise to help local services improve and to influence policy-makers, locally and nationally.
- Create a platform for victims, survivors and their families to be heard and to demand change.
- Offer support, knowledge and tools to frontline workers and commissioners.
- Provide accredited, quality assured training across the UK.
- Test innovative projects and approaches that make more families and individuals safe and happy.

How we work

- We focus on the practical: we believe in showing people what they can do, not telling them what they should do.
- We are independent.
- We are informed by evidence of what works; we gather evidence from data, frontline expertise and people with lived experience.
- We problem-solve.
- We learn from local provision and respect local circumstances, but show how national replication can be achieved.
- We work across organisational boundaries.

