Make a Change: Consultation

A report on a consultation on adapting Make a Change for older adults

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What is Make a Change?

The Make a Change (MAC) project was developed by Respect in consultation with Women's Aid Federation England (WAFE). It is designed to fill a significant gap in current service provision for situations where people know that domestic abuse is taking place, but the behaviour or concerns do not meet the threshold for a statutory referral.

By translating WAFE's flagship Change That Lasts approach to survivors into a corollary, whole-system, survivor-focused and early response to perpetrators, the project aims to:

- Intervene with abusive behaviour at an earlier stage than is typical, before it becomes entrenched and intervention is mandated by family court, criminal justice or children's social care agencies;
- Enable survivors to achieve safety and recovery for themselves and their children as soon as possible, and to seek professional help addressing their partners' behaviour without waiting for the involvement of statutory services;
- Encourage communities, including friends and family members, professionals and other agencies to see themselves as part of the solution, and empower them to take action to address domestic abuse;
- Reduce the broader social and financial impact of abusive behaviour.

Developed through consultation with those enrolled on behavioural change programmes, the MAC model is grounded in an established evidence base for safe and effective perpetrator work. It is designed to reduce the barriers that

communities, professionals and perpetrators face in seeking and accessing support, as well as to raise awareness of domestic abuse more generally.

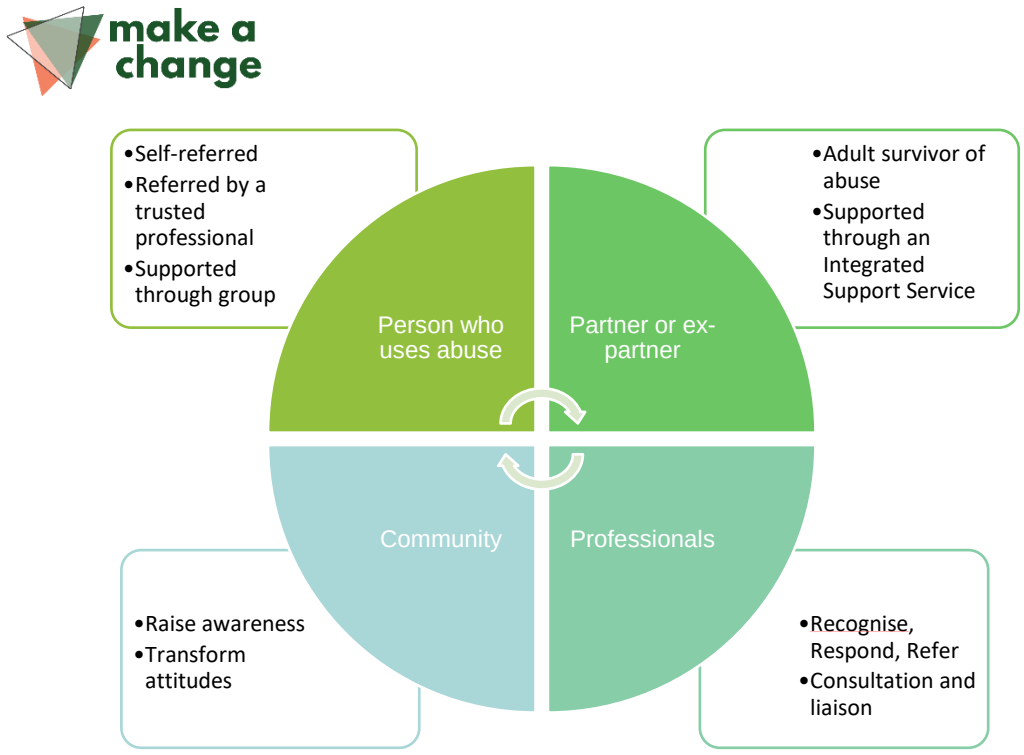

Figure 1. The Make a Change Model.

The MAC model involves four components: a largely group-based behavioural change programme for those who have used abuse; a one-to-one support service for their partners/ex-partners; a Recognise, Respond, and Refer training programme that equips professionals with the skills and knowledge to recognise signs of abuse, to respond when they have concerns and to refer to MAC or other agencies for additional support as required; and a community campaign that focusses on raising awareness of domestic

abuse, appropriate and available services for perpetrators, and transforming the social attitudes that underpin and maintain abusive behaviours.

Make a Change was piloted in Lincolnshire and East Sussex including Brighton & Hove, between 2018 and 2020. As part of the pilot evaluation, the research team was asked to conduct a brief consultation with organisations in East Sussex including Brighton & Hove, who support older adults in the community to explore the feasibility of adapting Make a Change for delivery to this population. We also completed a scoping review of literature on domestic abuse interventions for older adults to establish what is known about what works with this population.

A scoping review of interventions to address domestic abuse in late life

Introduction

Domestic abuse encompasses a wide range of harms, including physical, emotional, sexual, and financial abuse of people who are or have been intimate partners (World Health Organisation, 2010). While not all survivors of domestic abuse are women, women experience higher rates of repeat victimisation, are much more likely to be seriously hurt (Walby & Towers, 2017) or killed than male victims of domestic abuse (ONS, 2018), and are more likely to be subjected to coercive and controlling behaviours (Myhill, 2015). According to feminist theory, therefore, violence in intimate

relationships is an expression of broader societal patterns of patriarchal dominance and women's exploitation (D'Unger, 2005). It is essential to recognise that abuse of older adults may take several forms and that there is a distinction between elder abuse (abuse of older adults), which includes maltreatment in hospice care, or from professional or family carers, and domestic abuse, which is more specifically about abuse in the context of an intimate or previously intimate relationship (Straka & Montminy, 2006).

Domestic abuse can occur across the life cycle. It can include later life disclosure of many years of previously unreported abuse and abuse with onset in middle or late age (Seaver, 1996). A long history of abuse can dramatically impact a person's health: it can cause long-term physical health conditions, such as gastrointestinal disorders and hypertension; it increases the risk of developing mental health issues, such as depression and anxiety; ultimately, it increases the risk of premature death for the victim/survivor, due to the impact of poor health, repeated physical assault (especially on particularly frail individuals), and increased risk of suicide (Fisher & Regan, 2006; Women's Aid, 2007; McGarry et al., 2010).

It is fundamental to recognise and acknowledge the features of domestic abuse in late life, , given the predominant cultural representation of domestic abuse as a problem mainly impacting early to middle adulthood. While there is much in common to older and younger adults' domestic abuse experiences, there are also forms and dynamics unique to older adults' experiences. It is pivotal to realise how age and sex intersect and together

play a role in the dynamics and experience of abuse in a relationship (Lombard & Scott, 2013; Sirey et al., 2015).

Older survivors face significant barriers to seeking and receiving help, with many experiencing challenges related to mobility, health issues, or resignation feelings in response to long-term abuse (Brownell & Heiser, 2006; U.N., 2013). Dependency and a sense of guilt are often involved, especially when the victim has a caring responsibility towards the person who uses abuse towards them (Valor-Segura et al., 2014; Brownell & Heiser, 2006; Lachs et al., 1997). For some, lifelong financial interdependency can result in concerns about financial security, loss of the home, and worries about not being able to find another home, all of which can make it particularly difficult to address concerns about abuse or to leave the abuser (Mears, 2015; Solace Women's Aid, 2016). Sometimes abuse is not identified or might be justified by a survivor on the basis that it started at a time (or during a particular era) when abuse was seen as more acceptable or had not yet been recognised as a crime; in other cases, abuse is perpetuated by traditional religious beliefs, for example about the sanctity of marriage (Blood, 2004; Hyman et al., 2000).

The impact of domestic abuse on older adults and the specific nature of the experience of domestic abuse in later life suggest a need for specific interventions to support victims/survivors and challenge the behaviours of those who abuse. This scoping review aims to identify services that have been designed to address domestic abuse in late life and map the most recent available evidence around them.

Methods

Data sources

Academic papers and grey literature were selected from several databases: Web of Science, PubMed, Social Care Online, Google Scholar and Google Searches, encompassing Social Sciences, Medical Topics Psychology, Sociology and Social Care. Studies were retrieved at electronic search using database-specific keywords: index terms related to violence (domestic violence, domestic abuse, intimate partner violence, family violence, relationship violence, batterer, perpetrator), index terms relating to the sample (elder, old*, over 50, post-retirement, late life) and index terms relating to the intervention (intervention, programme, prevention, support). Other studies were retrieved at hand-search. Studies met the inclusion criteria if they had been published between 2009 and 2019 and written in English. A total of 91 studies were selected for inclusion, based on abstract and title, during the initial search.

Study selection

These 91 studies were then retrieved in full and assessed for inclusion. The following inclusion criteria were used: (1) studies must relate to programmes that aim to address domestic abuse in late life specifically, (2) studies must relate to interventions or services already implemented in real-life settings, and (3) studies must include evaluations of the cited programmes. As a result, N = 11 studies were selected for the quality assessment and included

in the review. Search results and study selection flowchart are presented in Figure 2. Selected papers were analysed thematically, and results were summarised using a descriptive table (Appendix 2).

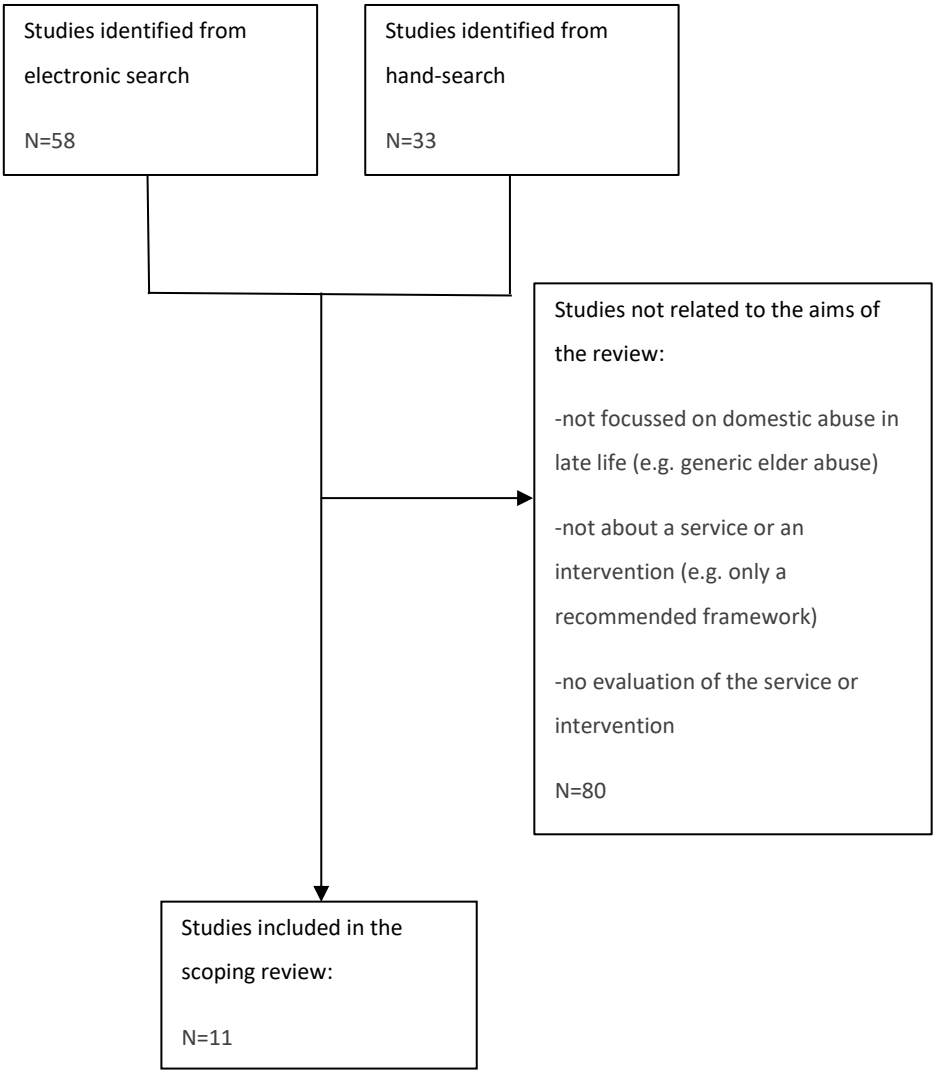

Figure 2. Study selection flowchart.

Quality Assessment

The Mixed Methods Appraisal Tool (MMAT) – Version 2011 was used to assess each study's quality. The internal validity was rated as Excellent, Good, Fair, Poor or Very Poor based on different criteria, given a qualitative, quantitative or mixed methods study, as shown in Appendix 1. A study was rated Excellent if they met 100% criteria on the MMAT Tool; a study was rated Good if they met 75% criteria; a study was rated Fair if they met 50% criteria; a study was rated Poor if they met 25% criteria; a study was rated Very Poor if they met 0% criteria.

Results

Types of intervention

The reviewed studies mainly focussed on women victims/survivors of domestic abuse experiences, and none of them evaluated perpetrator programmes for older adults who use abuse in their relationships. Services for survivors of domestic abuse in late life. The 11 selected studies described various interventions that have been recently implemented in Europe and America to support domestic abuse survivors in late life. Five studies were conducted in the United States; three studies were conducted in the United Kingdom; two studies were conducted in Canada; one study was conducted across Austria, Belgium, Bulgaria, Germany, Slovenia and Portugal.

The most common strategy that was adopted was to design **age-specific services.** Older adults affected by abuse in their domestic settings have unique, age-specific needs and services tailored to them seem to be a practical, cutting-edge approach. Canada is a trailblazer in this field, with the foundation of **transition houses** specifically for people fleeing abuse over 55 or 60 (Rutman et al., 2013) and adapting several existing structures to older adults's needs (LeBlanc & Weeks, 2013). These settings act as refuges and provide guests with a quiet, welcoming environment and assisted living facilities, including accessible spaces and housekeeping assistance (Rutman et al., 2013).

In the United Kingdom, older adults suffering from abuse still struggle to find services that accommodate their needs (McGarry et al., 2014; Carthy & Taylor, 2018); however, an innovative project, the Silver Project by Solace Women's Aid, proved to be effective in providing **tailored support** to victims of domestic abuse in their late life (Solace Women's Aid, 2016). Workers from the Silver Project in London provide practical and emotional support and reach women in their homes, when possible, to assess their needs in their complexity and set realistic goals to improve their safety; they also escort survivors to police stations and provide safety aids, like wearable alarms or "panic rooms".

Training for social and health care professionals was also provided in one setting (Struempel & Hackl, 2011). Red Cross volunteers, General Practitioners, nurses and social workers work on the frontline with vulnerable people of all ages; therefore, they need to recognise signs of abuse in older

adults, effectively communicate with survivors, and make them aware of local services that can help them flee abuse. Bringing up the topic of abuse with patients can be the most challenging part, but it is an act that is generally appreciated by older survivors, as it is a powerful icebreaker (McGarry et al., 2014). In other studies, professionals were involved in **focus groups**, either to evaluate their perceptions of the services and their knowledge in the field (McGarry et al., 2014; Carthy & Taylor, 2018) or to establish new networks that can provide effective **coordinated responses** to elder domestic abuse (Brandl & Dawson, 2011).

The importance of choosing specific approaches for **counselling** and **therapy** was also highlighted. Some programmes were focussed on empowering older women currently affected by abuse, using a feminist analysis of power and control, and supporting women by reinforcing their self-esteem, self-efficacy and **assertiveness** (Sirey et al., 2015; Tetterton & Farnsworth, 2011). It is a point of concern whether interventions focussed on boosting self-esteem, self-efficacy, and assertiveness may imply that victims should stand up for themselves; this conceptualisation might reinforce "victim-blaming" by burdening victims with the responsibility of abuse and inadvertently putting them at risk of reprisals from perpetrators. One programme used a life-story approach, supporting older women who had survived long-term abuse to integrate their life-story experiences and resolve inner or interpersonal conflicts (Tetterton & Farnsworth, 2011). Another programme adopted a **spiritually-focussed approach** to give sense to trauma (Bowland et al., 2012). These projects emphasise the need for many older women to find sense in their experience while respecting their personal beliefs.

A study examined the effects of **home visits** by trained police officers in Chicago, USA (Amendola et al., 2010). In this setting, senior services officers or domestic violence liaison officers from the Chicago Police Department visited and observed elderly residents who experienced at least one incident of domestic abuse in the previous three years, in order to evaluate if a home-visiting service could have an impact on re-offending rates.

Quality Assessment

Most of the reviewed studies were case studies or pilots. Two in eleven studies described randomised controlled trials; one described a non-randomised controlled trial; three used mixed methods designs, where quantitative descriptive and qualitative data were collected; five were case studies.

The majority of the selected studies met **satisfactory standards of quality**. Of the selected studies, four were rated “Excellent” using the MMAT tool, meaning that all quality criteria were fully met. Four studies had a “Good” rating on the MMAT tool, meaning that more than half of the criteria for quality assessment were fully met. While one study had a “Fair” rating, two studies had a “Poor” rating, meaning that two or one criteria were fully met, respectively. Only two case studies were rated as Poor, as they presented very little data about the evaluation processes. Samples were relatively small because of this study's highly specific subject, but researchers were aware of issues like ethnic diversity and class in recruiting participants. Studies where pre- and post-measures were used had relatively high drop-out rates – a

common issue in research on domestic abuse interventions more generally (McGarry et al., 2014). As a consequence, follow-up data was often not available in these studies, undermining their value.

The frequent use of **mixed methods** is a strength but meant that a higher number of quality criteria had to be considered, and the potential divergence between quantitative and qualitative data also had to be assessed. However, all mixed methods studies met high-quality standards, ranging from Good to Excellent, meaning that researchers carefully considered how findings can relate to contexts, sampling strategies and analysis processes. These quality assessments should be considered in light of the limited sample and initial scope of the various studies' research design.

Detailed information on study designs, quality ratings, study participants and contexts, interventions, measurements and study outcomes is presented in Appendix 2.

Main outcomes

The studies present different outcomes following the interventions that can be differentiated between outcomes for **survivors** and outcomes for **professionals**.

Survivors of domestic abuse in late life felt that interventions directed at them improved their sense of **safety** (LeBlanc & Weeks, 2013; Rutman et al., 2013; Solace Women's Aid, 2016). Either being hosted in a specialised "transition house" or receiving tailored counselling helped significantly older

survivors to feel more secure and able to **make decisions** about their future (LeBlanc & Weeks, 2013; Rutman et al., 2013; Sirey et al., 2015; Solace Women's Aid, 2016). Trained professionals can guide survivors to agree on safety plans and encourage **help-seeking behaviours** (Amendola et al., 2010; Solace Women's Aid, 2016), including referring to the police or obtaining a Non-Molestation Order. Overall, older survivors felt **more empowered** (Tetterton & Farnsworth, 2011; LeBlanc & Weeks, 2013; Rutman et al., 2013; Solace Women's Aid, 2016), and their **mental and physical health** were enhanced by specific therapies that combined cognitive restructuring, skill-building and assertiveness training. Abuse and health are strictly correlated, meaning not only that a long history of violence can impact one's health conditions, but also that the cycle of abuse can be perpetuated by underlying mental health issues, like depression, that can impair one's self-esteem and ability to imagine different future perspectives (Sirey et al., 2015).

Interventions directed at professionals had different aims and modalities. When professional training was provided to social and health care workers, satisfaction was high, and professionals confirmed that the topic was **relevant** for their job (Struempel et Hackl, 2011). Training directed explicitly to police officers in Chicago increased help-seeking behaviours in the local elderly population affected by abuse (Amendola et al., 2010), while establishing coordinated responses between law enforcement and domestic abuse agencies had a direct effect on the **number of arrests** and convictions in several diverse settings in the United States (Brandl & Dawson, 2011). However, the literature review suggests a lack of UK-based evaluated domestic abuse training programmes in late life. Focus groups in the United

Kingdom revealed that many professionals felt that they lacked the knowledge of older adults' domestic abuse experiences and did not have sufficient awareness of available services to respond effectively to their needs (McGarry et al., 2014; Carthy & Taylor, 2018).

Discussion

Overall, the studies presented in this review suggest value in offering tailored interventions for older adults. However, research on interventions to tackle domestic abuse in late life is still in its infancy, and there were no programmes explicitly focussed on behavioural change for older adults who use abuse in their intimate relationships. Further, the majority of evaluations were limited in scope, based on case studies and pilots.

Older survivors benefit from a range of tailored services for their needs: an integrated approach that considers the impact of sex and age seems to be the most effective. Women across the life cycle benefit from feminist approaches in counselling and therapy that challenge patriarchal statements and help them feel empowered and able to make their own choices. According to research, it is helpful to work on the underlying factors that prevent women from speaking out, from low self-esteem to the fear of not being heard – although it is debatable whether supporting them to speak up would place the burden of the abuse on victims or even provoke an escalation in the home. Some studies highlighted that women should be supported initially to address complex situations at home by making their

own home as safe as possible (Solace Women's Aid, 2016; Carthy & Taylor, 2018). This approach recognises that for many older women, the idea of leaving their home is a barrier to addressing the abusive behaviour of their partners (Solace Women's Aid, 2016). Helping victims/survivors to remain at home also recognises that abuse and older age are risk factors for homelessness (Mears, 2015). If staying at home is not possible, survivors should be supported to find a suitable refuge for their needs, which shall be quiet and accessible, and welcoming (Rutman et al., 2013). The evidence says that older residents in refuges highly value a welcoming environment, which positively affects their wellbeing during their stay (Rutman et al., 2013). There are some advantages to the use of refuge for older adults, supporting them to make connections with other victims/survivors of a similar age and reducing their sense of isolation during a very traumatic time in their lives (Rutman et al., 2013). Survivors should be guided in a path towards independence, possibly providing them with practical aid and advice about finding a new job and helping them financially in the first months of their new life (LeBlanc & Weeks, 2013).

A rights-based approach was also a feature of many programmes, supporting older victims/survivors to make informed decisions about their entitlements. This approach involves ensuring information about support services is accessible in locations older adults are likely to frequent (McGarry et al., 2014; Solace Women's Aid, 2016; Carthy & Taylor, 2018). Advertising should clearly state that abuse can happen throughout the life cycle, and older models should be featured in posters and flyers (McGarry et al., 2014; Solace Women's Aid, 2016; Carthy & Taylor, 2018). At the same time, it is

fundamental to provide extensive training to health and social care workers that work closely with older adults so that they can be equipped to recognise signs of abuse, speak directly with their clients in an appropriate way and signpost dedicated services, as some people may not be aware that what they are suffering from is abuse (Struempel & Hackl, 2011; McGarry et al., 2014; Carthy & Taylor, 2018).

Professionals might also need to be trained about phenomena explained by social psychology such as the 'ingroup-outgroup' effect, which may play a part in defining a biased depiction of how a person experiencing domestic abuse 'should' look like, therefore increasing the risk that older survivors and perpetrators go undetected (Billig & Tajfel, 1973). In the words of Hannah Bows, who has widely researched the topic of violence against older women: "the 'real rape' stereotype of the young, white attractive woman who is raped by a young stranger, often at night in a public place, has contributed to the exclusion of older victims and the denial that sexual violence occurs across the life course" (Bows, 2020).

Ultimately, the literature review highlighted the lack of funding for specialist domestic abuse services, pressuring them to provide a "one-size-fits-all" approach that is generally not adequate to meet older adults's needs (Ishkanian, 2014; Carthy & Taylor, 2018).

Services for perpetrators of domestic abuse in late life

While the review does not include interventions that aim to change abusive behaviour, lessons can be learned to develop an integrated service like MAC for older adults impacted by domestic abuse. The literature highlights that

leaving abusive relationships can be challenging for older survivors, which underscores the importance of addressing abusive behaviours at home. Such a strategy would enable survivors to remain in their homes when it is safe (and when they want) to do so, to reduce abuse, and increase their "space for action", meaning that victims'/survivors' life choices – restricted by the abusers and possibly already impacted by other health conditions – could be broadened by providing space for reflection, information and support (Kelly, 2003).

Training for professionals who support older adults emerged as a crucial need, enabling professionals to recognise the signs of abuse in older adults, respond appropriately, and refer when needed, avoiding common stereotypes that exclude the possibility that older women can experience 'real' gender-based violence (Bows, 2020). This suggestion is consistent with the MAC approach, which aims to provide training and awareness on a community base involving professionals and simple citizens.

Research also emphasises the importance of providing information and services accessible to older adults, an issue that seems relevant for both victims and survivors and those who behave abusively. Questions of accessibility need to be considered in the development of an integrated service for older adults.

Further research should prioritise the development and evaluation of services that address abusive behaviours in older adult relationships. Given the pilot and case study-based nature of the research reviewed, it is also

necessary for more robust evaluative research to build evidence on longer-term effectiveness.

Focus groups on the adaptation of Make a Change for older adults

Method

Focus groups were set up with older adults from the community and with professionals who worked in the statutory and voluntary sectors to support older adults, to gather feedback and suggestions about the potential to adapt Make A Change to provide an early and integrated programme for older adults who behaved abusively, and for their partners and recent ex-partners. The focus groups were conducted between December 2019 and February 2020; 10 individuals from 9 different organisations and 5 carers participated (Table 3). Some potential participants indicated that they could not make the focus group but would answer questions if sent in a survey form. 4 professionals and 3 carers completed online survey questions. It should be noted that there were attempts to engage with other older adult groups but that it was only the carers forum that responded to requests for engagement. In all focus groups, the questions focussed on the idea of an integrated service, particularly on developing services for those who behave abusively. Despite this focus in the questions, focus group participants often pulled the discussion back to a discussion of victims of domestic abuse. It was felt that this might reflect a more general and perhaps necessary

prioritisation of victims in the service landscape, making it more challenging to conceptualise services oriented to intervention for those who behave abusively and support victims/survivors.

Four focus groups were recorded and transcribed verbatim, and the conversations and survey responses were analysed thematically, using NVivo 12. Themes and quotes are summarised below to provide information on the main insights, concerns and ideas that emerged from the discussions. Given that the groups were conducted in a specific local area and within a relatively small sub-community of that area, we have not attributed quotes to specific participants to protect the anonymity of the individuals who made specific points. Findings will be presented in the following paragraphs.

Focus group	*Participant Role*	*Number*
1	Manager / Director Voluntary Sector	2
1	Manager Housing Support	1
1	Social Worker	1
1	Domestic Abuse Support Worker	2
2	Domestic Abuse Service Manager	1
2	Substance Misuse Service Manager	1
3	Carer	5
4	Domestic Abuse Service Manager	1
4	Carer Service Manager	1
Survey		
	Voluntary Sector Worker	1
	Local Authority / Public Sector Worker	3
	Carers	3

Table 3. Focus groups and survey participants.

Features of abuse in older adult relationships

Generational differences and traditional gender roles

Participants referred to generational differences in domestic abuse experience in all focus groups and survey responses, mainly how older adults might find it challenging to identify and name abuse due to 'traditional gender roles'.

> *I think there can be also, like, not in all cases, but in some cases, a generational tolerance of abuse. That it's, yeah, it becomes an accepted norm. Whereas, I think younger generations, maybe, yeah, it's more tuned, and more focused towards them in terms of challenging that. It's almost like the stigma of it, and I think that…or not even identifying that you're in an abusive relationship because, either you feel it's become the norm, or you actually don't think it's abusive.*
>
> *Added issues and complexities of generational norms…domestic abuse was seen as a private matter and treated as such by the Police, such as expectations of marriage.*

Traditional gender roles are seen as largely normalised for older adults, with some degree of abuse being seen as 'normal' or 'part of married life'.

> *I think, from my point of view, it's very difficult sometimes to unpick what has been traditional role models within couples. And what people think is normal.*
>
> *And it's quite difficult sometimes, where some, within a couple, they wouldn't identify that that is a problem, because that's been the norm.*

Professionals suggested that families' traditional roles could make it tough to identify when abuse was occurring, blurring boundaries about what was ordinary, 'traditional' behaviour, and what was abusive.

The notion that relationships are *private* and that abuse should not be discussed publicly was seen as something that was 'passed down' through generations, and particularly from other women in families.

> *And I think it's definitely a big generational thing. The idea that if it happens behind closed doors, you don't talk about it, it's private family life. And often, they've learned from their mothers, and their grandmothers, that's how it goes, stay quiet and you don't talk about it. And the other most common thing I hear is, oh but I can handle it. And that's what I hear from pretty much all of my older clients, I can handle it.*

In addition to the notion of gender roles and the privacy of the home, this professional also suggests that there is a stoicism amongst older victims/survivors, a value in being able to *endure* and *handle* the abuse they are experiencing. Several professionals and carers pointed to a broader normalisation of family violence for older generations, who grew up with more physical discipline and greater acceptance of abusive parenting practices than is seen as tolerable in the contemporary United Kingdom.

> *I think for that older sort of community, it really does tend to come from sort of childhood trauma, values, abusive parents and then just continuing a cycle of that with partners, not knowing what a healthy relationship is. Gender expectations and not realising what consent means, not having educated around any of those things and really not knowing much about what it is to be equal in a relationship in comparison to what we would consider that to be today. There's a*

legacy of something that's far more patriarchal and dominant around what the norms are for those sort of heteronormative relationships.

Some participants felt that this dynamic might also be a factor in the abuse parents experience at the hands of adult children:

Yeah in terms of experience of abuse from children to older sort of parents, for example, we saw some of that as well. Again, some of that seems to be more…it seems to be more prevalent again with mothers who had sons who would be abusive. And that often tended to trend around domestic violent partners who had perhaps passed, or were no longer involved, and then the son had taken on a lot of these behaviours and been brought up with these behaviours and it appears to be a cultural norm.

This construction of generational acceptance of traditional roles was also found in the accounts of carers:

And it's, you know, I say, I'd be interested, is it a generational thing, is that we think, oh we're the wife, so we've got to do this, and got to do that.

Some of it is, what you have to realise, they've been brought up where women were always portrayed, we were always the carer, you know, it's not like fast forward.

In this interaction, the traditional role of 'wife' was seen as following quite naturally into being 'carer'. In addition, these roles, with associated culturally constituted values of stoicism, endurance and self-sacrifice, were also seen as making acceptance of abusive behaviours more likely. In particular, the 'femininity training' women experienced about being 'nice' and 'caring' was

seen as playing a particular role in trapping older women in abusive relationships:

> *Carer 3: We're brought up from birth, to be nice.*
>
> *Carer 4: Yeah.*
>
> *Carer 3: Be nice.*
>
> *Carer 4: So is this our generation?*
>
> *Carer 3: And you sit round the edge, don't get in their way, be nice, let him have it.*
>
> *Carer 4: It's the generation.*

In one of the survey responses, there was a hint at a potential problem with this almost universal acceptance that traditional gender norms underpin abuse dynamics in older adult relationships:

> *There is supposition that because they are older there is a cultural aspect to the relationship - so called traditional roles. So DV and or coercion are used to maintain that status quo.*

The respondent notes that the dynamics of abusive relationships for the adults they support in their 50s do not seem markedly different from those of people in their 80s, suggesting that perhaps professionals are becoming too reliant on the 'traditional roles' explanation. Whilst the role of culture and tradition in maintaining domestic abuse needs to be understood, at the same time it is essential not to presume this and to take into consideration other potential barriers older adults might experience in disclosing abuse.

Differentiating abuse and dementia-related violence

Focus group participants highlighted that, from their experience, there were two broad types of abuse in older adult relationships: long-term relationships, where abuse has always been a feature, and relationships where a care need has shifted the dynamic of a relationship, and abuse has emerged later. They also indicated the need to recognise that violence and abuse might emerge when a partner has dementia but that this needed to be treated differently from domestic abuse. Professional participants highlighted that much of the violence and abuse that they see when supporting older adults is either explained – or worsened – by cognitive deterioration - dementia, strokes and similar age-related conditions.

> *You know, one of the most shocking elements of it, we find in some of our services, our dementia care services, where the personality of the person who's coping with dementia complete changes over a number of years and months, and they become quite abusive. You know, it's quite, it is shockingly common. We've had carers coming to some of our centres, with marks, you know, black eyes, that sort of thing, they've been assaulted by their loved one. Because their personality has changed, due to the deteriorating nature of the illness.*

This overlap with common age-related conditions can make it difficult to differentiate when domestic abuse does occur. One participant, who worked in domestic abuse services noted:

> *And like, for me, I'm not allowed to work with somebody who, the abuse has started as a symptom of their condition. So I do have a client I'm supporting at the moment whose partner has been abusive for 50 years, but has mixed dementia, and has had it for about three years. Because the abuse existed pre mixed dementia, I am allowed*

to work with them. But if it came on, and that was why the relationship was abusive, that's a no from our service.

Nonetheless, participants noted that sometimes pre-existing abuse was missed when dementia was also present: …complexities of symptoms of dementia masking historical abuse, those behaviours not being identified as abusive in case where they are and has been historic domestic and/ or sexual abuse.

There was a general sense amongst the professionals responding to the survey that the workforce needed more support to differentiate long-standing abusive behaviours and abuse that was purely linked to cognitive challenges. It is worth underlining that although the onset of dementia often coincides with anger and aggressive behaviours, and it is estimated that one-fifth of people living with dementia act aggressively towards their caregivers, cognitive impairment is not necessarily linked to abuse perpetration, and people who live with dementia are at higher risk of being victimised themselves (Orengo et al., 2008; Cerejeira et al., 2012; Fang & Yan, 2018).

It was also noted that there was insufficient support for those cases where violence and abusive behaviours were solely related to dementia or other age-related conditions. Generally, there was a perception that professionals needed more training, skills and resource to support older adults dealing with abuse and violence, regardless of its origin.

Abuse in the context of long relationships

Professionals and carers noted that, for many older adults, the abuse had taken place over many years, making it difficult to label and respond to.

However, the enduring nature of the relationship and the abusive behaviour is a core aspect of the experience of domestic abuse for older adults in long relationships:

> *It just wore me down, I mean, 50 years I've been with him, now, 50 years next year. And I think he's just worn me down.*

The sense of being 'worn down' over many years of abuse feels quite overwhelming in these extracts. The duration of abuse is seen as part of the process that entraps victims/survivors in the abuse. Whilst physical violence had been more readily identified as domestic abuse, emotional abuse and controlling behaviours were generally seen as more problematic to recognise in the context of a long marriage or partnership:

> Carer 1: But this has been going back years and years before the stroke. But until I had counselling, I didn't realise what was happening, but now I realise what's happening, I'm not sure whether it's harder. Because I can recognise it, but I'm now having to deal with resentment, and I hate him sometimes…But it's just, as I say, I've been in a difficult position, because I was very young when I met him, and he was older than me. And it had been going on for years, but he kind of made it look like he was protecting me, you know.

For this carer, it was only late in the relationship, when her husband was ill, and she started going to counselling, that she was able to recognise that his emotional abuse, his strategies of isolation, and his controlling behaviours were abusive. This was experienced as revelatory by her, but at the same time, at that particular point in her relationship, she did not particularly feel that the insight gave her much space for action.

Other carer participants echoed coercive control being more difficult for older adults to identify:

> *One hopes that the younger generation coming up does see what's, you know, coercive control behaviour… You know, when I heard about it, I knew that that fit right in, because I can recognise it… It is, it's recognising, isn't it.*

Professionals also suggested that older adults do not always identify coercion and control as abuse:

> *Professional 3: But I think that's another thing with it being older adults, the thing that I hear is, oh he's never hit me.*
>
> *Professional 4: Yes.*
>
> *Professional 3: Or, that I don't have bruises.*
>
> *Professional 4: So it's not a problem.*
>
> Professional 4:: No, so nothing like that has happened.

Given that male and female focus group participants who had experienced coercive and controlling behaviours indicated that they had not been easily identified as abuse, this does signal a need for developing materials on coercive control that are specifically designed for the older adult population.

It was also noted that, in long relationships, patterns of abuse could shift and change over time. For one participant, getting older itself was used as a tool of abuse by her partner:

> *I found, he changed a lot as well as I got older, and I kind of lost attractiveness, I don't know. I don't know what you'd say…. It changed the way, before I think he was always frightened that I'd meet somebody else, that was his fear. And then once I had my son,*

> *and I sort of got older, and everything, it got a lot more nasty. And he was all the time telling me, oh you couldn't go back to work, who's going to want you, you don't know anything, you know, and it just gets you down, and down, and down. And it is very difficult.*

Thus the view that she was 'older' and 'less attractive' was both an emotional attack and a tool to undermine her confidence in her ability to work, thus ensuring her ongoing financial dependency and intensifying her isolation in the home.

Retirement was identified as a particularly vulnerable time for those who had experienced domestic abuse for a long time. Carers and professionals both suggested that for many victims/survivors, there was a sense of being able to cope whilst one or both partners were out at work. Retirement was seen as an escalating factor that resulted in more abuse and less respite for victims/survivors.

> *And of course, we had one where the lady was just dreading the fact that her husband was about to retire, and then he'd be at home all the time. Whereas before, he was out of the house for certain lengths of the day, and she knew that his controlling behaviour would mean that he was there all the time.*

Therefore, services must be aware of how different life phases might signal shifts and changes in abusive behaviours. It is possible that transitions like retirement, or, as is described below, periods of illness, might intensify or change the nature of the abuse.

A range of abusers

Professionals and carers noted that there might be a broad range of abusers in older adult life, with abuse by adult children, friends and lodgers being concerns they have noted.

> *Violence abuse and coercion can be between two older partners but also between an adult child and their parent (as a 'carer') due to carer stress/ fatigue/ lack of support.*

Professionals noted that much of the abuse they see seems to be linked to finances:

> *So whether it's because that care is being pushed onto them, and they start, you know, experiencing more stress, and having to spend more time with that family member, you noticed that then, actually, they'll obstruct their care, or prevent carers from coming in whatsoever, Council care packages. There'll be a lot of financial abuse about looking at what they're going to inherit, and trying to manipulate that in some way.*
>
> *In these cases, finance plays multiple roles: as a motivation for control (to protect inheritances) and as a tool of control. Denying access to care functions to increase the older adult's isolation and dependence on the family member.*

Several participants also reported situations where friends were exploiting older adults financially as a 'price of friendship' or where lodgers were controlling older adults:

> *I had a situation with a lady in her late 70s, who had, she had a degenerative condition. And she had taken on, she didn't have any children, didn't have any family, but had taken on a lodger, years before, a young man. And by the time I got involved, he had, it was like a, he was sat in her, in the middle of her lounge, you know, big*

gaming chair, and a big screen in front of him. And he hadn't paid her any money. And he used to wash his clothes, but he would like chuck them all in this room, so they were all festering in this room. And he would, it was a terrible situation, and she was scared of him. She was very scared of him.

Whilst these may not meet the typical definition of domestic abuse as taking place between people in an intimate relationship, the domestic dynamics and exertion of power and control in the home means that there is often a common experience in these situations.

Where adult children are perpetrating abuse, this can be particularly difficult for older parents to identify and challenge:

I think actually, it's even harder when it's your own flesh and blood. It's hard enough trying to leave an abusive partner, if that's what you want to do, but when it's your own child, it's a really difficult dynamic.

While the focus of the Make A Change programme is to address abuse that may be happening between intimate partners or ex intimate partners, it is essential to recognise that for older adults, abuse in the home may not be restricted to intimate partners but can be perpetrated by a range of other close adults. This factor could add complexity to interventions that seek to address abusive behaviours and it is particularly challenging for the very old and frail or for those with additional care needs, where their dependency on others for care and company increases their risk of abuse and exploitation. It is essential that interventions that target perpetrators of abuse in late life shift their focus to include multiple types of domestic relationship or caring

responsibilities to address abuse perpetrated by intimate partners and grown-up children, paid carers, other relatives or friends.

Financial dependency and housing

Traditional gender roles were also seen as contributing to entrapment in abusive relationships, particularly for women, through financial dependencies.

> *And because they have had, the woman has had a traditional role bringing up the children and may not have worked. But if not worked, if she doesn't have a pension…And we've certainly helped clients where, we've gone in for one, to support with one thing, and covered situations like this. But one of the partners can't financially afford to move away, they don't have the resources to move away. Is there any family, children, going on.*

Financial and practical arrangements within long term relationships are often complicated and involuted. Disentangling lifelong financial and housing arrangements can feel like an insuperable barrier to abused partners and to those supporting them. It was also recognised that financial dependency in long relationships often disproportionately impacts women:

> Well often, one of the partners is financially depending on the other. And because they have had, the woman has had a traditional role bringing up the children, and may not have worked. But if not worked, if she doesn't have a pension. And we've certainly helped clients where, we've gone in for one, to support with one thing, and covered situations like this.

This element can present significant challenges to those experiencing abuse in long relationships when abuse occurs, as there are so many additional practical and emotional complexities. For example, there may be particular attachments around “home” that make separation or leaving more difficult:

> *And there's often a lot of co-dependence going on, as well. So as I'm unpicking, when you’ve got co-dependent relationships that have been built over years, and years, raised children, made a home, you know, that’s their base, their rock. It's very difficult to move away from that.*
>
> *I think a lot of it, too, is what goes on behind closed doors within people, and feel unable to talk about it. Just with (friend’s name), we just became very aware of, you know, what was going on there. And in a million years, she was never, ever going to leave him because, in her words, she had a reasonably good quality of life. Because they sort of had a nice house, and she, the fact that she was a prisoner in her house, it just, you know.*

For those individuals still living in the ‘family home’, this may have an emotional importance far beyond the sense of bricks and mortar. Homes are relational spaces and memory anchors and can occupy a powerful place in people’s sense of identity and emotional life. These aspects of home life need to be considered when supporting older adults experiencing abuse.

Financial dependency and the limited options available for alternative care arrangements can further reduce victims’/survivors’ sense of their space for action.

> *I ask myself that all the time, why. But my daughter says, put him in a home, so many people say to me, put him in a home. But I can't say*

he's ever been physically abusive, it's just, I don't know. I sit there and think, why don't I just walk out. Apart from the fact, I've got nowhere to go, but I mean, he couldn't survive on his own, and he would, I don't think he would be able to cope with just carers coming in four or five times a day. So he would have to be taken into care. But I don't know what's stopping me doing it, I really do not know.

In this extract, the intersection of the carer's perception of her role as wife, a sense of the compulsory nature of 'care' for her as wife, and the lack of viable alternatives contributes directly to her feeling of being *trapped* in caring for her abusive husband.

With older adults dependent on others for care, financial abuse can be a significant risk, reducing their space for action and potentially increasing risk to health and well-being. In the case below, the participant described a client who had control over the couple's finances, and was effectively 'hoarding' their money, refusing to spend it on heating, upgrading accommodation, or providing additional care:

And, but unfortunately, they had about £500,000 in the bank, and she had control of the money, wouldn't spend it, didn't see that they it was a problem living like that. So, you know, because we're a housing service, we go in and see the way people are living, and sometimes that control actually affects where they're living, and how they live. And it affects their health.

There may also be complexities in housing arrangements – for instance, in multigenerational households where adult children are living with their older parents:

Professional 3: And differently, within people's housing issues, if they're in a Council property, or if they're in, they want to move into, say, a sheltered accommodation, of course, the adult son can't go with them, can't they?

Professional 6: Yeah, and we've seen more and more older adults moving back in with their parents, because they've lost their property, or that they just then drop everything and move in with their parents again. So no matter what the parent wants, and then they don't want to make their child homeless, no matter whether they're in their 40s, 50s, they still don't want to make their child homeless.

Therefore, there may be a need for a more sensitive and responsive approach to family housing needs when abuse has taken place and consider the emotional and relational needs and the practical ones when exploring options for older adults who have experienced abuse.

Participants also flagged up the role of financial issues and housing issues in the perpetration of child to parent abuse:

There'll be a lot of financial abuse about looking at what they're going to inherit, and trying to manipulate that in some way.

The family that live a long way, away, they're starting to call in, and as you said, they're starting to think, well hang on a minute, it costs me money to get down here, and I'm going to do this, and I'm going to do that. And I want to protect the accommodation that we should be inheriting, and you're not going to take that away. And then, other members of the family kind of come out of the woodwork, and before you know it, there's all kinds of things going on, with an older person who perhaps doesn't have the capacity to realise that that's happening. And it can be quite difficult to access the legal systems to make sure that person is protected, as well. But obviously if we call

for protection, that can be quite complex, when you're working with this.

Financial dependency, housing challenges, and the availability of care alternatives are all essential features of abuse in older adult relationships, producing a sense of constraint that makes it harder for victims/survivors to envision possible alternative futures for themselves. These concerns need to be considered in planning housing and care for this group and need to be discussed openly and non-judgementally by those supporting older adults. The emphasis in support needs to be on increasing options for victims/survivors to enable more space for action, to open up space for them to consider other ways of living beyond abuse.

The carer role and abuse

There are many factors in the caring relationships that can leave both carers and cared for vulnerable to domestic abuse. The experience people with disabilities have of domestic abuse has been well documented by Ravi Thiara (Thiara et al., 2011). These dynamics did emerge particularly in talks about the caring role in older adult relationships. For example:

> My mother is very abusive, full stop, I'm afraid… But my mother is, to the point she won't let him (father) take his painkillers, because they're for mental people. He was prescribed diazepam to help with the pain in his neck. And that's what mental people take, so he's not allowed to take them. And she absolutely controls everything he does, what he eats, where he's allowed to go, what he's allowed to say. And he is appealing to me for help. *[…] I did actually once say something to her, but she put the phone down on me, and he*

claimed he'd never asked for anything – oh no, I didn't say there was anything wrong. And I really, I know he's being abused, and I don't know what to do about it.

It is evident in this extract that the abuse is a continuation of lifelong abusive behaviours, but that, through her carer role, the participant's mother has been able to intensify her abusive and controlling behaviours further. This situation strongly reiterates Thiara's important work on domestic abuse, disability and caring relationships. Focus group participants also described how carers might "take out" their resentment at the imposition of the carer role on their disabled partners, with abuse emerging as a feature of the relationship transition to a caring one:

And you know, to help her to understand the effects of his injury, and then to help her to understand what she could to do help him. I think, in the end, I think he did want to move out. And he used to go and sit on a bus and just travel round on buses all day, to get out the house, because he couldn't bear how she behaved towards him. She was definitely abusive.

Professionals suggested that the transition to being a carer / cared for could expose and intensify existing power dynamics within relationships:

Professional 5: And perhaps, where there's an imbalance of care needs, as well. So where somebody suddenly requires more care, and the partner isn't really ready to take on that responsibility. And there's a bit of a power imbalance, really.

For this reason, ensuring the carer is supported was seen as very important.

I think if you're talking about a change in, because of illness, often, trying to get carer support can be really valuable. Because it is a difficult job, being a full-time carer.

Carers and professionals supporting carers noted that carers were also subject to high levels of abuse from those they cared for. As noted above, it is vital to differentiate domestic abuse from the violence and abusive behaviours associated with cognitive deterioration. Nevertheless, it was notable that all the carers in our focus group and survey described how they or their friends and family were experiencing abuse in their caring role. The carer role itself can contribute to victims/survivors deciding to remain in abusive relationships:

Women can be the main carer of their partner or adult children so if they leave there will be a burden of guilt.

One aspect of this dynamic relates to the imposition of the caring role itself.

Professional 3: We have an elderly couple in our group at the moment. And he's not intentionally abusive, but the husband is wanting to be discharged from hospital, and just saying, he doesn't need carers because his wife will look after him, it's her job. And she can't, she's too old, he's too big, and too immobile. And in my mind, the bar for capacity is set too old. He's deemed capable of making his own decisions. Well, yes, what he wants. But there's nothing to stop him making decisions that impact on other people. […]

Professional 4: I've heard that so many times.

This phenomenon overlaps with more traditional ideas around the home's privacy and the sense of wives (and, to a lesser degree, husbands) being

expected to provide care. This idea is also echoed by the State's assumption that care, where needed, will primarily be provided within the family. Whilst this is not necessarily abusive in and of itself, it can be the basis for removing a sense of choice for the carer and can result in the sense of disempowerment that intensifies the sense of entrapment and lack of space for action. In the mentioned case, the husband is seen as making choices to refuse paid care, which would impact the carer wife, whose needs do not seem to be considered in the decision. This subtlety is noted by one of the carers whose partner did engage in a range of coercive and controlling behaviours, which she recognized as a lifelong pattern:

> *I've got that with my husband. And he's been discharged, well, nearly five years ago, now. The carers from the agencies just go, unless the carer is young and pretty. Anybody else, he's just so awful. So I've had three care agencies withdraw.*

Here, the partner's capacity to choose is respected by professionals, but there seems to be a lack of concern about the carer's ability to choose to care. She describes her husband as being extremely difficult with the paid carers provided, to the point where many agencies had blacklisted them. The effect was a sense that she had no choice but to provide the care for him, and his behaviour further isolated her and intensified his control.

> *Then I went to counselling, and it was only then, my goodness, I've been manipulated all these years, from the age of 17. But now, and he's helpless, but he's still doing it. He's using his helplessness to control … He's still, but now, I can recognise it.*

This carer particularly felt that the professionals supporting her and her husband failed to recognise the abusive dynamic and failed to intervene to provide her with the support she needed.

> I don't know. I don't think there's anything anybody could say to him, because he is so right, and in his own world. I've had, I have had social workers in the past – get out my house, I'm not having you, and blah, blah, blah. He won't go to any of these clubs, I mean, they've tried the stroke club. Because he's very disabled, I mean, he's not able to do anything for himself. He just won't, he's just, like the king of the castle, and you dare talk to me, you know. I don't know, the only way I can see out of it is a crisis. If there's a crisis, and he gets taken away, that's the only way I can see us getting out of the situation that we're in. *[…] But he can be very reasonable, like, when the doctor comes round, my poor wife, my poor wife needs help. And they all believe him, you know.*

Professionals, in this case, do not appear to be sufficiently aware of the carer's support needs. His refusal to engage with other support services and his abusive behaviour towards carers has largely gone unchallenged, leaving her isolated and without sufficient respite.

The sense of being trapped in the carer role with someone who has always been abusive can feel overwhelming and leaves carers in this position feeling that they have no way out of the abusive relationship.

> *Carer 1: …and I know it's a total and utter pain, and I'm a slave, virtually, but I can't see it changing. Unless, as I say, it naturally changed. […] I'm stuck with this giant toddler, is the only way I can describe him. Throwing his toys around, and screaming when he doesn't get his own way, wetting himself, he is a giant toddler.*

The stroke, in this case, has intensified already coercive and controlling behaviours, and the sense of being trapped with her abuser through caring is very evident in this extract.

Professionals saw lack of support for carers as potentially contributing to abusive behaviours, particularly where the carer role is seen as imposed:

> *I know the gentleman who had dementia, and his wife was the same age, but she wanted us to get him out, out of the house, wanted him to go and live in a home. Because she couldn't cope, she didn't want to. So it's, so having that carer, the carer services, is really important.*

The caring role itself might be used as a tool of control. One carer said:

> *Mine is so manipulative that he doesn't use the loo when the carers are there. The minute they've walked out the door, I mean, he is in pads – I need the loo. Well she's just gone, five minutes ago – I need the loo, now. And I get that up to five, six times a day, and I've got to transfer him onto the frame, put him on the toilet, nothing happens, he's always in his pads. And the threat is, well if you don't put me on the loo now, I'm going to do it in my pad, and he knows that I hate that....*

This kind of abusive behaviour might be quite difficult to identify as abuse since on the surface it might appear that using the toilet is a basic need and a feature of everyday caring. Someone observing this objection to supporting toileting without understanding the broader context of the relationship might even interpret the carer's objection as abusive in itself. However, in this case, the victim/survivor highlights that her husband refuses to toilet with the paid carer, insisting instead that *she* perform this aspect of personal

care, and that he often uses toileting as a kind of punishment when she returns after going out.

Another carer suggested that other aspects of their life were controlled and constrained by the person they cared for, who only allowed her to go out if it was related to his care needs:

> *And like you were saying, like your friend, I have to lie. Like, I got asked to a wedding, my nephew's wedding back in the summer, I had to lie, saying that I had to go to my daughter because she wasn't very well. So I had to get all changed for the wedding, and everything, and then put my ordinary clothes on, just so that I can get out and do something that normal people would just do.*

This sense of constraint and of not being 'allowed' to have a life beyond the carer role was extended through the use of phone technology for monitoring and 'checking up' on the carer when they were outside the house:

> *But once we started getting phones, I mean, he had the tracker on her, and he knew exactly where she was at any one time. So any lies we told, he could see through.*

It was notable in the focus group with carers that one participant's phone repeatedly buzzed during the 90-minute group, as the partner was 'checking up' on where she was and when she would return. It is essential to recognise that people with disabilities may feel very dependent on their carers and anxious when they are out, and some element of 'checking' is quite typical in caring relationships. However, when it is extended in this manner to a sense that the carer is being controlled through monitoring and checking, this

suggests something more concerning – especially when the behaviour is an extension of coercion and control present in the relationship before it transitioned to the caring relationship. The difficulty in ascertaining the difference between checking and monitoring is also a concern in and of itself. This situation again illustrates how challenging it might be to identify abuse in the context of a caring relationship, where distinctions between ordinary dynamics related to dependency from control and coercion can be complicated to draw. It is also imperative to consider challenging presumptions that older adults will not be technologically capable and recognise that digital stalking could be an experience for older victims/survivors in common with their younger counterparts.

Naming and disclosing abuse

Domestic abuse is often difficult to talk about, which was seen as a key barrier to accessing services and support. As discussed previously, participants observed generational differences in understanding of what constituted abuse, which would impact people's capacity to ask for help.

> *Also, the responses generationally to that abuse would be a massive shutdown for them in terms of that perceived concept of that's just what happens, you know. That's just okay, you don't talk about it and even with those who would experience sexual abuse for example, and older adults, you know sometimes they would be for the first time talking to us in my prior role, around things that had happened and they'd carried it their entire lives and it wasn't until they were in a gender specific service that was addressing substance misuse, they felt it was non-judgemental enough and open enough and empowered their voice enough, for them to get to the point and say well actually this happened to me and now I'm realising that actually*

this is just how I've coped with it. And never having thought about the pattern or considering that to be a trigger or any of those things.

Here, the participant has identified traditional values and an acceptance of abuse as 'normal' as contributing to help-seeking for older victims/survivors. In particular, participants felt that it would be more challenging for older adults to identify coercive and controlling behaviours and that they were more likely to recognise physical violence as abuse:

Carer 3: I think for most people, it means physical abuse. But my experience is, it's all been emotional and coercive.

Carer 1: Yeah, the same with me. I've not experienced physical abuse, but it is the controlling behaviour, and the manipulation, that gradually gets to us.

Participants felt that a significant challenge in providing an integrated domestic abuse service for older adults would be the difficulties of naming and disclosing abuse. We have previously discussed the perception that traditional gender roles might function to normalise abusive behaviours in older adult relationships, and clearly this might make it difficult to identify abuse.

Professional 3: And it's quite difficult sometimes, where some, within a couple, they wouldn't identify that that is a problem, because that's been the norm.
Interviewer: Right, so it's part of, sort of normal social interactions, it's normal for them?
Professional 3: Yes, yeah. So going in and trying to support a couple with something, or trying to, it's very difficult to address something that they're not telling you is an issue.

Generational differences were seen as a crucial factor to acknowledge in planning services for older adults. Professionals suggested that older adults might see abuse as restricted just to cases where physical violence has occurred and that recognising emotional abuse, coercion, and control might be more challenging:

> *Professional 3: But I think that's another thing with it being older adults, the thing that I hear is, oh he's never hit me.*
> *Professional 1: Yes.*
> *Professional 3: Or, that I don't have bruises.*
> *Professional 1: So it's not a problem.*
> *Professional 3: No, so nothing like that has happened. Even my mother-in-law, has taken, she's only in her early 60s, but really struggles with what I do. Because she says, what, so they have a bit of an argument, and then they come to you, what's that for? And she doesn't understand that abuse isn't just physical, she'd expect there to be bruising or broken bones, and that's when they'd need some urgent help.*

This cultural shift around the understanding that abuse is more than just physical violence requires careful consideration. Indeed, one aims of the Make a Change programme is to raise awareness of the nature of abuse by training professionals and members of the wider community to identify abusive and controlling behaviours beyond the usual definitions of violence. Materials that specifically target older adults and clarify the nature of healthy relationships and abusive relationships seem particularly important in supporting older adults to recognise and name abuse when it occurs.

Barriers to accessing services and support

Participants highlighted that there was generally a lack of specialist domestic abuse services, particularly for those who behave abusively, and that there was minimal specialist domestic abuse for older adults. This lack of support was seen as a significant barrier to accessing services for older adults who experienced domestic abuse.

Participants noted that the lack of services specialised for older adults meant that there might be access and mobility challenges, as services were not sufficiently adapted to older adults' needs. Further, rural isolation and challenges in getting to city or town-based facilities were seen as barriers to access for older adults.

> *I doubt they have the facilities to deal with people with poor mobility. Also refuges are quite raucous and I don't know how some of our older clients would cope.*

Participants also noted that funding cuts to domestic abuse services and social care services for older adults meant that service access and responsiveness were being further challenged.

> *The picture that you've painted, unfortunately, the effects of austerity, and local authority cuts, have had a massive impact on older adults. […] the demographics of East Sussex are such that, it is becoming an increasing older county, and people are living longer, with limiting, long term conditions. But by the same token, the funding for services that are specifically targeted at people, has diminished. […]*

Professional 3: I mean, I think even with Adult Social Care, we've seen, last year, we saw huge cuts. So that people assume that there are huge teams, and that those, again, no longer exist.

The reduction of community services for older adults results in fewer opportunities for support and impacts the likelihood that domestic abuse will be identified and responded to. This is a particular problem since professional participants indicated that it was sporadic that people sought support for domestic abuse per se. Instead, their abuse tended to be identified after help was sought for another need:

A lot of ours, a lot of the people we work with, haven't come to us for that reason. It's because, I mean, you know, making sure that organisations like ours know about it, so, you know, we could at least let people know. So I think working with agencies that are already out there working with older adults, would be useful.

Both professional and carer participants felt that older adults would be less likely to turn to domestic abuse services directly and were more likely to seek help in indirect or even serendipitous ways:

I don't think anyone would even know how to ask for that kind of support. I think it's probably far more likely to come out in a different way, in terms of perhaps a GP being seen for different things around stress and worry or anxiety, and not necessarily coming out as what it is.

This dynamic underscores the importance of community and professional awareness of domestic abuse in older adults to ensure that support and

information are available where help is sought, rather than confined only to specialist services.

Stigma and shame were widely perceived to be a problem that made it harder to identify abuse. One professional told us that when she provided a gender-specific service for domestic abuse survivors in some areas, her posters were regularly being taken down. She felt this was because some areas did not want to be seen as 'having a problem' like domestic abuse.

> *And going into little cafes… that's one I went in to, for example, that I'd spoken to about hiring the space, to hold groups like this and to talk to them about women's experiences and you know this was really important. And as soon as they heard what it was for, you know, that was not allowed, I was not allowed to hire that space for that group.*

Carers also noted that they might not want to identify with being a 'victim' and that people who behaved abusively would be put off by language that framed them as a 'perpetrator' or an 'abuser'.

> *Carer 1: And I didn't want to be thought of as a victim. When I realised what was happening in the counselling, I was sitting there one day and I thought, I feel like a victim, now, you know.*
>
> *Carer 4: You are a victim.*
>
> *Carer 1: But you don't want to feel like that, it's a shame to admit, well I'm weak, I can't deal with it.*

It is, therefore, crucial to think carefully about how an integrated service for domestic abuse might be represented. It is important to understand that older adults may not identify coercion and control as 'abuse' and that

labelling services for domestic abuse may result in them not being recognised by those who may need them. Besides, feelings of shame and stigma relating to domestic abuse may mean that, even if they recognised abusive behaviours, it would still be challenging to seek help for them. As one professional noted:

> *There's this level of, dare I use the word, shame, you know, I don't want to admit that this is happening to me, so it isn't. I'm ashamed of that time, I'm not going to admit it, I'm going to tolerate it. So, sometimes, when you're looking at services, it's how can they be accessed, but you don't want to go in with flashing lights saying, hey come here, if you need to be supported.*

Raising professional and community awareness

There was a strong sense amongst all participants that there was a need for professional training and support to raise awareness of the specific domestic abuse features experienced by older adults. It was seen as particularly important that professionals be aware that older adults experience abuse, that they may not always be able to recognise abuse when it happens, and the intersection of caring and domestic abuse experiences.

The discourse of the 'heroic carer' was recognised by Thiara (Thiara et al., 2011) as contributing to the invisibility of the abuse of people with disabilities. In her interviews, people with disabilities noted that people tended to assume their carer was a loving, self-sacrificing person, an assumption that made it difficult for their abusive behaviours to be recognised. A similar dynamic is also evident in carers' accounts about their abuse and the abuse experienced by other family members.

Well, my husband's GP is jolly, you know, everything is jolly good, oh you're doing a jolly good job… And all he can say, why aren't you doing his blood sugar more often. And I stand there like a naughty girl, because I'm not doing this and not doing that.

Although her GP was a little aware of the stressors she was experiencing, this had not been communicated to her husband's GP, who appeared to be oblivious to her difficulties. Another carer suggested that her and her friends' experience was that people in social care and in GP practices were not likely to ask about domestic abuse or even about the stresses of caring.

Carer 3: You can, the police, now, are taking coercive control seriously, and they do have a domestic violence arm, and you can just go…some women in my support groups have just gone to a police station and said, I need to report domestic abuse, it's not violent, it is coercive, and this is what's happening. And from there, they've been linked to people to help them. Whereas social workers, and GPs, are sort of backing off going, oh there's money in that, we can't do that… I do think, GPs, I mean, they're horribly overworked, but they're the first port of call.

Carer 4: But then, they just give you antidepressants. It's my fault, I'm depressed – oh have some pills.

Professionals noted that cuts in service provision might reduce the chances that domestic abuse be asked about or identified and that the lack of a service to refer older adults to meant that some behaviours – particularly those below the safeguarding threshold – would go unchallenged. This highlights a clear need for training and guidance on how to raise concerns about behaviours in relationships with victims/survivors and with those using

abuse. A carer described several missed opportunities for those supporting her to address the abuse she was experiencing:

> *Carer 1:* There's one thing you were saying about professionals, and I've had it said to me by a social worker, different people, when I've tried to sort of explain – but you look fine, you look really, like, you're really coping. I find that instantly a shut down. What should I look like, then. *[…]* You try and keep some sort of identity, but you're sort of judged, you know, you can have your nails done and you can do this, so you must be fine.
>
> *Carer 1: Yeah, I mean, I've had, as I say, social workers have come round, and one in particular, actually did tell me to leave him. But any whiff of social…luckily, we were living in a bigger house, and he used to come in round the back, because if my husband saw him, it would be, get out my house, I'm not letting you in here.*
> *Carer 4: But that must have been a flag to the social worker, that…*
> *Carer 1: Well he didn't know what was going on.*
> *Carer 4: But if he was saying, well why are you here, that should be a flag to that social worker, why are you…*
> *Carer 1: I suppose, if I wasn't, what could he do, if I wasn't sort of cooperating with him.*

These missed opportunities highlight the importance of professionals being trained to recognise signs of abusiveness and ask appropriate questions when they have concerns. The lack of a service to refer to was seen as a barrier to professionals asking about abuse:

> *I don't know where to go, I don't know what to do, and obviously they don't. I kind of get the impression they're thinking, well she's not doing much to help herself, so what can we do?*

Carers highlighted the importance of friends and people in the community as a support source and felt it was vital they have access to information about

domestic abuse, how to support people experiencing abuse and how to raise concerns about abusive behaviours safely. They also noted that when friends and family did not respond appropriately, it left them feeling even more isolated and helpless:

> *Carer 2 it changed a lot of dynamics with friends, because all of a sudden…*
>
> *Carer 3: Yeah, it's scary for them.*
>
> *Carer 2: Yeah, and sort of, you know, very sort of close friends, just, the telephone calls stopped, they didn't want to know, you know, sort of, and that. But it was a good way of finding out who your true, you know, who your true friends were.*

Access to information on how to support friends and family experiencing domestic abuse is key to enabling disclosure and access to assistance.

In addition, carers noted that their paid professional care team were also a critical source of support:

> *Yeah, the one I've got now. she's brilliant, and she's said to me all along, you know, I'll back you up. She's my lifeline, really, at the moment, yeah. Well, she's here. But no, she can see, she knows exactly what he's like.*

Equipping paid carers with the knowledge and skills to recognise and respond appropriately to abusive behaviours is potentially a powerful intervention for those experiencing abuse who may themselves struggle to name and address abuse.

Suggestions for an integrated domestic abuse service for older survivors

Professional participants placed a strong emphasis on safety planning and on 'mainstreaming' safety planning so that it was addressed across the adult social care sector:

> *I think it would be very much along the lines, as (Professional) said, about, it is very victim-focussed. So it's about ensuring safety as a priority, really. And putting measures in place, whatever they may be, whether that's Adult Social Care, whatever, the police, to ensure the safety of the victim. So it's not so much the focus on the perpetrator.*

Participants felt that older adults' services need to be built into the spaces and services people were already accessing. Participants did not feel that a named domestic abuse group would be accessible to older adults because of generational norms and issues stigma and shame:

> *I see very few older adults wanting to access services as a group… It's going back to the shame, and not wanting them to know, I don't want to talk about my business in front of other people. Because I'm not acknowledging that I'm in the same boat as they are. So that forms a barrier when accessing, or accepting support.*

Norms around maintaining the privacy of home life were seen as a significant barrier, and participants suggested that building domestic abuse response into other places was a meaningful way to address that barrier:

> I read something recently around work was happening in America, I've probably got the link somewhere although it will probably easily found, around a barber's shops being turned in…yeah, she's not your rehab, they're looking at that, and again it doesn't have to be that focussed but that's what they've done. I think pubs would be a great

> place to go to be fair, for people who are sort of older drinkers and in that behaviour and that tends to be…going back to my university days I used to get lots and lots of older gentlemen talking to me. So it's people that you just don't think of necessarily that we go to, to talk to about different things. *I think there's different places I could imagine, like churches, places like allotments.*

This suggestion is very much in keeping with both the 'Ask Me' (WAFE) and Make A Change approaches, which stress the importance of enabling a community response to domestic abuse. In addition to these community locations, participants suggested that responses be integrated into other services older adults might access:

> *And she was wheelchair-bound. And it was only joining the stroke club, and things like that, that she got out.*

Accessing support in non-specialist contexts empowered this individual and enabled her to create space for action.

> *Professional 4: But there's something in that, isn't there, about talking about things in the past. If you have, like a reminiscence session about growing up, and experiences that people had in the past, you get people on that topic, you know, they will…*
>
> *Professional 3: Yeah, we looked at, like, role models, anything that had role models coming up. I went in from the point of, you know, what would you want for your grandchildren, like, for your female grandchildren, what is it that you want them to be able to achieve in their lifetime. And looking at what things had been like that for them. And they really…*
>
> *Professional 2: That gets people talking.*
>
> *Professional 3: Oh, definitely, they really loved to talk about that.*

Carers felt that professionals and community members also needed to be equipped with the skills to guide them to addressing abuse:

> *I mean, I've had this counselling, but actually I'm left sort of in this limbo, now. Guide me the actual steps to break free, support me to break free.*

Key findings and recommendations

Key findings

Based on this consultation, several key findings can be identified:

- There is a need for an integrated service for older adults which addresses both victims/survivors and those who behave abusively.
- Such a service needs to recognise the specific features of domestic abuse for older adults and the role of generational and cultural norms, including faith-based norms, in the experience of domestic abuse.
- The role of age, sex and gender-role is worth considering, as an intervention for older male perpetrators of abuse would likely face intersectional issues, such as entrenched traditional misconceptions about the role of women as primary caregivers in the household.
- Age-related health conditions can also become tools for the perpetrators to coerce their carers.
- The service would also need to understand the specific dynamics of caring relationships and be equipped to address abuse of carers and of cared for partners in these circumstances. This would include tools to tackle the complexities of being home-bound, including the presence of sons and other people in the home who could have caring responsibilities or a role in perpetuating abuse.
- The stigma of domestic abuse was seen as particularly acute for older adults, and it was suggested that they might not readily recognise their

experience as ‘abuse’. Therefore, offering a service labelled as addressing ‘domestic abuse’ was seen as inappropriate. This suggestion highlights a coherence between the approach suggested by focus groups participants and the Make a Change approach, which does not require disclosure for engagement and avoids stigmatising language like ‘perpetrator’ in framing domestic abuse.

- The MAC early response approach was seen as acceptable and appropriate for adaptation for the older adult population.
- It was suggested that services need to be accessible to older adults and that locating them in appropriate spaces, such as community groups or services like Care for Carers or Stroke Club, was the ideal way to maximise access and engagement.
- Training interventions were seen as necessary for professionals and community members to build awareness of domestic abuse amongst older adults and enable recognition of and response to domestic abuse.

Recommendations

Based on this consultation, the following recommendations are made:

- A specialist integrated service for older adults experiencing domestic abuse, which encompasses interventions to help both victims/survivors and perpetrators of abuse and employs an intersectional lens, is needed.

- A motivational, educational approach is recommended to challenge cultural assumptions that perpetuate the cycle of abuse in late life: this is consistent with the ethos of the MAC programme.
- The MAC programme is suitable for adaptation to provide an integrated, early response to abusive behaviour in intimate relationships for older adults, as it works independently and privately to provide support to survivors and people who use abuse. This feature is particularly relevant, as older adults who experience abuse in their intimate relationships may be particularly reluctant to leave their homes: if safe, working within couples can be worthwhile to improve individuals' quality of life and wellbeing.
- MAC groups and training initiatives need to be integrated with other services and located within the community to maximise access. However, in planning services, it must be recognised that there is a risk that stigma will be a barrier to community integration, particularly in small communities. It is crucial to build in sufficient time and resources to address potential community resistance to local areas' development. Community engagement work will need to be done, including gaining the support of respected community members and community or organisational leaders to gain people's trust in the service.
- Training for professionals should be delivered to develop an understanding of how domestic abuse happens in older adults and how it might present in the context of caring relationships. Professionals need to be equipped with the knowledge and skills to

recognise abuse, respond to abuse, and, where appropriate, refer survivors and people who use abuse to an appropriate service. The "Recognise, Respond, Refer" training developed by Make a Change, which provides professionals with the skills and tools to address domestic abuse, as well as to signpost Make A Change in a non-judgemental way, can be enhanced with a specific module to address domestic abuse in late life.

- Participants highlighted the importance of a community response. An adaptation of the 'Ask Me' or Make A Change community response programme is essential to ensure that older adults experiencing domestic abuse can get support in an everyday context.

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Appendices

Appendix 1: Quality criteria for scoping review

Types of study	Methodological quality criteria
Pre-screening questions (for all types)	Are there clear qualitative and quantitative research questions (objectives), or a clear mixed methods question (objective)? Do the collected data allow address the research question (objective)?
1. Qualitative	1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)? 1.2. Is the process for analysing qualitative data relevant to address the research question (objective)? 1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?

	1.4. Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?
2. Quantitative randomised controlled	2.1. Is there a clear description of the randomisation (or an appropriate sequence generation)?
	2.2. Is there a clear description of the allocation concealment (or blinding when applicable)?
	2.3. Are there complete outcome data (80% or above)?
	2.4. Is there low withdrawal/drop-out (below 20%)?
3. Quantitative non-randomised	3.1. Are participants (organisations) recruited in a way that minimises selection bias?
	3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups
	when appropriate) regarding the exposure/intervention and outcomes?
	3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants

	comparable, or do researchers take into account (control for) the difference between these groups?
	3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?
	4.2. Is the sample representative of the population understudy?
	4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?
	4.4. Is there an acceptable response rate (60% or above)?
5. Mixed methods	5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the
	qualitative and quantitative aspects of the mixed methods question (or objective)?

5.2. Is the integration of qualitative and quantitative data (or results) relevant to address the research question (objective)?

5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results) in a triangulation design?

In addition to this, a separate quality assessment of the quantitative and the qualitative parts of the mixed methods study is done. In this case, the overall quality rating cannot exceed the quality of its weakest component.

Appendix 2: Summary of literature included in scoping review

Study and Design	Quality Rating (MMAT)	Participants and Context	Country	Intervention	Measurement	Study Outcomes
Amendola, Slipka, Hamilton,	Good. Significant	328 elderly residents from three	United States (Chicago).	This study aimed to evaluate the impact of home	1795 elderly residents were contacted on	Victims from the police sample were more likely to have at

& Whitman (2010) Non-randomised controlled trial	missing data at follow-up.	sample groups: 1) community non-victims (n = 159); 2) community victims (n = 121); and 3) a "police sample" consisting of elderly victims who had been visited by trained domestic violence/seni		visits from senior services officers or domestic violence liaison officers from the Chicago Police Department on elderly residents who experienced at least one incident of domestic abuse in the past three years. It also seeks to examine the	the phone by trained police officers and screened for cognitive capacity/demen tia and victimisation (except the police sample that had already been identified as "victims"). Then, a different survey was administered to victims and	least one subsequent abuse incident than those from the community sample. However, for those in the police sample, the number of forms of abuse that repeatedly occurred (> 10 times) went down. In addition, those in the police sample were more likely to have engaged in protective behaviours or service seeking than those in the community sample.

		or citizen victimization officers in the Chicago Police Department (n = 48). Participants in the three groups were current residents of the City of Chicago, aged 60 and over.		prevalence and types of abuse experienced by the elderly and the protective behaviours and risk factors that may influence the degree, frequency, or continuation of abuse.	non-victims. Victims were asked about: demographic characteristics; risk factors; protective behaviours; type, severity and frequency of victimisation. Non-victims were asked about: demographic characteristics, risk factors, protective	

					behaviours. Participants were interviewed twice at 10-month intervals. Interviews with non-victims ended after the screening after reaching the quota of 150 non-victims.	
Brandl, & Dawson (2011)	Very poor. Although the data sources are	49 communities, from large, urban areas,	United States.	OVW Abuse in Later Life Program is a three-year grant	Unclear from the paper.	Grantees have described the following positive outcomes as a result

Case study	relevant to address the research question, it is not clear how the evaluation process happened.	e.g. Seattle and Denver, to small, rural areas, e.g. East Prairie, Missouri. They include two tribes and represent the four corners of the USA.		cycle provided to eligible units of local government or non-governmental victim services in the USA. Applicants must have memorandums of understanding (MOUs) between four partner organizations: law		of being funded by the OVW after five years from the first implementation: 1) Creating multi-disciplinary elder abuse coordinated community response and protection teams to focus on systems responses to elder abuse. 2) Increased arrests and convictions for elder abuse. 3) Increased communication and collaboration between law

				enforcement, prosecution, ageing network, and a domestic violence or sexual assault victim services organisation. The programme requirements include committing to 1) Provide training to criminal justice professionals, governmental agencies, and		enforcement and APS. 4) Increased number of calls for assistance from law enforcement to APS regarding cases of elder abuse. 5) Increased requests for additional training by law enforcement, prosecutors, APS, and others working collaboratively on elder abuse cases. 6) Established specialised elder abuse units in the prosecutors' offices,

				victim assistants to enhance their ability to address elder abuse in their communities (2 to 3.5-day training). 2) Provide cross-training to professionals working with older victims (2 to 3.5-day training). 3) Develop or enhance a coordinated		including assigning a special investigator to a prosecutor's office to assist with the investigation and prosecution of elder abuse cases. 7) Review and revise state laws to enhance the protection and services provided to vulnerable older adults.

				community response (CCR) to abuse in later life. 4) Create or enhance services for victims who are 50 years of age or older.		
Strümpel, & Hackl (2011) Case study	Very poor. The paper aims to describe the procedure that brought to the training course design,	More than 200 professionals and volunteers in health and social care (14 trial training were conducted	Austria, Belgium, Bulgaria, Germany, Portugal and Slovenia.	The "Breaking the Taboo" project was coordinated by the Austrian Red Cross and aimed to raise awareness on violence against older women in	Unclear from this paper.	No specific training courses on violence against older women for staff of health and social services could be found previous to this project. Evaluation data are available only from the Austrian

	more than an accurate evaluation of its effects.	with an average of 15 participants each).		families amongst community health and social services. In the "Breaking the Taboo-II" programme, a two-day training for a range of professionals all around Europe was designed, including nurses, home helps, care assistants, social workers, Red Cross volunteers,		experience. In general, workshop participants perceived the topic as very relevant to their work. Most participants were very interested in the subject, and almost all workshop participants could contribute examples from their own experience. However, it became clear that this is a sensitive topic and raised anxiety among some

				visiting services and crisis intervention workers. The training programme, based on an extensive literature search and analysis of existing training materials for professionals, was composed of nine modules focussing on aspects like defining and		workshop members. As participants need time to talk openly about such sensitive issues and establish an open and trustful atmosphere, it is needed if the workshop is to be successful and effective. No further outcomes are presented in this paper.

				recognising violence in older women and intervention, cooperating with other organisations and caring for oneself.		
Tetterton, & Farnsworth (2011) Case studies	Good. The analysis process is reflective and accurate. However, two case studies may	2 older women who survived domestic abuse.	United States (Virginia).	Participants discussed the effectiveness of different interventions to help them cope with a history of long-term domestic abuse.	In-depth interviews.	Researchers identified that these features improved life outcomes for participants: having a welcoming and engaging approach, encouraging and supporting the telling

	not be enough to answer the research question.			The first participant underwent late life counselling based on a feminist approach that involved cognitive strategies to manage anger and develop assertiveness, including journaling. The second participant used domestic abuse		of one's story, assisting in the process of empowerment. Participants eventually gained more assertiveness, self-awareness and self-confidence, with a focus on the concept of "empowerment from within" to regain control of their lives.

				shelters, was involved with Al-Anon, underwent counselling during her life cycle, and eventually hedged to flee the town where she lived.		
Bowland, Edmond, & Fallot (2012) RCT	Good. No clear description of blinding between groups.	43 community-dwelling women survivors of interpersonal trauma, aged	United States (Missouri)	This study evaluated the effectiveness of an 11-session, spiritually-focussed (Christian) group	Pre-test and post-test measures: Geriatric Depression Scale, Post Traumatic	The treatment group had significantly lower depressive symptoms, anxiety, and physical symptoms at post-test compared with

		55 and older, randomised into treatment or control groups. One-third of the sample also disclosed chronic emotional abuse in their current primary relationship.		intervention with older women survivors of interpersonal trauma, including domestic abuse. Facilitators were trained using the Trauma Recovery and Empowerment Model and were versed in feminist teleological approaches to	Stress Diagnostic Scale, Beck Anxiety Inventory, Patient Health Questionnaire Somatic Symptom Severity Scale; Spiritual Assessment Inventory; forgiveness scale (Idler) and Interpersonal Religious Discontent of	the control group. In a separate analysis, post-traumatic stress symptoms also dropped significantly in the treatment group. Outcomes were maintained at follow-up.

				interpersonal trauma. The intervention was chosen because it is a manualised psychoeducational, cognitive restructuring, and skill-building approach to addressing spiritual struggles in trauma recovery.	RCOPE. Follow-up 3 months later.	

LeBlanc, & Weeks (2013) Descriptive, case studies	Excellent.	25 transition house directors.	Canada (rural and urban settings in both primarily Anglophone and Francophone communities).	"Transition houses" are residential facilities for abused women and children, which are often the first contact for women seeking help from domestic abuse. Support groups are often offered within these settings.	An online survey about the transition house characteristics and how many women in midlife and older visited the transition house in the previous year and the previous 5 years; semi-structured telephone interviews to address the	47% of transition houses considered in this study applied for funding to make improvements to accommodate older victims; 41% of them sought consultation with seniors specialists; 24% received and 41% provided specific training to address domestic abuse in late life; 18% offered special programming for older victims; 88% accommodated

					extent to which transition houses meet women's needs in midlife and older.	special needs, and 100% specified that domestic abuse occurred in the whole life cycle in their media campaigns and said they would ensure that older victims felt welcomed. While policies, accessibility, privacy, support, and outreach could be improved to meet older women's needs, the transition houses offered safety and space to make crucial

						decisions for women across the lifespan. Possible improvements may include support groups led explicitly by older women, job assistance, and assistance covering daily living expenses for older women aiming to start a new life.
Rutman, Hubbersteiy, Hume, &	Excellent.	39 among residents, former residents, volunteers,	Canada (South Surrey, BC and	This study aims to evaluate the impacts of transition house services, AMA	Focus groups and in-depth interviews. Residents' experiences	Overall, residents and former residents learned about services and supports that can help them in

Kruchten (2013) Case studies		staff, managers and coordinators of the two houses.	Montréal, Quebec).	House and SAVA, designed specifically for older residents in two Canadian locations and to identify fundamental principles and practices that lead to successful outcomes. Ama House operates as part of a transition house model, is designed	were also evaluated with creative methods, including poems.	the community, got connected to health services and community resources they needed, felt supported both emotionally and practically, and felt that they increased their sense of safety and personal control. Outcomes did not differ significantly across the two different realities. However, residents at AMA House felt an increased sense of

				specifically for women, and has a harm reduction approach. SAVA has two distinct components: accompaniment and refuge. Older women and men who have experienced abuse can access accompaniment, transportation and support and/or they can		connection with other people who lived the same experiences. Community partners at both sites commented on the importance of staffs' positive practice of finding the balance between providing as-needed and individualized support and yet "not taking over" for the women. This balanced approach enabled older women to achieve and maintain

				access refuge; volunteers provide the accompaniment and transportation. SAVA consists of two rooms within a seniors' assisted living facility; residents in the facility do not know that these rooms are designated for older adults fleeing abuse. Homes were		their independence and to "realise that they could take care of themselves". Challenges in implementing SAVA included: 1) Lack of (total) engagement by community partners; 2) Project has not yet become fully utilised by community-based health care providers; 3) project's multiple sponsoring organizations led to challenges concerning having a clear, shared

				provided with assisted-living facilities and were quieter than usual transition homes.		vision and open communication between project partners; 4) (Peer) volunteer-based model may be unrealistic/unsustainable - may place too many responsibilities/burdens on volunteers; 5) Lack of stable, ongoing funding. Challenges in implementing Ama House included: 1) Ama House's availability does not

						meet demand; 3) Women can be reluctant to leave; 4) Ensuring that residents' health, psycho-geriatric and/or medication-related needs are met. At SAVA, suggestions for improvement included: more community-focused information about and awareness regarding SAVA's availability. At Ama House, suggestions

						for improvement included: 1) Availability of on-site counselling; 2) Having additional staff available on all shifts; 3) Having a van at the House that could be used for resident transportation to appointments and activities.
McGarry, Simpson, & Hinsliff-Smith (2014)	Good. The sample is not representative of the population,	18 individuals from a range of agencies and organisations	United Kingdom (England).	Services to address domestic abuse in later life in the UK include victim support	Postal questionnaires, semi-structured telephone interviews (up to 1-hour long).	Three main themes were identified: 1) a lack of conceptual clarity between domestic violence and elder abuse; 2)

Descriptive, case studies	and the response rate was meagre, but the reasons for this are clearly explained and justified.	from both the statutory and voluntary sectors provided specific domestic abuse support services or general services and support for older adults (aged 59 years and over) and 3		and advice services, domestic abuse charities, mental health charities, health and social services for safeguarding adults, refuges, community mental health services and police safeguarding hubs.	The questions related to the nature of the organisation and range of services provided, the existence of policies and guidelines relating to domestic abuse within the organisation, specific training, awareness of abuse among older adults and	the complexity of family dynamics and abusive relationships; 3) deficit in dedicated service recognition and provision for older adults. Older adults may find difficulties in recognising services that might be appropriate for their needs. On the other hand, service providers may be unable to distinguish between the different forms of abuse

		older women survivors of domestic abuse.			perceptions of the barriers to adequate service provision.	affecting older adults or be aware of the alternative referral pathways or service support. Older survivors also underlined that refuges might not be appropriate or accessible to older individuals who have age-specific needs and felt that the language and the images used in domestic abuse awareness-raising materials, for

						example, images of younger men and women on posters, may not engage with older adults.
Sirey, Halkett, Chambers, Salamone, Bruce, Raue, & Berman (2015) RCT	Fair. No clear description of randomisation and significant missing data at follow-up.	68 older women suffering from concomitant domestic abuse and depression. Participants were randomized to receive elder abuse	United States (New York City).	The goal of this pilot program was to test the usefulness of an adapted Problem-Solving Therapy (PST) and anxiety management programme, called PROTECT, integrated into elder abuse	Pre-test and follow-up 16 weeks later in-person or on the phone. Measures: PHQ-9 test for depressive symptoms; perceived change in the level of abuse; perceived self-	PROTECT clients experienced a more significant decrease in depressive symptoms than victims who received a standard mental health referral. Women in the PROTECT group also reported significantly improved self-efficacy feelings in problem-solving

		resolution services combined with either PROTECT or a mental health referral.		services to reduce depression and improve self-efficacy. PROTECT is delivered in eight sessions after a clinical evaluation, with at least the first session delivered face to face. Each subsequent session is conducted using problem-solving	efficacy in dealing with problems; satisfaction with the services received.	and were more likely to report having "most or all" of their needs met at follow-up. PROTECT intervention may mitigate some of the psychological factors that contribute to the perpetuation of abuse on older women, such as low self-efficacy and a sense of guilt.

				worksheets completed either in person or over the telephone. For this pilot program, flexibility in delivery format (in person or via telephone) was provided to consider the potentially unstable living situations of participants.		

Solace Women's Aid (2016) Descriptive, case studies	Excellent.	120 older women affected by sexual and domestic violence (60% of the women came from BME backgrounds; 49% were registered disabled); 328 professionals and referral partners.	United Kingdom (London).	The Silver Project aim was to support 150 women over three years. Its core purpose is to: 1) provide a domestic and sexual violence service tailored to meet the specific needs of women over the age of 55, to improve their safety, health, confidence, resilience and	Analysis of monitoring data; analysis of feedback from service users; case reviews and analysis of progress against Support Plans/Safety Plans; analysis of training feedback; interviews and focus groups with staff.	The outcomes for the Silver Project were as follows: 50 women a year improved their safety through engagement with the project; 50 women a year improved their health and confidence through engagement with the project; 100 practitioners a year increased their understanding of domestic/sexual violence and the impact on older

				independent living skills; and 2) to deliver training to a range of practitioners from local authorities, health and older adults services, domestic violence agencies and other voluntary organisations, to increase their awareness of the obstacles		women through engagement with the project. 80% of women reported reducing their risk levels due to receiving adequate risk assessments and tailored safety plans. This is evidenced by reported changes to risk levels, improved health and self-confidence, and isolation reduction. Women also reported an improvement in their safety through a

				and risks facing women in this age group, and to help them spot survivors of domestic and sexual violence.		range of options such as seeking alternative housing, obtaining a Non-Molestation order and collaborative work with the police to place security measures in the home and courts, including “care-link” wearable alarms. Service users asked for a wider diffusion of advertising posters and remarked on the importance of representing older

						women. However, it was recognised the importance of educating older women about what abuse is in order for them to reach the services; also, being directly questioned by a GP about abuse was highly valued. Women had mixed experiences in their contact with police, but overall they appreciated 1-1 meetings with practitioners,

						especially when they were set in their homes.
Carthy, & Taylor (2018) Case studies	Excellent.	18 practitioners from services that support victims of domestic abuse or support older adults.	United Kingdom (England).	Services to address domestic abuse in later life in the UK include refuges, housing support and sexual assault referral centres. Funding cuts in the UK have negatively affected the DA sector, with many funding	Semi-structured interviews.	Participants described the barriers which prevent older women suffering from domestic abuse from accessing help, including a lack of awareness among the public and the professionals of the existence of specialist support services and insufficiency of services per se. Some professionals

				providers looking for cost-effective solutions. This situation often created a 'one-size-fits-all' generic approach to service delivery, resulting in a lack of specialist knowledge and experience and inadequate approaches to tackle older		admitted lack of specific training, listed the necessity of domestic abuse services to remain "hidden" as a possible barrier for users to access them, and stated the importance of making older women aware of signs of abuse in order for them to approach the services. Many women do not want to leave their home; instead, they want to

				women's specific needs.		stay but safely. Working to empower older women to safely manage the home environment was considered an essential job for domestic abuse services.