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Older Women and Domestic Abuse: Through a glass darkly

Purpose: This paper offers a profile of domestic abuse of older women and its impact on their health and wellbeing; explores some of the conceptual tensions that exist in this field; and discusses current policy and practice responses to this group of victim-survivors.

Approach: It is a review paper drawing on material from a range of sources; it has policy, practice and research implications.

Findings: Although there is growing recognition that older women are victims of domestic abuse it tends to be regarded as a 'younger women's issue' and to be subsumed under the umbrella of elder abuse. This not only removes the gendered element but it also uncouples it from the lifecourse where, for many, its roots lie. It also tends to foreground 'old age' as the primary dimension of risk. There is a tension between the justice oriented approach of the domestic abuse system and the welfarist approach that imbues the safeguarding system. There is a need for integration between the two systems. Also, for the health and care system to be more alert to the needs of older women at risk. We need to achieve a more effective balance between protection and justice, accord a greater level of agency to older victim-survivors, and ensure they have access to domestic abuse law, policy and appropriate support services.

Originality: This paper adopts a critical lens and makes a number of new arguments.

Introduction

Domestic abuse is a growing issue for older women (Box 1: Definition of Domestic Abuse). Data suggests that in 2017/18 140,000 women aged 60 to 74 experienced domestic abuse in England and Wales; this figure rose to 180,000 in 18/19 and to 200,000 in 2020[1] (Age UK, 2019, 2020; Office of National Statistics, 2022). This is likely to be a significant underestimate; we also know nothing about the prevalence of domestic abuse in women aged over 74. How we respond to domestic abuse for this population is a conceptual, practice and service-related challenge. It is perhaps particularly complex - and conceptually opaque - in relationship to women with 'care and support needs'. Under the Care Act 2014 (Box 2) they are subject to safeguarding procedures. Whilst 'elder abuse' does not exist as a separate category in law, there is widespread acceptance that it is distinctive and warrants particular attention (Box 3: Definition of Elder Abuse). The intersection of family caring with the abuse discourse adds an additional layer of complexity. How far older women, with or without care and support needs, are included under the purview of domestic abuse policy, is a related question. It is inside this multidimensional terrain that my paper is situated.

Box 1: A person's behaviour towards another is defined as domestic abuse if both people are aged 16 or over and are personally connected to each other, and the behaviour is abusive (Domestic Abuse Act, 2021, Part 1: Sections 1 and 2)

Box 2: Under the Care Act 2014 the local authority has a duty to investigate when it has reasonable cause to suspect that a person with care and support needs is experiencing, or

[1] The Office of National Statistics urges caution when using data collected during 2021 and 2022. Due to the pandemic there were reduced data collection periods and lower response rates; this compromises the quality of the data and makes comparisons between earlier surveys difficult.

is at risk of, abuse or neglect and, because of those care and support needs, cannot protect themselves from the abuse or neglect, or the risk of it (Section 42)

Box 3: Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. It includes physical, sexual, psychological, and emotional abuse; financial and material abuse; abandonment; and neglect (World Health Organisation, 2002)

In this paper I will: offer a profile of domestic abuse of older women and its impact on their health and wellbeing; explore some of the conceptual tensions that exist in this field; and discuss current policy and practice responses to this group of victim-survivors. I am focusing on older women and physical abuse because there is a strong gendered dimension to this form of abuse at all ages. I acknowledge that it is often interlinked with other forms of abuse. My focus is also intimate and personal relationships - 'the family'- and not paid carers. Abuse is certainly perpetrated by paid carers but the nature of this abuse is particular and worthy of attention in its own right. I refer to victims as victim-survivors (unless quoting from a third party) as this is the preferred descriptor used by women who have been exposed to domestic abuse (Women Against Abuse, 2022). It is important to note that the data and legislation I refer to in the paper relates to England, England and Wales, or the whole UK. This speaks to a number of complexities related to devolution.

Older Women and Domestic Abuse

Domestic abuse is a hidden phenomenon, particularly amongst older cohorts. Although some data is collected on the prevalence of domestic abuse amongst women aged 60 to 74, we have no data on women aged 74 years and over at the present time[2] (UK Parliament, 2021). This not only means that the true prevalence of domestic abuse amongst older women is unknown but it perpetuates the myth that it is predominantly a 'younger women's issue'. It is noteworthy that it was only in 2017 that the Crime Survey for England and Wales included people aged 60-74; the previous cut off age for experiencing domestic abuse was 59! This is a blatant example of structural age discrimination especially when one considers that data from other sources suggest that older women experience domestic abuse at similar, if not higher rates, than their younger counterparts (Women's Aid, 2013). There is additional evidence of an increase in rates of domestic abuse, and of severity of abuse too, of women of all ages during the Covid-19 pandemic (Women's Aid Foundation, 2020). Risk may have been heightened for older women who were less likely than younger women to have access to online forms of communication or be able to leave their homes. We do know that nearly three quarters of *all* victim-survivors of domestic abuse are female and four in five perpetrators are male (Office of National Statistics, 2022).

Safeguarding data collated annually from English local authorities suggests that in 2017/18, 25% of all safeguarding referrals to English local authorities were for 'physical abuse' (NHS Digital, 2018). Two thirds of these were related to a family member; the majority of victims were older women. A 2011 study identified that 28% of older women in Europe had

[2] In October 2021, the upper age limit of respondents completing the self-completion modules was removed. As pandemic issues compromised the Crime Survey for England and Wales in 2020 and 2021, robust data on women aged 75 years and over is unlikely to be available before 2023 (drawing on the 2022 survey data).

experienced 'at least one kind of violence and/or abuse' by 'someone close to them over the last year' (De Donder *et al*., 2011).

A survey of domestic abuse amongst older women conducted by the charity Safelives (2016) highlights the distinctive features of this population. They are much more likely than younger victim-survivors to: be abused by a family member (44% vs 6%) or intimate partner (40% vs 28%); live with the abuser (32% vs 9%); and have a disability (48% vs 13%). Lacking the physical ability to leave, commensurate with being disabled or frail, is a fundamental barrier to a woman fleeing abuse. On average older victim-survivors experience domestic abuse for twice as long as younger women before seeking help, if they ever do. Many have lived with domestic abuse for a long time; for example, the Safelives (2016) survey identified that over a quarter of respondents had experienced abuse for at least twenty years. In 2017, only 3.1% of users of domestic abuse services in England were aged 61 years or over (Age UK, 2020). This low proportion reinforces the tendency to believe that domestic abuse 'does not affect older people'. In turn, the systemic invisibility of older women in domestic abuse services contributes to their limited capacity to offer appropriate support.

Factors that influence reluctance to disclose abuse include: dependency on the perpetrator for care and/or money; fear about the consequences of reporting the abuser; unwillingness to give up a lifetime's investment in a marriage, family and home; a feeling of being undeserving; limited recognition of abuse; and lack of awareness of services. Where a woman's home has been adapted to meet her disability related needs she is particularly reluctant to seek help believing that alternative suitable accommodation is unlikely to be found or that institutional care could be forced upon her (ADASS, 2015). Generational attitudes encouraging women to remain silent also play a role as does the traditional belief that 'you've made your bed so you'd better lie on it' (Scott *et al.*, 2004). Financial dependency is a particular risk factor for the current cohorts of older women as they are less likely than younger generations to have an independent source of income (Davies *et al*., 2011).

Impact of Domestic Abuse

While research in this area may be limited, existing evidence - axiomatically - suggests that domestic abuse has a negative impact on older women's health and lives (Women's Aid, 2013, 2019). This is especially the case if it is sustained (Trevillion *et al*., 2013). As McGarry *et al*., (2013) point out 'the prolonged effects of abuse on physical and emotional well-being may be particularly momentous for older populations' as they have been exposed to abuse for longer and may be weakened by ill health (p203). Long term abuse is linked to increased morbidity, including permanent disability, and premature death.

Physical health problems include: hypertension, trauma related injuries, gastro-intestinal disorders, musculo-skeletal disorders; and sleep problems, persistent nightmares and/or flashbacks (McGarry and Simpson, 2011). The effects of exposure to abuse throughout the adult lifecourse is associated with significantly increased risk of depression, anxiety and other mental health problems (Scott *et al.*, 2004). Sustained abuse is implicated in suicide, psychosis, post-traumatic stress disorder and eating disorders (Williams and Watson, 2016). The *2014 UK Adult Psychiatric Morbidity Survey* (McManus *et al*., 2016) identified that more than half of respondents who had experienced 'severe abuse or violence in childhood or adulthood' could be defined as clinically depressed or anxious. Another study found that, amongst women aged

60 and over, experiencing domestic abuse 'in the past 12 months' was associated with four times the odds of 'adverse psychological symptoms' (Stockl and Penhale, 2015).

Older women who have experienced abuse at an earlier time in their lives, and have not resolved the related trauma, experience anger, frustration, helplessness, and hopelessness (McGarry and Simpson, 2011). Re-victimisation, or an extension of existing abuse, amplifies the damage (McGarry *et al*., 2016). A lack of recognition of abuse deepens erosion of self-esteem and self-worth (Acierno *et al*., 2001). Links between childhood abuse and long term damage to mental health have been reinforced by recent research; it also confirms a connection between childhood abuse and risk of abuse in adulthood (Oram, 2019).

Domestic abuse is also associated with loss of friendships, jobs, money, and opportunities. There are often wider impacts on family relationships too, including fractured links with adult children, siblings and other relatives. The victim-survivor may find themselves very isolated - living with their abuser alone - having severed links with their families and social networks (Women's Aid, 2007).

In terms of service usage one US study evidenced that for a significant proportion of referrals of older women to mental health services, domestic abuse was an underlying factor. Reluctance to acknowledge the abuse on the part of staff amplified the women's sense of powerlessness (Acierno *et al.*, 2010). Related evidence suggests that although training about domestic abuse increased awareness and knowledge, health professionals remain reticent about actually engaging with the issue with patients (Age UK, 2020). According to a recent study, older women are rarely included in decision-making around safeguarding. They are routinely constructed as 'inherently vulnerable' and unable to meaningfully participate (Lonbay, 2018).

There is very limited work exploring the relationship between abuse, including domestic abuse, experienced earlier in the lifecourse and late life mental health outcomes. Most work to date, extends the lens of analysis into mid-life but not beyond. This is an(other) example of structural ageism. There is an assumption that all mental health issues that older people experience are linked to old age not to lifecourse issues (Milne, 2020). It also ignores the fact that women are disproportionately exposed to domestic abuse across the *whole* lifecourse.

The Nature of Domestic Abuse

Although there is no single pattern, domestic abuse in later life tends to either be a continuation of a long-standing pattern e.g. an embedded dimension of marriage, or it is related to changes in the living situation, declining health and/or increased dependency (O'Keefe *et al*., 2007). Prominent features of abusive situations are: social isolation; a poor quality long term relationship between the abuser and the older woman; and dependence on the abuser (Lachs and Pillemer, 2004). A shared living situation is a significant risk factor; loss of social networks, due to ill health or retirement from paid work, are also factors (Wydall *et al*., 2018). Other life events that may increase risk include, children leaving home, the menopause, and the abusive partner experiencing poor health (Montminy, 2005).

Carer stress has been identified as a key cause, or amplifier of, risk of physical abuse. Evidence indicates that people with dementia are particularly vulnerable, with challenging behaviour

often cited as a trigger. Risk is heightened in contexts where the carer has been subject to abuse *by* the cared for person; this is not an uncommon experience for carers of relatives with dementia (Ash, 2014; Isham *et al*., 2020). In a study with well-defined target populations, 11-20% of family carers reported physically abusing their relative (Cooper *et al*., 2009).

It is important to acknowledge that there are an increasing number of family carers in the UK supporting older relatives with co-morbid conditions. The cared for population is older and much more dependent than it was twenty years ago; dementia is also a key feature. There is a higher number of very elderly people living in the community; fewer people are admitted to a care home. Care tasks are also more demanding, time consuming and complex (Larkin *et al*., 2019). Health and social care services are 'reserved' for those in greatest need. Carers have been subject to a 'double whammy' of welfare rationing too: cuts to services for themselves *and* the people they support (Milne and Larkin, 2023). Far fewer carers gain access to support than was the case a decade ago. Manthorpe and Iliffe (2016) suggest that there is a cruel, rather dark, side to the increased expectations of carers, that '… the effects of poorly resourced care (services) become framed as a moral failure on the part of family carers who may be accused of being abusive or neglectful of the person they care for' (p. 22). These pressures are likely to increase the risk that carers will lash out or make a mistake with medication as a consequence of fatigue or overwork (ADASS, 2011). That the carer population is also ageing is additionally relevant; over a third of all carers are aged 65 years or over. Many older carers have health problems of their own and struggle to provide physically demanding care tasks such as bathing (Milne and Larkin, 2023). Gender intersects with caring in two key ways. The majority of older people being cared for by a relative are women. Over 60% of all carers are female too; this gendered profile is particularly pronounced in mid-life. Amongst older spouses the gender profile is much more even.

It is not universally accepted that domestic abuse may be a consequence of onerous care responsibilities. Wydall *et al* (2018) strongly challenge this connection warning that it risks victim blaming and may, falsely, suggest a causative link between 'physical frailty, ill health, dependency' and abuse. There is a related risk that it casts the person who is cared for in a very undesirable light, as passive, burdensome and without agency. Research has failed to produce evidence that care-giver stress is a cause of abuse as opposed to, in some cases, a contributory factor (Wolf, 2000). Wydall *et al* (2018) regard domestic abuse as a much more complex multidimensional issue that warrants in depth analysis.

Whether abuse that comes to light when caring is required is *new* abuse is a related issue. It may be an extension of a pre-existing pattern. We know relatively little about long term abuse of older women. The fact that research has focused on 'carer related abuse' rather than on abuse that precedes any need for care speaks to two issues. Conceptually and methodologically it is less complicated to explore abuse with a clear 'cause'. Whilst we may condemn carers for abusing their relative we can (often) appreciate the challenges carers face. Engaging in research about marital or filial abuse, that may have long term roots, is a much more complex endeavour and requires engagement with a host of structural and systemic issues. Whilst some of these issues are emerging into the light, there is a great deal of conceptual, methodological and service-related work to be done. It is to the conceptual terrain that I now turn.

How is Domestic Abuse of Older Women Conceptualised?

One of the fundamental schisms in this field is how work on elder abuse and domestic abuse has evolved; they occupy parallel but largely separate domains. Penhale and Porrit (2010) consider that 'research on elder abuse has focused on age and largely neglected considerations of gender, whilst research from within the sphere of domestic violence has not fully considered aspects relating to age' (p. 11). Scott *et al*., (2004) exposes the role played by power; they observe that while domestic abuse is often viewed as a gendered abuse of power, amongst older women it is routinely treated as a 'sub-set' of elder abuse. The particular experiences of older women are largely ignored. The fact that it is 'often overlaid by the complexities of ageing, circumstances and changing family dynamics' further contributes to the conceptual challenges (McGarry *et al*., 2014, p. 207).

This matters for at least two reasons. How the issue is conceptualised affects how it is explored and researched. It also informs how it is responded to. Whilst domestic abuse is increasingly recognised as an issue of public concern, including the focus of social policy, elder abuse is viewed as a private matter and is the subject of a safeguarding response. Lloyd (2012) argues that 'justice is widely regarded as the moral framework for public life, (whereas) care is seen as the moral framework for private life' (p. 6). Although there is growing acceptance that the principles of justice should sometimes apply in the private domain, for example around issues of domestic abuse, these have yet to take any meaningful shape for older people (Milne, 2020). There is a tendency to 'welfarise' older victim-survivors i.e. offer a safeguarding response, rather than a justice related response i.e. domestic abuse legislation and policy. This not only denies them access to justice but also to support systems developed to support victims of domestic abuse (McGarry *et al*., 2011; Clarke *et al*., 2012). This could be constructed as discriminatory. While justice options are not always desirable, older women should be entitled to make informed decisions about whether they wish to pursue these in the same way as younger women.

A welfare oriented response also perpetuates the conceptual status of domestic abuse of older women as a private matter. Nowhere is this more prominent than in the caring arena; in safeguarding teams there is evidence of reluctance to intervene in 'family care arrangements' (Ash, 2014). This not only encourages professionals to ignore, or fail to be alert to, domestic abuse but it prioritises welfarist notions of 'age related vulnerability' and 'carer stress' rather than the rights and agency of the older woman. Intervention also challenges a deeply embedded policy and public narrative about family care. Care tends to be characterised as wholly virtuous and carers as kind and competent (Scourfield, 2005). This idealisation sits ill with a discourse about abuse. There is a tendency to ignore the complexity of the care relationship, abuse issues that may precede caring, and the older woman's perspective. A heroic narrative does not invite a social justice response.

Constructing domestic abuse as a safeguarding issue also removes the gendered element and, importantly, it uncouples it from the lifecourse where for many women its roots lie. Ageism is a prominent, but largely invisible feature of this pattern which reinforces the separation of domestic abuse experienced in later life from abuse experienced earlier in life. Recent studies of older victim-survivors draw on explanations highlighting the gendered dynamics of power and control (Solace Women's Aid, 2021). This work focuses more on the nature of the long term relationship between the woman and her abuser rather than her age or health or the carer

under stress narrative (Brandl and Cook-Daniels, 2002). It also engages with a 'survivor', as opposed to a 'victim', related discourse and with the coping strategies older women adopt.

Policy and Service Responses

In many ways the legislative story mirrors the conceptual one. In a recent study of Welsh policy development Wydall *et al.,* (2018) found that the introduction of two Acts - *Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act* 2015 and the *Social Services and Well-being (Wales) Act* 2014 which placed safeguarding 'adults at risk' on a statutory basis - were considered in isolation despite passing through the Welsh Assembly at the same time. There is only one cross reference to the overlapping terrain of domestic abuse and abuse of older people.

The *Domestic Abuse Act 2021* introduced a statutory definition of 'domestic abuse' in law for the first time[3] (Box 1). It encompasses people who have been in a relationship, or are relatives, and there is explicitly *no* upper age limit. Whilst welcoming the legislation, Age UK (2020) suggests that for older people to be genuinely protected the policy process must go further than simply looking at domestic abuse through the lens of criminal justice. It asks for a new law that recognises the important role of health (and other) agencies in tackling domestic abuse and in helping victims leave abusive relationships (if they wish to); also, which engages with ensuring that support for survivors is in place. Age UK's focus on health care practitioners reflects the fact that it is in primary or secondary care where abuse most often comes to light. In essence, the Charity is arguing that the new law will fail to offer protection to older people because it does not appreciate the distinctive nature of domestic abuse in later life nor what is needed to effectively tackle it.

Addressing the paucity of appropriate services is a key dimension of developing a coherent response. Domestic abuse services tend to be focussed on younger women with children. Most refuge accommodation, for example, is unsuitable for meeting the needs of older women, especially if they have mobility issues (Blood, 2004; ADASS, 2015). A recent pan Wales study revealed that few statutory or third-sector agencies accord equal access to older people compared with younger people (Wydall *et al*., 2015). Although this study highlighted the need for safeguarding and domestic abuse services to work together more effectively, other commentators take a broader view arguing that a genuinely integrated approach must incorporate (at least) primary and secondary health care and older people's social care services too (SafeLives, 2016). This echoes Age UK's call for a more integrated policy framework.

Indications of progress are mixed. During the law-making process in Wales, referred to at the start of this section, Clarke *et al*., (2012) recommended 'a joint code of practice and the identification of shared principles to achieve a more symbiotic relationship' between (what became) the 2014 and 2015 Acts, i.e. between domestic abuse and elder abuse. This advice was not heeded; an opportunity to pursue an integrated agenda was missed. On the other hand, domestic abuse has been the specific focus of a public health guideline and quality standard relating to 'all those aged 16 years and over'[4] by the *National Institute for Health and Care*

[3] The majority of the provisions in the act apply to England and Wales, or England, only; the act includes analogous provisions for Scotland and Northern Ireland extending the extraterritorial jurisdiction of the criminal courts

[4] It also covers children and young people aged under 16 who are affected by domestic violence and abuse.

Excellence (NICE) (2014). Its reach is very wide, encompassing front line staff in a range of health, social care and community settings. It aims to ensure that when a person exposed to domestic abuse - or where there are indicators of abuse - comes into contact with *any* service they will be asked about it and offered access to specialist advice and support. The guideline development group acknowledged that there is a lack of evidence in relationship to 'interventions to prevent domestic abuse of older people' and that more work in this field is needed. There is no specific mention made of older women.

A number of factors contribute to the 'invisibility' of older women in the domestic abuse field. Under-recording is a fundamental issue. The historical imposition of an age limit in the Crime Survey for England and Wales is a stark example. Local authorities in England and Wales are handcuffed by inadequate recording systems. Professionals are obliged to select *only one of five* categories of abuse: physical, emotional/ psychological, financial, neglect and sexual. This makes it very difficult to engage with issues of domestic abuse, patterns of long-term abuse, or abuse that takes more than one form. Wydall *et al*., (2015) found that, in seventeen of the twenty-one local authorities consulted in Wales, social workers tended not to follow the domestic abuse pathway, but went down the adult safeguarding route, *irrespective* of the individual needs of the older person. This speaks to the conceptual issues already discussed: practice issues are discussed in the next section.

The under-recording of domestic abuse at a local level undermines the generation of accurate data about incidence and ultimately the development of appropriate services (McGarry *et al*., 2014; Roberto *et al*., 2014). Some would argue that this is a profoundly ageist deficit that reinforces silo-thinking and contributes to the lack of attention paid to older women.

Practice Issues

Despite the variation in terminology used most commentators call for *all* health and social care professionals who have contact with older women to be alert to domestic abuse issues (Benbow *et al*., 2018).

Staff working in front line services, like emergency departments of hospitals or GP practices, may fail to recognise injuries consistent with domestic abuse such as bruising or fractures attributing these to age related frailty or a fall (Women's Aid, 2007). Older women may collude with these assumptions, 'hiding' the abuse. This is especially likely if the abuser is present. Research shows that older women rarely voluntarily disclose abuse. However, being asked makes disclosure *much* more likely especially if it is repeated enquiry over time, although it is critical that this is done in a safe place (Zink *et al*., 2006, p. 852). There is a related need to recognise that whilst some abuse commences later in life, it may be part of a long-term pattern. They may overlap but they are nevertheless distinctive. Many older women need time, reassurance and to feel confident about the services available *before* they disclose abuse and accept help. Other work describes older victim-survivors as 'leaping' at the opportunity to access help once they find out that they are believed and services are available (ADASS, 2015). In person engagement is especially important to older women. Reduced face to face contact - necessary during Covid lockdowns but now increasingly accepted as routine - makes it less likely that domestic abuse will be identified.

There are a number of social work specific issues. Many social workers report struggling to navigate the territory between safeguarding and domestic abuse procedures (McLaughlin *et*

al., 2016; Robbins *et al*., 2016). Lack of awareness about domestic abuse resources can make a 'welfare' response more likely (Wydall *et al*., 2015). However, where social workers form part of a co-ordinated community response *and* there is evidence of third-sector support through the involvement of a specialist advocate, older victim-survivors report feeling well served and empowered. Although there is evidence that integrated safeguarding and domestic abuse training results in improved detection rates public spending cuts threaten investment in training (Clarke *et al*., 2012).

Contextual issues also influence practice (Milne and Larkin, 2023). A balance needs to be sought between two intersecting pressures: the strong policy emphasis on maintaining older people in their own homes *and* our reliance on family carers to provide support, vs the statutory requirement to ensure an older person is safe. Scourfield (2005) argues that an idealised views of carers contributes to practitioner reluctance to act. Fears about alternative care arrangements being as bad as, or worse than, the older woman's current situation is also a real concern and one that may well be justified.

There is one example of a safeguarding model which has been infused with the rights-based orientation of a domestic abuse approach. *Making Safeguarding Personal* (MSP) is a user oriented, outcomes-focused approach that enables safeguarding to be 'done with, not to, people' (Lawson *et al*., 2014). It is based on principles of co-production, enabling conversations about what matters to the person and what may need to change. MSP speaks to the principle of empowerment: treating the older woman as an expert in her own abuse experiences and devising her own (potential) resolutions. More user-oriented approaches also allow for the opportunity to engage with lifecourse issues that may amplify risk including: the long-term nature of domestic abuse; childhood abuse; discrimination; poverty; and chronic ill health (Milne, 2020).

Despite concerns over the additional time required to employ MSP - and the risk of it being recruited as a 'managerial audit tool' - practitioners consider that it can lead to beneficial outcomes for service users, carers and front-line staff (Cooper *et al*., 2015). It started as a national programme (in England) in 2009 and was piloted in over fifty local authorities in 2013-2014. Although it remains an actively supported initiative, research demonstrates that a 'significant shift' is required in practice to ensure that older women's wishes and voices are - routinely - central to decision-making in safeguarding processes (Wydall and Zerk, 2017; Local Government Association, 2021). Although not specific to MSP, Zerk and Wydell (2020) observe that this level of engagement is likely to be particular challenging in situations where the older women is very disabled, has communication difficulties, and/or has dementia.

There is evidence that specific tools, designed to help identify abuse, are not commonly used with older people (Clarke *et al*., 2012; McCarthy, et al., 2017). In their research Wydall et al., (2015) found that, in many local authorities, social workers used familiar in-house forms rather than a specialist tool such as the *Domestic Abuse, Stalking and Harassment and Honour-Based Violence Risk Identification Checklist Risk-assessment tool* (DASH-RIC). By not employing the DASH-RIC, opportunities to detect domestic abuse are more likely to be missed and access to the services of an Independent Domestic Violence Advisor (IDVA) denied (Sharp-Jeffs and Kelly, 2016). IDVAs provide independent specialist support for safety planning and access to services for victims at the highest risk of serious harm or death. In 2017/18 only 5% of people accessing an IDVA were over the age of 60 years. Age UK (2020) makes the case for more IDVAs being employed in health and care settings commonly

accessed by older people; there is a related need to ensure greater access to them for older women in all contexts.

Conclusion

Older women who experience domestic abuse are situated on the intersection of a number of conceptual and applied tectonic plates: safeguarding adults; domestic abuse; elder abuse; support for adults with care and support needs; family care; and justice and rights for women at risk of abuse. Exploring this terrain has made visible some of the ways in which these issues intersect. It has also highlighted a number of challenges that need to be addressed if we are to improve older women's safety.

Talking about domestic abuse of older women, including women who are disabled, frail or have dementia, and who may have been subjected to abuse for many years, is a good starting point (Penhale, 2018). Challenging the default assumption that domestic abuse only happens to younger women is a related issue. A primary deficit is a failure to collect data on domestic abuse across the whole lifecourse. Research with older victim-survivors is critical too: listening to their lived experiences and learning about their coping strategies, including pathways out of abuse. This work needs to include women with care needs and those being supported by both male and female family carers. Other work is needed on long term abuse, including marital and filial abuse.

Research and analysis on domestic abuse needs to engage much more overtly with older women's issues and the distinctive nature of their abuse histories and trajectories. Older women, with or without care needs, have a right to *both* protection and justice. It may well be that for some the balance is tipped towards protection but this does not eclipse a woman's right to agency and autonomy and to make informed decisions (Clarke *et al*., 2016).

A key barrier to promoting a more justice-oriented approach is lack of services for older victim-survivors. These include: refuges with more appropriate accommodation, more - and more access to - IDVAs and related specialists, legal services, and therapeutic support such as counselling. There is a significant need to offer front line health and social care staff training on signs of domestic abuse in later life and, where there are indicators, effective ways to enquire about it. Given how impactful integrated safeguarding and domestic abuse training appears to be, it is a no brainer to invest in this widely.

In terms of limitations, I acknowledge that I have not discussed the roles of safeguarding forums such as Multi-agency risk assessment conferences; nor have I included data from safeguarding adults reviews. Important as these are, the focus of my paper was the wider domestic abuse terrain. I have not engaged in discussion about abuse *by* women, some of whom may be carers; this is for another day. I hope my paper will contribute to enhancing the visibility and understanding of domestic abuse of older women, improving practice, and delivering justice for this underserved group of victim-survivors. It is a political, policy and practice issue as well as a profoundly personal one; it is also an issue whose time has come.

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Legislation

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