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Identifying and responding to domestic abuse in the older population: Key challenges and complexities

Many older people are subjected to domestic abuse every year and yet this is an issue that has been neglected in terms of policy, practice, and research. The aim of this research was to develop knowledge and understanding of how key agencies identify and respond to domestic abuse in the older population. A qualitative study, utilising semi-structured interviews with practitioners from statutory and voluntary sector agencies and two older women who had experienced domestic abuse, was undertaken. Findings show that the recognition of domestic abuse in later life is limited, although participants suggested that it was more readily identified now than previously. The complexities of abuse in older age can impact on whether abuse is identified as domestic abuse and it is suggested that age discrimination also impacts on this recognition. Where domestic abuse is identified, there are issues with how it is responded to, including a lack of services to refer on to for older people and a lack of age appropriate tools and resources to draw upon. Issues that complicate this area of practice include the cross over between elder abuse and domestic abuse for older people, particularly where care and support needs are present.

Key words: Domestic abuse/ violence, interpersonal violence, older people, adult safeguarding, elder abuse, thresholds.

Introduction

Many older people are subjected to domestic abuse (DA) every year, but responses have been neglected in terms of policy, practice, and research. Older victims/survivors[1] can therefore be considered a 'hidden group', based on a false assumption that DA only impacts younger people (Mcgarry & Simpson, 2011; Mohammed, 2018; Straka & Montminy, 2006; Wydall & Zerk, 2017). The UN suggest this misconception may be maintained because violence against women is a taboo subject in many societies due to "deep rooted sexist/ ageist prejudices and stereotypes and discriminatory cultural/ societal norms"(Šimonović, 2022, p.2). Whilst attempts have been made to estimate the prevalence of DA against older people, gathering accurate data is difficult. Benbow et al. (2018) suggest that this is partly due to the use of multiple terms and different ways in which data is collected. Nevertheless, across Europe, there is evidence demonstrating that many older people experience DA each year (AGE UK, 2022; García-Moreno et al., 2013; Luoma et al., 2011; Stöckl et al., 2012).

[1] Please note that the language victim/survivor is used throughout this paper. This is in recognition that whilst health and social care services may use the term 'victim', some people find the term 'survivor' more empowering. As Women Against Abuse (2023) point out, 'the journey from victim to survivor is unique to each person' and we use the term 'victim/survivor' in this paper 'to represent this continuum'.

This paper reports findings from research which explored DA in the older population (defined in this study as anyone over the age of 65). The project was initiated by a Safeguarding Adults Board[2] (SAB) following growing concerns about DA in this population group. The project explored the knowledge base and practice approaches from the perspective of practitioners and older people who had experienced DA.

The conceptualisation of domestic abuse and elder abuse

The World Health Organisation (WHO, 2021) refers to 'intimate partner violence' as 'behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours'. In the UK DA is broadened to include abuse which occurs between people aged over 16 who 'are personally connected' (which includes partners, ex-partners, parents, and relatives) (Domestic Abuse Act 2021). Abusive behaviour under the Domestic Abuse Act 2021 (UK) includes physical, sexual, economic, psychological, emotional or other abuse, as well as including violent, threatening, coercive or controlling behaviour (Domestic Abuse Act 2021). Contrastingly, the WHO define elder abuse as 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to the older person' (WHO, 2022). As such, definitions of elder abuse can encompass DA. This is the case under the English legislative framework for adult safeguarding, the Care Act 2014 which considers adult abuse broadly and cites DA in the accompanying statutory guidance as a 'type' of abuse alongside other categories including psychological, physical, sexual, financial, and emotional abuse all of which can be elements of DA (DHSC, 2023). A key distinction is related to the perpetrators; elder abuse in the WHO global definition is perpetrated by anyone in a 'relationship of trust' (which would include paid care workers), whereas the DA definition is focused on perpetrators who are 'personally connected' (for example, partners/family members) (Domestic Abuse Act 2021). Nevertheless, regardless of who perpetrated the abuse, when the victim/survivor is an older person with health and social care needs, the concern is that it may be

[2] Safeguarding Adults Boards (SABs) oversee adult safeguarding work within each locality. See SCIE (2016) for more information about SABs.

viewed through the lens of an adult safeguarding concern, rather than as an incident of DA (McGarry et al., 2014). Whilst adult services and safeguarding processes may offer some appropriate support, a focus on care needs may lead to older people not being offered specialist support which would be helpful to them and available to younger women (McGarry et al., 2014; Wydall & Zerk, 2017).

Explanations of elder abuse often focus on the dependency of the older person and the supposed burden that this places on the caregiver (Abolfathi Momtaz et al., 2013; Fang et al., 2019; Gholipour & Khalili, 2020). This can be linked to the family violence perspective; the view that violence within families arises through an attempt to resolve conflict and that it is normal for this to occur (Lawson, 2012). This is reflected within the English statutory guidance which acknowledges that abuse can occur 'because a carer is struggling to care for another person' (DHSC, 2014, S.14.40). Contrastingly, feminist perspectives assert that DA is primarily a gendered issue and that violence occurs as an attempt to exert control (Lawson, 2012). This is supported by evidence that the majority of victims/survivors are female and the majority of perpetrators are male, a pattern which is also apparent in cases of DA in the older population (AGE UK, 2019; Bows, 2019; Pathak et al., 2019). However, adult safeguarding has developed without a focus on gender. For example, within the English context, the term 'adult at risk', focuses on inherent vulnerability with its inclusion of people who are 'unable to protect themselves' as a 'result of care and support needs' (Care Act 2014). Gender has largely been ignored within the literature on adult safeguarding, despite most victims/survivors being female; O'Keefe et al. (2007) reported that the majority of victims/survivors in their research on elder abuse were women (2.3% compared to 0.6% for men). The lack of a gendered analysis of elder abuse may also contribute to the invisibility of older people who experience DA. In these cases, the person's age, care-giving dynamics, dependency, and perceived vulnerability may all serve to obscure the view of abuse arising because of gender inequality and power dynamics. This may shift the focus towards an adult safeguarding response. Straka & Montminy (2006) suggest a failure by practitioners and agencies to take account of both age and gender dimensions of DA results in neither service providing an adequate response. The UN reiterated this concern arguing that

persistent discriminatory values in society hinder development of understanding and research about the intersection between age and gender in relation to abuse against older women (Šimonović , 2022). Additionally, it has been suggested that differences in how types of abuse were first identified has impacted on routes of support that are offered; elder abuse was first noted in the medical literature, whereas awareness of DA was raised by the 'women's movement of the 1970s' (Burston, 1975; Penhale, 2008, p. 176). Overall, there appears to be a 'lack of conceptual clarity' around the distinction between DA and abuse which falls within the remit of adult safeguarding (McGarry et al., 2014, p. 204). The aim of this research was therefore to develop knowledge and understanding of how key agencies identify and respond to domestic abuse in the older population. . The research questions were:

1. What factors influence the identification and categorisation of abuse in the older population?
2. How do practitioners respond when they identify DA in the older population?
3. What challenges are experienced when identifying and responding to DA in the older population?

Consequences and challenges for older victims/survivors experiencing domestic abuse

The identification and responses to DA in the older population are complicated by some unique challenges (Carthy & Taylor, 2018). It is important to understand these, as well as the consequences of DA for the older population, to guide effective responses and service provision. Additionally, it has been suggested that older women need a more tailored response than generic service provision (SafeLives, 2016). However, campaigns designed to raise awareness about DA have primarily focused on younger victims/survivors (Safelives, 2016). The challenges faced by older victims/survivors of DA, highlighted by existing research, are discussed below.

There is a greater likelihood of a caring dynamic in the relationship which may act as a barrier to seeking help (Mcgarry & Simpson, 2011; Wydall & Zerk, 2017) or contribute to the abuse being considered solely through an adult safeguarding lens. Health and mobility issues may also impact on ability/willingness to leave or seek support (Lundy et al., 2009; McGarry et al., 2014; Wydall & Zerk, 2017). Financial barriers, self-blame, and reactions from others may also impact on help-seeking (Beaulaurier et al., 2008; Wydall & Zerk, 2017). Poverty is prevalent in older age, but this may be compounded for women who are more likely to live in poverty than men (Purdam & Prattley, 2021). Older women are more likely to have had husbands controlling finances this may facilitate financial abuse and coercive control (Bisdee et al., 2012; Purdam & Prattley, 2021). Challenges associated with having potentially lived with the abuse for a long time include the complexity of relationships and potential 'anxiety about leaving behind a "lifetime of contributions to the family business, homes, and other assets" such as pets or treasured possessions' (Safe Lives, 2016, p. 13). Band-Winterstein & Eisikovits (2009) also identified that ongoing abuse changed across the life-course with a shift from physical abuse to other forms such as emotional abuse. The authors stated that 'only death or another dramatic move […] can end the lifelong violence' (ibid, p. 177).

Experiences of DA may be intensified for older people (Teaster et al., 2006). Abuse impacts older people's physical and mental health and emotional wellbeing (Knight & Hester, 2016; McGarry et al., 2011). It can also create a sense of emotional isolation and powerlessness (McGarry et al., 2011). There is also a lack of awareness amongst older people about the existence of services. Where they are aware of them, they may feel that they do not meet their own needs or are inaccessible to them (McGarry & Simpson, 2011). Additionally, there is little research that takes an intersectional lens; few studies have considered the experiences of older victims/survivors from ethnic minorities, or LGBT older people (Gutman et al., 2020; Westwood et al., 2018). This also contributes to the lack of suitable service provision for older victims/survivors.

Methodology

This research arose from the concerns of a SAB about the prevalence of DA among older people in the region and agency responses to it. The overall aim of this research was to develop knowledge and understanding of how key agencies identify and respond to domestic abuse in the older population. A qualitative research approach was selected as a 'good fit' to address the research question for several reasons. The first was to accommodate the nature and depth of data required (Silverman, 2013). The second was to allow flexibility of design and purposive sampling of those with insight into the phenomena to be studied in an attempt to achieve closeness to the world being studied (Patton, 2015). In addition, Guba (1978) described qualitative enquiry as "a "discovery orientated" approach that minimizes investigator manipulation of the study setting and places no prior constraints on what the study outcomes should be" (Patton, 2015).

Sample, participants, and recruitment

Due to the multi-agency nature of DA and adult safeguarding work, a multi-agency sample was sought for the research. These agencies were included as practitioners working within these services were likely to have experience of identifying and responding to DA in the older population. A purposive sample was chosen for this study comprising workers from key statutory and voluntary sector organisations. An overview of participants is included in Table 1.

Table 1: Details of the participants

Participant (Pseudonym)	**Organisation**	**Statutory/non statutory**
Julie	Ambulance service	Statutory
Gill	NHS trust	Statutory

Mary	Strategic role DV-Local Authority	Statutory
Sally	Carer lead – Local Authority	Statutory
Sarah	Refuge worker	Non-statutory
Lisa	Sexual violence project co-ordinator	Non-statutory
Patricia	DA project worker	Non-statutory
Pamela	Social worker –Local Authority	Statutory
Carrie	Expert by experience	Not applicable (NA)
Louise	Expert by experience	NA

Ten participants were recruited. The experts by experience were two older women who had received support following DA. Older people with experience of DA were approached via gatekeepers in women's refuges who passed on information about the research. The women had the option to contact the researcher directly but chose to do this via the gatekeepers. The older women who took part in the research both expressed that they wanted to share their experiences with others. As one of them stated: 'I just wanted to share my experience of what I've been through and if I can do it they can do it'.

The recruitment process for practitioners involved gatekeepers in each organisation who shared information about the research. Participants were recruited who had experience of working with older survivors of DA. A multi-agency sample was appropriate for this research as responsibility for identifying and responding to DA does not rest solely with a single agency. It was therefore important to consider the perspectives of a range of practitioners to understand what the commonalities were across agencies.

Methods and data analysis

Semi-structured interviews were used to gather in depth data. Interviews provided a degree of intimacy that contributed to the experts by experience feeling 'safe' discussing personal matters.

Interviews were audio recorded and transcribed. The topic guide for practitioner's interviews focused on recognition of DA in the older population (e.g. 'what is your understanding of DA as an issue for older people?'), the responses to such abuse (e.g. how do you/ your agency respond when older people are involved?'), and the suitability of responses and services for older people (e.g. 'what do you feel works well for older people?'). The topic guide for the interviews with the older women focused on their experiences of accessing and receiving support following DA (questions included, for example, 'please can you tell me how you first came to be involved with services?' and 'if you were to give advice to agencies or services, what advice would you give them?'). The topic guides were constructed to address the research questions and were informed by the literature and our own previous research and practice experience. The use of semi-structured interviews also allowed participants the opportunity to raise other areas of discussion.

During the field work for this research the UK went into full lockdown due to the Covid 19 pandemic. As a result, while 5 of the 10 of the interviews were undertaken in person, the rest were conducted virtually with one exception who provided a written response. Data was analysed using thematic analysis. Following transcription, both researchers viewed and coded the data separately. Codes were then clustered into themes and the researchers discussed, shared, and reviewed these together. Following analysis of the findings a workshop was convened with key agencies to explore the data and discuss potential responses to the study findings. These discussions are drawn upon in the conclusion.

Ethical considerations

Data was anonymised and pseudonyms were assigned. The interviews with the older women focused solely on their experiences of accessing support and did not ask them about their experiences of DA. However, both women chose to share this information within the research interview. Interviews would have been halted if participants had become distressed and follow up support was available, but these measures were not required. Informed consent was obtained

from every participant taking part in the research and the research was given ethical approval by XXXX Committee [anonymised for peer review].

Limits of the research

This was a small-scale project. The purposive sample limited participation to professionals who had experience working with older people who had experienced DA. Future research could encompass a wider range of professionals to see if similar issues arise. There is also a need to engage more widely with the experiences of a more diverse group of older people.

Findings

Findings covered three key areas; identification, complexity, and adequacy of responses to DV in the older population.

Identification

Some participants felt that DA in later life was not recognised, particularly if it had been ongoing for many years, though it was more likely to be picked up now than previously. Mary was not confident that it was 'on everyone's radar', and it was 'under reported' with the focus being on younger women. It was felt age should not make a difference in relation to identification of DA, Pam argued:

> 'I think people still struggle ... to record DA. I think if somebody was being physically assaulted, it […] wouldn't necessarily be an understanding that that could be DA…'

DA in older women is not being categorised as such due to age discrimination supporting the stereotype of DA being an issue for younger women. Patricia pointed to the age limits placed on recording of DA in the British Crime Survey to support this point and discussed how gender should be the focus, not just the person's age:

> '…It is a gendered issue; it disproportionately affects women […] perpetrators are disproportionately male. …I come across it all the time […] professionals […] don't realise that it's not elder abuse, it is actually DA […] this abuse is happening because she's a woman, it's not happening because she's older…'

Practitioners found abuse such as sexual assault more shocking and a greater 'internal challenge' when the victim/survivor was an older person (Lisa). DA being overlooked and blamed on health issues was also seen as problematic (Sarah). The police were identified as having a challenging role often making decisions on limited information resulting in more general welfare referrals being made to social services rather than a situation being categorised as DA. There was concern about agencies' lack of knowledge of this issue within ethnic minority communities. Respondents suggested one barrier to offering people support is the person did not recognise themselves as a victim/survivor. Gill commented:

> 'she didn't recognise it herself.........Just this is normal, this is it, this is what happens to me and it's because I've done this and I've done that. She didn't recognise herself as a victim.'

Intergenerational attitudes were seen to influence recognition of DA with women being told they should not leave their husband but instead 'work through your problems' and 'put up with' what went on behind 'closed doors'. While it was felt that these attitudes were changing, the continued presence of such a norm was viewed as the reason why it can remain hidden, why

victims/survivors are reluctant to seek support, and why some women stay in abusive relationships. These situations may be difficult for professionals to understand but as Louise, a survivor of DA, explained:

> ‘... police and doctors have wanted me out for a long, long time.
> But ... it’s something that only the person ...can decide.’

It is important that the woman’s self-determination is maintained throughout the support process. Present campaigns on DA were not seen as connecting with older women with the focus usually being on younger women. Providing information at venues older women may go to was seen as important with hospitals and GP surgeries needing to be particularly alert.

Complexity

The complexity of abuse in later life was acknowledged in several ways including abuse being perpetrated by a range of family members, not just a partner. Pamela suggested that if the abuser is a partner there may be variable recognition by other family members:

> ‘[they] don’t always see it as abuse, it’s just mum and dad … it varies between families maybe not recognising that something’s wrong.’

Failure by children to recognise abuse can impact on the support the person receives and the victim/survivor may be encouraged to remain in the abusive situation. Participants had different views about what older people may want. Some suggested that some older people may want less interference in their lives as older women may feel more enmeshed in the relationship because of its duration, concerns about finances and pensions, and being of retirement age with work not being seen as a route to independence (Mary). Alternatively, Sarah felt it was:

> ‘A misconception that older people want to remain in the relationship due to factors such as the length of marriage, pressures from adult children and extended family, finances etc…. I understand that these are all barriers… but many women do want to leave.’

Thus, cautioning practitioners not to make assumptions and there may be a way forward that can be pursued by the victim/survivor with support. Level of dependency on an abusive carer was another complicating factor due to difficulties accessing the person if the abuser was present and victims being worried about who would care for them if they disclosed the abuse. Concern was also expressed that carer stress could act as a ‘smoke screen’ to historic DA. Sarah suggested if these elements are present the history of abuse may not be explored, whereas it would for a younger person.

Responses

While there was consensus that DA for older people may have certain characteristics and services needed to be age appropriate, other elements such as a focus on the person's needs, listening to what they want, and supporting decisions were seen as central to support offered. Sarah argued:

> ‘Victims often relate better to those who they have similar experiences with or can understand what they are experiencing. This means that recovery groups where older people are mixing with much younger victims can at times not work very well.’

This was reinforced by the two participants with lived experience, one of whom said ‘I couldn’t stay […] it had big families in it’. Emergency responses such as the refuge or a care setting were often not suitable for older women fleeing abuse. Budget restrictions and short-term funding for voluntary organisations were seen as barriers to developing more diverse services. Mary

suggested a more flexible interpretation of care and support needs under the Care Act 2014 could increase the scope for a wider range of support when people are in need. The relevance of assessment tools was also questioned, for example, in relation to questions that focus on whether young children are impacted by the abuse. Participants also highlighted that a commonly used risk assessment, the DA, Stalking and Honour-based violence (DASH) risk checklist and Multi Agency Risk Assessment Conferences may not focus on health and dependency vulnerabilities, but rather drug and alcohol red flags. These may not be as pertinent for older people thus masking more relevant risk factors.

Multi-agency concerns

Despite agencies in this study having different roles there was a sense of trying to work together., The critical role of the police and heath care workers in identification was highlighted alongside concern that DA training was not mandatory in health settings; Mary argued for the upskilling of GPs and nurses. Pamela suggested that while social workers would respond to crisis situations, their role was more likely to be in referring victims/survivors to other agencies, rather than offering ongoing direct support. Therapeutic input was seen as lacking for victims/survivors who may still be trying to come to terms with past as well as present abuse.

DA and Adult Safeguarding

It was recognised that DA is not always a safeguarding issue, and other needs should be present before making a referral to safeguarding. Sarah expressed concern that while ageist attitudes might lead to someone being taken through the safeguarding process when not required, she had also found it difficult to have some people accepted in the process as 'the victim has capacity'. Mary noted that care should be taken when applying thresholds for inclusion to safeguarding and Sally was concerned that the person might not get the support they need outside of the safeguarding process. An incident where DA was perpetrated by the victim/survivor's own child was seen as more likely to go into safeguarding.

The impact of covid

Operation of services was impacted by the restrictions imposed because of the covid pandemic. Agencies had to change how they engaged with people, but while online contact worked well for some it did not for others who put off getting support until face-to-face contact could resume. Participants were concerned that during online contact the perpetrator could be in the house, off camera controlling what the victim/survivor said. In addition the 'opportunity for people to disclose will ... ' have been massively limited'. Delays in the court system meant criminal prosecution of offenders taking longer increasing women's need for support over a longer period.

Discussion

This research highlighted challenges in identifying and responding to domestic abuse in the older population. Age discrimination and generational attitudes may obscure the picture of domestic abuse for practitioners and older people and impacts on how professionals respond to situations. For example, there were differing views about whether older people would want to leave an abusive situation. Family and caregiving dynamics also further complicate by contributing to the lack of recognition of DA as an issue for older people and to difficulties for older people in accessing support. These findings are corroborated by other research which has identified family and caring dynamics, financial (in)dependence, cognitive and health issues, length of time experiencing abuse, and a focus on age, rather than gender as unique challenges for older people (McGarry et al., 2014; Penhale, 2021; Wydall & Zerk, 2017). Our research also highlighted a lack of understanding of risk factors for older people and an issue with thresholds for safeguarding as a barrier to support. This is problematic as adult safeguarding appears to be the main route for support for older people experiencing DA; there is a lack of age-appropriate DA services. Concerns around the lack of training for multi-agency professionals on DA in later life were also raised.

The key underlying issue is a lack of recognition of domestic abuse as an issue for older people. Ageist assumptions may feed into this and a lack of clarity around the distinction between DA and elder abuse also creates difficulties (McGarry & Simpson, 2011). Adult safeguarding is focused on age and support needs and often conceptualised as an issue with care because of health or disability (McGarry, et al., 2014). DA has been more widely theorised from a feminist perspective which foregrounds gender and highlights the role of power dynamics in the oppression of women (Lawson, 2012). Straka, & Montminy (2006) recommend a collaborative approach by agencies which takes account of both age and gender dimensions of domestic abuse and older women. While collaboration between agencies is demonstrated in this research an intersectional lens is lacking and gender is largely ignored in the literature on elder abuse.

This is problematic for several reasons, including the impact it has on access to criminal justice and on the types of services that are available to older people. In a context where the focus is on age and or disability/health, not gender, aspects of the caring dynamic are more likely to be noticed, thus making it more likely that abuse will be conceptualised as an adult safeguarding concern, rather than one of DA. Although DA is specifically considered in England within the policy framework (DHSC, 2023), there is a separate legislative framework and a range of services available to those identified as experiencing DA. Professionals need to understand that DA services offer something distinct, which is unlikely to be provided if DA is responded to under care needs/adult safeguarding. It seems apparent that there are some challenges ahead about how social workers and other professionals differentiate DA from 'other' elder abuse and how it is therefore incorporated and managed within the safeguarding system.

People who have health and social care needs (which meet eligibility thresholds for support) are entitled to a range of services and support that people without such needs (or with a lower level of need) are not entitled to access (DHSC, 2023). These needs would also bring them within the remit of the adult safeguarding processes, if required. The concern is that this may dilute the focus on DA into a greater focus on social care support. This may mean that referral to DA services does not happen and the unique characteristics of the older person's experience and needs are

missed. This further obscures the need for those services limiting the opportunity for older people to engage with specialist support that younger people can access. This is apparent in the lack of services available for older victims/survivors of DA (Wydall & Zerk, 2017). This corresponds with research by Jakobsson et al. (2013) where professionals expressed concern about limited resources.

A further consideration is about the application of thresholds for support in DA situations which may not be so definitive as with situations based on physical health need. If no care and support needs are identified for the older person experiencing DA then they would not fulfil the eligibility criteria for access to services. Studies across Europe have highlighted several needs for older women subject to DA including mental/emotional health needs which are not so readily identified (Nägele et al., 2010; Pathak et al., 2019; Stöckl & Penhale, 2014). In circumstances where a person is experiencing such needs connected with DA, perhaps thresholds can be interpreted more broadly to ensure appropriate support alongside a place of safety and the meeting of basic needs, if required. Different agencies have different roles. While some focussed more on receiving disclosures and identifying abuse others, mainly in the voluntary sectors, provided services and direct support. A more flexible approach and interpretation of thresholds could help address this issue and ensure older people do not fall through the net and could receive a greater level of support. Robbins et al. (2016) have commented on the marginalisation of the role of social workers in supporting victims/survivors.

A further challenge is the lack of DA services for older people. Workers may be forced to make inappropriate placements due to the lack of options available. This supports McGarry et al. (2014, p. 208) who also identified a 'deficit in dedicated services for older people'. There are also limitations with existing resources, for example, the DASH risk assessment includes questions about children and pregnancy and the FREEDOM programme 'describes in detail how children are affected' by DA as both are geared towards younger women.

Conclusion

This research reinforces messages from previous studies around the complexities of DA in later life and highlights the need for significant change in the way that it is identified and responded to within adult health and social care services. These findings demonstrate a lack of awareness of DA in the older population, a distinct set of complexities and issues faced by older people, and a lack of suitable assessment and support resources. A focus on gender is required, indeed a more intersectional approach that 'incorporates the nexus of age, disability, gender and violence' would be beneficial (Penhale, 2020, p.173). Older survivors of DA are a diverse group with varying needs that require a more bespoke response. We propose several recommendations.

(1) Services for older people need to be developed.

This research has provided additional evidence around the need for services that are responsive to the needs of older people who are victims/survivors of DA. There is a need for adequately funded and suitable service provision which includes refuge services, as well as emotional and practical support for older people. Pathways to alternative housing also need to be available for older people. 'One stop shops' (one place where a range of services can be accessed) are useful for support. Older people may want access to services which reflect their differing needs and to be included with other people their own age. This is supported by Brandl et al. (2003, p. 1493) who outlined that provision of support groups specifically for older women helped them to realise that they were 'not alone'. Ensuring services have this element of delivery has implications for the way grant funding from government is allocated, the commissioning of services, and their delivery by provider organisations. In addition, long term funding is required to allow for suitable planning.

(2) Raising awareness of DA as an issue for older people.

Awareness raising for older people, practitioners, family members and carers is required. Greater awareness amongst the general population and amongst older people specifically is important to ensure that people can recognise an abusive situation and understand how to access support. This could be supported by services having ‘champions’ for older people to help raise awareness and create dialogue about DA in the older population to help to reduce stigma and make this issue more visible. Awareness raising can also be supported by information that is inclusive of and accessible to older people, providing them with advice about services. Practitioner knowledge of available services also needs to be developed. Opportunities for networking and information sharing about community resources and organisations is required.

(3) Training should be designed and delivered to support the health and social care workforce in recognising and responding to DA in the older population.

There is a need for significant workforce development around DA in the older population (Carthy & Taylor, 2018; McGarry & Simpson, 2011; Robbins et al., 2016) particularly for primary care, other health and private sector workers who may be at the frontline of disclosure. Training should support workers to recognise signs of DA in the older population, how to respond appropriately, its relationship to safeguarding, and what DA services are available. Existing DA and adult safeguarding training needs to specifically address DA in the older population. While health locations were singled out as important as points of contact for identification of abuse, training across all agencies is required and opportunities for multi-agency training are important (Wydall et al., 2018).

(4) Review of tools and processes to ensure they are fit for purpose.

Older people should routinely be asked about DA in the way that younger people are and the processes followed should ensure that work is not focused on assumptions based on the person’s age. Not all DA tools are tailored for older people and need to be adapted to remove unnecessary content and add content more appropriate for their unique needs. In the UK, The Ministry of

Justice alongside the Prison and Probation Service, while not referencing age specifically, have in their Domestic Abuse Pathway (2020) recognised this potential duality of need, referring to both adult safeguarding for people with care and support needs and DA services (Ministry of Justice & HM Prison and Probation Service, 2022). If this could be echoed in other policy guidance such as the Care Act Statutory Guidance it would help to ensure both areas of support are offered. DA could be flagged on assessment forms and advice could be offered around differentiating DA and elder abuse, and the application of thresholds. This may help to support, particularly for social workers, their role working with older people experiencing DA.

(5) Professional curiosity and reflective practice should be supported.

The nature of social work practice can be an important determinant of the responses to DA in the older population. It is important to allow time to build a trusting relationship and fully explore the issues and gain an understanding of what is happening. Practitioners need time to explore the full picture and ensure that care and support needs are not obscuring DA. Practitioners should be supported to reflect on their practice and make sure that decisions are not underpinned by ageist assumptions It is also important to get an accurate history of the person to understand whether the abuse is a recent change or has been ongoing. This is supported by Benbow et al.'s (2019) analysis of Domestic Homicide Reviews where they noted a history of DA as a key theme.

This research has added to the limited body of literature which has explored the DA of older people. There is a need to highlight the prevalence of DA in the older population and develop support and services to respond to this appropriately. Practitioners need to recognise the unique characteristics of DA in the older population and its binary nature if associated with care needs/safeguarding.

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