Domestic abuse and the co-existence of dementia

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Contents

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Dewis Choice.

Introduction

Dewis Choice is a Welsh Initiative based at the Centre for Age, Gender and Social Justice at Aberystwyth University. Established in 2015, the Initiative uniquely combines a co-produced service with research on domestic abuse in later life.[1]

The bespoke service has been designed by and for older victim-survivors of domestic abuse, offering long-term intensive support for up to three years and providing a service for all older people except for those receiving in-hospice care. As such, it represents a response to the gap in service provision for this age group.

Dewis Choice is the first longitudinal prospective study globally to examine the decision-making processes of older victim-survivors as they seek help and access to justice.[2] Dewis Choice has highlighted the diverse 'lived experiences' of 131 women and men aged 60 years and over who have experienced abuse from intimate partners and/or adult family members.[3] In our research sample, dementia has featured in a fifth of our cases, highlighting the need to further explore this hidden population of victim-survivors and perpetrators.

With dedicated funding from Comic Relief (2019-2021), researchers from Dewis Choice have examined the co-existence of dementia and domestic abuse. Our interest in this area arose from our previous research on the Evaluation of the Access to Justice Project that found those living with dementia and experiencing domestic abuse were more vulnerable. The heightened vulnerability was because many victim-survivors were 'unfriended' and there was no evidence in the case files that a referral to specialist domestic abuse services had been made.[4,5]

The researchers evaluated the value of a strength-based intervention to create 'expanded space for action'.[6] The research team designed a 'rapid engagement response' model working with clients, families, and practitioners to increase a sense of 'social connectedness';[7] and build on an individual's social capital.[8] In addition, researchers examined ways in which legal measures can be used to protect and safeguard older victim-survivors where domestic abuse and dementia co-exist. This toolkit has been developed based on our research findings.

The toolkit aims to address gaps in practitioners' knowledge on the co-existence of domestic abuse and dementia. The toolkit offers practical advice to professionals and includes a safety planning tool.

1 Wydall, S., Clarke, A., Williams, J. and Zerk, R. (2019). Dewis choice: A Welsh initiative promoting justice for older victim-survivors of domestic abuse. In Violence Against Older Women, Volume II (pp. 13-36). Palgrave Macmillan, Cham. DOI: 10.1007/978-3-030-16597-0.

2 Wydall, S. Freeman, E. and Zerk, R. (2020). Transforming the Response to Domestic Abuse in Later Life: Dewis Choice. Llandysul, Gomer Press.

3 Wydall, S. & Freeman, E. (2020). Domestic Violence in Health Contexts: A Guide for Healthcare Professionals. McGarry, J. & Ali, P. (eds.). Switzerland: Springer Nature. Visit our website for practitioner toolkits at: https://dewischoice.org.uk/information-and-advice/resources/ Do You See Me? is a short co-produced documentary exploring the lived experiences and first-hand accounts of older LGBTQ+ people who are victim survivors of domestic abuse. Gordine, C., Wydall, S., Zerk, R., Chapman, T., Joiner, A., Craine, J., Mitchell, X. and Bulman, R., 17 Nov 2020, The Centre for Age, Gender and Social Justice.

4 Williams, J., Wydall, S. and Clarke, A. H. (2013). Protecting older victims of abuse who lack capacity: the role of the Independent Mental Capacity Advocate, Elder Law Journal, 3(2), pp. 167-174.

5 Clarke, A., Williams, J., Wydall, S. (2016), Access to Justice for Victims/ Survivors of Elder Abuse: A Qualitative Study, Social Policy & Society,15 (2), pp. 207-220. DOI:10.1017/S1474746415000202

6 Kelly, L., Sharp-Jeffs, N. and Klein. (2014) Finding the costs of freedom: How women and children rebuild their lives after domestic abuse, Solace Women's Aid. [online] available at: https://www.endviolenceagainstwomen.org.uk/wp-content/uploads/Costs_of_Freedom_Report_-_SWA.pdf

7 Morgan, T., Wiles, J., Park, H.J., Moeke-Maxwell, T., Dewes, O., Black, S., Williams, L. and Gott, M., 2021. Social connectedness: what matters to older people?. Ageing & Society, 41(5), pp.1126-1144.

8 Office of National Statistics. (2020). Social capital in the UK: 2020. [online], available at: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/socialcapitalintheuk/2020 (accessed on 8th August 2021).

Dewis Choice

Understanding Dementia

What is dementia?

Dementia is the term used to describe a group of symptoms affecting cognitive function caused by diseases of the brain, the most common of which is Alzheimer's disease. Other types of dementia include vascular dementia; dementia caused by Huntingdon's disease and Parkinson's disease; Lewy Body and frontotemporal dementia. A person can be diagnosed with more than one form of dementia, known as mixed dementia.

Dementia caused by diseases of the brain is progressive, but the rate of progression will vary for each individual depending on many factors including which type of dementia they have. Dementia can also be the result of an infection, alcoholism, or injury to the brain. Unlike dementia caused by diseases of the brain, these types of dementia may improve over time.[9] Knowing which type of dementia a person has is important in understanding how dementia may progress, how the person is likely to be affected, and how you can better support them.

It is important to respect the rights of the person with dementia and ensure they are listened to and treated as an individual with a range of life experiences, feelings, relationships, and preferences. Thus, there is a **'no one size fits all'** approach and the support each individual wants and needs will vary.

What is the prevalence of dementia in the UK?

Research by the Alzheimer's Society (2019) estimated there were approximately 850,000 people in the United Kingdom living with dementia. [10] The figure is expected to increase to over 1.5 million people by 2040. Although age is not a cause of dementia, the risk of developing dementia does increase with age. The majority of people living with dementia are over 65 years of age, and it affects one in six people aged 80 years and above. Women are disproportionately affected by dementia compared to men, with women accounting for 65% of people living with dementia in the UK.[11] Additionally, 60–70% of people providing care for a person with dementia are women.[12]

How can dementia affect a person?

Dementia affects a person's cognitive function, and the symptoms differ for everyone depending on which part of the brain is affected. A person with dementia will often develop problems with their memory, for example, remembering recent events and conversations. They may also have difficulty with their ability to process information and sequence tasks, for example, remembering to fill a kettle with water first before switching it on to make a cup of tea.

A person's cognitive function can fluctuate, so it may be better on some days than others or at different times of the day. If this is the case, practitioners should identify the best time to engage with the individual and put support services in place. Strategies such as keeping a diary and making notes and putting these in prominent places can help as visual prompts and reminders for those living with dementia.

As dementia progresses, a person can develop problems with communication and language, such as recalling the correct word to name an object or place. Dementia can also affect a person's mobility, perception of time and space, and visual perception, for example, they may have difficulty judging the distance and time it takes to cross a road or the height of a step. Certain types of dementia can also cause visual and auditory hallucinations.[13]

Dementia symptoms can cause a person to become confused, disorientated, or distressed, and they may become agitated because they are unable to express their needs or tell someone that they feel pain. It is not unusual for a person with dementia to have changes in their mood which can include becoming depressed, anxious, and withdrawn.[14] However, it should not be assumed that mood changes are an inevitable feature of dementia, and the reasons for a change in mood should be explored. A person may be struggling to cope with symptoms or a diagnosis of dementia, but they may also be feeling depressed because they are isolated from their social contacts, and/or afraid because they are experiencing domestic abuse from someone close to them such as an intimate partner, family member or both.

'it should not be assumed that mood changes are an inevitable feature of dementia.'

A person with dementia may be able to continue carrying out daily activities independently including working and socialising for some time, following a diagnosis. However, as dementia progresses, it will affect a person's mental capacity and physical health. As such, those with dementia are likely to develop needs for care and support, which can lead to an increasing dependency on family, friends, and service providers. Dementia also increases the risk of being vulnerable to economic, physical, sexual, and psychological abuse by family members.[15]

9 Alzheimer's Society. (2018). What is dementia? [online] Available at: https://www.alzheimers.org.uk/about-dementia/types-dementia/what-dementia [Accessed 2 Jul. 2021].

10 Alzheimer's Society. (2019). Alzheimer's Society's view on demography. [online] Available at: https://www.alzheimers.org.uk/about-us/policy-and-influencing/what-we-think/demography [Accessed 2 Jul. 2021].

11 Prince, M., Knapp, M., Guerchet, M., McCrone, P., Prina, M., Comas-Herrera, M., Adelaja, R., Hu, B., King, B., Rehill, D. and Salimkumar, D., 2014. Dementia UK: update second edition report produced by Kind's College London and the London School of Economics for the Alzheimer's Society

12 Alzheimer's Research UK (2018). Prevalence by gender in the UK - Dementia Statistics Hub. [online] Dementia Statistics Hub. Available at: https://www.dementiastatistics.org/statistics/prevalence-by-gender-in-the-uk/ [Accessed 30 Sep. 2021].

13 Alzheimer's Society. (2016). Symptoms of dementia. [online] available at: https://www.alzheimers.org.uk/about-dementia/types-dementia/symptoms-dementia#content-start [Accessed 2 Jul. 2021].

14 Alzheimer's Society. (2016). Depression and dementia. [online] Available at: https://www.alzheimers.org.uk/about-dementia/symptoms-and-diagnosis/depression-dementia [Accessed 2 Jul. 2021].

15 Flannery Jr, R.B. (2003). Domestic violence and elderly dementia sufferers, American Journal of Alzheimer's Disease & Other Dementias®, 18(1), pp.21-23.

Mental Capacity

What is mental capacity?

The legal definition of mental capacity refers to the ability of a person to understand, retain and use information to make specific decisions about their life. A person may lack the capacity to make specific decisions if they have an impairment of, or disturbance in, the functioning of the mind or brain and this affects their ability to make a decision. Influenced by many factors, there are three timeframes in which a person may lack capacity, these include:

1. **long-term** for example, due to a learning disability, brain injury or dementia
2. **temporary** for example, through loss of consciousness or the effects of drugs or alcohol
3. **fluctuating** where an individual's mental capacity can fluctuate, so they may demonstrate less capacity on certain days or at certain times due to factors including stress, medication, tiredness or ill-health.

Assessing mental capacity

Where a concern is raised about a person's mental capacity a formal assessment by a qualified professional may be necessary. Mental capacity assessments are normally carried out by a social worker or healthcare professional, although in complex situations they may require a GP, psychiatrist, or psychologist.

Practitioners working with individuals where a concern has been expressed about their mental capacity should clarify if a formal assessment has taken place. If an individual is assessed as lacking capacity, and there is a concern that they are at risk of or experiencing abuse, a referral must be made to the local authority safeguarding adults' team. If a practitioner is concerned that an individual they are engaging with may lack capacity, and there has been no formal assessment, they should seek advice from the local authority safeguarding adults' team.

Decision-making under the Mental Capacity Act (MCA) 2005

The Mental Capacity Act (MCA) 2005 (England and Wales), provides the legal framework for assessing mental capacity, decision-making and protecting individuals who fall under its remit from abuse. Under the Act, a person must be **assumed** to have capacity unless it is established that he/she/they lack capacity. Before any action is taken, or decision is made on a person's behalf, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less **restrictive** of the person's rights and freedom of action. Furthermore, a person should not be treated as unable to make a decision unless all practicable steps have been taken to help them do so without success. For example, in cases where capacity fluctuates, and it is appropriate and safe to do so, time should be given to allow the person to make a decision for themselves.

Where people have limited knowledge about dementia, they may make false assumptions that a person with dementia automatically lacks capacity in all areas of decision–making. In reality, a person with dementia may retain full capacity in all areas of their decision-making for some time.

Mental capacity is also **'decision specific'** so a person may have the capacity to make certain decisions for example, who they have contact with or what they eat, but lack the capacity to make other decisions, for example, managing complex finances.

A person cannot simply be assumed to lack capacity because they have an impairment or because they make decisions others may deem to be **unwise.** For example, a person may decide to give money to a friend and others may feel that is a bad decision, but it does not mean they lack the capacity to make the decision or should be prevented from exercising personal choice.

As dementia progresses, a person's mental capacity to make certain decisions autonomously will be affected and they will need support from others to help them make their own decisions. Partners, family members, friends and practitioners may play a part in supporting decision-making and, where necessary, make decisions on a person's behalf. The MCA sets out the options for people to make plans about who they wish to make decisions on their behalf if they are deemed to lack capacity at a future date. In these circumstances, any action carried out, or decision made, on behalf of a person who lacks capacity must be done, or made, in their **best interests.** The MCA also contains the legal framework for best interest decisions to be made (see legal guidance section).

The Co-Existence of Dementia and Domestic Abuse

What is domestic abuse?

In England and Wales, the Domestic Abuse Act 2021 defines domestic abuse as:

> 'a single incident or course of conduct between those who are aged 16 years or over who are, or have been, **intimate partners** or **family members**.'

Domestic abuse is rarely an isolated incident and often consists of a pattern of abusive behaviours including:

- physical
- sexual
- psychological
- emotional
- economic
- controlling or coercive behaviour, or other abuse.

Domestic abuse can affect anyone, regardless of age, gender, sexuality, race, ethnicity, or economic status. It is estimated that for the year 2020, 2.3million adults aged 16 to 74 years experienced domestic abuse, the majority of whom were female.[16] Typically, the response to domestic abuse, including risk assessment models and service provision, have been developed primarily from research on the experiences of young women experiencing abuse from male partners.[17] This can be problematic for victim-survivors who fall outside of this category, in particular:

- older victim-survivors, where signs of domestic abuse are often missed or mistaken for signs of ageing
- victim-survivors who have care and support needs, for example, where a person has a disability or health condition
- older victim-survivors caring for a perpetrator who has needs for care and support
- older victim-survivors of domestic abuse perpetrated by adult family members, for example, an adult child, grandchild, sibling or parent
- older victim-survivors of domestic abuse who are LGBTQ+
- domestic abuse involving multiple victim-survivors or multiple perpetrators.

16 Stripe, N., 2020. Domestic abuse during the coronavirus (COVID-19) pandemic, England and Wales: November 2020. Office for National Statistics, 25.

17 Wydall, S. and Zerk, R. 2017. Domestic abuse and older people: Factors influencing help-seeking, Journal of Adult Protection, 19(5), 247-260. DOI: 10.1108/JAP-03-2017-0010.

Coercive or controlling behaviour

Coercive or controlling behaviour in an intimate or family relationship became a criminal offence under section 76 of the Serious Crime Act 2015. The legislative definition describes coercive or controlling behaviour as:

Coercive behaviour
is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten a victim.

Controlling behaviour
is a range if acts designed to make a person subordinate and/or dependent by isolati ng them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive or controlling behaviours restrict a person's freedom to make autonomous decisions about how they live their life and their ability to enact their choices without fear of reprisal. Perpetrators use abusive behaviours to attack a victim-survivor's identity, affecting their sense of self-esteem.

In isolation, individual incidents of abusive behaviour may be hard to identify. Domestic abuse is rarely restricted to a single incident. In many cases, the abuse consists of a pattern of behaviours, where the perpetrator seeks to establish and maintain power and control over their partner/ex-partner or family member, which can significantly impact multiple areas of a person's life.[18]

A particular concern where there is the co-existence of domestic abuse and dementia is that domestic abuse may not be recognised and responded to effectively, increasing the risk of harm to the older victim-survivor.[19]

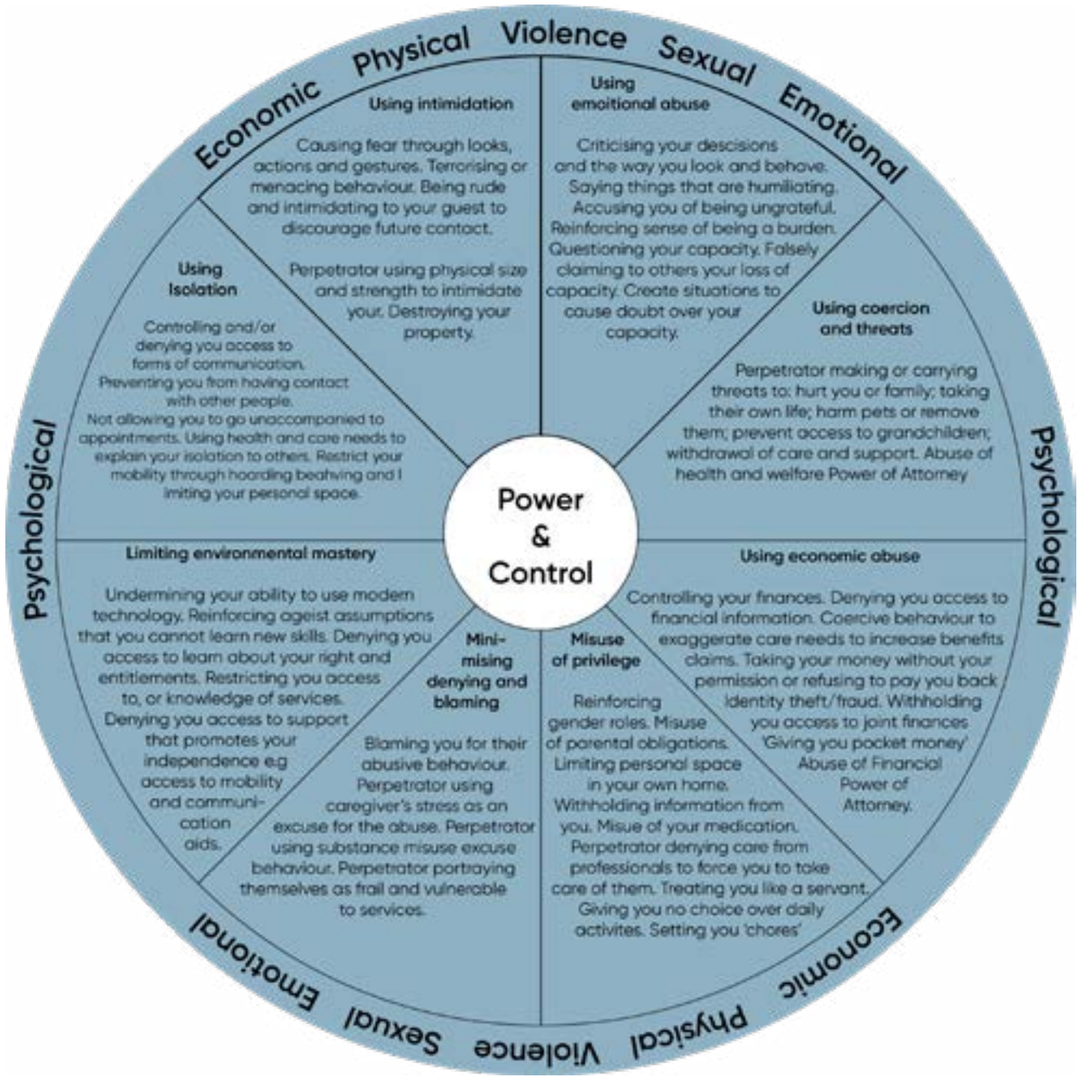
18 Wydall, S., Clarke, A., Williams, J. and Zerk, R. 2018. Domestic abuse and elder abuse in Wales: A tale of two initiatives. British Journal of Social Work, 48(4), pp. 962-981.

19 Williams, J., Wydall, S., Clarke, A. H. 2013. Protecting older victims of abuse who lack capacity: the role of the Independent Mental Capacity Advocate, Elder Law Journal, 3(2), pp. 167-174.

An adapted Duluth Power and Control Wheel

The Duluth Power and Control Wheel was developed by Pence, McDonnell and Paymar (1982) as a tool to help explain the variety of ways perpetrators use power and control to manipulate and abuse that may not be physical in nature.

Researchers at Dewis Choice have adapted the Duluth Wheel. The adapted version is informed by the six-year longitudinal study that captured the 'lived experiences of 131 older victim-survivors that engaged with the Dewis Choice Initiative. The wheel demonstrates a range of abusive behaviours older victim-survivors said they experienced from intimate/ex-intimate partners and/or family members.



An individual can experience domestic abuse from an intimate/ex-intimate partner and/or an adult family member or multiple family members at any stage of their life and this is no different for people living with dementia.

'The different relationship dynamics of domestic abuse and harm when dementia is a feature'

The Dewis Choice research sample highlighted three types of relationships where dementia featured. First, the client was caring for a perpetrator who has a diagnosis of dementia. Second, the client experiencing domestic abuse was living with dementia. And third, both the victim and the perpetrator had dementia. In all three, the individuals, particularly those in a caring role, struggled to find appropriate help and support from services prior to a referral to Dewis.

When can domestic abuse co-exist with dementia

- Harmer living with dementia
- Both victime-survivor and harmer living with dementia
- Victime-survivor living with dementia

The individual can experience harm from an intimate or ex-intimate partner, family member

Supporting older victim-survivors who care for a person with dementia

Where a relationship has been positive in the past, displays of aggression by the person with dementia may be due to changes in the brain, pain, confusion, or fear. But it is important to consider that aggression may have been part of an individual's behaviour before they developed dementia and that domestic abuse perpetrators may develop dementia in later life. Practitioners need to explore the history of the relationship with the victim-survivor, identifying past and present experiences of abuse, if they intend to provide effective support, including safety planning and trauma support given the long-term and current impact of the domestic abuse.

Where there is evidence that the domestic abuse is a direct result of dementia in a previously healthy relationship, a victim-survivor may feel conflicted about disclosing the full extent of the abuse, due to feelings of loyalty to their partner or family member. Our research has found that in some cases, older victim-survivors have minimised the abuse through fears that they will be deemed unable to cope by family members and practitioners and that their partner may be placed in care. Thus, a sensitive approach by practitioners is essential to build trust and ensure the victim-survivor feels able to talk openly about their experiences and fears.

In both incidences where the domestic abuse predates dementia and where abuse is a direct result of dementia, discussions and assessments of safety and caregiving should be dynamic and adapted to changes in abusive behaviours and the wishes, human rights, and entitlements of the older victim-survivor.

A perpetrator with increased physical frailty and dependency should not be viewed as posing less risk to a victim-survivor. Longitudinal research by Dewis Choice found that where a victim-survivor has become a caregiver for a perpetrator who has developed dementia, victim-survivors are at increased risk of severe abuse and harm. For example, providing intimate care can place a victim-survivor in close physical proximity to a perpetrator, increasing the risk and severity of physical abuse. Our research found instances of perpetrators kicking, gripping, or leaning on a victim-survivor and using objects such as walking sticks to assault a victim-survivor. Additionally, safety measures and coping mechanisms that victim-survivors found worked in the past, for example, spending time outside of the home, may no longer be possible or effective where the victim-survivor is the sole caregiver.

> 'victim-survivor may feel conflicted about disclosing the full extent of the abuse'

Where the victim-survivor chooses to continue to provide care to the perpetrator with dementia, it is essential that care and support assessments and plans take into account the abusive and coercive behaviours. Practitioners should explore with the victim-survivor which areas of caregiving they feel safe to provide, for example, they may be happy to provide meals, but not assist with washing and dressing.

Practitioners should not assume the victim-survivor will want to stay in a relationship with the perpetrator and it is essential they are provided with the same information about their rights and options as any other victim-survivor. It is possible the victim-survivor may want to end the relationship but be fearful of the response of practitioners, family, and the wider community. If this is the case, provide a validating response to the victim-survivor and listen to their concerns, while affirming that their safety, health and well-being is as important as anyone else's.

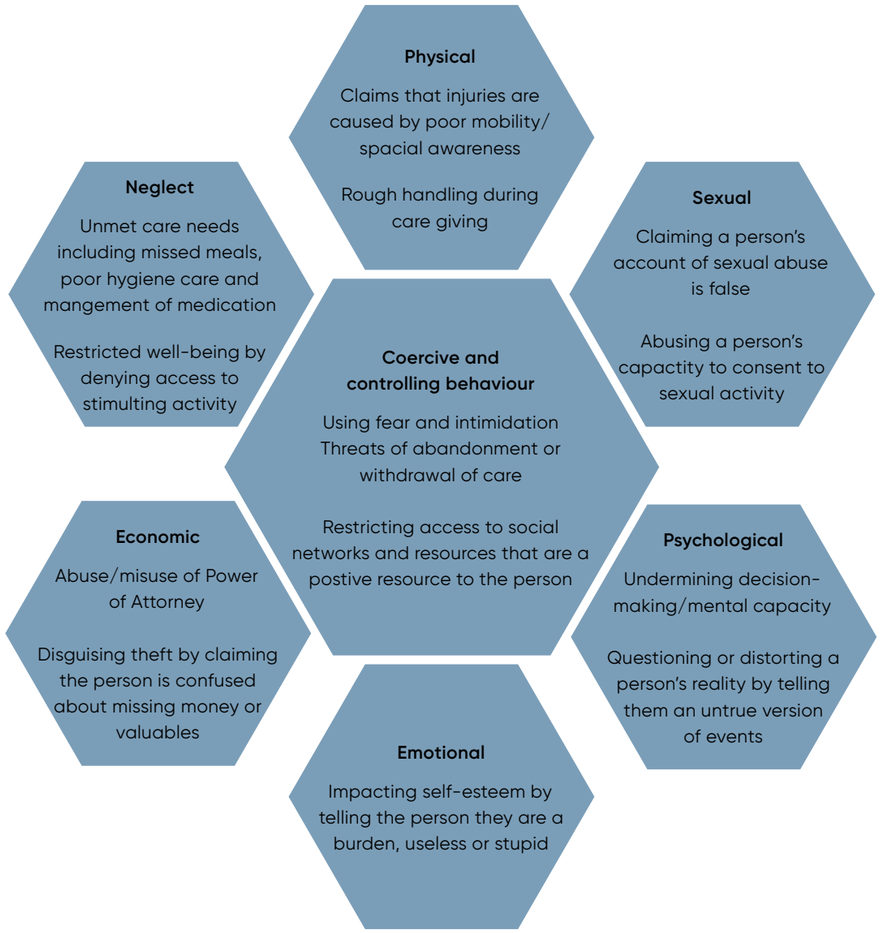
Supporting victim-survivors of domestic abuse who have dementia

A victim-survivor with dementia may experience additional forms of domestic abuse and coercive control targeted specifically at their dementia. For example, the perpetrator may undermine the victim-survivor's mental capacity and neglect their needs for care and support.

The impact and signs of domestic abuse for a victim-survivor with dementia may be mistaken for, or disguised by, signs of dementia. This can include:

- gas-lighting;
- physical injury;
- loss of mobility;
- neglect of care needs;
- malnutrition and dehydration;
- poorly managed continence;
- soiled or inappropriate clothing;
- increased isolation;
- loss of independence and autonomy;
- significant harm to mental health including depression, anxiety, withdrawal and low self-worth.

Below is a diagram that illustrates examples of perpetrator behaviour where the victim-survivor has dementia.



For a victim-survivor with dementia, perpetrators of domestic abuse can deliberately act to cause confusion and disorientation, undermine capacity and promote fears that the individual will not be believed if they disclose abuse. Often a diagnosis of dementia will be manipulated by perpetrators to increase power and control in the relationship by acting as a barrier between service providers, the community, and family members. The use of power and control can significantly reduce victim-survivors access to beneficial sources of support. Perpetrators may seek to create real or perceived extreme dependency on them by victim-survivors with care and support needs. Perpetrators will often present as caring and attentive to the outside world. This can lead to domestic abuse being incorrectly identified as carer stress.

As dementia progresses, a person's ability to safeguard themselves and manage their risks may be affected by their declining mental capacity. A person may no longer be able to recognise the signs that the domestic abuse is escalating and be unable to deploy strategies that have worked in the past. A person with dementia may also lose the ability to understand and make decisions about the level of risk they are exposed to by the abusive person.

Case study

Rosemary* is a female client aged 86 years, living with dementia. Rosemary has experienced domestic abuse from her husband throughout their marriage of 62 years. Rosemary was referred to the project by a social worker, who said she attempted to refer Rosemary for specialist domestic abuse support, but the domestic abuse organisation stated they lacked the skills and necessary training to respond to the dementia.

Prior to the onset of dementia, Rosemary states she was able to manage her safety as she was able to identify her husband's abusive triggers, remove herself from the same room and hide in the bedroom. As Rosemary's dementia progressed, she says she is no longer able to recognise the signs of potential escalation in the perpetrator's behaviour and is unable to remember that direct confrontation results in more serious injury. On occasions, Rosemary's instant reaction was to leave the family home; however, this was not always carried out safely i.e., climbing through the bathroom window. Despite the increasing risks, Rosemary expressed a wish to remain living in her home with her husband.

The Dewis Choice team worked with the social worker, Rosemary and safe family members to identify the range of trigger points for the perpetrator. It was identified that that Rosemary's husband would get particularly angry when Rosemary burnt his food (due to forgetting it was in the oven) or if Rosemary forgot to take her medication. Attempting to disrupt the perpetrators behaviour, carers were put in place daily to provide meals and administer medication.

Rosemary's husband had acted hostile towards family members and carers to discourage them from having contact with Rosemary. The Dewis Choice team worked with the social worker to identify safe people within Rosemary's informal social networks. Family members were informed about the abuse Rosemary was experiencing and how the perpetrator's hostile behaviour was an abusive tactic to isolate Rosemary. As an informal protective factor, family members devised a plan to have regular contact with Rosemary and set up a 'WhatsApp' group to share information on Rosemary's well-being and safety. Neighbours and a local hairdresser were invited to the group. This group monitored the situation and shared information with the social worker and the Dewis Choice team. In addition, Rosemary's social connectedness was increased.

*not her real name

The case study demonstrates the benefits of multi-agency tailored support for the victim-survivor achieved through a coordinated community response. The response can include a variety of organisations including local authority adult safeguarding; domestic abuse; health; social care; housing; police and dementia advocates. The case study also highlights the importance of including family, friends, and community, who are identified as beneficial to the victim-survivor, in the safety plan.

Supporting older people where the victim-survivor and the harmer have dementia

In some cases, both the victim-survivor and the harmer will have a diagnosis of dementia. In these circumstances, practitioners should be wary of prioritising the health and care needs that are related to dementia over responding to domestic abuse.

> 'The best interests of one person should not override the best interests and safety of the other'

Each person should be allocated their own worker and their individual needs, including safety and well-being, should be assessed both separately and as a couple. The best interests of one person should not override the best interests and safety of the other. For example, it may be deemed it is in the best interests of a harmer with dementia to remain in the family home. However, it may be deemed in the best interests of the victim-survivor for the harmer to be removed from the family home. Multi-agency working is essential in complex cases such as these. It is possible that safeguarding referrals may be raised for both parties.

Risk should be considered for each person and assessments should be dynamic and reviewed more frequently. Care and support plans should take into account the needs of each individual and be informed by the risk assessment process.

The victim-survivor should be offered domestic abuse support, and advocacy if required, independent of the support in place for the harmer.

In these situations it may be possible that family members are involved in decision-making for both the victim-survivors and the harmer. For example, one person may act as a Lasting Power of Attorney for both (see legal guidance section). Practitioners should take care to ensure family members involved in decision-making are aware of the abuse and any risks identified. Family members should be supported to make informed decisions that are in the best interest of both parties.

‘More than one’: Increasing Social Connections

The importance of social connections

Social connections consist of a variety of relationships and interactions with a range of individuals and groups including intimate partners, family, friends, the wider community, and service providers. Although there will be variation in the amount and type of social connections each individual wants and needs, most people will be connected to ‘more than one’ other person regularly. For example, an individual may share a meal with family, chat with a neighbour, attend a health appointment and visit a friend, all of which could involve engaging with four separate individuals or groups over a day or week. Social connections are something many of us take for granted and may not even give much thought to, however, these links are crucial to maintaining well-being.

Individuals with high levels of ‘social connectedness’ (i.e., positive links to their community) are more likely to form supportive relationships[20] which are contributory factors for promoting positive mental and physical health. There is also evidence to suggest positive connections with friends and community can contribute as much, and in some cases more, to well-being in older age than family networks.[21] In contrast, social isolation has been linked with increased risks of developing health conditions including, coronary heart disease and dementia,[22] and is viewed as a contributory factor in shortening life expectancy.

This section will examine how and why perpetrators deliberately isolate victim-survivors from social connections, highlighting the impact this has on the victim-survivor’s safety and well-being. It will then discuss the benefits of having more than one social contact and provide practical information and advice on how practitioners can increase social contacts. Examples will then be given to illustrate how perpetrators undermine the autonomy of victim-survivors and how practitioners can identify abusive behaviours. The section will conclude with practitioner key skills.

Our research shows that over time victims-survivors of domestic abuse will become socially isolated and restricted from forming supportive relationships by the perpetrator.[23] Perpetrators of domestic abuse act to closely monitor and reduce the number of social interactions of the victim-survivor to prevent them from being able to disclose and seek help for the domestic abuse they are experiencing.

Furthermore, isolation enables a perpetrator to exercise high levels of coercion and control over an individual and increase levels of dependency on the perpetrator for access to social networks and services.

20 Bowins, B., 2021. Social connectedness in States and Processes for Mental Health: Advancing Psychotherapy Effectiveness. London: Academic Press. (p. 41-46)

21 Gouveia, O.M.R., Matos, A.D. and Schouten, M.J. (2016). Social networks and quality of life of elderly persons: a review and critical analysis of literature. Revista Brasileira de Geriatria e Gerontologia, 19(6), pp.1030–1040.

22 Seegert, L. (2017). Social isolation, loneliness negatively affect health for seniors, Association of Health Care Journalists, [online] available at: https://healthjournalism.org/blog/2017/03/social-isolation-loneliness-negatively-affect-health-for-seniors/

23 Wydall, S. (2021). Intimate Partner Violence - Transforming the response to older victim-survivors in later life in The Routledge International Handbook of Domestic Violence and Abuse Edited Book. Devaney, J., Bradbury Jones, C., Holt, S., Macy, R. J. & Øverlien, C. (eds.). 1 ed. Taylor & Francis,Vol.1.

Examples of perpetrator behaviour that restricts victim-survivors’ social connections

Ageist assumptions of older people can mask the signs of domestic abuse. Declining physical and mental health along with increasing needs for care and support, are often viewed as part of a normal ageing process. Increased isolation is often not questioned as the assumption is that people naturally become less socially connected as they age. For example, if an older person stops taking part in social activities it is often assumed this is due to ill health or reduced mobility.

An older victim-survivor who has needs for care and support may be dependent for care on an intimate partner or family member who is abusing them in a variety of ways. In these situations, the perpetrator is in a position of power to manipulate their role as a carer to increase the social isolation of the older person and create extreme dependency. Our longitudinal research has found examples where perpetrators increase isolation both within the home and the community. Abusive behaviour in the home included monitoring, controlling, or removing communication devices (telephones, hearing aids, post). There were also examples where perpetrators deterred visitors by being rude or suggesting the victim-survivor was too unwell for visitors. In the community, perpetrators made it difficult for or refused to assist the older person to leave their home to socialise or access services when they want to do so. In addition, we found examples of older victim-survivors being unable to use public transport to attend social events or visit friends because the perpetrator was controlling the finances.

Our research found that perpetrators were aware when dementia had caused the victim-survivor to become less inhibited and that this increased the likelihood of domestic abuse being disclosed. In these cases, perpetrators may claim the victim-survivor has difficulty communicating with others without their assistance. The perpetrator will try to control conversations by speaking on

behalf of the victim-survivor and prioritising their own views. The victim-survivor may feel they have lost their autonomy in social interactions and can only connect with others through the perpetrator.

When a perpetrator is providing care for a person with dementia they may present to others as an attentive and indispensable carer, which can disguise isolating and controlling behaviours. In most cases when victim-survivors attend social engagements they are accompanied by the perpetrator. Therefore, there may be limited opportunity for the victim-survivor to engage independently with service providers, family, friends, and the wider community. There is also a risk the person with dementia can feel isolated to the extent that the perpetrator can position themselves as their 'one' social connection, acting as a barrier to the wider social world.

Practitioners engaging with people with dementia should be wary when a person appears to have only 'one' social connection and consider:

- How socially connected is the person with family, friends, and community?
- How connected and engaged is the person with providers of services that are beneficial to them, for example, GP, care provision and third sector organisations?
- Has the person become isolated, for example, do they rarely leave the home to attend social activities and/or have they stopped having visitors to their home?
- If the person has become isolated, what are the barriers to them engaging socially?
- Is the person accompanied in all their interactions by one person? If so, can opportunities be created to speak with the person individually?
- Does the person have a voice, or does someone always seek to speak on their behalf?
- Does a partner or family member seek to promote or undermine the person's autonomy?

Practitioners engaging with a person with dementia may be in a unique position to access the person on their own and may be the only avenue for a person to disclose abuse. Therefore, it is important that practitioners are aware of the co-existence of dementia and domestic abuse and they are vigilant to the signs of abuse. After a diagnosis of dementia, victim-survivors may feel more fearful of the perpetrator and vulnerable to their abusive tactics. Practitioners should create a safe space for victim-survivors to talk and engage independently with a broad range of social connections. The purpose of this is three-fold; first, it will provide space for victim-survivors to voice their feelings and experiences, independent of the perpetrator. Second, it will help to build trust with others which is particularly important because the perpetrator will often claim that no one will believe the victim due to their dementia. Third, it will increase opportunities to seek help and support.

Increasing social connections can reduce a sense of isolation for victim-survivors and be a protective factor. Social connections can help to safeguard victim-survivors, particularly in cases where individuals cannot take steps to try to keep themselves safe. For example, perpetrators may be less inclined to act abusively in front of other people and therefore, their presence may act as a temporary deterrence. If the perpetrator is abusive publicly, the domestic abuse is more likely to be observed. Social contacts can help distance the victim-survivor from the perpetrator and/or report the abuse to relevant agencies.
Our research has found, in cases where there are more 'eyes and ears' on the ground monitoring the situation, the better it is to safeguard the older person.

Moreover, a person with dementia can be positively supported by building on positive social connections. For example, engagement in purposeful activities can help to stimulate the brain, which is particularly important for those living with dementia. Social networks can also provide avenues for support to maintain independence and autonomy for longer.

Examples of perpetrator behaviour that undermines victim-survivors' autonomy

Our research found that perpetrators will seek to undermine the autonomy of victim-survivors. The behaviours can be disguised by caring roles, for example, carrying out tasks for the person with dementia rather than supporting them to carry out tasks themselves, which encourages a dependency on the perpetrator. These behaviours can be difficult to identify but they may become apparent if they are consistent and form part of a pattern of behaviour. Perpetrator behaviour may include:

- focusing on what the person with dementia can't do rather than what they can do
- refusing to support the person to carry out the task themselves
- not allowing the person significant time to complete tasks
- setting the person up to fail
- presenting tasks in a way that seem daunting or overwhelming
- refusing adaptations or assistive devices that might support autonomy
- refusing offers of help and support from formal and informal contacts for the person with dementia.

Practitioner key skills

1. Create opportunities and a safe space to speak to the person with dementia on their own (see engagement tool)
2. If you are carrying out a health, benefits or care assessment, ensure at least part of the assessment is carried out alone with the person with dementia
3. Ask the person with dementia about their relationships and if they are concerned or afraid of the behaviour of someone close to them
4. Reassure the person with dementia that you will not share something that they tell you in confidence with their partner or family members
5. Ask whom the person with dementia trusts and feels they can confide in, it may be a family member, friend or practitioner
6. Do not assume social isolation and lack of engagement with social networks is a feature of the dementia, and explore any barriers to engagement
7. Explore with the person with dementia how many social connections they have on a regular basis, if they would prefer more, and with whom
8. Ask who the person with dementia enjoys having contact with and, if they have lost contact with someone, how would they like support to get back in touch
9. Find out what activities the person with dementia likes, or would like to do, and identify what barriers are preventing them from engaging
10. Find out what social activities are available in the person's local area and help them access them
11. Seek to connect the person with dementia with independent support and/or advocacy to help increase their engagement with social connections and service providers.

Engagement Techniques

Engaging with a person who has dementia and has disclosed domestic abuse

Practitioners with little or no prior knowledge or experience of working with people who have dementia may feel concerned about how they can engage and support a person where there is the co-existence of dementia and domestic abuse. Although many victim-survivors of domestic abuse who are living with dementia will be eligible for a local authority safeguarding response, individuals engaging with Dewis Choice have expressed the value of also receiving support from a domestic abuse practitioner. Safeguarding practitioners and social workers supporting victim-survivors with dementia have also cited the benefits of the involvement of a domestic abuse practitioner in gaining an insight into the history and impact of the abuse. This section provides practical information and advice to improve engagement with victim-survivors who are living with dementia.

1. Before making contact

Practitioners should gain as much information about a victim-survivor with dementia and their situation as possible before meeting with them. This may be achieved through an informal discussion with the person who is making the referral. The referrer may have recorded factual information only on the referral, but they may have additional insight, observations or perspectives they are willing to share through discussion. If a referrer leaves an organisation or ceases involvement with the individual their insight could be lost, so aim to speak to them as soon as possible. Some questions you can ask the referrer are:

- Who did/does the person disclose domestic abuse to?
- When and where do they feel free to disclose, for example, their own home, a day centre, a friend's home? Is this a place they felt safe to disclose/discuss the abuse and could you access this space safely to meet with them?
- What disclosures has the person made in the past and how have these been addressed and responded to?
- How socially connected is the person?

Ask about the family network, friendship groups and community links?

- Who does the person trust, for example, family members, friends, nurses, advocates? Is the person they trust aware of the perpetrator behaviour and if so, do they recognise it as domestic abuse?
- Is there anyone the person has expressed distrust or dislike of? Is there anyone who they appear apprehensive or agitated in the presence of? (Note: the person may be aware a family member, friend or professional also has a relationship with the harmer and are afraid that they will disclose information to them).
- Does the individual have any known communication difficulties, for example, a hearing impairment?
- Are there any ways of engaging with the person that are known to work well?
- What are safe subjects for discussion? Does the person have interests or topics they like to talk about that can help you engage and build rapport and provide a calming focus if they become distressed or distracted?

2. Mental capacity and cognitive function

A diagnosis of dementia does not automatically mean a person lacks decision-making capacity in any given area. Depending on the type of dementia and how advanced the dementia is, the person may have full or limited capacity and this will influence how you engage with them. Information on the law relating to mental capacity and decision-making, including who has the legal right to support decision-making or make decisions on a person's behalf is provided in the legal guidance section of this guide. If you are informed a victim-survivor lacks capacity, you should enquire:

- Has the person had a formal assessment of their capacity? If so, by whom, when and what was the outcome?
- If the person has been assessed as having fluctuating, or a lack of capacity, how is their engagement affected? For example, if the person has fluctuating capacity, when is the suggested best time to engage? How can you tell if it is a good time to engage or if it's better to postpone for another time?
- Does anyone have a legal right to make decisions on the person's behalf, for example, a Lasting Power of Attorney or Deputy, and do you need to consult them?
- If there is a Lasting Power of Attorney in place and has this been activated?
- Is the person with Lasting Power of Attorney or Deputy the person alleged to be causing harm?

3. Creating a safe space

Gaining access to a victim-survivor living with dementia to speak with them alone can present challenges, particularly if they need support with communication. Professionals known to the victim-survivor may be willing and able to support with access and communication. Practitioners should consider the following issues:

- In the same way, you would engage with a victim-survivor who does not have dementia, create a safe space to have a discussion, free from interruption and where there is no risk of being overheard.
- If the person has made disclosures in a particular location, for example, a day centre, consider if it is possible to arrange a private space here to talk, as this may be a place where they feel comfortable and safe to disclose.
- Reduce or remove stimuli, for example, ensure the television is turned off and reduce background noises as these can be distracting to a person with dementia and may cause difficulty in concentration and

following conversations.
- People with dementia often benefit from familiarity and routine and may have items placed in order or a way that provides visual reminders. Be respectful of space and personal belongings, ask before moving or touching items and ensure that they are put back in the same order or position.

4. The time to engage

Practitioners should be prepared to be flexible in arranging meetings with a victim-survivor who has dementia. In addition to identifying the best place to engage, practitioners should consider the following in identifying the best times:

- Check if the person has a routine, as familiarity and routine can be important to a person with dementia, and be flexible in planning your meeting around this. For example, does the person have visiting carers or regular mealtimes?
- Find out the best time to meet with the person to maximise engagement. Some people with dementia may find it easier to concentrate and engage in conversation in the morning and others in the afternoon.
- Some people with dementia experience a set of symptoms known as 'sundowning,' which can include increased agitation, tiredness, and confusion, at the time of the day when the daylight is fading. This is particularly important to bear in mind during the winter months when daylight is reduced, and practitioners should avoid arranging meetings late in the afternoon.
- Allocate more time to meet with the person with dementia than you would for someone who does not have dementia.

5. Verbal and physical communication

A person with dementia may have difficulty reading verbal and physical cues. They may also have difficulty communicating and ordering their thoughts and feelings. To aid communication and provide validating responses practitioners should:

- Speak clearly and slowly and use short sentences.
- Encourage self-determination. This can be achieved by introducing yourself and asking, "Is it okay if I sit with you? Can I talk with you?"
- Each time you meet remind the individual who you are and why you are there.
- Ask the person where they would prefer you to sit and try to position yourself at eye level. An older person, and particularly someone with dementia, are more likely to have hearing or sight difficulties, so check they can hear you fully. If they wear glasses or a hearing aid, check they are using them and that batteries are charged. Ensure any written information you give is in an accessible format, for example, larger font.
- Avoid having discussions about the person with dementia in front of them, without including them, for example, discussions with practitioners and family members. Ensure that your response is validating by reassuring the person you believe them and have time to listen to them.
- Ensure your body language and facial expressions match what you are saying. For example, you may normally smile encouragingly when discussing difficult subjects, but this may be misinterpreted.
- Use people's names, rather than their relationship status to describe who you are talking about, for example, "John," rather than, "Your son."
- Keep your questions open, for example, "Tell me about John," rather than, "Do you remember when John did…?"
- Reassure the person that they are not to blame for what has happened to them.
- Give the person time to respond and be comfortable with silence. It may take them a while to order their thoughts and find the words to verbalise them and if you jump in too quickly opportunities may be missed.
- You can help the conversation by reminding the person what they have said before moving to ask another question. Keep questions simple, asking one thing at a time.
- If the person does not answer the question asked, acknowledge what has been said and encourage them to say more about the answer they provided.
- For a person with dementia, sentence construction may be disordered. Reflect what the person has said back to them and try to avoid correcting them as this can cause distress.
- Be careful not to dismiss disclosures because part of the story doesn't fit or varies at different times.
- Demonstrate empathy, for example, if the person struggles to find the right word or makes a mistake, say, "I find that hard too" or "I do that sometimes too."
- If the person is engaging well, make the most of the opportunity and expand the time you spend with them if possible.
- If the person begins to become tired or distracted ensure you have a break or bring the discussion to a close.

6. Additional tools

If you are aware of professionals who have good engagement with the victim-survivor, ask them if they use any additional tools or methods you could adopt to encourage engagement. Depending on the individual and their preferences, you could consider the following:

- Purposeful activity- Consider joining with the person in an activity while you talk to relieve tension and help with focus, for example, art or craft activity, jigsaw puzzle.
- Diary/reminders- Check how the person records information and reminders, for example, using a diary to record routines, appointments, contacts, who has visited and why. If safe to do so, ask them to make a note of your meetings.
- Talking Mats- Consider the use of communication tools, for example, Talking Mats uses picture cards to help express thoughts, feelings and emotions and can help relieve frustration in communication.
- Sensory fiddle objects- Studies have highlighted the benefits of tactile stimulation for people with dementia to promote trust and feelings of calm. Consider taking sensory objects, known as 'fiddle toys,' with you when you are interacting with a person with dementia.

Case study

Sheila*, aged 75

Sheila has a diagnosis of dementia but prefers not to use the term, describing instead how she has difficulty with her short-term memory, which is better on some days than others. Sheila experienced financial and emotional abuse from her youngest son and was referred for support to help manage her relationship with her son ongoing and for emotional support with the impact the abuse had on her. Shelia's Choice Support Worker (CSW) noticed their conversations were repetitive and when Sheila tried to expand and explain further, she sometimes had difficulty finding the words. The CSW was aware Sheila spent long periods alone and sometimes felt bored and frustrated and, as she used to enjoy painting, suggested they could draw or colour together while they talked. The CSW said:

"Sheila and I sat opposite each other, both busy using the colouring books. The conversations we had throughout the visit were far more natural. We talked about things that we hadn't talked about before, there was less repetitiveness and it didn't seem like she needed to force a conversation. There were even periods where nothing was said for a minute or two, where we both sat in silence. I was surprised by the focus she had throughout this visit."

The CSW noted that when Sheila was colouring, she was calmer. Sheila was able to express her feelings about her son, the abuse, the response of other family members and what she valued in terms of ongoing support.

*not her real name

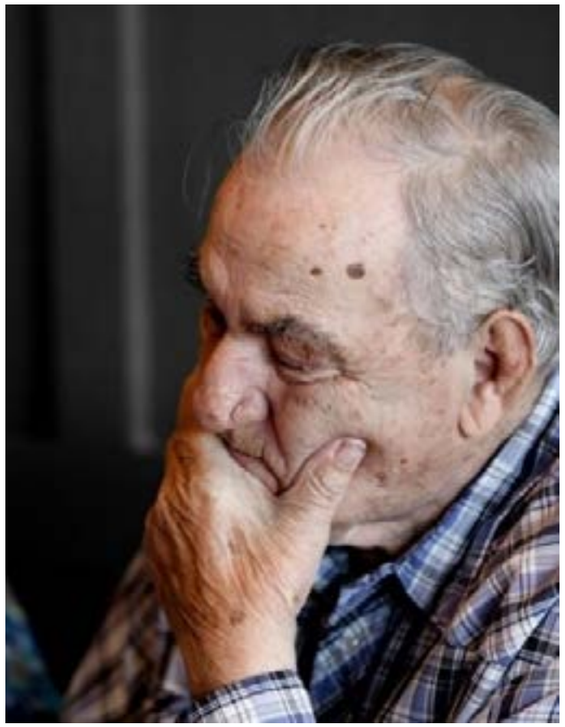
Safety planning

Safety planning with victim-survivors of domestic abuse

Safety planning helps victim-survivors of domestic abuse to plan for both their immediate and long-term safety. A safety plan should be designed with the victim-survivor and concentrate on key areas of concern. For example, identify a person the victim-survivor can make contact with if they are at immediate risk and explore how they will do this.

A safety plan may also involve others named by the victim-survivor, who agree to take action on their behalf. For example, a victim-survivor may share a code word with a family member or neighbour so that they can signal safely to them if they need them to call for help. Consideration should be given to the safety of everyone involved or named in the safety plan and no action should be included that places another person at risk. It is important to ensure that everyone involved in the safety plan is fully aware of what is expected of them. With the victim-survivors consent, the safety plan can also be shared with key people and agencies working with the victim-survivor.

The actions in a safety plan should feel achievable considering what has, or has not, worked in the past and if these actions are still working. Safety planning should also be dynamic and reviewed regularly, taking into account changes in circumstances and identified risks.

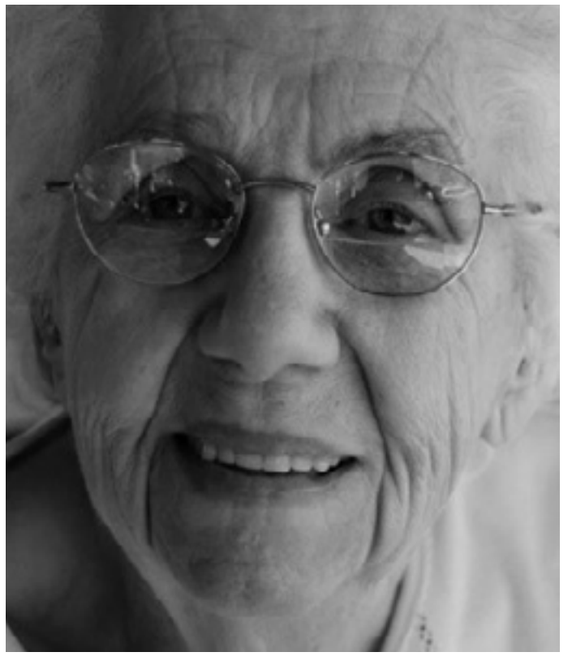


Safety planning in the context of dementia and domestic abuse

For a safety plan to be effective it should be tailored to the victim-survivor's unique circumstances and needs. Where a victim-survivor has dementia, they are likely to need support from others in devising and carrying out the actions on a safety plan. In circumstances where a victim-survivor lacks capacity to understand risk, make decisions about their safety, and carry out actions in a safety plan, the actions may be devised and carried out entirely by individuals and organisations supporting the person. Where domestic abuse and dementia co-exist, a safety plan will need to take account of whether:

- the victim-survivor has dementia
- the perpetrator has dementia
- there have been significant recent life changes affecting the relationship dynamic, for example, loss of support network, retirement, change in living arrangements, change in physical or mental health
- there was a history of abuse before the diagnosis of dementia
- abuse is identified as behaviour resulting directly from dementia
- the perpetrator is an intimate partner/ex-intimate partner or family member/s
- there is more than one victim-survivor
- there is more than one perpetrator
- the victim-survivor and/or perpetrator have any disability, mobility, or health needs
- the victim-survivor or perpetrator has needs for care and support;
- the victim-survivor is receiving care from the perpetrator
- the victim-survivor is a caregiver for the perpetrator
- the victim-survivor or perpetrator has been formally assessed as lacking capacity in areas of their decision-making
- there are external sources of support, for example, family, community, and practitioners who can be part of the safety plan.

Safety planning should be dynamic and reviewed regularly, taking into account advances in dementia, associated changes in behaviours and capacity, and increased needs for care and support.
The following tables suggest actions for consideration in safety planning where dementia and domestic abuse co-exist. The actions chosen will depend on whether the victim-survivor has dementia or is experiencing abuse from someone who has dementia. The actions should be tailored to the victim-survivor's circumstances. For example, depending on a victim-survivor's mental capacity, and physical health, some of the actions may be inappropriate or may be carried out by a designated person in a supporting role.



If maintaining a relationship or contact with the abusive person

Calling for help

Identity who to call, in which situation, for example, police, family member or neighbour

- A victim who has dementia may have difficulty remembering phone numbers and need to have these written down.
- Where a person becomes aggressive as a direct result of their dementia, a family member or friend may be skilled in calming them.

Establish how the person can call for help

- Is there a landline and is it accessible?
- If there is a mobile phone ensure it is charged, kept with the person and contact numbers are saved.
- If there is access to a care call alarm, for example, in case of falls, the call centre can be informed of the abuse and requested to call for a police response alongside medical assistance if the alarm is activated.

Who can help and how

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Leaving the home safely

Is it safer to leave the property, or stay and call for help?

How will they leave the property?

- The safest route out of the property
- Keys to regain access to the property

Where will they go ?

- During the day
- During the night (some of the options available during the daytime may not be available at night or weekends)

What transport will they use and at what times of day or night is this available, for example, what times do taxi firms operate?

If there is access to a vehicle, ensure it is:

- Parked in direction of travel
- Not blocked in
- Keys are accessible

Where the person who has dementia is abusive and the victim-survivor is their carer, identify who should be contacted to provide emergency care for the person with dementia

Access to emergency items/emergency bag

The victim-survivor may be planning to stay in a relationship or in contact with the person who is abusing them. However, it is advisable that they have access to emergency items in case they need to leave their home at short notice to secure their safety. For such an eventuality, it is useful to prepare an emergency bag with essential items, which should be stored where they can be accessed quickly and not found by the person who is abusing them. Items not in daily use could be kept by a friend or relative. Money and contact details should be kept immediately accessible.

Items to consider including in an emergency bag or accessible in an emergency

- Money, bank cards, forms of identification, passport, National Insurance number, important documents (e.g. benefits information)
- Medication, medical information and contacts, continence products
- Phone and charger, address/contact book
- Aids, for example, glasses, hearing aids (batteries)
- Clothing
- Toiletries
- Small precious belongings, for example, jewellery and photos

Increasing safety in the home

A victim-survivor who is experiencing abuse from a person with dementia can take steps to increase their safety in the home including:

- Recognising signs that the person with dementia is becoming agitated and using tried and tested methods to diffuse the situation or remove themselves to a place of safety
- Consider obtaining a care call alarm to summon help in an emergency and ensuring the call centre is aware of the circumstances
- Removing items that could be used as a weapon
- Creating a safe space in the home, for example, a room the victim-survivor can go to, with a locking door or door wedge and communication device to seek help
- Creating a safe space to sleep to minimise harm during the night, for example, a separate bedroom
- If a victim-survivor is unable or unwilling to fit a lock to their bedroom door, consider fitting a sensor so they are alerted if their door is opened

It is important to recognise that in taking measures to protect themselves, victim-survivors should not take actions that deprive the person with dementia of their liberty and doing so may be a criminal act. For example: locking someone in a room; using restraints such as tying a person to a chair, or misusing medication to sedate a person.

Forward planning following a diagnosis of dementia

When a victim-survivor has a diagnosis of dementia

When a person has a diagnosis of dementia and it is identified that they are experiencing domestic abuse, consideration should be given to plans that can be put in place to protect safety in the future as the dementia advances.

If the abuse is recognised early stages following a diagnosis and there is no assessment of lack of capacity in decision-making the following steps can be taken

Discussion should take place with the individual about their future safety and well-being, including:

- Consideration that they may lose the ability to take steps to keep themselves safe and what the consequences would be
- Discussion on any prior history of abuse in the relationship and the possibility of an increase in abuse as dementia progresses. Including the possibility of the recurrence of abusive behaviours that were a feature early in the relationship. For example, there may have been sexual abuse early in the relationship and the ability of the survivor to prevent this may be reduced if there is a loss of capacity
- Whether they want to leave or end the relationship in the immediate future
- Future care and support needs
- Financial planning

Financial, property and assets

Check if there is a financial power of attorney in place.

- If the person who is abusive holds power of attorney consider removing this
- Identify a trusted person who can be appointed as power of attorney
- Seek legal advice over jointly held assets o Open an individual bank account
- Make adjustments to jointly held finances, for example, standing orders, loan payments, credit cards incoming payments such as business income, pensions and benefits
- Consider making and updating a will
- Ensure any savings, bonds, shares, cash are identified and secured

Health and welfare

Check if there is a health and welfare power of attorney in place.

- If the person who is abusive holds power of attorney consider removing thi
- Identify a trusted person who can be appointed as power of attorney

Consider making an "Advance Statement," expressing wishes for future health and care needs. An advanced statement is not a legally binding document but must be taken into consideration by people making decisions. The statement must be made and signed while someone still has capacity, and placed somewhere safe, for example, with medical notes.

Housing

Consider actions to remove an abusive person from the home or prevent them from accessing the home through:

- Use of occupation order
- Securing the home to prevent access, for example, changing locks, fitting window locks and alarms
- Remove or arrange collection of property belonging to the abusive person from the home to avoid them using it as an excuse to regain access

If leaving the home and applying for housing from a local authority, ensure they are aware the victim-survivor is fleeing abuse, to ensure priority access for housing. If a victim-survivor is moving into sheltered accommodation or a residential care setting, the person in charge should be made aware of the abuse and of possible attempts by the abusive person to access the victim-survivor.

Protective orders

Consideration should be given to putting protective orders in place to ensure an abusive person cannot regain access to a victim-survivor if they lose their capacity to consent to contact. Orders can include:

- Non-molestation order
- Occupation order
- Restraining order

After an incident has occurred, police can issue a Domestic Violence Protection Notice (DVPN) to grant immediate protection to the victim-survivor. This notice prevents the perpetrator from contacting the victim-survivor.

Within 48-hours of the DVPN being served, the Police can request a longer-term Domestic Violence Protection Order (DVPO) preventing the perpetrator from returning to a residence or having contact with the victim-survivor for up to 28 days.

Disrupting abusive behaviour

If a victim-survivor is staying in a relationship, or contact with an abusive person, consider measures that can be put in place to disrupt and minimise opportunities for abuse, including:

- Increasing the victim-survivors social connectedness to maximise opportunities to disclose abuse and for others to identify signs of abuse
- Seeking consent to share information with individuals and organisations involved with the victim-survivor, making them aware of the abuse so they can be alert for signs
- Careful consideration or care and support plans to enable intimate care to be provided independently

Pets

If there are pets in the home, and the victim-survivor does not feel able to leave them, they should be included in the safety plan:

- Can pets go with the older person to their identified place of safety? If not, identify someone willing to have the pets temporarily
- Some animal charities will arrange to temporarily foster the pets of victim-survivors of domestic abuse. Contact them for advice in advance.

When a victim-survivor is experiencing abuse from a person with a diagnosis of dementia

A victim-survivor's views of the relationship and the actions they choose to take may vary depending on whether they experienced abuse from the person prior to a diagnosis of dementia or if the abuse results directly from dementia. Consideration should be given to:

- Past abuse in the relationship
- Does the victim-survivor wish/choose to stay in a relationship with the person or want help to leave/end the relationship?
- Does the victim-survivor want to provide care for the person and, if so, what type of care can they provide safely
- What additional care and support can be provided by others to assist the victim-survivor to keep safe – in an emergency and in the longer term?
- Can respite provision be put in place to allow space for the victim-survivor?
- What emotional support can be put in place for the victim-survivor?

Improving safety planning within practitioner circles

There are several actions practitioners can adopt to improve safety planning for victim-survivors which include:

1. Be professionally curious and encourage other practitioners to adopt professional curiosity in their practice with potential victim-survivors, families and between professionals.

2. Share concerns with line managers and bring troubling cases forward to multi-agency meetings or for discussions with colleagues.

3. Create and facilitate opportunities for discussion and information sharing that include all relevant parties, and ensure information is shared appropriately, in a timely fashion and clearly.

4. Work in collaboration with other organisations that may hold specialisms that you do not. For example, domestic abuse workers and dementia specialists can offer a holistic approach that will improve safety planning, decision-making, and individual well-being. Ensure that there is clarity

5. In situations where the victim-survivor has significant loss of capacity, and where safe to do so, identify and involve non-abusive family members, communities, neighbours and friends in safety planning. Individuals known to the victim-survivor may hold information that can provide a greater understanding of the situation and be uniquely positioned to identify signs of domestic abuse and help-seek on behalf of the victim-survivor.

6. When speaking with family members, friends and neighbours, use the opportunity to raise their awareness of domestic abuse, what help and support services are available and what to do if they suspect or identify abuse in the future. Often people are aware something is happening, even if they don't identify it as abuse, and want to help but are not sure what to do or are afraid of being seen as interfering.

7. Put support in place for the individual providing care. Domestic homicide reviews indicate a strong link between care providing and domestic homicide. In cases of adult family homicide, the carer is most likely to be the victim. In contrast, in cases of intimate partner homicide, the carer is most likely to be the perpetrator.[24]

8. Where a victim-survivor is a tenant of social housing, consider what support the housing provider can offer, for example, support plans to assist with living safely; everyday tasks; social or leisure contacts; emotional well-being; finances; communication; physical health and mobility. These support plans should be reviewed annually.

9. Work with organisations that have built rapport and trusting relationships with victim-survivors and family members, including housing associations, community workers and voluntary organisations.

10. People living with dementia can experience a loss of self-confidence and a lack of trust in their judgement. This is further compounded by the behaviour of a perpetrator, who will often undermine their decision-making. When disclosures occur, it is crucially important that practitioners take the disclosures seriously and reassure the person they are believed.

24 Sharp-Jeffs, N. and Kelly, L. (2016). Domestic homicide review (DHR): case analysis. Project Report. Standing Together Against Domestic Violence, London Metropolitan University.

Legal guidance

What is adult safeguarding?

Adult safeguarding means protecting a person's right to live safely, free from abuse and neglect. Safeguarding processes should protect the health, well-being, and rights of an "adult at risk", supporting the individual to exercise choice and control over how they want to live.

Protection for "adults at risk"

Local authorities in England and Wales have a duty to assess and meet the needs for care and support and promote the well-being of adults and their carers. Local authorities also have a duty to act to safeguard adults who are identified as an "adult at risk." An "adult at risk" is an individual who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs)
- Is experiencing, or is at risk of, abuse or neglect;
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

Under section 126 of the Social Services and Well-being Act (Wales) 2014 and section 42 of the Care Act (England) 2014, a local authority has a duty to make, or cause to be made, such enquiries it considers necessary to decide whether a person is an adult at risk; and to decide what action, if any, should be taken and by whom.

The primary legislations local authorities must adhere to when responding to adults with care and support needs and adults at risk are:

Social Service and Well-being (Wales) Act 2015

Care Act (England) 2014

The Mental Capacity Act 2005

The Human Rights Act 1998 underpins all of the above Acts, in that, safeguarding processes are not to act in a way that is inco mpatible with a person's human rights including:

Article 2 – right to have life protected
Article 3 – right not to be subjected to inhuman or degrading treatment
Article 5 – right to liberty and security
Article 6 – right to a fair hearing
Article 8 – right to respect for private and family life, home, and correspondence.

How to make a safeguarding referral

Members of the public and practitioners representing organisations can report concerns about an adult at risk and/or make a referral to the Local Authority Adult Safeguarding (England and Wales). Details can be found on your local authority website. Alternatively, you can call your local authority to seek advice and guidance. It is best practice to seek consent from the older person before making a safeguarding referral. There are some circumstances in which the need to seek consent can be overridden. These circumstances include: if it is not safe to seek consent; the person does not have the capacity to consent; the person is at risk of serious harm or neglect; and/or another person has been identified as at risk of harm and neglect.

What happens when a safeguarding referral is made (a concern is raised)?

When a safeguarding referral is made, a practitioner (safeguarding officer or social worker) is allocated. The practitioner will establish how safe contact can be made with the individual concerned. Depending on the nature of the referral and identified risks, safeguarding practitioners may identify other professionals who are in contact with the individual, for example, healthcare professionals. In some cases, a multi-agency meeting may take place to form a plan to safeguard the individual and decide which practitioners are best placed to carry out the actions in the plan. The six principles that underpin all safeguarding practices are:

1. **Empowerment** - supporting individuals to make decisions and choices about safeguarding actions;
2. **Prevention** - raising awareness and providing information about abuse and neglect and what help is available;
3. **Proportionality** - ensuring the safeguarding response is proportionate and appropriate to the risk;
4. **Protection** - ensuring organisations and practitioners know what to do and how to respond to abuse;
5. **Partnership** - working with organisations and communities to prevent and identify and report abuse, whilst ensuring information is shared appropriately to keep individuals safe;
6. **Accountability** - ensuring everyone knows their role, responsibility and accountability in keeping individuals safe.

If an adult is not eligible for a safeguarding response, safeguarding practitioners should provide advice on other services available locally that can offer advice and support, for example, local domestic abuse organisations.

Protection for "adults at risk" The Mental Capacity Act (MCA) (England and Wales) 2005

Mental capacity is the capacity of an individual to make decisions for themselves. When a person is assessed as lacking capacity to make specific decisions for themselves, they may need support to make those decisions and, in certain situations, a person may be appointed to make best interest decisions on their behalf. The Mental Capacity Act (MCA) 2005 (England and Wales) defines the decision-making right of individuals who are assessed as lacking capacity and those making decisions on their behalf.

The Act has five key principles:

Principle 1: Assume a person has capacity unless proved otherwise.

Principle 2: Do not treat people as incapable of making a decision unless all practicable steps have been tried to help them.

Principle 3: A person should not be treated as incapable of making a decision because their decision may seem unwise.

Principle 4: Always do things or take decisions for people without capacity in their best interests.

Principle 5: Before doing something to someone or making a decision on their behalf, consider whether the outcome could be achieved in a less restrictive way.

The five key principles above must underpin all acts carried out and decisions taken about the Act. Principles one to three support the process before or at the point of determining whether a person lacks capacity, whilst principles four and five support the decision-making process if the person lacks capacity.

Under the MCA a person is determined to lack capacity if:

- they have an impairment of, or disturbance in the functioning of, the mind or brain;
- as a result of the impairment or disturbance, they are unable to make a decision about a particular matter at that time.

A person may lack capacity for a variety of reasons, for example:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A learning disability;
- Confusion, drowsiness.

Section 3 of the MCA states that an individual is unable to make a decision for themselves if they are unable to:

(a) understand the information relevant to the decision

(b) retain that information

(c) use or weigh that information as part of the process of making the decision

(d) communicate his/her decision (whether by talking, using sign language or any other means).

Mental capacity is decision specific, and it may be possible for someone to make a decision regarding one matter: for example, choosing what to eat, and not another matter, for example, complex financial decisions. Every effort should be made to find ways of communicating with and supporting the individual to make their own decisions, before deciding that they lack capacity to make a decision.

When decisions are made on behalf of a person, best practice normally involves consulting with family, friends, carers, and other professionals. However, it is important to consider, where there is domestic abuse from an intimate partner or family member, that family member or partner will not always have the persons best interests at heart and may prioritise their own interests i.e., misuse of a person's finances.

Who can make decisions on a person's behalf?

The MCA defines the legal process for best interest decision-making on behalf of individuals who lack capacity. People can plan in advance, for the event they may later lack capacity, by granting a Lasting Power of Attorney (LPA) to a trusted person to act on their behalf. For adults assessed as lacking capacity, who has not been appointed a LPA, an individual, normally a family member, can apply to the Court of Protection to be appointed as a Deputy to act on the person's behalf. In situations where a person does not have a LPA or a Deputy the Court of Protection can appoint the Local Authority to make decisions on the person's behalf.

Lasting Power of Attorney (LPA)

Practitioners supporting an older person who has disclosed they are experiencing domestic violence and abuse should identify whether they have appointed a Lasting Power of Attorney (LPA). It is possible the abusive person is appointed with LPA and, in this case, the older person should be advised to consider removing them. In the event the older person experiencing abuse has a diagnosis of dementia, a safety plan may also involve the individual appointing a trusted person with LPA while they still have full capacity to do so. Mental capacity is decision specific, and it may be possible for someone to make a decision regarding one matter: for example, choosing what to eat, and not another matter: for example, complex financial decisions. Every effort should be made to find ways of communicating with and supporting the individual to make their own decisions, before deciding that they lack capacity to make a decision.

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where there is domestic abuse from an intimate partner or family member, that family member or partner will not always have the persons best interests at heart and may prioritise their own interests i.e., misuse of a person's finances.

What is a Lasting Power of Attorney?

A Lasting Power of Attorney **(LPA)** is a legal document that lets a person (the 'donor') appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. Attorneys' can be relatives or friends, who would not be paid, or a solicitor who would usually charge fees. A person can appoint one or more people to act as an attorney and state whether they are authorised to make decisions independently or jointly. There are two types of **LPA**, one for decisions about health and welfare and one for decisions about property and financial affairs. A person can choose to make one or both types of **LPA**.

Health and welfare lasting power of attorney

Use this LPA to give an attorney the power to make decisions about things like:
- your daily routine, for example washing, dressing, eating
- medical care
- moving into a care home
- life-sustaining treatment

It can only be used when you're unable to make your own decisions.

Property and financial affairs lasting power of attorney

Use this LPA to give an attorney the power to make decisions about money and property for you, for example:
- managing a bank or building society account
- paying bills
- collecting benefits or a pension
- selling your home

It can be used as soon as it's registered, with your permission.

When can an attorney make decisions on someone's behalf?

An attorney appointed to make decisions for "Health and Welfare" can only start making decisions when a person is unable to do so because they "lack capacity," to make decisions. If someone appoints an attorney to make decisions for "Property and Financial affairs" they can designate if they want them to make decisions straight away, or when they "lack capacity."

Before a person can begin to act as an attorney the **LPA** must be registered with the Office of the Public Guardian (see contact details) and stamped **"VALIDATED-OPG."**

Considerations over who is appointed with LPA

When choosing a person/s to appoint as LPA, the older person should be encouraged to consider:

- Do they trust the person to make decisions that are in their best interest?
- Does the person have a good understanding of the older person's wishes and respect their values?
- Does the person want/agree to be appointed as LPA?
- Does the person have the time and resources to carry out the duties of an LPA?
- Is it likely the person will be unduly influenced by others in carrying out their duties as LPA?

Who can be an attorney?

An attorney must be:

- At least 18 years old
- Have mental capacity
- Not be declared bankrupt or subject to a debt relief order if the power relates to property and financial affairs.

A donor may appoint more than one attorney. It is recommended that two are appointed, in the case that one is unable to act for the doner in the future. When there is more than one attorney, the donor may decide to appoint them to act:

- **Jointly** – they must always make decisions together. If one attorney loses mental capacity the LPA is no longer valid.
- **Jointly and severally** – they can all act together or independently. In this case, if one attorney loses capacity, or is no longer able to act, the LPA will remain valid.

How can you check if someone has an LPA?

If an individual says they have an **LPA** to make decisions on someone's behalf they should be able to evidence this by showing the original stamped **LPA** or a certified copy, signed and dated on each page. To find out if someone has appointed an attorney, who is appointed, and what decision-making is granted you can search by filling in the online form "OPG100" with the Office of the Public Guardian (see contact details).

How can an LPA be abused?

An attorney may not always act in the best interests of the donor and may abuse their position. A person may breach their position of LPA if they:

- Use funds to purchase large gifts for themselves or others;
- Apply for credit cards or loans in the donor's name;
- Spend the donor's money unusually or extravagantly;

- Prevent healthcare or social care workers from accessing the donor;
- Do not follow medical advice which would be in the donor's best interests;
- Are found otherwise to not be acting in the best interests of the donor.

Can an attorney be removed?

An attorney can be removed at any time by the donor, provided they still have capacity to make decisions. Information on how to remove an attorney or make changes to a LPA is available from the Office of the Public Guardian (see contact details).

What can you do if you suspect an attorney is misusing or abusing an LPA?

If you suspect an attorney is not acting in the best interests of the person who has given them LPA you can report your concerns to the Office of the Public Guardian (see contact details). The OPC will investigate complaints against attorneys.

Deputies

If a person who is assessed as lacking capacity does not have a LPA in place a person can apply to be appointed a 'deputy' to make decisions on the person's behalf. To become a deputy a person has to apply for authorisation from the Court of Protection. There are two types of deputy:

- **Property and financial affairs deputy:** To do things like pay a person's bills and organise their pension
- **Personal welfare deputy:** To make decisions about medical treatment and how someone is looked after

A person can apply to be one or both types of deputy and a court order will detail what they can and cannot do. As soon as the deputy receives the court order they can begin to act on the person behalf.

Differences between a Lasting Power of Attorney (LPA) and a Deputy

Although the role of a LPA and a Deputy are similar there are some differences, in particular, the additional administration a Deputy is required to undertake. A Deputy is expected to pay an application fee and an annual supervision fee. If they are appointed as a property and financial affairs deputy, they may be required to pay a 'security bond,' a form of insurance to protect the finances of the person to whom they are appointed deputy. A deputy is also required to send an annual report to the Office of the Public Guardian **(OPG)** explaining the decisions they have made.

Advanced Decisions and Advanced Statements

An **"Advanced Decision"** and an **"Advanced Statement"** are documents detailing what a person's wishes are in the event they no longer have capacity to make specific decisions for themselves. The key difference between an Advanced Decision and an Advanced Statement is that an Advanced Decision is legally binding whereas an Advanced Statement is not.

An **"Advanced Decision"** is a legally binding document and, as such, should be signed, dated and witnessed. An "Advanced Decision" details a person's decision to refuse life-sustaining medical treatment, for example, the circumstances in which they do not want to be resuscitated. An "Advanced Decision" will only be applied if, at the point, a specific medical decision is being made, the person is assessed as not having capacity to make the decision under the Mental Capacity Act 2005. An "Advanced Decision" should be placed with GP and hospital records to ensure it is accessible.

An **"Advanced Statement"** can include instructions on any aspect of a person's life, for example, where or how a person would like to be cared for, who they would like to have contact with, what a person's religious beliefs are or what they want to happen to their body after they die. An Advanced statement is not a legal document but it is advisable for the individual and a witness to sign and date the statement as people tasked with making best interests decisions should take the statement into account.

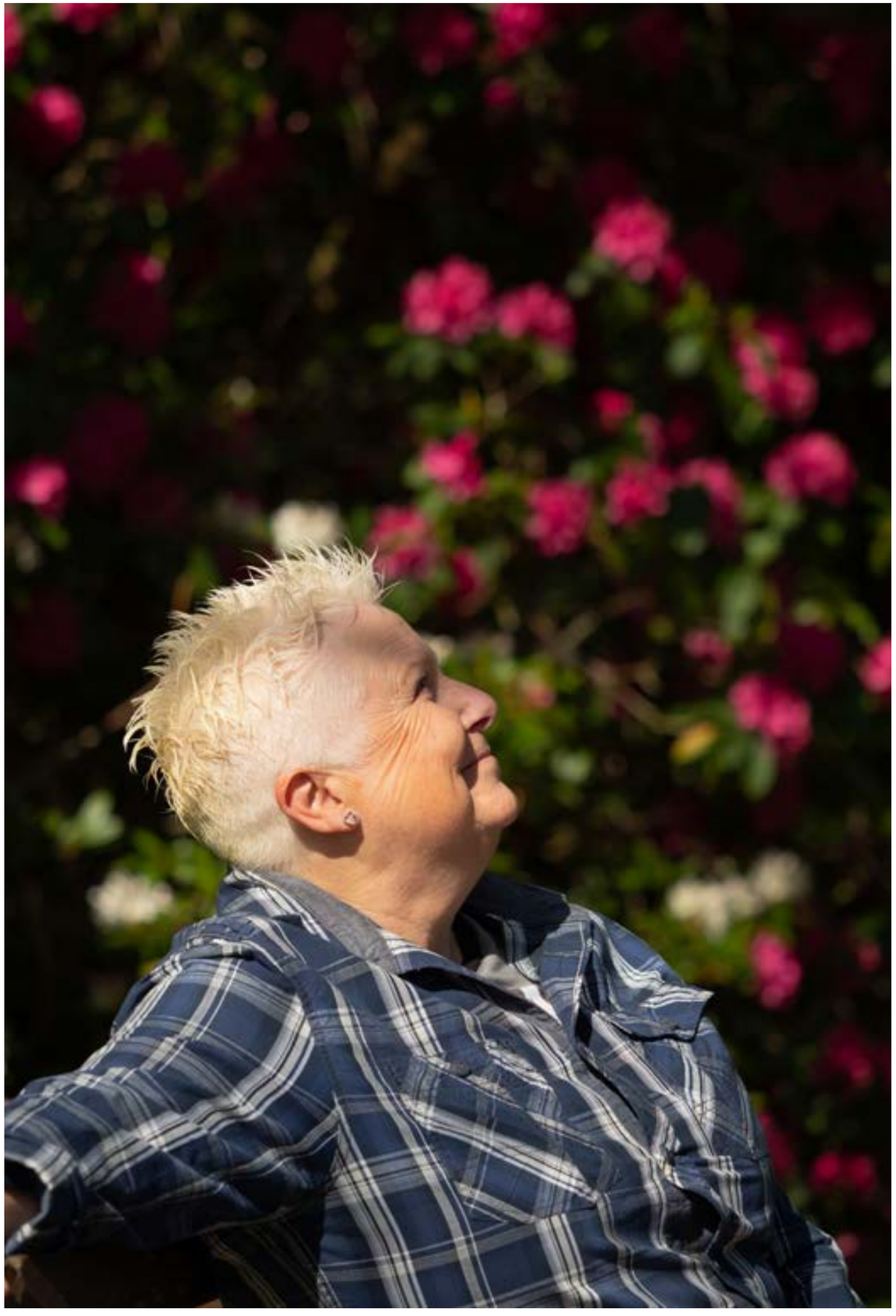
Contact details for the Office of the Public Guardian:

Email: customerservices@publicguardian.gov.uk
Telephone: 0300 456 0300
Textphone: 0115 934 2778
Website: https://www.gov.uk/power-of-attorney

Considerations for legal professionals working with older people

Legal professionals, including solicitors specialising in working with older people, may have received little or no domestic abuse training. Also, despite the definition of domestic abuse including abuse perpetrated by adult family members, most training, if available in the local area focuses exclusively on intimate partner violence and abuse. When advising an older person on appointing an LPA solicitor, practitioners should be mindful that they may be subject to coercion by a family member who does not prioritise their best interests. This is particularly relevant when a family member is in a caring role and accompanies the older person at appointments. Thus, legal professionals must adhere to the Law Society (2020) guidance,[25] in speaking to the older person on their own and ensuring, where appropriate, they have access to independent advice and/or advocacy.

25 The Law Society. (2020). Meeting the needs of vulnerable clients, [online], available at: https://www.lawsociety.org.uk/topics/client-care/meeting-the-needs-of-vulnerable-clients (accessed on 7th July 2021)



Summary

This toolkit has been brought to you by the Dewis Choice Initiative based at the Centre for Age, Gender and Social Justice at Aberystwyth University. The content for the toolkit has been informed by the research findings from the Initiative and has been funded by Comic Relief. The toolkit has been designed for practitioners and anyone who would like to know more about responding effectively to older victim-survivors of domestic abuse where dementia is also a feature.

The toolkit began with information about the nature and extent of dementia within the United Kingdom. It outlined the key principles of the Mental Capacity Act 2005 and reviewed what practitioners must do to uphold individuals' rights and entitlements when assessing capacity or making decisions regarding someone who has fluctuating or limited capacity. The toolkit then provided a detailed overview of the co-existence of dementia and domestic abuse, highlighting perpetrator behaviour and offering practitioners advice and guidance on how to effectively support victim-survivors. A case study was offered to illustrate the role informal social contacts can play in safeguarding victim-survivors.

The 'more than one' section of the toolkit explained the importance of maintaining social connections for victim-survivor's well-being and independence. Perpetrator behaviour to restrict victim-survivor's access to social connections and undermine their autonomy were discussed and signs for recognising the abuse were highlighted. This section ended on key skills for practitioners.

The section on engagement techniques explored in detail how practitioners can engage with a person who has dementia and is experiencing domestic abuse. The section provided practical advice and tools for engagement, ending with a case study drawn from Dewis Choice.

The safety planning section provides practitioners with information on how they can plan for both immediate and long-term safety of victim-survivors in the context of dementia. There is advice and guidance for practitioners to carefully consider themselves, with victim-survivors, and where appropriate adult family members. In addition, guidance is offered on how practitioners can work with other practitioners to improve safety planning for victim-survivors illustrated how colouring whilst talking with the client helped to make the client feel calm and express her feelings about her son.

The final section of the toolkit offered legal guidance for practitioners supporting victim-survivors of domestic abuse where dementia is also a feature. This section began with an outline of the role of adult safeguarding in safeguarding 'adults at risk'. It then moved on to discuss the Mental Capacity Act 2005 and when decisions can be made on behalf of a person who lacks capacity. Details of Lasting Power of Attorneys (LPAs), Deputies, Advance decisions and Advance Statements were given. The toolkit concluded with considerations for legal professionals working with older people.

Futher Reading and Resources

A range of resources, including research publications, practitioner guidance and tools, short films and training, can be accessed at: https://dewischoice.org.uk/

Wydall, S. (2021), 'Intimate Partner Violence – Transforming the Response to Older Victim-survivors in Later Life': The Routledge International Handbook of Domestic Violence and Abuse Edited Book. Devaney, J., Bradbury Jones, C., Holt, S., Macy, R. J. & Overlien, C. (eds.). 1 ed. Taylor & Francis, 1(27), P. 14.

Wydall, S., Freeman, E., Zerk, R. (2020), 'Transforming the Response to Domestic Abuse in Later Life: Dewis Choice Practitioner Guidance'. Llandysul, Gomer Press.

Wydall, S. & Zerk, R. (2019), "Listen to me, his behaviour is erratic and I'm really worried for our safety…": Help-seeking in the context of coercive control (Submitted) In: Criminology and Criminal Justice.

Wydall, S., Clarke, A., Williams, J. & Zerk, R. (2019), 'Dewis Choice: A Welsh Initiative promoting justice for older victim-survivors of domestic abuse' Violence Against Older Women: Responses. Bows, H. (ed.). 1 ed. Springer Nature, Vol. 2. p. 13-36 24 p. (Palgrave Studies in Victims and Victimology).

Wydall, S. & Freeman, E. (2019), 'Older People and Domestic Violence and Abuse' in Domestic Violence in Health Contexts: A Guide for Healthcare Professionals. McGarry, J. & Ali, P. (eds.). Switzerland: Springer Nature

Wydall, S., Clarke, A., Williams, J. & Zerk, R. (2018), 'Domestic Abuse and Elder Abuse in Wales: A Tale of Two Initiatives' In: British Journal of Social Work. 48, 4, p. 962–981

Wydall, S. & Zerk, R. (2017) 'Domestic abuse and older people: Factors influencing help-seeking', Journal of Adult Protection, 19(5), pp. 247–60.

Clarke, A., Williams, J. & Wydall, S. (2016) 'Access to justice for victims/survivors of elder abuse: A qualitative study', Social Policy and Society, 15(2), pp. 207–20.

Signposting

Emergency services

Police, Ambulance, Fire Emergency calls: 999
(If you call 999 from a landline, and are unable to speak, coughing or tapping in 55 on the keypad will signal to the call operator that you are in danger, allowing them to keep the line open and send officers to your location)

Police non-emergency calls – 101

Local Authority Safeguarding Adults

Contact details and information on how to raise a concern/make a referral can be found on each Local Authority website.

Domestic abuse services

Domestic abuse national support & advice
England: 24-hour domestic abuse helpline (Refuge) - 0808 200 0247;
Wales: Live Fear Free 24-hour violence against women, domestic abuse and sexual violence help line - 0808 801 0800
Scotland: 24-hour domestic abuse and forced marriage helpline - 0800 027 1234
Northern Ireland: 24-hour helpline for victims of domestic and sexual abuse - 0808 802 1414

Women's Aid (National branches)
Find your local branch at:
https://www.womensaid.org.uk/

Rights of women
Legal advice and information for women including domestic violence and sexual violence.
National line: Tues - Thurs 7 - 9pm, Friday 12pm - 2pm - 020 7251 6577

The Men's Advice Line
National advice line for male domestic abuse survivors:
Monday - Friday 9am - 5pm, Wednesday 9am - 8pm - 0808 801 0327

ManKind Initiative
National help and advice line for male victims of domestic abuse:
Weekdays, 10am - 4pm - 01823 334244

Hourglass
National helpline:
Monday - Friday 9am - 5pm - 080 8808 8141

LGBTQ+ national support and advice

Galop
National LGBT+ domestic abuse helpline:
Monday - Friday 10am - 5pm, Wednesday and Thursday until 8pm - 0800 999 5428

LGBT Foundation
Advice, support and information to LGBT communities: 0345 330 3030

BAME national support and advice

BAWSO
24-hour helpline: 0800 731 8147

Southall Black Sisters
Helpline: Monday, Wednesday - Friday 9:30 - 16:30 - 02085710800

IKWRO
(Help for Middle Eastern and Afghan women and girls)
Monday - Friday 9.30-5.30 - 0207 920 6460

National charities who support older people and their families

Age UK
Support and advice with range of topics including abuse, benefits, hospital stays, care homes etc.
National advice line: 8am – 7pm, 365 days a year - 0800 678 1602

Red Cross
National advice line for local contacts and services: 0344 871 1111

Royal Legion
Support for veterans and their families
National number for local contact and services: 0808 802 8080

MacMillan Cancer Support
Physical, emotional and financial support
National advice line, 8am - 8pm 7 days a week: 0808 808 0000

Dementia specific charities

Alzheimer's society
Advice and support for people with dementia, family, friends and professionals:
0330 333 0804

Benefits advice

Age UK
National advice line: 8am - 7pm, 365 days a year - 0800 678 1602

Citizens Advice Bureau
Advice with claiming benefits, debt, consumer issues, housing.
National phone service: Monday - Friday, 9am - 5pm - 03444 111 445

Pension credit claim line
(gov.uk) - 0800 99 1234

Mental Health national support and advice

MIND
Advice and support for anyone experiencing a mental health problem
Info line to connect to local services: 9am - 6pm Mon - Fri - 0300 123 3393

Samaritans
Help line, 24 hours 7 days a week: 116 123

Cruse Bereavement Care
Emotional support to anyone affected by a bereavement.
Mon & Fri 9.30am - 5pm, Tues, Weds & Thurs 9.30am - 8pm - 0808 808 1677

Animal charities

RSPCA Pet Retreat
Foster placements for pets: 0300 123 8278

Dogs Trust Freedom Project
Foster placements for dogs:
08000 298 9199

Rights of older people

Older People's Commissioner for Wales
Protects and promotes the rights of older people throughout Wales: 03442 640 670

Commissioner for Older People for Northern Ireland
Safeguarding and promoting the interests of older people in Northern Ireland:
028 9089 0892

Office of the Public Guardian
Helps people to stay in control of decisions about their health and finance
and make important decisions for others who cannot decide for themselves
England and Wales: 0300 456 5780
Scotland: 01324 678349

Office of Care and Protection Northern Ireland
0300 200 7812

Glossary of terms

Advocate: an independent person who supports an individual to have their wishes and views heard or expresses the individual's wishes and views on their behalf.

Cognitive function: mental processes that take place to carry out tasks, for example, recalling and using information, remembering the steps to carry out an activity and physical coordination.

Family member: a person who is a spouse, former spouse, child, stepchild, grandchild, parent, stepparent, grandparent, niece, nephew, mother-in-law, father-in-law, brother, brother-in-law, sister or sister-in-law.

Harmer: an individual who is using behaviour that is abusive but may not be defined as a perpetrator, for example, where abusive behaviours are a direct result of dementia and there is no pattern of coercive control. The term is also used where there is ambiguity regarding the cause of the behaviour.

Mental capacity: the ability of an individual to remember, recall and use information to make a decision.

Multi-agency: process or response involving the cooperation of a group of agencies.

Older person: there is no official definition of an older person. However, for the purpose of this toolkit, and the initiative's funding body, an older person is defined as an individual aged 55 years and over.

Perpetrator/alleged perpetrator: a person who carries out a harmful act, for example, acts of abusive behaviour.

Professional curiosity: practitioners seek to understand and question a situation, for example, signs of abuse or the behaviour of family members, rather than accepting explanations at face value.

Specialist domestic abuse service: a third sector organisation who specialise in working with victim-survivors, and in some cases perpetrators, of domestic abuse.

Victim-survivor: a person who has, or is, experiencing domestic abuse. Can be used interchangeably with "victim". It should be noted that, not all people who have experienced domestic abuse identify with the terms.

Well-being: the state of being/feeling physically and mentally well. Well-being is subjective and will vary from person to person. The components that facilitate well-being, for example, home, activities, social connections, will also vary depending on individual preferences and needs.

With special thanks

To all the victim-survivors who shared their lived experiences with us.
To Ageing Better resource for providing the imagery.