

**MARVOW** 2.0

Coordinated Multi-Agency Response  
to Violence against Older Women

# Manual of Operation

Coordinated Multi-Agency Collaboration for cases of  
violence against older women



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#### Deliverable 4.1: MARVOW 2.0 Manual of Operation

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## List of abbreviations

CJS: Criminal justice system

CCR: Coordinated Community Response

DV: Domestic violence

EASI: Elder Abuse Suspicion Index

EIGE: European Institute for Gender Equality

EU: European Union

GBV: Gender-Based Violence

GDPR: General Data Protection Regulation

IPV: Intimate Partner Violence

MARAC: Multi-Agency Risk Assessment Conference

MARVOW: Multi-Agency Response to Violence Against Older Women

NAP: National Action Plan

NGO: Non-Governmental Organisation

PP: Perpetrator Programme

PTSD: Post-Traumatic Stress Disorder

REAMI: Risk on Elder Abuse and Mistreatment Instrument

STIs: Sexually Transmitted Infections

TISOVA: Training to Identify and Support Older Victims of Abuse

VSS: Victim Support Service

WHO: World Health Organisation

WHOSEFVA: Working with Healthcare Organisations to Support Elderly Female Victims of Abuse

CSOs: Civil Society Organizations

# 1. Introduction

Violence against older women is a complex and pervasive problem that requires a comprehensive and coordinated response by multiple sectors. As the population in Europe and in Western societies is aging, it becomes increasingly essential to recognise and address the unique vulnerabilities faced by older women, who may experience various forms of violence; physical, emotional, financial, and sexual, and others. The **MARVOW 2.0 Manual of Operation** (Manual) for coordinated multi-agency collaboration has been designed to provide a functional framework for organisations and professionals involved in supporting older women who are victims of Domestic Violence (DV). However, it is worth mentioning that DV is rooted in gender-based violence, which in turn is based on *“unequal power and control over women,”* according to Dr. Avni Amin, Head of the Rights and Equality across the Life Course Unit at WHO and HRP. In addition, *“for older women and women with disabilities, their dependency and isolation are further exploited by perpetrators, increasing their risk of abuse. Services must be responsive to their needs and identify appropriate contacts through the health and care systems, so that all women experiencing violence can access empathetic, survivor-centred care.”*<sup>1</sup>

In recognizing that effective intervention and support for older women requires collaboration across diverse agencies—such as law enforcement, healthcare providers, social services, and community organisations—this Manual serves as a guide to facilitate core processes at the extent of multi-agency collaboration.

By embracing a survivor-centred approach, we aim to ensure that older women receive comprehensive and tailored support addressing their specific needs and circumstances.

This Manual outlines the principles of coordinated multi-agency collaboration, practical strategies for building effective partnerships, and best practices for ensuring the safety and well-being of older women. It emphasises the importance of training, information sharing, and continuous evaluation to enhance the effectiveness of interventions. By working together, a supportive environment could be

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<sup>1</sup> WHO, 2024. *WHO calls for greater attention to violence against women with disabilities and older women.* Available at: <https://www.who.int/news/item/27-03-2024-who-calls-for-greater-attention-to-violence-against-women-with-disabilities-and-older-women>



created aiming not only to protect older women from violence but also to empower them to regain their autonomy and dignity.

A systemic approach for care and protection should be created ensuring the recognition of the value and dignity of older women and fostering an effective community response towards violence and abuse. Through collaboration, improved outcomes for older women can be achieved, ensuring that they receive the respect, protection, and support they deserve.

## 2. Glossary

Important definitions regarding the manual, definitions of terms and acronyms used in the manual.

### Ageism

The World Health Organisation (WHO) defines ageism as *“the stereotypes (thoughts), prejudice (feelings) and discrimination (actions or behaviours) directed towards others or oneself based on age”*.<sup>2</sup>

### Coercive Control

Coercive control refers to a pattern of domination that includes tactics to isolate, degrade, exploit and control victims, hindering women’s development, their ability to exercise citizenship, and the well-being of families, communities and society. It includes components such as coercion, sexual coercion, intimidation, regulation, surveillance, limiting resources and outside support, degradation, control and isolation (Stark, 2009). At least three facets of coercive control are identified: intentionality or goal orientation in the abuser (versus motivation), a negative perception of the controlling behavior by the victim, and the ability of the abuser to obtain control through the deployment of a credible threat (Hamberger, L. K., Larsen, S. E., & Lehrner, A., 2017)<sup>3</sup>.

### Carers

A carer<sup>4</sup> (or caregiver) is someone who provides long-term care to a person with significant care needs, such as an older adult with reduced functional ability. According to the World Health Organization, long-term care includes a wide range of personal, social, and medical support to help individuals maintain their daily functioning and dignity. Carers can be informal, such as family members, friends, or neighbours who provide unpaid care without formal training; or formal, meaning paid professionals who may have received training.

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<sup>2</sup> *Global report on ageism*. Geneva: World Health Organisation; 2021. Licence: CC BY-NC-SA 3.0 IGO.

<sup>3</sup> *Coercive control in intimate partner violence*. *Aggression and Violent Behavior*, 37, 1–11.

doi:10.1016/j.avb.2017.08.003

<sup>4</sup> World Health Organization. (2020). *Supporting informal carers of people with dementia*. WHO. Retrieved from <https://apps.who.int/iris/handle/10665/331683>; World Health Organization. (2022). Definitions of Long-term care. Available at: <https://www.who.int/europe/news-room/questions-and-answers/item/long-term-care>.

## Coordinated cooperation

Coordinated cooperation refers to the collaborative efforts of various organisations and agencies—such as law enforcement, healthcare providers, social services, educational institutions, and non-governmental organisations (NGOs)—working together to address complex issues or crises. This approach is particularly important in situations where a single agency may lack the resources or expertise to effectively respond to a problem, such as domestic violence, mental health crises, or public health emergencies. Multi-agency cooperation aims to create a coordinated response that enhances service delivery, improves outcomes for individuals and communities, and ensures that diverse perspectives and expertise are integrated into problem-solving efforts.<sup>5</sup>

## Domestic Violence

Domestic violence (DV) refers to all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim (CoE [Council of Europe], 2011).

## Disability

A physical or mental impairment that substantially limits one or more major life activities of such an individual; a record of such an impairment; or being regarded as having such an impairment.<sup>6</sup>

## Discrimination

Discrimination consists of “*actions, practices, or policies that are applied to people on account of their perceived or real membership in some socially salient group and that impose some form of disadvantage (negative discrimination) or advantage (positive discrimination) on them.*”<sup>7</sup>

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<sup>5</sup> Home Office. (2019). Multi-agency working: A practical guide for practitioners and managers. Available at: <https://www.gov.uk/government/publications/multi-agency-working-a-practical-guide-for-practitioners-and-managers>.

<sup>6</sup> World Health Organisation (WHO). (2011). *World report on disability*. Retrieved from <https://www.who.int/publications/i/item/world-report-on-disability>.

<sup>7</sup> Global report on ageism. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO.

## Family (Informal Caregiver)

An informal caregiver is generally characterized as someone who offers unpaid, ongoing support with activities of daily living (ADLs) or instrumental activities of daily living (IADLs) to an individual with a chronic illness or disability. Caregivers vary in their relationships with care recipients (e.g. spouse, adult child, other relative, neighbour, or friend), their living situations (e.g. living with the care recipient or living separately), their role as either a "primary" caregiver or one offering secondary or supplemental support, the care recipients' clinical conditions (e.g. dementia, frailty, stroke, etc.), and other factors reflecting the level and nature of their caregiving involvement (Roth, D., 2015).

## Formal Caregiver

A formal caregiver is a volunteer or paid employee who provides services under a formal service system.

## Gender-Based Violence

Gender-Based Violence (GBV): Gender-based violence refers to *"any harmful act directed against an individual or a group of individuals based on their gender. It is rooted in gender inequality, the abuse of power, and harmful norms. GBV is a serious violation of human rights and a life-threatening health and protection issue". The Istanbul Convention, as the benchmark for international and European legislation on tackling gender-based violence, frames gender-based violence and violence against women as a gendered act which is 'a violation of human rights and a form of discrimination against women'.*<sup>8</sup>

## Gender based violence against older women

It refers to any harmful act directed at a woman based on her gender and age, which results in physical, psychological, sexual, or economic harm. This form of violence is rooted in power imbalances and gender discrimination, and it can take many forms, including physical abuse, emotional or psychological abuse, sexual violence, financial exploitation, neglect, and abandonment. Older women may experience GBV in both private and public settings, and it is often exacerbated by factors such as

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<sup>8</sup> EIGE. *What is gender-based violence?* Available at: <https://eige.europa.eu/gender-based-violence/what-is-gender-based-violence>.

ageism, social isolation, disability, or dependency. Gender-based violence against older women is a violation of their human rights and a significant public health and social issue.<sup>9</sup>

### Intimate partner Violence (IPV)

Intimate partner violence (IPV) refers to any pattern of behaviour that is used to gain or maintain power and control over an (ex) intimate partner. It encompasses all physical, sexual, emotional, economic and psychological actions or threats of actions that have a harmful impact on another person.

### Older people

The United Nations use the standard of age of 60 years old so to describe “*older people*”<sup>10</sup>. This may seem young in the Global North where major gains in life expectancy have already occurred. However, whatever age is used within different contexts, it is important to acknowledge that chronological age is not a precise marker for the changes that accompany ageing. There are significant variations in health status, participation, and levels of independence among older people of the same age. The Draft Recommendation on the promotion of rights of older persons of the Council of Europe, refers that ‘*The present recommendation applies to persons whose older age constitutes, alone or in interaction with other factors, including perceptions and attitudes, a barrier to the full enjoyment of their human rights and fundamental freedoms and their full and effective participation in society on an equal basis.* In addition, the Council of Europe Member States have identified chronological ages at national level whereby persons enjoy specific rights for being older’.<sup>11</sup>

### Protective factors

They are the qualities, conditions, or components that, when present, have the power to minimise vulnerability conditions or mitigate or eliminate risks. A protective factor is defined as a condition or

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<sup>9</sup> World Health Organisation (WHO). (2018). *Elder abuse*. [WHO website](#).

<sup>10</sup> UN (2024). *Emergency Handbook*. Available at: <https://emergency.unhcr.org/protection/persons-risk/older-persons>.

<sup>11</sup> AGE Platform. AGE Platform Europe contribution to the UN DESA Call for NGO input to the OpenEnded Working Group on Ageing. Available at: <https://social.un.org/ageing-working-group/documents/fourth/AGE.pdf>.

characteristic that helps people deal more effectively with stressful events and that lessens the risk of vulnerability, such as skills, strengths, resources, support systems and coping strategies.<sup>12</sup>

## Perpetrator

It refers to a person who commits acts of domestic or intimate partner violence. It is recognized that perpetrators of violence are predominantly men, while survivors are mainly women. Within this document, the term “perpetrator” refers to men who use violence unless otherwise indicated.

## Perpetrator Risk Factors

The Centers for Disease Control and Prevention (CDC) has identified several factors that contribute to the risk of becoming a perpetrator of violence against older women. These factors, which occur at an individual, relational, and societal level, may or may not be direct causes for abuse.<sup>13</sup>

## Risk Assessment

*“The assessment of the safety risks a particular survivor faces on a case-by-case basis, according to standardized procedures and within a multiagency framework. Risk assessment includes an assessment of the lethality risk, the seriousness of the situation and the risk of repeated violence”.*<sup>14</sup>

## Risk management

*“The process by which all relevant stakeholders manage the safety risks identified in a risk assessment. These activities may be directed towards survivors (e.g. safety planning), towards perpetrators (e.g. using police powers to pursue, detect and disrupt offending behaviour) or towards survivors and perpetrators in combination. The scope and type of activities undertaken should be informed by risk assessment, implemented within a multiagency framework and monitored for effectiveness. The aim of*

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<sup>12</sup> Perttu, S., Laurola, H., Blank, K., Solohub, O., & Lind, M., (2020). *How to Identify and Support Older Victims of Abuse A training handbook for professionals, volunteers and older people*. TISOVA Project. Available at: [https://kakopoiisi.gr/wp-content/uploads/2023/05/02\\_TISOVA\\_Training-handbook\\_ENG.pdf](https://kakopoiisi.gr/wp-content/uploads/2023/05/02_TISOVA_Training-handbook_ENG.pdf).

<sup>13</sup> National Clearinghouse on Abuse in Later Life (NCALL). (2013). *An Overview of Elder Abuse: A Growing Problem*. Available at: <https://www.napsa-now.org/wp-content/uploads/2015/10/101-The-Intersection-of-Stalking-and-Elder-Abuse-8.pdf>.

<sup>14</sup> Council of Europe (CoE) (2011), ‘Council of Europe Convention on preventing and combating violence against women and domestic violence’ in Istanbul Convention, Article 51.

these activities is to try to reduce the threat posed by the perpetrator and protect the survivor from further violence and abuse”.<sup>15</sup>

## Sexism

Sexism is prejudice, stereotyping, or discrimination based on a person’s sex or gender. It is rooted in the belief that one sex (usually men) is inherently superior to another, and it is often manifested through social norms, institutional practices, and cultural expectations.<sup>16</sup> When sexism intersects with age, the result is often called gendered ageism (or “double jeopardy”): older women face discrimination not just because they are female, but also because they are older.<sup>17</sup>

## Survivor

It refers to any person who has experienced domestic violence or intimate partner violence. It is similar in meaning to “victim” but is generally preferred because it implies resilience. Within this document, “survivor” refers to older women unless otherwise indicated.

## Survivor Risk Factors

Factors that might upsurge an older adult’s risk of victimisation incorporate: the survivor’s poor physical or mental health, functional disability and dependence, cognitive deficits, financial dependence, social isolation, and prior exposure to trauma. The gender of the survivor has also been identified as a risk factor, since women are thought to make up the majority of survivors of violence against older women.<sup>18</sup>

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<sup>15</sup> Council of Europe (CoE) (2011), ‘Council of Europe Convention on preventing and combating violence against women and domestic violence’ in Istanbul Convention, Article 51.

<sup>16</sup> Hand MD, Ihara ES. Ageism, Racism, Sexism, and Work With Older Healthcare Clients: Why an Intersectional Approach Is Needed in Practice, Policy, Education, and Research. *Int J Aging Hum Dev.* 2024 Jan;98(1):27-38. doi: 10.1177/00914150231171843. Epub 2023 Apr 27. PMID: 37113108.

<sup>17</sup> Westwood S. "It's the not being seen that is most tiresome": Older women, invisibility and social (in)justice. *J Women Aging.* 2023 Nov-Dec;35(6):557-572. doi: 10.1080/08952841.2023.2197658. Epub 2023 Apr 25. PMID: 37097812.

<sup>18</sup> Strongman, H., Gadd, S., Matthews, A., Mansfield, K. E., Stanway, S., Lyon, A. R., & Bhaskaran, K. (2019). Medium and long-term risks of specific cardiovascular diseases in survivors of 20 adult cancers: a population-based cohort study using multiple linked UK electronic health records databases. *The Lancet*, 394(10203), 1041-1054.

## Victim-centred Approach

A victim-centred approach *is a framework that prioritises the rights, needs, and well-being of victims throughout all stages of response and support. This approach ensures that victims are treated with respect, dignity, and empathy, allowing them to retain control over decisions affecting their lives. By focusing on the victim's perspective and unique needs, it aims to minimise re-traumatization and promotes safety, empowerment, and access to necessary resources, such as legal, medical, and psychological support.*<sup>19</sup>

## Violence against older women

It refers to any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women aged 60 and older including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. This can also include financial abuse, exploitation or deprivation of resources, neglect, and abandonment.<sup>20</sup>

## Vulnerability

Vulnerability for older women refers to the heightened risk of experiencing negative outcomes due to a combination of factors that affect their well-being and security. These factors can include social isolation, financial, health factors, physical, or emotional dependence on others or impaired capacity for self-care or self-protection, gender-based violence, lack of access to services, and cultural attitudes.<sup>21</sup>

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<sup>19</sup> European Institute for Gender Equality. (2022). *Victim-centred approach in the context of gender-based violence*. EIGE. Available at: <https://eige.europa.eu/>.

<sup>20</sup> Violence Against Women and Girls Resource Guide, Brief on Violence against older Women, The World Bank, 2016

<sup>21</sup> World Health Organisation (WHO). (2021). *Gender and age-related vulnerability in health emergencies*. Retrieved from <https://www.who.int/publications/i/item/WHO-2019-nCoV-Older-people-2021-1>.

## Forms of violence against older women

**PHYSICAL ABUSE:** The deliberate use of physical coercion and physical or drug-induced restraint that causes physical harm, suffering, functional impairment, acute or chronic sickness, distress, or even death.<sup>22</sup>

**SEXUAL ABUSE** is defined as any non-consensual sexual act or behaviour that occurs against an individual's will. This includes a wide range of behaviours, such as unwanted sexual touching, coercion, harassment, exploitation, and rape. Sexual abuse can happen to individuals of any age, gender, or sexual orientation and can occur in various contexts, including domestic settings, institutions, or public spaces. The fundamental element of sexual abuse is the lack of consent, which may stem from manipulation, coercion, or the inability of the victim to give consent due to factors such as age, mental capacity, or intoxication.<sup>23</sup>

**EMOTIONAL / PSYCHOLOGICAL ABUSE:** Behaviors, verbal or non-verbal, that cause mental suffering, anguish, fear, or distress. Such actions could have short-term, long-term, immediate, or delayed impacts that the survivor may fail to immediately understand or acknowledge.<sup>24</sup>

**NEGLECT:** Failure to provide essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living, or shelter to an older person in need, whether by a caregiver or another person with whom they have a trust relationship, that puts the older person at serious risk of health and/or safety issues related to age, disability, and cultural norms.<sup>25</sup>

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<sup>22</sup> World Health Organisation (WHO). (2021). *Understanding and addressing violence against women: Intimate partner violence*. Retrieved from <https://www.who.int/reproductivehealth/publications/violence/vaw-intimate-partner-violence/en/>.

<sup>23</sup> World Health Organisation (WHO). (2021). *Sexual violence against women: Key facts*. Retrieved from <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>.

<sup>24</sup> World Health Organisation (WHO). (2013). *Understanding and addressing violence against women: The health sector response*. Retrieved from <https://www.who.int/reproductivehealth/publications/violence/9789241505417/en/>.

<sup>25</sup> United Nations. (2017). *Report of the Special Rapporteur on the rights of persons with disabilities*. Retrieved from <https://undocs.org/en/A/72/133>.

**FINANCIAL ABUSE / EXPLOITATION:** The misuse, exploitation, or illegal use of an older person's resources by a caregiver or another trusted person in order to benefit someone other than the older person. This includes, but is not restricted to, denying an older person access to, knowledge of, or utilisation of private advantages, resources, possessions, or assets<sup>26</sup>.

**ABANDONMENT:** the act of leaving a person in a situation where they are unable to care for themselves or meet their own basic needs, resulting in harm or risk of harm. Abandonment may involve leaving someone without necessary care, supervision, or support, often leading to physical, emotional, or psychological distress for the affected individual.<sup>27</sup>

**OBLIGE OLDER WOMEN TO LIVE SOMEWHERE THEY DO NOT WANT TO:** This is quite common in cases of older women and is associated with severe violations of the rights of older women, but also with multiple forms of abuse against older women. In particular, it is linked to psychological and emotional violence since forcing someone to live in a place she does not want can cause significant emotional distress. It can make one feel powerless, anxious, and isolated, which could lead to depression, fear, or a loss of dignity. It can also lead to social isolation, depriving her of social connections, family support, and a sense of community.

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<sup>26</sup> National Center on Elder Abuse (NCEA). (n.d.). *Financial exploitation*. Retrieved from <https://ncea.acl.gov/faq/financial-exploitation.aspx>.

<sup>27</sup> World Health Organisation (WHO). (2021). *Elder abuse*. Retrieved from <https://www.who.int/news-room/factsheets/detail/elder-abuse>.

## 3. Responding to Domestic Violence through Multi-agency Collaboration

### 3.1 National level

#### 3.1.1 Overview

Many EU countries have adopted National Action Plans (NAPs) to ensure a comprehensive approach to address and combat domestic violence. Spain has adopted the Comprehensive National Strategy Against Gender-Based Violence, which includes specific measures to address various forms of gender-based violence, including domestic violence. It mainly focuses on the coordination among various government departments, including shelters and legal aid. In Cyprus, the government adopted a National Action Plan aiming at preventing and combating domestic violence by recording specific activities and implementing bodies.<sup>28</sup> In Greece, the National Strategy for Sustainable and Equitable Development 2030 is linked to the abuse of older women through its axes for sustainable development, human rights, and social justice. In this context, the strategy proposed the protection of vulnerable social groups, such as older women, from all forms of violence and discrimination. In particular, it promotes policies to reduce social inequalities and create strong social welfare systems, which include measures to protect older women from violence, such as psychological, physical, economic, and domestic abuse. These policies strengthen support networks and access to social services, providing better care and protection for older women. In addition, the gender equality strategy incorporates the need to prevent violence against women of all ages, including older women, by promoting awareness raising, education and support mechanisms.<sup>29</sup>

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<sup>28</sup> National Action Plan; Cyprus. Available at:

[http://www.familyviolence.gov.cy/upload/downloads/actionplan\\_2010-2013.pdf](http://www.familyviolence.gov.cy/upload/downloads/actionplan_2010-2013.pdf).

<sup>29</sup> UN Women, Implementation of the Agreed Conclusions of the 60th Session of the Commission on the Status of Women on “Women’s empowerment and the link to sustainable development”: Contribution by Greece.

Protocols and guidelines are also adopted by the EU countries to provide detailed procedures for how different agencies should collaborate, share information, and respond to cases of domestic violence. Protocols and guidelines ensure that agencies follow standardised procedures, which helps in providing a consistent response to victims. They also facilitate effective communication and coordination among agencies, reducing the risk of duplicated efforts or gaps in services. Bulgaria has established national guidelines to improve responses to domestic violence and protect victims through standardised procedures for police, healthcare providers, and social workers on how to handle domestic violence cases and guidelines for offering immediate support and long-term assistance to victims, including older women. In Austria, security police case conferences are held in cases where women affected by violence are found to be at high risk. These are made up of the police, the violence protection centre and perpetrator work. However, the case conference can only be convened by the police. The other organisations can request that the police convene the conference. There are regional working groups made up of different professional groups. However, this is not standardised and often depends on the commitment of individual experts. Inter-ministerial working groups on the protection of women and children from violence are organised at federal level. These serve to exchange expertise throughout Austria.

Some EU countries, such as France<sup>30</sup>, involve cross border collaboration between Member States to address cases of domestic violence, which includes victims or perpetrators. This collaboration is based upon the European Protection Order and the EU Victims' Rights Directive. The main aim is to ensure that victims who move across borders receive consistent support and protection and to facilitate the sharing of information and resources between countries, improving the effectiveness of responses. Some EU countries collect and process the data on domestic violence. The aim is to understand the scope and assess the effectiveness of responses, and to improve policies. In Germany, the Federal Statistical Office collects and publishes data on domestic violence and other related issues for

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<sup>30</sup> In France, the law provides for close collaboration between different agencies to better address domestic violence. For example, victims can now file a police report directly at the hospital, with the assistance of medical staff, thereby facilitating access to justice and immediate support. Additionally, Operational Liaison and Intervention Committees (COFIL) have been established. These COFIL bring together police services, the justice system, healthcare providers, and associations to coordinate their actions, share information, and develop joint action plans. However, this system is not yet standardized.

authorities to update and upscale national policies and response strategies. Austria produces annual reports on domestic violence, including data on victim demographics and agency responses. Funding and support programmes provide financial resources for initiatives aimed at combating domestic violence and supporting victims. The Italy National Fund for the Prevention of Violence against Women has been established to support targeted projects aiming at preventing and responding to violence against women. It funds initiatives such as awareness raising campaigns, support services, and training programmes and promotes multi-agency collaboration and victim support.

### 3.1.2 Greece

#### a. Legal framework, country-specific policies and procedures.

In Greece, there is limited available data to estimate the number of cases of violence against older people, while there is no comprehensive information system at national level for recording and collecting data on the complaints and the cases of gender-based and domestic violence against older women.

Older women face a greater risk of any form of violence related to older women due to different aspects. Cultural and societal aspects are of vital importance, since ageism and sexism need to be taken into account, while older women have grown up with different standards, principles and beliefs make it more difficult for them to understand the signs of violence. Systemic gaps and lack of knowledge and tools for professionals are also significant considering that they do not know how to recognize the violence and how to refer or manage such cases when it is related to older women. The weak institutional framework increases the number of cases that are not referred or managed effectively. Digital exclusion is one more considerable factor, since older women remain excluded by information related to the signs of violence and services provision.

In Greece, there is no specific legislation on violence against older people. The protection of women victims of violence is defined by Laws 3500/2006 and 4531/2018 (which ratifies the Istanbul Convention on Preventing and Combating Violence against Women and Domestic Violence, 2011), without focusing on age groups, but is a general law for the prevention and management of domestic and gender-based violence cases. The Istanbul Convention recognizes violence against women as a

violation of human rights and a form of discrimination against women and defines violence and gender-based violence against women as a gender-based act that constitutes a «violation of human rights and a form of discrimination against women». Law 4531/2018 and the EU Directive 2012/29/EU (article 22) foresees support for survivors of violence and the use of tools and methodology by professionals and Victim Support Services to assess and evaluate the risks related to the survivors. The main aim is to ensure and maximize the safety of survivors.

European Member States, have an obligation to monitor the implementation of policies and measures against violence by adopting legislative or other instruments and interventions to ensure that inequality, abuse and violence are combated. In addition, according to *Law 3500/2006, article 21* and the *New Code for Municipalities and Communities*, the Social Services of Local Authorities may provide counselling support and material assistance to victims of domestic violence. However, this is largely determined as much by the discretion of professionals as it is by the ability, educational background and expertise that service professionals have, in addition to fulfilling their other duties and responsibilities.

With regard to the phenomenon of violence against women and girls, including older women, there are directives and regulations that refer to the current legislative framework of European Union countries, including Greece, which has incorporated the relevant regulations into its national law. Specifically:

1. *Directive 2012/29 of the European Parliament and of the Council* establishing minimum standards on the rights, support and protection of victims of crime – Right to protection for victims in all European Member States
2. *Regulation 235/2014 of the European Parliament of the Council*, in March 2014, establishing a financing instrument for democracy and human rights worldwide. The Regulation foresees promotion and mainstreaming of gender equality, including equal treatment and the elimination against inequalities, including measures to combat all forms of domestic violence against women.
3. *Regulation 1381/2013 of the European Parliament and of the Council* through which a high priority is given to the development of coordinated actions and the strengthening of political will to combat violence against children and women, but also more broadly to high-risk groups such as older women.

4. *European Directive 2012/29/EU "Compensation to victims of sexual offences"*, which provides for facilitating access to legal procedures for victims of sexual violence and the exercise of their right to claim compensation for sexual offences committed against them by the perpetrator and/or the State.
5. Greece adopted the *European Parliament resolution of 5 April 2011* on the priorities and general characteristics of a new EU policy framework to combat violence against women.

The General Secretariat for Demographic and Family Policy and Gender Equality (GSFGE) is responsible for the implementation of the Istanbul Convention and for adopting measures to prevent, address and combat gender-based violence and violence against women and girls. The Hellenic Police and the Police Directorates of each prefecture and region in cooperation with the Public Prosecutor's Office also contribute to the prevention and response to the phenomenon of violence, while ensuring the protection and safety of the victims. In Greece, Domestic Violence Offices have been set up as part of the Hellenic Police to ensure effective management of incidents of gender-based and domestic violence. Bodies of the National Mechanism for Gender Equality, including the Research Centers for Gender Equality (KETHI) and the Regional and Municipal Equality Committees plays an important role in preventing, addressing, combating and eradicating violence against women, as well as the adoption of initiatives to strengthen the above-mentioned objectives.

In Greece, there is the National Helpline of the General Secretariat for Equality (15900) and the National Centre for Social Solidarity (197) which operate 24/7. Several Social Organizations, Civil Society Organizations and NGOs are also active in supporting survivors of domestic and gender-based violence and in general tackling the phenomenon through raising awareness and train professionals involved.

The National Action Plan for Gender Equality 2021-2025 pays special attention to "Preventing and combating gender and domestic violence", and the aims and specific actions to be formulated. The provisions will be implemented by all Greek Ministries to combat gender inequality and the phenomenon of violence. However, there is no clear reference to older people.

Lastly, in Greece, in February 2024, amendments were made to the Criminal Code and the Code of Criminal Procedure to address domestic violence, with the implementation of strict laws and the activation of all stakeholders. According to Law 5090/2024 (Government Gazette A 30 - 23.02.2024)

«Interventions in the Criminal Code and the Code of Criminal Procedure for the acceleration and qualitative upgrading of criminal proceedings - Modernization of the legislative framework for the prevention and combating of domestic violence», amendments are foreseen in order to maximize the safety of victims of gender-based violence, to combat impunity and to speed up the criminal procedure through swifter administration of Greek justice. The main aims are to ensure the absolute priority of such cases, to provide effective and efficient protection for victims, the speedy processing of cases, the pacification of the affected family relationships through the institution of restorative justice and, ultimately, the fair trial and just punishment of the victims. Regarding the work with older perpetrators, in Greece, there is the perpetrator programs -referring to all perpetrators, regardless their age- that are mainly carried out within the framework of “Penal Mediation” as a process which is fully described in the 3500/2006 Act which is the main and primal legislation for combating Domestic Violence. Several legal provisions are foreseen within the frame of Penal Mediation aiming to provide a “restorative justice treatment” to the perpetrators, but with no clear reference to the age factor. The process initiates with the issue of the “Prosecution Orders” issued by the Public Prosecutor Offices or by Court Orders to the perpetrators. In order for the process to be in effect, the victims’ consent is required. The Perpetrator programs are implemented by either public agencies or certain organizations, such as NGOs, hospitals’ social services, or other social services. However, most of the services providing perpetrator work are not specialized in this kind of interventions. The process is implemented for misdemeanors, such as simple bodily harm, threat, insult, or coercion. It requires three conditions to be in place: the perpetrator not to commit further violence, participation in counseling, and compensation provision for the victim. In case the perpetrator fails to comply with the abovementioned agreement, the prosecutor can terminate the process, and further legal proceedings will be applied. The total duration of the Program is three years, while the frequency of the meetings is set in accordance with the personal work and social commitments of the perpetrator, taking into consideration difficulties that may arise, such as working conditions, etc. The main aim is consistency, dedication, and replicability. However, this process is not foreseen for more significant gender-based crimes (i.e., rape, sexual abuse, etc.) and there is no process in place for this kind of perpetrators.

The main actors implementing the process at the national level are The National Centre for Social Solidarity (EKKA), UWAH, VIA STOP (as Non-Governmental Organizations), and local public authorities

ordered by the local Prosecutors orders. EKKA includes therapeutic counseling and treatment programs, and is active in Athens and Thessaloniki, while other non-governmental organizations cooperate with the Prosecutors Office in other areas of Greece. VIA-STOP is implementing the Program in Kavala, UWAH in Heraklion while there are also other stakeholders implementing the Perpetrator Programs, such as the hospital in Mytilini, social services in rural communities, such in Grevena, Kilkis, and Ptolemaida and some Mental Health Units, such as in Agios Nikolaos, Crete. There is neither an institutionalized procedure nor a non-formal process for collaboration between different services, such as victim support services (VSS), mental health services, child protection services, or healthcare or geriatric facilities. Cooperation between engaged services prevails as a primal priority in order to avoid “double interventions”, the engagement of non-authorized entities in the process, and the confusion of roles of professionals and agencies.

Good practices:

In Greece, the University of the Third Age operates aiming to provide lifelong learning for people over 65 years of age, with the main objective of activating and empowering them. Among these, trainings are also implemented on the recognition and understanding of different forms of violence, as well as how to disclose and manage incidents of violence against older people. There is also audiovisual material<sup>31</sup> created as information material and posted<sup>31</sup> on the online platform of the University of the Third Age<sup>32</sup>.

In addition, the «SOS 10-65 Lifeline» operates in Greece, aiming to ensure quality and dignified living for the most sensitive social group, that of older people (65+). They receive reports and referrals of violence, mistreatment or neglect of the older people and refer the cases to the authorities or the relevant services.

UWAH also operates a 24- SOS Helpline for women victims of violence. Professionals immediately assess, based on specific tools and methodology, the risk of women, and refer the cases in the authorities when needed. They also provide (distance) counselling to older women victims of violence. In addition, in the framework of the European Project TISOVA, UWAH in cooperation with the Social Services and Open Protection Centres for Older People of distinct municipalities in the region, held

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<sup>31</sup> <https://www.youtube.com/watch?v=N1UwQ41g25g>

<sup>32</sup> <https://www.peoplebehind.gr/panepistimio-tritis-ilikias>

meetings with older women to inform them about rights and how to recognize the signs of violence and what to do in case they are victims of any form of violence.

Regarding the work with older perpetrators, there is a significant lack of an institutionalized process. Professionals have inadequate knowledge on how and where to refer the cases and in most cases, they are limited to communicate with the perpetrators and manage each individual case in an informal way and by their own initiative, and with limited knowledge regarding the issues and specific needs of older perpetrators.

### b. Challenges.

One main challenge for professionals is the close relationship between older women and their perpetrators. In most cases, the perpetrator is a family member from whom they are depended on, i.e., their children, hence it is difficult for them to recognize and refer the violence. Disclosure of older women and distinct health and physical problems remain a challenging factor. When the perpetrator is the caregiver, it is hard to replace them, while it is also hard for a professional to have a private talk with the older women when the caregiver is always around.

Inadequate and inappropriate structures and institutions providing care services together with the understaffing and the lack of expertise on gender-based violence, especially regarding older women results in limited access of those women in Support Services. The lack of a structured intervention protocol to coordinate communication and action among services, as well as a single mechanism to control procedures and cooperation, in cases of violence of older women, lead to professionals' actions based on personal responsibility, worker resilience or interpersonal relationships.

Professionals lack of knowledge regarding the recognition, approach and referral of the perpetrators to the suitable services.

### c. Needs.

All the above challenges make it necessary to implement measures and procedures that will ensure the provision of appropriate and specialised support to elderly women victims of violence. In particular:

- Training, capacity building for professionals and mutual learning activities are needed to:
  - increase their expertise regarding case management and multi-agency collaboration.

- enhance their knowledge on trauma-informed approach avoiding re-traumatization/ secondary traumatization.
- Formation of tools & intervention protocols is needed to:
  - setting up a well-established system of cooperation among all services involved in the management and care of older women.
  - Establishing a coordinated response, common language and understanding of the phenomenon
- Multi-agency & multi-institutional cooperation, coordination and collaboration among services is needed to:
  - Ensure effective case management in a more holistic approach.
  - Avoid staff fatigue.

### 3.1.3 Austria

#### a. Legal framework, country-specific policies and procedures.

Austria has ratified the Istanbul Convention and has had a law on the protection against domestic violence since 1997, making it a pioneer in Europe. There is no country-specific legal framework in cases of violence against older women.

Relevant Stakeholders, when it comes to violence against older women, are e.g. women protection centres, women support services, specialized social services, police, the health sector, justice, organisations that offer mandatory offender work...In general, networks for multi-institutional cooperation exist, but mostly without a focus on older women and not standardized.

But still multi-institutional cooperation often depends on individual commitment. Regarding data protection, it must be said a lot of it works informally, as only then it is possible to help.

And there is a lack of coordination and responsibility of this, when it comes to coordinated multi-institutional cooperation, which would make a big difference.

Case management protocols are only partially in place. The cooperation varies from region to region.

Victim protection groups have been obligatory in hospitals since 2011, in some cases newly established. Within the victim protection groups there is a good network and there are standard operation procedures There is mandatory reporting and there are guidelines in hospitals on how to proceed in a case, although each hospital has its own guidelines. Yet, there are still a few hospitals

where such guidelines are lacking. From practice, however, it is reported that the guidelines are often useless due to the glaring nursing crisis in Austria. There is an urgent need for outside resources, a need for more care places. In the registered doctors' sector, it is much more difficult.

Good practices:

In Vienna, a dedicated working group has been in place since 2008, particularly dealing with the issue of domestic violence against older women, which was initiated by the Vienna Women's Emergency Hotline. This working group meets 3-4 times a year and includes representatives from hospitals victim protection groups, social services, retirement homes, police headquarters, Red Cross, Pro senectute (NGO for work with older people), psychosocial services, women's shelters and violence protection center. Within the framework of the working group, a "flow chart" was drawn up, which defines what should happen in a case of violence against older women in the context of a police removal:

"Possibilities for the removal of people in need of care in the case of domestic violence". The document is freely accessible. The Vienna Women's Emergency Hotline sees itself as a kind of coordinating body for Vienna by networking the Viennese victim protection groups.

Another special thing about Vienna is the GIP-Support. It stands for Violence in the intimate. Each case of violence happened in Vienna in which the police were involved has to be reported to the GIP Support: Each case a removal order has been or a removal order should be issued but it is not possible because the man cannot be found. The GIP-Support is available 24/7 and is specially trained; it is a purely internal police centre. This is not a specialised service for older women, but it is mentioned here, because it brings help to them.

The Toolbox Victim Protection is considered good practice in Austria. Presented as "Starter Set for Victim Protection Groups" it aims specifically at hospital management and staff. It contains standardized, tried and tested instruments and clinical treatment paths, names possible regional cooperation partners, and provides information about regional events on specific topics. It is applicable to all adults, not specific to women, but also has a focus on violence against people in need of care.

A major issue is the unavailability of accommodation places for older victims or offenders after a police removal. A new project funded by the Ministry of Social Affairs is to survey the need for accommodation for offenders and for victims. This is to be followed by the implementation of pilot projects in Vienna and Upper Austria. In some regions there is a list of places to give to the police to

which perpetrators can turn for accommodation. The project is organized by Pro senectute (NGO for work with older people) and a synergy with MARVOW 2.0 is planned.

### b. Challenges.

There is a very high vulnerability and danger of women in old age, not least because the men are often demented or addicted. Obtaining a restraining order is extremely exhausting for old women, psychologically and physically. Police, court, many institutions are involved. The confrontation with many institutions is very exhausting for old women, thus an obstacle to act. It was also noted that shelter networks are a big issue with older people. Settings for older women need to be different because of the rootedness, the needs, and not necessarily due to financial issues. They don't want to leave; they don't want to give up home. Old women need other places. They already feel the finitude. This may be a different need which is not met. Nursing cases exacerbate the problem as care is a huge problem in Austria. There are hardly enough accommodation options for victims and perpetrators. The serious nurse's shortage is a major problem in the health sector. There are protocols but not actual beds, so that coordination cannot help either. Often the only option is to commit them to psychiatric care. In addition, there is a lack of continuing care, e.g. beyond the 2 weeks of removal. This also requires better cooperation with relatives. Regarding multi-institutional cooperation there is a problem with data protection and a coordinated multi-institutional cooperation is missing. Another bis issue is a lack of data.

### c. Needs.

The current situation is characterized by a lack of accommodation, no adequate care, and with it the specific dynamics that are triggered. Awareness is there, it is being worked on. But there are many gaps. It happens that the removal cannot be carried out because there is no possibility of accommodation for offenders or victims. Reachability of affected women in the established sector is a major issue. One important approach is the mobile professional groups, care services. They are not yet included in the cooperation. There is a general a lack of data, there is also a need for more up-to- date and accurate data when it comes to violence against women in old age. In Austria, for example, only our association, the Association of Autonomous Austrian Women's Shelters counts Femicides. In

Austria there is a high number of femicides in general, and especially a high number (27% in 2023, 35% in 2022) of older women affected.

### 3.1.4 Cyprus

#### a. Legal Framework and Policies

In Cyprus, there is a considerable lack of priority given to topics relating to third age, despite the island following worldwide trends in an ever-increasing ageing population. It is, thus, no surprise that there are no policies in place that specifically target violence against the elderly, nor policies that specifically target violence against elderly women. The legal and policy framework in Cyprus has been strengthened in recent years and covers all forms of gender-based violence against women and domestic violence. While these policies do not explicitly target older women who are victims of abuse, they apply to them in lieu of their sex/gender and their status as family members, in cases of domestic violence.

Following Cyprus' ratification of the Istanbul Convention in 2017 (N. 14(III)/2017), several legal and policy measures have been taken by the Cypriot authorities in order to prevent and combat violence against women and domestic violence and promote gender equality. These positive developments include the passing of Law 115(1)/2021 on the Prevention and Combating of Violence against Women and Domestic Violence and Related matters (VAW Law 2021), ensuring harmonization of the legal framework with the provisions of the Istanbul Convention, including in relation to prevention, prosecution, and protection of victims. One of the many novelties under Law 115(1)/2021 is the criminalisation of forms of sexual and gendered online harassment such as sexual images/videos taken without consent and disseminated online. Femicide, has also been incorporated into the law as an offence of violence against women and recognizing it as the most extreme form of gender-based violence. Other relevant legislative provisions for the prevention and combatting of gender-based violence in Cyprus can be found in criminal law, including in the Criminal Code. Women victims of domestic violence in Cyprus have legal access to protection measures under both criminal law and civil law, including temporary protection orders restraining the perpetrator from contact with the victim, as well as restraining orders prohibiting perpetrators from entering or remaining in the marital home. Important measures, planned under the 2017-2019 National Action Plan to Prevent and Combat Domestic Violence include the preparatory work for the setting up the "one-stop-shop" crisis

intervention centre for victims of violence against women namely Women's House (see Good Practice), as well as the adoption of a risk-assessment protocol for the police to assess risk in cases of intimate partner violence. In 2023, a fully institutionalised national co-ordinating body (the National Co-ordinating body for the Prevention and Combating of Violence against Women under the Ministry of Justice) with dedicated resources was established, tasked with coordinating, implementing, monitoring and evaluating comprehensive policies on violence against women, as well as with fostering co-ordination between the relevant stakeholders.

While multi-agency co-operation and coordination among all relevant agencies and specialist support services has been embedded in various provisions of the 2021 VAW Law, its practical implementation has not been fully realised. More than twenty years ago, the Advisory Committee for the Prevention and Combatting of Violence in the Family, within its mandate to promote services to address all aspects of the issue of domestic violence, prepared a manual of Multi-agency Procedures for Handling Incidents of Domestic Violence (2002) to clarify the tasks and role of professionals in the process of handling cases of domestic violence. This manual, also approved by the Council of Ministers in 2002, provides the framework through which relevant services (e.g., Social Welfare Services, Police, Health Services, Legal Services and Non-Governmental Organisations) and practitioners involved in handling cases of domestic violence, work together. According to an independent evaluation of the implementation of the manual however, many front-line professionals remain unaware of the existence of statutory procedures and of their mandate to follow them. The evaluation report highlights that the extent and quality of implementation of the procedures appears to depend on the commitment of each service to, amongst others, treat domestic violence as a priority issue.

#### Good Practice:

In late 2020, as part of Cyprus's implementation of its obligations stemming from the Istanbul Convention, a multi-agency and multi-professional crisis centre known as the Women's House was set up on a pilot basis in the capital city of Nicosia. The Women's House, operated by the Association for the Prevention and Handling of Family Violence, operates as a multi-disciplinary crisis centre, where professionals from various specialties and State Officers such as Clinical Psychologists, Social Workers, members of the Police, etc., work under the same roof/structure to provide protection and specialised support to victims of violence (and their children). Professionals from different support services hold

weekly meetings in-situ to discuss individual cases, create a risk-management plan for the victim and ensure the implementation of protection measures. While the services of the Woman's House can be accessed island-wide through the 24-hour helpline 1440, in practice accessibility to all victims is limited to those residing in the district of Nicosia.

## b. Challenges

Data collection:

As foreseen by the Istanbul Convention and the Victims' Rights Directive, comprehensive data collection on all forms of violence against women disaggregated by sex and age of victim and perpetrator, type of violence as well as relationship between victim and perpetrator, is urgently needed. Despite the objective to create a centralised database on all forms of violence against women, included in two successive national action plans on domestic violence, no progress has been made thus far. The data that are currently being collected are, in fact, insufficient for providing a comprehensive picture on the prevalence of domestic violence and other forms of violence against women, the support and protection provided to victims and, more generally, the response of the relevant institutions. This data gap on violence against women and domestic violence is highly problematic, as it impedes an in-depth understanding of the root causes of violence and limits the state's capacity to develop targeted and evidence-based policies and measures, as well as monitor their implementation. The lack of robust data also renders violence against older women invisible as the current data collection methodology categorizes victims only as minors or adults, ie. as over or under 18.

Lack of awareness of existing statutory procedures:

An obstacle to effective multi-agency cooperation and coordination is the lack of exchange of information between relevant services. The failure to share information leads to system failures that put women at increased risk of further harm. Confidentiality and protection of personal data are cited as obstacles in the exchange of information between the services involved, even when inter-agency cooperation is needed, and joint data management is *legally permitted*. Compliance with principles of personal data protection under the Physical Protection Act Persons against the Processing of Personal Data and Free Movement of these Data Law (Law 125 (I) / 2018) (GDPR), reportedly constitutes a

challenge for the Police and other services involved. In recognition of this challenge, a specific article providing for the exchange of essential information among relevant services was included in the 2021 VAW Law but it is not clear whether the mechanisms are in place for this to be fully implemented in practice.

Lack of focus on specific population groups:

In Cyprus there are no policies or other measures, such as national strategies and action plans, to respond to violence against women or domestic violence affecting groups of women exposed to or at risk of intersectional discrimination like migrant women, women with disabilities or single mothers. Expectedly, the development of the legal and policy framework on the prevention and combatting of violence against women and domestic violence does not specifically consider the overlapping vulnerabilities of older women victims of violence, nor are there any provisions for older women who are victims of violence but whose abusers are not a partner nor ex-partner but an offspring or a caregiver. Consequently, this omission shapes the practice and operation of front-line services and prevents the development of expertise and specialisation among front-line professionals to respond to the specific needs of victims with intersecting vulnerabilities.

Stakeholder exchange:

Overall, despite the presence of multi-agency collaboration protocols, practical implementation reveals a lack of well-structured coordination, cooperation and communication among relevant stakeholders and front-line services. Various government and third-sector agencies engage sporadically, encountering challenges in effective case handling, data processing, and establishing standardized practices. Collaboration between NGOs and governmental organizations is inconsistent, lacking a cohesive framework, and training efforts on abuse against older people lack standardization and fail to address the specific dynamics of violence against older women.

### 3.1.5 Bulgaria

#### a. Legal framework, country-specific policies and procedures

The definition of domestic violence and the respective roles of competent authorities for protection of the victims, are given in the civil Protection Against Domestic Violence Act /PADVA/ from 2005, with latest amendments in 2023. It regulates the rights of persons who have suffered from domestic violence, protection measures and the procedure for the application of the latter. The Law aims to give quick and effective protection and to provide help and support to persons who have suffered from or at risk of domestic violence, and to exercise a preventive and deterrent effect on the perpetrator of the violence. (Art.1a). The basic principles on which the PADVA is built are: rapidity and even urgency of protection; instant separation of the abuser from the victims; a variety of safe measures; combining judicial protection with social protection and rehabilitation measures; cooperation between public authorities and the non-governmental sector.

Violence against older women is the scope of the law in two points:

- violence in intimate relationships
- violence from children, grandchildren and other relatives (including blood relatives and relatives in-law)

The changes in the Act show greater attention to the problems of older people who are in a situation of violence and their limitations to ask help. However, the Act is gender neutral and does not specifically treat women as more affected by violence. Legal protection can be requested by the victim of violence, but also by:

- the director of the Social Assistance Directorate, when the victim is helpless due to severe disability, illness or old age.
- the prosecution, when the victim cannot protect himself due to helplessness or dependence on the perpetrator

When the victim is a minor or is helpless due to disability, illness or old age, the court may decide to grant legal support and and engage a free lawyer.

In the summer of 2023, the Bulgaria's National Assembly approved amendments to the PADVA. The establishment of the National Council for the Prevention of and Protection from Violence will respond to the need for coordination between the authorities responsible for fighting domestic violence as

well as create and implement state policies for the prevention of and protection from domestic violence. The existence of a single specialized and constantly working body will help for the creation of a common policy and its effective implementation from all stakeholders aiming at prevention and fight against domestic violence in Bulgaria. The development and implementation of a Coordination mechanism for help and support for suffered domestic violence are among the anticipated responsibilities of the National Council. This is a long-awaited change that will lead to timely and enhanced care and protection for victims as well as to clear responsibilities, rights, case work rules and coordination between the competent authorities.

National Information System covering all cases of domestic violence and specifying who the victims were, the type of violence, what measures were taken and which institutions were responsible in each particular case is being created.

There is a National strategy for active life of elderly people in Bulgaria 2019-2030. It is focused on support for employment, learning, active life, better health, etc. There is nothing in the document related to protection from violence.

Good practices:

After the recent changes in the Protection Against Domestic Violence Act, state and municipal bodies, medical facilities and legal entities are engaged in supporting the victim. When they receive a request for judicial protection, they are obliged to send the request for a protection order to the relevant district court within 24 hours. This is to help older women who do not have access to the Court. They can seek help from public bodies in their community - municipality, social services.

Training has begun for public authority staff across the country on what to do if a victim reports domestic violence and how to help her obtain a court order of protection.

## b. Challenges

In Bulgaria, there is no special Law that refers to older women and their specific problems. Cases of violence are established within PADVA. Domestic violence legislation is gender neutral in Bulgaria. There is no focus on gender-based violence, much less on violence against older women. The Istanbul Convention was rejected and not only was it not ratified, but the Constitutional Court also decided that it violated the Bulgarian Constitution.

The subject of gender-based violence against women in Bulgaria is very sensitive and delicate. Bulgarian society has a deeply rooted notion of gender difference where there are still traditional gender roles without a real sense of gender inequality. Bulgarian society as a whole still denies the existence of a power imbalance between males and females as well as the prevalence of violence and abuse.

There is no coordinated support for victims. They have to do everything themselves. Many important systems such as health care are not involved. Doctors do not report violence against elderly women, even when there are visible signs. Social workers and home assistants do not recognize violence against elderly women because they are not prepared for it. Abuse and violence are difficult to recognize by professionals. The risk and needs assessment is not complete. Professionals apply universal approaches to work. There is no common understanding and coordinated actions.

### c. Needs of actors / needs of beneficiaries

Capacity building of frontline professionals to recognize violence against older women. Raising the awareness of professionals about the phenomenon, the specific needs and limitations of older women. Acquiring skills to communicate with victims.

To offer coordinated support - health, social, financial, work to correct the behavior of the perpetrators. Health and social services and organizations working to protect victims of violence to improve their cooperation.

To build a model of multi-agency cooperation in cases of violence against older women. Services to establish common understandings, approaches, risk assessment tools and case management procedures.

## 3.1.6 Italy

### a. Legal Framework.

Italy is currently ranked 14th in Europe for gender equality, with a Gender Equality Index score below the European average and well behind the top three countries (Sweden, Denmark and Netherlands)<sup>33</sup>. This couples with high rates of violence against women: over 31,5% of women aged between 16 and

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<sup>33</sup> <https://eige.europa.eu/gender-equality-index/2023/compare-countries>

70 years have experienced violence<sup>34</sup>. The country has also seen significant increases in femicides since 2019.

With the 1996 Sexual Violence Bill, violence against women was no longer regarded as a widely accepted private fact but as a social problem. The 2011 Istanbul Convention, ratified by Italy in June 2013, prompted the Italian government to adopt a range of legislative and policy instruments to prevent and tackle violence against women regardless of their age. One of the main objectives of this regulatory framework is to increase integration and coordination of front-line services when dealing with women who are victims of violence and abuse.

In 2015, the Italian government published the first National Strategic Plan on Male Violence against Women to develop an organic response across the country. The Plan aims to strengthen government action on the multiple aspects of violence against women and has been updated three times jointly with key actors (ie. regions, local authorities, women support services etc). From prevention and protection of victims to punishment of perpetrators, as well as the training and education of all those in direct or indirect contact with victims, the national strategic plan provides the reference framework for developing and implementing homogeneous practices across the country. It outlines the different areas of intervention in which the institutional and private actors can be involved but also their roles when coming across victims and/or working together with other front-line services. The Plan therefore presumes multi-agency and multi-level scenarios. An Inter-Ministerial Steering Committee and a technical committee coordinate implementation of the National Strategic Plan while a national observatory collates data and monitors its performance.

Alongside the National Strategic Plans, the Italian government has adopted a number of regulations to enhance its response to violence against women. By introducing new gender-based control, offences and law enforcement measures, these regulations sometimes require key services to collaborate. 2001 - Measures to fight violence in family relationships<sup>35</sup>. It introduced important preventative measures, including the 'removal from the family home' of the perpetrator and the allocation of his income to the victim in need.

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<sup>34</sup> <https://www.istat.it/statistiche-per-temi/focus/violenza-sulle-donne/il-fenomeno/violenza-dentro-e-fuori-la-famiglia/il-numero-delle-vittime-e-le-forme-di-violenza/>

<sup>35</sup> <https://www.gazzettaufficiale.it/eli/id/2001/04/28/001G0209/sg>

2009 - Measures to tackle sexual violence and stalking<sup>36</sup>. It introduced a new criminal offence, the stalking, and the possibility for the victim to be admitted to legal aid even when her income exceeds the national thresholds. It introduced the possibility of issuing “warnings” to perpetrators of stalking and a total ban for perpetrators to attend places regularly attended by the victims.

2013 - Urgent provisions on security and combating gender-based violence as well as on civil protection and the commissioning of provinces - It strengthened the ‘warning’ system and introduced harsher penalties for the crimes of family abuse, stalking and sexual violence. It ensures greater protection for victims in the criminal justice system and requires enhanced collaboration among key local services to support victims.

2017 - National guidelines for health authorities and hospital authorities on rescue and socio-medical assistance to women victims of violence - They require healthcare settings to put in place integrated interventions when treating the physical and psychological consequences that male violence produces on women's health, as well as involving other relevant key services to guarantee timely and adequate integrated care to victims.

2019 - The Red Code - It introduced a number of new criminal offences, including forced marriage, revenge porn and permanent facial damage. It raised penalties for existing gender-based criminal offences. It also provided for a specialised and mandatory training of all police officers dealing with violence against women. An enhanced version published in 2023 of the code accelerates prosecution of gender-related criminal offences.

2023 - Anti-Violence and Abuse of Women Act - It strengthens preventative measures and prioritises gender-based criminal offences over other offences within the criminal justice system. Only specialised prosecutors can deal with violence against women. Recovery programmes for perpetrators are foreseen. New national guidelines for training front-line professionals in various capacities are expected to be published in 2024.

All Italian regions adopted regional legislation implementing the national framework set out above. The regional legislation encourages and supports multi-agency collaboration but does not mandate it. As it stands, Italy does not have a statutory multi-agency protocol neither at the regional level nor the national one. This results in a very fragmented response to violence against women across the country. Most regions are setting up governance models that enhance integration of front-line

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<sup>36</sup> <https://www.gazzettaufficiale.it/eli/id/2009/04/24/09A04793/sg>

services exploit, y lack operational protocols to adequately identify and work with victims. Additionally, the regional governance models tend to exclude front-line services that normally work with older women.

Among the regions that are heading towards a multi-agency approach to tackle violence against women there is the Veneto region. The protocol they have developed specifies the local area it covers, the adhering front-line services and their specific functions. The protocol also sets out practices and processes for referring and supporting victims - from case assessment and management to monitoring and evaluation of the pathways out of violence. The protocol can be tailored to the needs of each local area across the region. Through the project called “Seconde a nessuno”, the Veneto region is also implementing a multi-agency protocol for identifying and supporting refugee and migrant women who experience violence and abuse.

Furthermore, the Veneto region is the only region taking forward initiatives targeting older women specifically. The project “Si-cura” supported over 200 hundred older women between 2018-2020 in their pathways out of violence. Alongside providing advice and support to the victims, the project offered specialised training to social services and day centres for older adults and run awareness campaigns to caregivers and local communities. Si-cura was followed by another project, Dalia, which enhanced multi-agency collaboration for the detection, referral and management of cases of violence involving older women. Dalia raised awareness among front-line services on violence against women aged 65+, so they were adequately identified and supported. Dalia also contributed to shaping pathways out of violence tailored to the specific needs of older victims.

## b. Challenges & Needs

Front-line services need to have a better understanding of gender-based regulations (national and regional) when older women are victims. They need to understand the vulnerability factors of this specific target group and the multiple forms violence against older women can take. They need specific protocols that operationalise the existing regional governance models while including front-line services working with older women. Ideally, the specific protocols should be mandatory and adopted by central government, so a multi-agency approach is seamlessly implemented across the country. Awareness raising and capacity building are key to enabling front-line services to work with older women in the context of multi-agency collaboration.

Older women often are not aware that they are being abused because they were raised in a historical time in which violence against women was considered normal. Even if older women identify as victims, they might not know how to ask for help. In Italy, the political narrative and awareness campaigns never target this target group, so older women tend not to report and/or access support services dedicated to women who are victims of abuse and violence. Also, the national stats cover violence against women up until 70 years old, shaping the perception that older women cannot be victims. Therefore, this age group needs to: be educated on violence against older women; receive timely information on support services available to them; and be supported with accessing those services if they are not able to do so.

### 3.1.7 Spain

#### a. Legal Framework

Organic Law 1/2004 of 28 December, on Comprehensive Protection Measures against Gender Based Violence<sup>37</sup> enshrines and guarantees a series of rights for all women who are or have been victims of gender-based violence. Under Organic Law 1/2004, any woman subjected to any act of physical or psychological violence, including crimes against sexual freedom, threats, coercion or arbitrary privation of freedom, perpetrated by her spouse or ex-spouse or by the person with whom she holds or held a similar relationship of affectivity, even without cohabitation, is a victim of gender-based violence.

In different autonomous communities regional laws have extended the forms and contexts of gender-based violence beyond that of intimate partner violence, extending women's rights but not criminal proceedings.

In Catalonia, for example Law 17/2020, amending Law 5/2008, of 24 April 2008, on the right of women to eradicate gender-based violence<sup>38</sup> establishes new forms of violence (such as digital, obstetric, institutional, vicarious and second order violence, the latter against people giving support to victims/survivors) and new settings (such as the workplace, social and community spheres, the family

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<sup>37</sup> See:

[https://www.coe.int/t/dg2/equality/domesticviolencecampaign/countryinformationpages/spain/LeyViolenciadeGeneroingles\\_en.pdf](https://www.coe.int/t/dg2/equality/domesticviolencecampaign/countryinformationpages/spain/LeyViolenciadeGeneroingles_en.pdf)

<sup>38</sup> See: [https://igualtat.gencat.cat/web/.content/Departament/Normativa/normativa/llei\\_5\\_2008\\_EN.pdf](https://igualtat.gencat.cat/web/.content/Departament/Normativa/normativa/llei_5_2008_EN.pdf)

beyond the couple, the educational environment, the digital sphere, political life and the public institutions).

These laws have very few specific provisions for older women: both the Spanish Organic Law 1/2004 in Article 28 and the Catalan Law 5/2008 (amended by Law 17/2020) in Article 36 state that women who are victims of gender violence will be considered priority groups in access to protected housing and public residences for older people. The Catalan Law also has a specific article on “old age”, Article 69, which reads: “The Government must promote effective awareness-raising strategies aimed at the group of older women, so that they know the resources and strategies to deal with violence against women and can adopt active positions in the face of these situations, for which it must provide specific information of male violence against older women”.

### c. Data on gender-based violence against older women

Macroencuesta 2019:

According to the results of this national representative survey with 9.568 women 16 years and older residents in Spain<sup>39</sup>, 8.5% of women aged 65 or older have suffered physical and/or sexual violence from a partner at some point in their lives, compared with 16.1% of women aged 16 to 64. 22.9% have suffered some form of psychological violence, compared with 34.9% of women aged 16 to 64. The lower prevalence of violence among older women is explained by a lower incidence of violence from past partners. However, if we look at what happens in their current relationship, older women show higher prevalences of violence than women under 65: 4.4% have suffered physical or sexual violence at some point in their lives from their current partner, 10.1% emotional violence and 5.2% economic violence, compared with 2.6%, 8.1% and 2.5% respectively of women aged 16 to 64.

12 month prevalences show a similar pattern. The differences are not significant in relation to violence from a current partner: 0.8% of women aged 65 and older have suffered physical violence (compared to 1% of women aged 16-64), 1.4% sexual violence (compared to 1,3%), 10,6% psychological violence (compared to 11,8%) and 2.9% economic violence (compared to 2%) in the last year. But the differences between older women and the rest are quite marked in the case of violence from past partners: 1.4% of women aged 65 or older have suffered some type of violence from past partners in the last 12 months compared to 9.0% of those aged between 16 and 64.

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<sup>39</sup> See: <https://violenciagenero.igualdad.gob.es/macroencuesta2015/macroencuesta2019/>

Importantly, there were significant differences in reporting and help-seeking between older and younger victims. Older victims reported less to the police (17.6% in comparison to 22.5% of younger victims), accessed less to formal help (e.g., in the justice system: 25.1% in comparison to 37.3%) or to psychological support (13.3% in comparison to 28.1%) and disclosed less to their social networks seeking informal help (54.5% in comparison to 81.3%).

#### European Survey on Gender-Based Violence 2022

Prevalence rates in this study with 6,465 women residents in Spain aged between 16 and 74 years old<sup>40</sup> were slightly different. Lifetime prevalences for psychological IPV were 18.5% for women between 65 and 74 (compared to 27.8% for women 16-74, 8.5% for physical violence (compared to 12.7%) and 3.7% for sexual violence (compared to 6.7%) and 8.9% for physical and/or sexual violence (compared to 14.4% for all ages). Lifetime prevalence for any kind of IPV (physical, sexual and/or psychological) was 19% for women aged between 65 and 74 (compared to 28.7% for all women), 5-year prevalence was 3% (compared to 11.2%) and 12-month prevalence 1.5% (compared to 4.4%).

#### Good practices:

As good practices in Spain we can point out a **series of recent studies and publications** on gender based violence against older women, both on the national level<sup>41</sup> and the level of autonomous communities<sup>42</sup> and provinces<sup>43</sup>. Most of these publications and reports include data on the prevalence of violence against older women, information on their specific risk and vulnerability factors and their

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<sup>40</sup> See: [https://violenciagenero.igualdad.gob.es/violenciaEnCifras/Encuesta\\_Europea/](https://violenciagenero.igualdad.gob.es/violenciaEnCifras/Encuesta_Europea/)

<sup>41</sup> See [Estudio sobre las mujeres mayores de 65 años víctimas de violencia de género](#). Delegación del Gobierno para la Violencia de Género (2019)

<sup>42</sup> See: [Violencia machista contra las mujeres mayores en las relaciones de pareja y/o expareja: Guía para la detección y el acompañamiento inicial](#). EDE Suspergintza Intervención Social (2022).

Violencia de género contra las mujeres mayores: Plan de Atención Específico. Junta de Andalucía (2021).

Les violències masclistes vers les dones grans: una aproximació feminista i interseccional. Institut Català de les Dones, Generalitat de Catalunya (2022).

[Violencia contra las mujeres mayores. Interacción del sexismo y edadismo](#). Instituto Navarro para la Igualdad (2020).

Herrero, I., Díaz, C. (2023). [Violencia de género y mujeres mayores en la Comunidad Autónoma de Euskadi: visibilizando una vulnerabilidad opaca](#). Bilbao: Emakunde.

<sup>43</sup> See: [Guía orientativa para la atención y detección de la violencia de género en mujeres mayores](#). Diputación de Jaén (2021)

specific needs and some recommendations or guidelines on how to address violence against older women.

Another good practice is the only specific protocol for addressing gender based violence in older women that we found in our desk research, from the municipality of Calvià in Mallorca. This “Protocol for detecting gender based violence in women aged 65 or over” suggests a 3 phase detection and assessment process:

1. It offers 3 different lists of “associated risk factors in women aged 65 or older” to be used by 1. health professionals, 2. psychologists and 3. social workers as a pre-screening, to decide whether to go on to phase 2.
2. Use a) WAST short version and b) the CMT (a regional 10 item screening instrument), if these detect GBV, go on to phase 3, if not, use the Psychological Abuse Scale Applied in Couples (EAPA-P), 19 items, if psychological violence is detected, go on to phase 3 if not go on to follow-up
3. Assess the severity of the violence suffered according to three different lists of indicators: 1. for physical and sexual violence (health symptoms), 2. for psychological violence (mental health symptoms), 3. for the social realm (social and relationship indicators)

Given the number of recent studies published in Spain, there clearly seems to be a growing awareness, both by public administrations and policy makers and by professionals, about the importance of violence against older women and the need to specifically address the phenomenon.

### c. Challenges

The main challenges regarding violence against older women in Spain have to do with a lack of social awareness for the problem, including among the older women themselves, a lack of specific protocols (including risk assessment and case management tools) and of training for professionals on how to address it and the lack of specific services for older women victims of gender based violence. Many of these challenges are also reflected in the needs of actors and beneficiaries described in the next chapter.

#### d. Needs of actors / needs of beneficiaries

Regarding the needs of professionals involved in addressing violence against older women, one of the recent reports published in Catalonia<sup>44</sup> described interesting results from a survey responded by 93 professionals (95% women; 42% worked in women's counselling services, 13% in social services and 11% in health services). The main results showed that 72% of professionals say elderly women identify GBV less than younger women, 57% think they are more vulnerable and 64% believe they hide having suffered violence. Regarding the reasons for older women not reporting the violence, 84% mention dependency on the perpetrator, 72% economic dependency, 64% shame or guilt and 59% difficulties in identifying violence.

Regarding Risk Assessment tools, 12% believe they are adapted to the realities of older women, 58% that they are not and 25% don't know these tools. As the main priorities for services regarding their response to older women workers suggested

1. Improving the coordination between services,
2. Developing (specific) intervention methods,
3. Training in identification,
4. Sensitization campaigns,
5. Development of evaluation tools.

Finally, 80% of professionals said there was no coordinated multi-agency response including both services for gender-based violence and for older people, showing a clear need for improvement in this field.

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<sup>44</sup> See: [Les violències masclistes vers les dones grans: una aproximació feminista i interseccional](#). Institut Català de les Dones, Generalitat de Catalunya (2022).

## 3.1.8 France

### a. Legal framework, specific policies and procedures

French legal framework:

Domestic violence: Over the past twenty years, France has adopted a series of laws and measures targeting all victims of domestic violence and covering all aspects of domestic violence. These include children, who are co-victims of violence. They do not target a specific age group.

Recognised criminal offences:

Domestic violence:

Aggravated assault (spouse/former spouse/civil partner/cohabiting partner, aggravating circumstances).

Psychological abuse within the couple.

Sexual violence

Rape: any sexual penetration by violence, coercion, threat or surprise.

Femicide:

Murder committed by a spouse/former spouse is an aggravating circumstance (life imprisonment possible).

Legal framework for victim protection:

- Protection order (PO) created in 2010, issued by the family court judge (JAF) within a maximum of six days (since 2020), may include: removal of the violent spouse; prohibition of contact; temporary allocation of housing; modified or suspended parental authority; emergency telephone (TGD).
- Emergency telephone (TGD): allows a woman under threat to contact the police immediately.
- Anti-approach bracelet (BAR): device enabling geolocation and alerting the wearer if the perpetrator approaches.
- Emergency accommodation: dedicated places in shelters; immediate shelter provided by the local authority if necessary.

- Complaint, report: complaint at any police station/gendarmerie (obligation to receive the victim); 24-hour online reporting via the Ministry of the Interior's platform.  
Procedure for the removal of a violent spouse by the public prosecutor.

Procedures for victims:

- Requests for immediate assistance<sup>45</sup>

17 police/gendarmerie

114 SMS for people in danger

3919 anonymous and free helpline

3977 national helpline for older adult victims of abuse<sup>46</sup>

arretionslesviolences.gouv.fr: Anonymous chat platform of the Ministry of the Interior (24/7)

- Filing a complaint: in person, online (pre-complaint), or via a third party (doctor, social worker).
- Medical examinations: a doctor can issue a certificate of total incapacity for work (ITT) for use in criminal proceedings.
- Legal and social support: specialised associations (CIDFF, France Victimes, Fédération Nationale Solidarité Femmes); legal aid available.

National public policies:

Main laws:

- Law of 9 July 2010: creation of the Protection Order; concept of psychological violence; extension of 'domestic' to all intimate partners and ex-partners.
- Schiappa Law 2018: broadening of the concept of harassment, extension of the statute of limitations for sexual crimes against minors
- Grenelle des violences conjugales 2019: strengthening of the Protection Order; TGD and BAR widely deployed; breach of medical confidentiality authorised in cases of immediate danger.
- 2020 Law: easier withdrawal of parental authority in cases of serious violence.
- Law of 28 February 2023: improved protection (enhanced training, fast-track procedure).

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<sup>45</sup> [https://www.info.gouv.fr/actualite/violences-faites-aux-femmes-quels-recours-pour-les-victimes?utm\\_source=chatgpt.com](https://www.info.gouv.fr/actualite/violences-faites-aux-femmes-quels-recours-pour-les-victimes?utm_source=chatgpt.com)

<sup>46</sup> ALMA Allô Maltraitance des personnes âgées (Helpline for Elder Abuse)

National strategies:

- 2021-2025 National Strategy for Gender Equality:

Prevention (education, campaigns); systematic training for professionals, strengthening of judicial monitoring.

Zero femicide target: protocol for serious and immediate danger, coordination between police, justice system and associations.

Specific policies:

Training for all frontline professionals (health, social services, police, justice system), in accordance with the Istanbul Convention.

Frontline professionals can contact:

- The Coordination Support Mechanism (DAC), a single point of entry for professionals and organisations working with people in complex health and life situations. A DAC is a regional platform whose mission is to offer coordination support to anyone (of any age, in any situation) whose life is complicated by medical, social or medico-social issues.

Healthcare professionals must contact:

- The Regional Health Agency (Agence régionale de santé, ARS), which plays a supervisory role that may lead to administrative injunctions and local institutions.
- The public prosecutor, with the victim's consent. This consent is not necessary if the victim is a vulnerable person or an adult in immediate danger and unable to protect themselves due to the moral coercion resulting from the influence exerted by the perpetrator of the violence (Article 226-14 of the Penal Code).

Older women:

Although there is no specific law for older women, France adopted a law for the protection of elderly people on 8 April 2024.

It specifies:

"Any person who becomes aware of facts constituting abuse, within the meaning of Article L. 119-1, towards an adult in a vulnerable situation due to their age or disability, shall report them to the unit referred to in Article L. 1432-1 of the Public Health Code. Persons subject to professional secrecy may report acts constituting abuse in accordance with Article 226-14 of the Criminal Code.

Acts reported via a single national telephone number are also forwarded to the unit under a protocol established between the managers of the telephone service and the regional health agency.

The unit forwards the reports without delay for assessment and processing.

In accordance with the interests of adults in vulnerable situations and professional secrecy, and under conditions determined by decree, this unit informs the persons who reported the acts constituting abuse of the follow-up given to their report.

In addition, Article L. 1432-1 of the Public Health Code is amended to provide for, within each department, 'a unit responsible for collecting, monitoring and processing reports of abuse of adults in vulnerable situations due to their age or disability'.

#### Best practices

France has several recognised best practices and mechanisms aimed at taking into account the needs, rights and autonomy of older people, beyond strictly welfare-based approaches:

- Departmental public service for autonomy (SPDA): a mechanism aimed at simplifying and coordinating the procedures for older people (and people with disabilities) and their carers. It brings together local actors (social services, health services, regional health agencies, France Services, CCAS) to offer a single point of entry that is better targeted and more effective.
- The National Solidarity Fund for Autonomy (CNSA) has published a guide to help local authorities develop public policies to combat the isolation of elderly people, based on a systemic and collaborative approach between stakeholders (social, health, municipal, associations).
- Local Information and Coordination Centres (CLIC) and Regional Autonomy Centres are local structures that:
  - provide free information to older people and their relatives about their rights and the assistance available to them;
  - coordinate the various stakeholders involved in the care of the individual (social services, associations, professionals);

- provide assistance with completing applications (APA, home help, etc.) and respond to specific needs.

- Personalised Autonomy Allowance (APA): one of the main French public policy instruments for elderly people who are losing their autonomy. It provides funding for the assistance and services needed to remain at home or in a care facility, adapted to each individual situation.

Measures integrating rights and the fight against abuse:

- The fight against elder abuse is part of a National strategy (2024-2027) that aims to:
  - facilitate the identification and treatment of risks of abuse;
  - improve prevention and training for professionals;
  - promote a culture of 'good treatment';
  - strengthen reporting tools (in particular 3977).

#### **b. Needs of actors / needs of beneficiaries**

Measures and procedures need to be put in place to ensure appropriate and specialised support for elderly women who are victims of violence:

- Training and skills development for professionals, as well as experience-sharing activities, in order to:
  - Develop their case management expertise
  - Improve early detection
  - Improve multidisciplinary collaboration
  - Prevent re-victimisation or secondary trauma.
- Development of intervention tools and protocols in order to:
  - Structure a solid system of cooperation between all services involved in supporting elderly women
  - Promote a coordinated response, a common language and a shared understanding of the issues.
- Multidisciplinary and multi-institutional cooperation and coordination for effective and comprehensive management of situations, in particular:
  - Better cooperation between the police and the justice system
  - Better identification of resources where women can receive advice and assistance.

Finally, the National Consultative Commission on Human Rights (CNCDH) recommends:

- Better informing older people about their rights;
- Combating ageism and stereotypes;
- Greater involvement of older people in the development of public policies that affect them;
- Adopting an individualised approach that respects the diversity of life experiences.

Developments to follow:

Recent proposed legislation (e.g. aimed at amending Article 222-14-3 of the Criminal Code) seeks to explicitly include economic violence in the criminal definition of domestic and intimate partner violence. This would amount to legal recognition that acts such as deprivation of resources, control of property, or prohibition from working do indeed constitute violence in the criminal sense. In progress.

## 3.2 EU Level

Addressing violence against older women through the scope of multi-agency work involves a comprehensive approach integrating policies, and effective practices at the EU level. In the next chapters, there is a detailed breakdown of the background, approach, and main principles for responding to this topic.

*Multi-agency collaboration* involves the active cooperation between different organisations (i.e. social services, healthcare providers, law enforcement, legal services, and NGOs and professionals from different fields) so to provide inclusive services to beneficiaries. The main goal is to provide a comprehensive response that addresses the complex needs of older women experiencing DV.

The 2018 FRA Report highlights the impact of ageism at three different levels: (1) the individual level, (2) the group level, and (3) the societal level. At the individual level, it charts the impact in terms of unequal access to health care, heightened risks of poverty, exposure to violence, abuse and neglect.<sup>47</sup> At a global level, there is a significant gap in data on the prevalence, patterns, and types of violence experienced by older women, particularly in low- and middle-income countries. There is also a lack of research on the factors that increase the risk of such violence, its impacts, and the obstacles older

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<sup>47</sup> Quinn, G., & Doron, I. (2021). Against Ageism and Towards Active Social Citizenship for Older Persons; The Current Use and Future Potential of the European Social Charter. *Council of Europe*.

women face in reporting incidents or seeking help. More evidence is needed to fully understand these issues and develop effective interventions.<sup>48</sup>

### 3.2.1 Policies & legal Framework

Addressing DV against older women within the EU framework involves several policies, legal instruments, and procedures designed to promote multi-agency collaboration and protect victims.

**The EU Charter of Fundamental Rights**<sup>49</sup> includes provisions relevant to violence against older women, such as the right to dignity, the right to protection from inhuman or degrading treatment, and the right to access effective remedies. The Charter of Fundamental Rights of the European Union enshrines the right to personal integrity (Art. 3) and prohibits torture and inhuman or degrading treatment (Art. 4).

**The UN Convention on the Rights of Persons with Disabilities**, ratified by the EU on 23<sup>rd</sup> of December 2010, includes protection measures against exploitation, violence, and abuse of individuals with disabilities.<sup>50</sup>

**EU Directive 2024/1385** focuses on combating violence against women and DV across all EU Member States. This directive aims to strengthen protections for victims, criminalise various forms of gender-based violence, and ensure better access to justice. The directive specifically addresses critical issues such as female genital mutilation, forced marriage, and various forms of cyber violence like non-consensual sharing of intimate images and cyberstalking.<sup>51</sup>

In addition to criminalisation, the Directive emphasises for the intensive victim support, prevention measures, data collection, and cooperation across Member States. It also seeks to uphold the EU's commitment to gender equality and human rights, ensuring victims receive the necessary protection and support while promoting the equal participation of women in all societal aspects.

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<sup>48</sup> World Health Organisation. (2024). *Violence against women 60 years and older: data availability, methodological issues and recommendations for good practice*. World Health Organisation.

<sup>49</sup> Charter of Fundamental Rights of the European Union, 2000/C 364/01. (2000). Official Journal of the European Communities, C 364, 1–22. <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A12012P%2FTXT>.

<sup>50</sup> AGE Platform Europe, (2023). AGE Platform Europe's submission to call for inputs: Violence, abuse and neglect against older persons, available at: <https://www.ohchr.org/sites/default/files/documents/cfi/subm-2023-07/subm-violence-abuse-neglect-cso-age-platform-europe.pdf>.

<sup>51</sup> Dylan, P. (2024). VSE Statement on the Violence Against Women Directive. Available at: <https://victim-support.eu/news/vse-statement-on-the-violence-against-women-directive/#:~:text=Today%2C%20June%2013th%2C%202024%2C,of%20VAW%20and%20domestic%20violence>.

The Victims' Rights Directive (2012/29/EU) includes provisions for victims of DV, ensuring their right to support, protection, and access to justice. It emphasises a victim-centred approach and provides guidelines for addressing the needs of all victims, including older women. The Victims' Rights Directive sets minimum standards for victim protection, requiring EU Member States to ensure that all victims, regardless of their circumstances, have access to information on support and legal recourse. As of October 2024, this Directive is under revision.<sup>52</sup> The European Parliament proposed easier and safer ways to report crime, free legal aid for victims who cannot pay for their own legal assistance, training of public authorities, awareness raising and protection from secondary victimisation and glorification of past crimes.<sup>53</sup> Unfortunately, the Council of the European Union rejected or diluted the proposal, removing or weakening specific rights, including the commitment to coordinate services to only a consultation of CSOs, which would affect any future multi-agency collaboration.<sup>54</sup>

The Istanbul Convention or “Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence” provides a comprehensive framework for addressing all forms of violence against women, including older women, through prevention, protection, and prosecution.<sup>55</sup> It defines various forms of violence, including psychological violence, stalking, and economic abuse. It also encourages the development of coordinated multi-agency responses and services. The ratification of the Istanbul Convention is a step of vital importance for the EU to promote more effective preventive policies to combat violence against women, make the EU accountable, and enhance data-collection at both EU and national level.<sup>56</sup>

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<sup>52</sup> Revision of the victims' rights acquis. (2024) Available at: <https://www.europarl.europa.eu/legislative-train/theme-a-new-push-for-european-democracy/file-revision-of-the-victims-rights-acquis>

<sup>53</sup> World Elder Abuse Awareness Day: EU States must reinforce Victim's Rights! (2024). Available at: <https://www.age-platform.eu/world-elder-abuse-awareness-day-eu-states-must-reinforce-victims-rights/>.

<sup>54</sup> Joint Statement in Reaction to the Council Position on the Victims' Rights Directive Revision (2024) Available at: <https://victim-support.eu/news/joint-statement-in-reaction-to-the-council-position-on-the-victims-rights-directive-revision/>

<sup>55</sup> EU accession to the Council of Europe Convention on preventing and combating violence against women ('Istanbul Convention'), available at: <https://www.europarl.europa.eu/legislative-train/theme-a-new-push-for-european-democracy/file-eu-accession-to-the-istanbul-convention>.

<sup>56</sup> FACTSHEET; The Istanbul Convention: A vital opportunity to end violence against women!, available at [https://www.womenlobby.org/IMG/pdf/european\\_coalition\\_factsheet\\_final\\_all\\_logos.pdf?4577/f4d8bdb21d7e0992413bf7609622bf1ec2964517](https://www.womenlobby.org/IMG/pdf/european_coalition_factsheet_final_all_logos.pdf?4577/f4d8bdb21d7e0992413bf7609622bf1ec2964517).

The European Union ratified the Istanbul Convention on 28 June 2023, becoming a party to the treaty. To date, 38 countries and the EU have ratified the Convention. However, it is not yet in force in all EU member states: Bulgaria, Czechia, Hungary, Lithuania, and Slovakia have not ratified it. In addition, Turkey withdrew from the Convention on 1 July 2021, Latvia has moved to withdraw in 2025, following a parliamentary vote on 31 October and the Polish government has announced its intention to withdraw, but the withdrawal has not been enacted.<sup>57</sup>

**The European Union Gender Equality Strategy (2020-2025)** includes objectives and actions to address violence against women and promote gender equality, with implications for addressing violence against older women as part of broader gender equality efforts. The Strategy Plan highlights the need to prevent violence through the development of measures, including education and public awareness. It also focuses on the improvement of the support systems and access to justice for victims of gender-based violence, including older women.

The EU Strategy document emphasises a coordinated, multi-agency approach to protect and support victims, upon tailoring to their specific needs of vulnerable groups, including older women who may face violence. Recognizing the importance of a victim-centred and age-sensitive approach, the strategy advocates for services that account for the specific barriers older women may face, such as increased dependency and isolation. By encouraging cooperation among healthcare providers, social services, law enforcement, and NGOs, the EU aims to ensure that these victims have accessible pathways to support and justice. Last but not least, the strategy promotes cross-sectoral training to equip professionals with the skills needed to recognise and respond to signs of abuse, while also enhancing reporting mechanisms to make them more approachable for older victims. Preventive measures, such as public awareness campaigns coordinated across agencies, are also a priority, aimed at uncovering and addressing the often-hidden issue of violence against older women.

All in all, the EU strategy proposes for delivering sustainable and tangible support to all age groups addressing their specific needs, ensuring their safety.

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<sup>57</sup> EU accession to the Council of Europe Convention on preventing and combating violence against women ('Istanbul Convention'), available at <https://www.europarl.europa.eu/legislative-train/theme-a-new-push-for-european-democracy/file-eu-accession-to-the-istanbul-convention>

It promotes the building of a robust support system that is inclusive, preventive, and adaptable to the complex needs of older victims.<sup>58</sup>

### 3.2.2 Basic principles and standards of the Istanbul Convention

Although the term "age" is only mentioned in the Istanbul Convention, with the term appearing only four times, the Convention's provisions are crucial for upholding the human rights of older women. It is indisputable that the ratification of the Istanbul Convention prevails as a significant step toward acknowledging and addressing violence against older women. While violence against older people is not exclusive to older women, they experience multiple and intersectional forms of abuse. A recent UN Advocacy Brief on Older Women<sup>59</sup> highlights how ageism intersects with gender-based discrimination, where the combined effects of ageism and sexism intensify discrimination and inequality. As a result, older women have consistently faced structural disadvantages and discrimination throughout their lives.<sup>60</sup>

The preamble of the "Istanbul Convention" highlights key European and international recommendations that shape the Convention. It recognises violence against women *as a structural issue*, stating that this violence stems from historically unequal power relations between men and women, resulting in the domination and discrimination of women, which hinders their full progress. It further asserts that achieving legal and actual equality between genders is essential in preventing violence against women.

The Convention acknowledges that women and girls are disproportionately vulnerable to various forms of violence—such as domestic violence, sexual harassment, forced marriages, and female sexual mutilation—which constitute serious violations of their human rights and significant barriers to gender equality.

In Article 3, the Convention defines "violence against women" as any act of gender-based violence likely to cause physical, sexual, psychological, or economic harm, whether in public or private settings.

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<sup>58</sup> European Commission. (2020). *EU Strategy on victims' rights (2020-2025)*. Publications Office of the European Union. Available at <https://eur-lex.europa.eu>.

<sup>59</sup> UN Advocacy Brief on Older Women, available at <https://www.ohchr.org/sites/default/files/2022-03/UN-Advocacy-Brief-Older-Women.pdf>.

<sup>60</sup> The EU ratification of the Istanbul Convention would help protect the rights of older women. (2022). AGE Platform, available at <https://www.age-platform.eu/the-eu-ratification-of-the-istanbul-convention-would-help-protect-the-rights-of-older-women/>.

It also describes DV as acts of violence within a family or relationship, regardless of cohabitation. Moreover, it defines gender-based violence as violence directed at women due to their gender or that disproportionately affects them and clarifies that "women" also includes girls under 18. The Convention's primary goal is to protect women from all forms of violence and ensure the prevention, prosecution, and elimination of such violence. Article 7 requires a comprehensive response from Member States, ensuring victims' needs are met, including access to healthcare, housing, education, justice, and employment, along with independent residence rights and support for social and political inclusion. States that are parties to the Istanbul Convention have the option to extend the convention's protections to all victims of DV according to Article 12. Should they choose to do so, they can take into account specific considerations related to DV against vulnerable groups, such as children and the older women, and implement appropriate measures to prevent such violence.<sup>61</sup>

### 3.2.3 Key Principles at EU level

Sustainable and effective response to DV, including violence against older women, involves coordinated efforts among various organisations to provide comprehensive support and protection. This collaboration is crucial for addressing the complex needs of victims and ensuring a unified response.

The EU emphasises the importance of coordinated collaboration to effectively combat DV and GBV.<sup>62</sup> Several key principles guide these collaborative efforts, ensuring a comprehensive and coordinated approach across sectors and member states. These principles are embedded in EU strategies, directives, and funding programmes and aim to create an integrated response to GBV. Some of the main principles include:<sup>63</sup>

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<sup>61</sup> Hester, M., & Lilley, S. J. (2016). Preventing violence against women: Article 12 of the Istanbul Convention (2016).

<sup>62</sup> European Commission. (2023). *The Commission welcomes political agreement on new rules to combat violence against women and domestic violence*. [https://ec.europa.eu/commission/presscorner/detail/en/IP\\_23\\_3385](https://ec.europa.eu/commission/presscorner/detail/en/IP_23_3385)

<sup>63</sup> Logar, R., & Vargová, B. M. (2021). Effective multi-agency co-operation for preventing and combating domestic violence training of trainers manual; 2015. *Council of Europe: Strasbourg*.

## 1. Political Priority

Political will is the backbone of any systemic response to GBV and violence against older women. Without political priority, efforts to combat violence often remain fragmented, underfunded, or deprioritized. Governments need to view GBV as not just a social issue but as a critical human rights violation affecting the well-being of people and the stability of their societies. Political priority is of great importance as through the adoption and implementation of a legal framework and policies to address gender-based violence against older women, key steps towards this end are being pursued. Through the involvement of the political dimension, the cooperation of all the services and professionals involved is achieved in a harmonious framework with distinct roles and responsibilities, which undoubtedly enhances the effective management of incidents.<sup>64</sup>

## 2. Financial Support

Without dedicated funding, even the best-intentioned policies and frameworks fail to be implemented effectively. Financial support ensures that support programmes have the resources they need to increase the number of professionals working in the field, establish an ongoing and constant training for all professionals involved to enhance their skills and knowledge, fund shelters, and run coordinated campaigns to raise awareness and support victims.

## 3. Victim-Centred/Survivor-Centred Approach

A core principle of coordinated collaboration is placing the needs and rights of victims at the centre of all efforts. EU directives, such as the Victims' Rights Directive (2012/29/EU), stress the importance of ensuring that victims of DV and GBV receive appropriate support, including protection, healthcare, and legal assistance. Collaboration between law enforcement, social services, healthcare providers, and NGOs is essential to offering a holistic, victim-centred response.

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<sup>64</sup> Colombini, M., Mayhew, S. H., Lund, R., Singh, N., Swahnberg, K., Infanti, J., & Wijewardene, K. (2018). Factors shaping political priorities for violence against women-mitigation policies in Sri Lanka. *BMC international health and human rights*, 18, 1-12.

#### 4. Integrated Service Provision

Integrated services provision, includes cooperation between criminal justice systems, healthcare providers, social workers, housing services, and specialised support organisations. By linking these services, the EU aims to ensure that victims do not face fragmented or inconsistent responses but instead have access to continuous, comprehensive care from reporting violence to receiving long-term support.

#### 5. Prevention and Early Intervention

Prevention of DV and GBV is a priority for the EU, and coordinated collaboration is key to effective prevention. This principle focuses on early identification of risks, including through education, intensive community outreach, and working with frontline professionals (e.g. social workers, healthcare workers) to recognise signs of violence. Front line agencies need to plan and implement intensive prevention actions including continuous awareness raising actions, which highlight the urgency for response and non tolerance about the phenomenon.

#### 6. Information Sharing and Data Protection

Effective collaboration relies on the sharing of information between agencies, such as police, healthcare providers, and social services. However, the EU stresses that this must be done in compliance with data protection laws (e.g. GDPR) and must respect victims' confidentiality. Protocols for information sharing are crucial for coordinated action, particularly in high-risk cases, while ensuring that victims' privacy is safeguarded.

#### 7. Cross-Sectoral Training and Capacity Building

To improve coordinated collaboration, joint training programmes for professionals working in various fields, including law enforcement, healthcare, social services, and the judiciary need to be promoted at any level. These programmes ensure that all professionals involved have the appropriate capacity to effectively respond to DV and GBV, understand the needs of victims, and can coordinate effectively. Capacity-building / mutual learning initiatives foster building trust and mutual understanding among different sectors and create a common framework for addressing violence.

## 8. Coordination and Accountability

Effective multi-agency collaboration requires clear roles and responsibilities among participating agencies. The EU encourages the establishment of local and national coordination mechanisms, such as specialised DV task forces or inter-agency committees, to oversee and guide the implementation of GBV policies. These structures ensure that each agency is accountable for its role in prevention, protection, and prosecution efforts, and that there is an effective division of labour.

## 9. Perpetrator Accountability and Rehabilitation

While victims' rights are prioritised, the EU also highlights the importance of holding perpetrators accountable and providing rehabilitation programmes where appropriate. Multi-agency collaboration between the criminal justice system, social services, and specialised organisations helps ensure that perpetrators are prosecuted, while also offering behavioural change programmes that can prevent recidivism.

## 10. Comprehensive Legal and Policy Framework

EU principles promote the creation of comprehensive national and regional policies that incorporate coordinated collaboration in addressing GBV. These frameworks include legal protections for victims, prosecution of offenders, and guidelines for coordinated responses across sectors. The Istanbul Convention, which the EU ratified in 2023, provides a blueprint for establishing such a legal framework, advocating for the integration of multiple stakeholders in the fight against GBV.

## 11. Sustainability and Long-Term Support

Coordinated collaboration in the EU also emphasises the need for sustainable, long-term support for victims. This principle focuses on ensuring that victims receive continued assistance even after immediate crises have been resolved, including long-term housing, financial support, and psychological care. Agencies are encouraged to work together to provide this ongoing support, preventing victims from falling back into dangerous situations.

## 12. Monitoring, Evaluation, and Data Collection

Continuous monitoring and evaluation of multi-agency collaboration efforts are key to improving responses to DV and GBV. The EU promotes the use of standardised data collection across Member States, ensuring that agencies gather reliable data on incidents of GBV, the effectiveness of interventions, and outcomes for victims. The WHO highlights the gap in data collection related to the cases of GBV against older women since violence does not cease to exist over time, but is usually not reported or recorded and remains hidden.<sup>65</sup> Regular evaluation helps to identify gaps in the system and to refine multi-agency responses accordingly.

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<sup>65</sup> United Nations. (2023). Human rights experts call for inclusive data collection to end gender-based violence in old age. Available at: <https://www.ohchr.org/en/press-releases/2023/06/human-rights-experts-call-inclusive-data-collection-end-gender-based#:~:text=In%202018%2C%20the%20World%20Health,are%20comparatively%20lower%20than%20elsewhere.>

## 4. Literature Review

### 4.1 Adopting a Victim-Centred and Human Rights-Based Approach

When working with older women, professionals should adopt a victim-centred and human rights-based approach. This means developing a framework that prioritises victim safety and creating policies and protocols specifically designed to enhance it. Professionals should ensure that the voice of all victims is taken into consideration, and that their safety is a high priority. Professionals working with older women should take into consideration themes and sub-themes mostly related to this population. In particular, ageism, perpetrator-related factors (age, relationship with the survivor, illness), social and gender norms, lifelong IPV, etc.<sup>66</sup>

Financial support should be provided when necessary to assist survivors, and their autonomy should be respected by allowing them to make their own decisions. It is crucial to avoid judgement and blame for victims' choices, instead focusing on encouraging and empowering them to resist violence and exploitation, affirming their right to live free from fear and violence.

Professionals should show respect for older women's feelings and desires. Additionally, respecting the victims' rights to privacy, protection from violence and data confidentiality is essential. Building trust in the support system involves providing victims with the information they need and fostering confidence in the services offered. This comprehensive approach ensures that the needs and rights of all victims are met with dignity and respect.<sup>67</sup>

### 4.2 Safety and protection

Addressing the safety and protection of older women - victims of DV - requires a nuanced, comprehensive approach that ensures their well-being and addresses their unique needs. In particular:

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<sup>66</sup> Meyer, S. R., Lasater, M. E., & García-Moreno, C. (2020). Violence against Older Women: A systematic Review of Qualitative Literature. *PloS one*, 15(9), e0239560.

<sup>67</sup> Logar, R., & Vargová, B. (2015). Effective Multi-agency Co-operation for Preventing and Combating Domestic Violence.

## 1. Non-Discriminatory Approach

It is essential to ensure that older women receive the equal level of protection and support as younger victims. This means providing services and interventions that are free from age-related bias or discrimination. The approach should recognise and address the specific vulnerabilities faced by older women, such as mobility issues, social isolation, and health concerns. Services and support systems should be designed to be inclusive of older women, considering their unique experiences and needs. This includes tailoring interventions to be age-appropriate and culturally sensitive, ensuring that older women are not marginalised or overlooked in the broader context of DV prevention and support. Special measures and policies need to be adopted with regard to older women survivors of GBV. Shelters seem to be unsuitable for this group of victims, as they typically require more complex and comprehensive care. Instead, residential homes seem to be a more appropriate solution. The Council of Europe recommends that "*Member States should ensure the provision of sufficient and suitable residential services for older persons who are no longer able or willing to remain in their own homes*".<sup>68</sup> All shelters should ensure they are easily and immediately accessible by all groups of women facing GBV. However, older women often face physical constraints that are reflected into barriers for them to access traditional shelters. Therefore, accessibility-friendly facilities are needed, (*i.e.*, adapting spaces to accommodate walkers, canes, or other assistive devices are critical). The majority of the shelters are designed for short-term stays, which may not suit older women who require longer recovery times due to physical or emotional frailty, and/ or face difficulties transitioning to independent housing due to fixed incomes or health-related limitations.

## 2. Safety

Professionals need to be safe for conducting risk assessment for cases of abuse of older women. Risk assessment includes evaluating physical safety, financial security, and the potential for continued abuse. Tools and procedures should be adapted to account for the unique risks' older women face, such as dependency on caregivers or limited mobility. Targeted safety measures should be implemented, such as tailored safety planning and protective orders, which specifically address the needs of older women. This might include adapting safety plans to consider mobility aids, home

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<sup>68</sup> Council of Europe (2014): Recommendation CM/Rec(2014)2 of the Committee of Ministers to Member States on the promotion of human rights of older persons, adopted on 19 February 2014, Strasbourg. At [https://search.coe.int/cm/Pages/result\\_details.aspx?ObjectID=09000016805c649f](https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805c649f).

modifications, or other practical considerations that affect their safety. Professionals should ensure that safe housing options are accessible and suitable for older women. This includes providing shelters or temporary accommodations that are adapted to accommodate their physical needs and ensuring that these facilities are equipped to handle the specific issues faced by older individuals.

Older women often face economic dependency on their partners due to years of unpaid caregiving or limited workforce participation. Many may have insufficient pensions or savings to live independently, which compounds their hesitation to leave. In many European countries, the lack of affordable housing is an emerging systemic issue. Temporary shelters may provide immediate safety but do not address the need for stable, longer-term housing. Governments and NGOs could develop long-term housing solutions tailored to older women, such as subsidised senior housing or co-housing arrangements with integrated support services.

Older women may have developed coping mechanisms over decades, including normalising abuse or prioritising their partner's care over their own safety. Leaving may also involve grappling with social stigma or cultural expectations. Training service providers to offer trauma-informed and age-sensitive support prevails as a key priority. Counseling and peer support groups specifically for older women can address unique concerns. Multidisciplinary teams could involve care services, social workers, and legal advisors engaged with older women to create a more holistic safety plan that considers both partners' needs.

Removing the older perpetrator from home can be logistically and ethically complex, particularly if they are unwell or require support themselves. Law enforcement and social services may hesitate to intervene in such cases. Multi-disciplinary teams of social workers, health professionals, and law enforcement can collaborate to enforce protection orders while ensuring perpetrators' care needs are met and they can help balance enforcement with sensitivity to the complexities of abuse against older people.

### 3. Due Diligence to Prevent and Protect

Engaged professionals should adopt a proactive approach to prevent violence and protect older women. This involves not only responding to incidents but also actively working to prevent abuse through education, outreach, and community engagement. It is of vital importance to establish systems for regular monitoring and follow-up with older women who have been identified as victims

of DV. This helps to ensure that protective measures remain effective and that any new risks are promptly addressed. Different professionals need to work closely with each other, such as experts from gerontology, DV, etc., to develop and implement best practices for protecting older women. This collaboration ensures that interventions are informed by expertise in the specific needs of older populations.

#### 4. Alternatives to Violence

It is essential to provide a range of support services that offer meaningful alternatives to violence. This includes counselling, legal assistance, and financial support, tailored to the needs of older women. These services should aim to empower older women to seek help and escape abusive situations. Developing programmes that focus on empowering older women to assert their rights and access the resources they need remains a key priority. This may include workshops on personal safety, legal rights, and financial independence, designed to enhance their ability to live free from violence. Behaviour change programmes for older adults are also of vital importance through the establishment of intervention programmes for older perpetrators, focusing on managing aggression, dealing with past trauma, and navigating age-related challenges. Programmes should be designed for the unique needs of older individuals, including slower-paced and accessible formats.<sup>69</sup>

The community needs to be engaged with community organisations, including those that focus on ageing and older people's rights, to create a supportive network for older women. This network can provide additional resources and support and help to foster a community culture that is intolerant of violence against older individuals.

### 4.3 Identifying high-risk cases

Risk assessment is crucial for identifying potential dangers, eliminating threats to older women, and ensuring their safety. According to a literature review, the most straightforward and reliable indicators of DV risk are prior assaults or repeated victimisation. The primary goal of risk assessment is to gauge the level of danger to enable professionals to implement appropriate safety measures and protections for victims.

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<sup>69</sup> Eisner, M. P., & Malti, T. (2015). Aggressive and Violent Behavior. *Handbook of Child Psychology and Developmental Science: Socioemotional processes*, 3, 794-841.

Risk assessment can be defined as the process of estimating the likelihood that a harmful behaviour or event will occur. This involves evaluating the frequency of such behaviours or events, their potential impact, and the individuals affected. It is important to recognise that risk is dynamic and can change rapidly, sometimes even within short periods, depending on the victim's evolving circumstances. Several aggravating factors or specific situations can heighten the risk level, such as separation, court hearings, illness, retirement, or unemployment. Therefore, risk assessments should be conducted systematically, regularly, and in close collaboration with the victim to ensure a comprehensive and responsive approach to their safety.<sup>70</sup>

## 4.4 Multi-Agency Collaboration Models

### 4.4.1 Multi-Agency Risk Assessment Conference<sup>71</sup>

One of the examples of the multi-agency cooperation model is the Multi-Agency Risk Assessment Conference (MARAC) model, which was developed in the UK in the early 2000s. MARACs have since been implemented throughout the UK, Europe, the US and elsewhere. Multiple studies have found that MARACs, when implemented correctly, have significant impacts on reducing harm to victims of DV.<sup>72</sup>

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<sup>70</sup> Logar, R., & Vargová, B. (2015). Effective Multi-agency Co-operation for Preventing and Combating Domestic Violence.

<sup>71</sup> MARVOW Project. (2021). Training Materials on Multi-agency Models, available at:

<https://marvow.eu/training-materials-on-multi-agency-models/>.

<sup>72</sup> Multi-Agency Risk Assessment Conferences (MARACs) have emerged as a key model for coordinating responses to high-risk domestic violence cases, with robust evidence supporting their effectiveness when implemented properly. Evaluations, such as Robinson's (2006) study of the Cardiff MARAC, show that approximately 60% of victims experienced no repeat victimisation within six months, highlighting the model's potential to reduce harm. The Home Office's review (Steel et al., 2011) corroborates these findings, noting both reductions in repeat abuse and improvements in inter-agency information sharing, though it emphasizes significant variation in practice across regions. More recent analyses (Davies, Barlow & Fish, 2023; Walklate, Godfrey & Richardson, 2021) indicate that MARAC effectiveness is contingent on consistent agency attendance, clear communication protocols, and strong leadership, with adaptations during crises such as the COVID-19 pandemic illustrating both the resilience and the operational challenges of the model. Overall, the literature suggests that MARACs' impact extends beyond immediate safety outcomes to strengthen multi-agency collaboration, but their success relies heavily on fidelity to established procedures and sufficient resourcing.

MARAC conferences usually occur monthly or twice a month, during which representatives from various agencies/service providers come together to discuss high-risk cases. Typically, these can include police, judges, victim protection facilities, offices for youth & families, child protection, educational institutions, counselling centres, hospitals, probation & perpetrator programmes, housing offices etc. After sharing all relevant information about the victim/survivor, participants discuss options for increasing the safety of the victim/survivor and their children. These are terms used to create a coordinated action plan for the specific person.

In addition to managing the risk to the victim/survivor, MARACs should consider other family members, including children and should seek to manage the behaviour of the perpetrator. MARACs protect the rights of victims in two important ways. First, all information shared at MARAC conferences should be kept confidential and only used to reduce the risk of harm to those at risk. Second, all conferences should include representatives of victims, such as victim support organisations or domestic violence shelters.

Increasingly, MARACs are also considering interventions to be made regarding perpetrators, to reduce risks to victims, hold perpetrators accountable, and promote behaviour change, if possible. This requires involving representatives of perpetrator intervention programmes in the MARAC conferences. It also typically requires identification of the range of interventions that are available to perpetrators in the community. Doing so can help professionals share ideas and interventions across agencies and develop more holistic responses to perpetrators.

Various success factors have been identified for effective MARACs, which include:

1. Individual assessment of high-risk victims to determine whether they are at risk of new and repeated victimisation, intimidation and retaliation, and what assistance and protection measures they need.
2. The danger to the victim and the resulting risks to the victim shall also be assessed and interventions planned.
3. Providing services and interventions to the victim based on their need for assistance, including the possible effects of trauma.

4. Optimising the work and resources of victim support agencies - A systematic approach based on needs and risks will help agencies make better use of resources and provide assistance that is more effective.
5. Risk assessment and support activities are planned and monitored. A common information space on the risks of violence will be set up between the agencies to protect the victim. The identified risk is shared and analysed with other institutions at the same time so that their interaction can be assessed.
6. The chances of re-victimisation are reduced, as the victim does not have to “prove” his or her status in several different institutions. However, in order to be successfully implemented, multi-agency models should be stipulated by political and agency will, motivation and resources. In this context, agencies and policy makers should start addressing these issues at policy level.

#### 4.4.2 Coordinated Community Response

The dominant system-based multi-agency cooperation approach, known as Coordinated Community Response (CCR), was first developed in 1980 in Duluth, Minnesota, to improve responses to domestic violence perpetration. CCR is a holistic approach to addressing IPV and is implemented by local councils of service providers, who work together to ensure that victim support organisations effectively work with service providers from other parts of the system to ensure that the holistic needs of victims are adequately met.

Service provider networks involve community-wide agencies such as the police, legal system, social service providers (e.g. victim advocates), government, health care systems, and educational and vocational programmes. CCRs are considered to be most effective when they are guided by an underlying philosophical framework that minimises conflicting theories about abuse, how to protect victims and how best to hold offenders accountable. This may require participants to examine and debate assumptions that they hold regarding abusers and victims.

Another element is that CCRs should both be based and lead to the development of further policies, procedures, and protocols that standardize the actions of practitioners responding to DV. An essential element of CCRs is the development of policies, procedures, and protocols that standardize the actions of practitioners responding to DV. These standardised frameworks aim to reduce inconsistencies and address policy gaps between agencies. Achieving this requires a system-wide

mapping exercise to clearly define the roles, potential interventions, and procedures for each actor involved in the system, in order to work in a successful multi-agency framework.

However, it is important to recognise that establishing a CCR in the first place depends on the creation of foundational policies to support its development. These initial policies must provide the structural framework for collaboration, delineate the responsibilities of participating agencies, and outline the mechanisms for data sharing, accountability, and interagency coordination. Without these preliminary steps, it is challenging to create the conditions necessary for an effective CCR.

Thus, the development of a CCR is inherently a two-step process. First, high-level policies must be established to lay the groundwork for coordination and shared objectives. Once these are in place, the CCR can lead to the refinement and harmonisation of detailed procedures and protocols to ensure an integrated, system-wide response to DV. These should be aligned to reduce contradictions and fill in gaps in policies between different agencies, identified via a system-wide map that charts out the roles, possible intervention actions, and procedures of each actor in the system.

Within well-functioning CCRs, alongside survivors' safety, there should be a focus on perpetrators' accountability. All interventions need to pose a responsibility for violence on the perpetrator. During CCRs, all possible interventions to keep perpetrators accountable are discussed (criminal sanctions, protection measures, referral to perpetrator programmes), as well as the implementation of those measures. In cases of violence against older women, implementation of some measures can be challenging, so CCRs have a very important role in this context. A final component of effective CCRs is the presence of ongoing training and evaluation to ensure that the system continues to meet the needs of victims and the community. Training should focus on ensuring that all participants understand the goals of the CCR, are aware of new policies and have up-to-date skills. Regular monitoring and evaluation of the system should be done to assess the effectiveness of policies and procedures in protecting women and reducing abusive behaviours.

### 4.4.3 MARVOW Multi-agency Model

The MARVOW model integrates system-wide CCR (Coordinated Community Response) models with client-focused MARAC (Multi-Agency Risk Assessment Conference) processes, creating a mutually reinforcing framework. This integration also takes into account the unique aspects of cases of violence against older women. The structure and flow of this model are depicted in figure 1 below.

Individual case conferences involve the participation of all relevant front-line workers within the region. These participants should represent various key sectors, including criminal justice, perpetrator intervention programmes, domestic violence support services, and senior support organisations.

Within these conferences, participants collaboratively address specific cases to identify effective intervention strategies. They may also analyse archetypal cases, or "victim personas," that reflect different scenarios of violence against older women such as spousal abuse, child-to-parent abuse, or caregiver-to-patient abuse. Through this process, gaps in existing services are identified, and potential workarounds are explored and documented. To maintain effectiveness and responsiveness, these case conferences should be held more frequently, ideally on a monthly basis.

Insights and findings from individual case conferences feed into system-wide meetings that include key decision-makers from relevant agencies. These meetings, while less frequent—perhaps quarterly—are critical for driving systemic improvements. The outcomes of these meetings must include clear, actionable steps. Responsibilities for each action item should be explicitly assigned, and timelines for completion must be established to ensure accountability and progress.

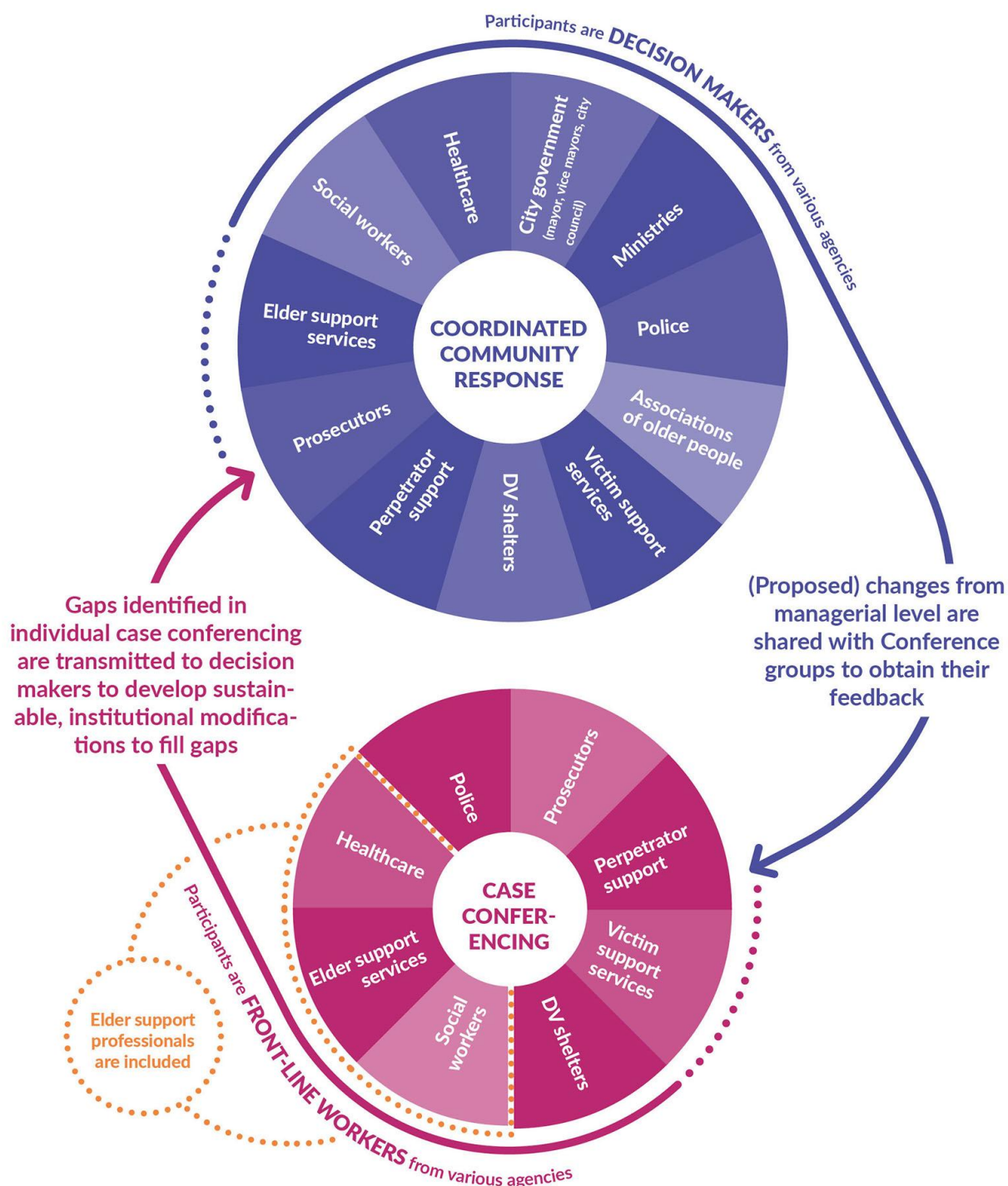


Figure 1: MARVOW Multi-Agency Model

## 5. Fundamentals of Multi-Agency and Interdisciplinary Work

Multi-agency cooperation significantly enhances responses to DV against older women, as DV affects victims in multiple ways and requires interventions across various service sectors, including social services, criminal justice, and healthcare. Within these domains, a diverse range of institutional and professional actors—both public and private—play a role in delivering services.

Moreover, DV services must address the needs of three key target groups: victims, perpetrators, and affected third parties, such as children or other family members. The nature of these services varies depending on factors such as the age of those involved (minors, adults, or older individuals), the type of abuse (physical, emotional, financial, etc.), and the relationship between the abuser and the victim. Additionally, DV is deeply influenced by societal norms, attitudes, and beliefs, which differ across local, regional, and national contexts.

Multi-agency cooperation is not static; rather, it evolves throughout the DV response process based on the specific goals of different service components.

### Case Identification

The identification of potential DV cases could be significantly improved through inter-agency collaboration. Different pathways exist for identifying victims, for example:

**Law Enforcement:** Police responding to DV calls may or may not arrest the alleged perpetrator but can refer victims to social services or domestic violence shelters for support. Courts (e.g. family courts, criminal courts) may identify DV during:

- Divorce proceedings
- Protection or restraining order hearings
- Victims may disclose abuse to legal aid or court advocacy services.

**Direct Shelter Contact:** Victims may directly contact a shelter, which can then consult public agencies (such as the police, prosecutor's office, and court records) to verify case details.

**Healthcare System:** Medical professionals working at emergency departments, general practice (GP), mental health, sexual health, as well as carers, often encounter DV victims and may recognise physical signs of abuse, such as injuries (unexplained or frequent), and/or or behavioral indicators or mental

health symptoms (e.g. depression, anxiety, PTSD). They afterwards refer victims to law enforcement, social workers, or other relevant agencies.

**Social Services: Professionals working at Social Services often uncover DV during:** Professionals in social services often uncover DV during home visits, family assessments. Direct disclosures from victims also provide critical information. Social service workers play a key role in assessing risk and coordinating with law enforcement, healthcare, and support organizations to ensure victims' safety and access to resources.

**Institutions for Older People:** Staff may detect DV through changes in behavior, frequent absences, or disclosures from victims, family members, or friends. Observations of controlling or intimidating behavior by caregivers, children, or partners during meetings also serve as indicators. Safeguarding procedures guide staff on when to raise concerns or make referrals to relevant agencies, helping to protect vulnerable older adults.

**NGOs and Helplines:** Shelters, advocacy services, crisis hotlines, and support groups often serve as the first points of contact for victims. Individuals may self-refer or be referred by other agencies. These organizations assess immediate safety needs, provide emotional support, and coordinate with law enforcement, healthcare, or social services to ensure comprehensive and timely intervention.

Effective communication, cooperation and coordination at local level (local and regional level) between agencies involved are crucial for properly identifying and documenting cases. Organisations can only work together effectively and coordinate their activities if they create "connectors" for cooperation, since an organisation cannot implement policies or practices in other organisations. Moreover, binding agreements on how to work with other organisations are required; while each organisation should also designate staff whose responsibilities include close cooperation with partner organisations. Networking and cooperation also require each participating institution to have clear guidelines and professional standards regarding domestic violence. Poor coordination can severely weaken the ability to detect and respond to DV incidents.

## Risk Assessment

Another critical area of cooperation is risk assessment. Service providers may have conflicting perspectives on how serious a particular case is, often due to differing organisational priorities.

- Victim-centred Organisations prioritize the protection of victims and are more likely to advocate for the removal of an abuser from the home.
- Reconciliation-Focused Organisations may aim to keep couples together and take a different approach to risk assessment.
- Resource-Limited Agencies may set higher thresholds for determining high-risk cases due to capacity constraints.

Risk assessment assesses survivors' risk and maximises their safety; while making organisations work together under a common philosophy and understanding of the phenomenon in general and the severity of the risk per se.

Multi-agency-cooperation allows stakeholders to develop coordinated, standardised risk assessment strategies that not only ensure victim safety but also addresses institutional challenges.

## Comprehensive Victim Support

Once risk has been assessed and a case has been identified, victims often require a broad range of services to help them leave an abusive situation and build independent lives. These include:

- Psychological Support: Counseling, therapy, or substance abuse treatment.
- Legal Assistance: Prosecution of perpetrators, restraining orders, child custody and support arrangements.
- Economic Support: Relocation assistance, access to housing, and financial independence services.

The interrelated nature of these issues underscores the need for seamless cooperation. For example, substance abuse can affect employment stability, mental health issues may weaken a victim's resolve to leave an abuser, and ongoing legal battles can prevent a fresh start. Organisational boundaries, information silos, and competing institutional priorities can hinder the effectiveness of support services.

### Perpetrator Intervention

- Addressing DV effectively also requires interventions targeting perpetrators. These programmes aim to reduce violent behaviors by addressing the underlying beliefs, attitudes, and triggers that contribute to abuse.
- Perpetrator programmes are often delivered as part of the criminal justice system, such as probation conditions or alternatives to incarceration, which are mandatory for perpetrators.
- Voluntary Programmes, on the other hand, offer counselling and behaviour change work to men who seek support or are referred by other services without a court order.

Such programmes must be closely linked to survivor support services to ensure that victim safety remains the priority.

### Public Awareness and Societal Change

Long-term solutions to DV require addressing societal attitudes that enable or normalise abuse. Multi-agency-cooperation can enhance the effectiveness of public awareness campaigns by leveraging different platforms and expertise.

For example:

- Police officers and shelter workers can conduct joint educational sessions in schools to highlight the physical and psychological consequences of DV.
- Service providers can use their respective communication channels to reach different audiences.
- Agencies can coordinate messaging to avoid contradictions and ensure clarity, reinforcing messages such as encouraging bystanders to report abuse, reducing stigma against victims, and emphasizing that anyone can be a victim.

Effective multi-agency cooperation is essential for a comprehensive response to domestic violence against older women. From case identification and risk assessment to victim support, perpetrator intervention, and public awareness, collaboration among law enforcement, healthcare providers, social services, and other stakeholders ensures a more holistic, coordinated, and effective response to

DV. Overcoming barriers such as poor communication, conflicting priorities, and institutional limitations is crucial in creating a system that prioritizes victim safety and long-term societal change.

## 5.1 MARVOW Multi-Agency Collaboration in Operational Protocol

The MARVOW project offers a concrete, evidence-based model for how multi-agency domestic violence services can operate effectively to protect older women.<sup>73</sup> MARVOW brought together stakeholders from elder care, health care, social protection, criminal justice, victim-support services, and perpetrator programmes across several European countries (Austria, Estonia, Greece, Germany) to identify systemic gaps and build capacity for coordinated response.<sup>74</sup>

Multi-agency collaboration is essential for responding to DV against older women because the effects of abuse are complex and require coordinated interventions across social services, criminal justice, healthcare, and specialised support organisations. These services are delivered by a wide range of public, private, and non-profit actors, particularly within complex social service systems that cannot be managed by one organisation alone. DV responses must address the needs of victims, perpetrators, and affected third parties, and interventions vary according to the age of the people involved, the type of abuse, and the relationship between victim and perpetrator. Societal norms, attitudes, and beliefs further influence both the prevalence of DV and the types of responses that are available. Multi-agency work therefore includes the organisation of case meetings, system-wide meetings, joint interventions, information exchange, referrals, follow-up procedures, and appropriate documentation. The MARVOW project highlighted why such cooperation is indispensable, especially as European countries increasingly rely on networked service provision. Many public services are delivered through partnerships between governmental agencies, NGOs, and private providers. However, such partnerships often face challenges: jurisdictional disputes between agencies, competition for limited funding, reluctance to take responsibility for complex cases, and cultural differences in professional ethics or priorities. These barriers can lead to duplication, fragmentation, or gaps in services for older women experiencing DV.

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<sup>73</sup> MARVOW, (2022). Multi-Agency Responses to Violence against Older Women. Available at: <https://www.work-with-perpetrators.eu/marvow>

<sup>74</sup> MARVOW, (2022). Best Practices. Available at: [https://naistetugi.ee/wp-content/uploads/2020/04/MARVOW-Best-Practices-Report.pdf?utm\\_source=chatgpt.com](https://naistetugi.ee/wp-content/uploads/2020/04/MARVOW-Best-Practices-Report.pdf?utm_source=chatgpt.com).

To address these challenges, agencies must establish clear cooperation protocols, designate contact persons in each organisation, and hold regular inter-agency meetings to discuss both individual cases and broader systemic improvements. Formal collaboration agreements can strengthen coordination, while effective data-sharing mechanisms—aligned with GDPR and other privacy regulations—can facilitate smoother referrals and follow-up actions. Strengthening the role of victim-support organisations within multi-agency frameworks is also crucial. This requires integrating training on DV against older women into the professional education of social workers, healthcare providers, law enforcement officers, and legal professionals. Family nurses, care assistants, and others who frequently interact with older women should receive targeted training to identify and respond to abuse. Training should also extend to local authorities, emergency services, older adults themselves, and the wider community to raise awareness and encourage intervention.

Expanding and adapting telephone helplines and support services to meet the specific needs of older women is another key priority, especially for those who rely on traditional communication channels or have limited digital literacy. Strengthening perpetrator accountability is also essential, including enhancing survivor-centred perpetrator programmes and promoting regular cooperation between victim-protection and perpetrator-intervention services.

Ultimately, multi-agency cooperation in responding to DV against older women must operate on both the survivor level and the system level. At the survivor level, agencies must coordinate services to provide holistic, tailored support to individual victims. At the system level, agencies must streamline service pathways, reduce duplication, fill service gaps, and create a continuum of care. These two levels reinforce each other: system-wide improvements facilitate smoother client-level coordination, while case-based collaboration can reveal structural gaps in the system. Effective multi-agency cooperation therefore requires clear role definitions, regular communication, and robust mechanisms for information sharing, all aimed at ensuring the safety and well-being of older women. It should outline who provides which services, where and how often these services are delivered, and how case meetings, system-wide meetings, interventions, data exchange, follow-up, and documentation are organised.

## 5.2 Functions and activities

### 5.2.1 Implementing laws and procedures

Although the legal and policy framework in most European countries has been strengthened covering all forms of gender-based violence against women and domestic violence, it mainly applies to them in lieu of their sex/gender and their status as family members, in cases of domestic violence; not explicitly targeting the factor of age in respect of the gender. Moreover, in some countries even if a legal framework exists targeting cases of abuse against older people, however, there is no equivalent framework for the protection of older women against abuse. This could be characterised as a blind spot at policy implementation ignoring the age sensitivity of older women.

All professionals involved in cases of abuse against older women—whether from the Criminal Justice System or other sectors—must have a thorough understanding of the relevant legal framework, including their responsibilities for detecting, assessing, and reporting abuse, the types of evidence required by judicial authorities, and the appropriate referral pathways and professional roles to ensure effective protection and support for victims.

Within this context, a strong, coordinated, direct, prompt and effective cooperation between the professionals of CJS and other services (e.g. social services, VSS, Perpetrator programmes, health units etc.) is needed, stipulated by corresponding policies, guidelines and protocols. In terms of this collaboration, coordination, monitoring and evaluation is needed to validate the efficacy of multidisciplinary work, and the efficacy of the policies implemented thereof.

All agencies involved—such as Victim Support Services (VSS), health units, specialised services for older people, social services, and nursing homes—need to have clearly defined roles to ensure that cases are handled in a way that prioritises the safety of the victim. While the police have often served as the central point of contact where survivors report incidents and where an initial assessment takes place, this approach may not always be the most effective or appropriate, particularly for older women who may be reluctant to engage with law enforcement. Instead, a coordinated, multi-agency approach ensures that interventions are carefully managed, risks are minimized, and the survivor receives the support and protection they need throughout the process.

Given this cultural and situational nuance, health services seem to have a pivotal role in a coordinated response. They often serve as the first contact/ reception point, have greater accessibility and

familiarity to older survivors, and are less intimidating than law enforcement; making them more effective points of contact for detecting abuse and initiating support processes. Their involvement as the primary coordinators can also ensure that survivors are connected to necessary support services', making all the appropriate referrals, in cases immediate police involvement is not achieved. The role of the police in cases of domestic violence is to assess immediate risk and, when necessary, implement emergency interventions to protect the victim. In Austria, for example, police can issue short-term protective measures, such as exclusion or restraining orders, to remove the alleged perpetrator from the shared residence and reduce immediate danger. However, more formal pre-trial measures—such as house arrest, reporting obligations, or other restrictions—generally require court involvement and, in some cases, consultation with the prosecutor. Beyond these measures, the police are responsible for collecting formal reports, conducting preliminary investigations, informing victims of their rights, providing updates on prosecution progress, and supporting awareness campaigns to encourage reporting. While police often serve as the first point of contact for survivors, a coordinated approach with courts, social services, and support agencies is essential to ensure victim safety and effective case management.

**At some countries, such as Greece and Italy, to comply with the relevant legislation, there are dedicated units to prevent and combat gender-based violence. These units receive multidisciplinary training and cooperate with other institutions and organisations. They consist of female inspectors and superintendents who listen to and support victims within protected spaces. In terms of successful cooperation, protocols to effectively work with perpetrators and quickly access key information on victims and offenders since early intervention are also required, along with a database where all interventions concerning this type of crime are recorded, making it possible to immediately verify the existence of previous interventions in the same house and enabling immediate information sharing between police units, as in the case of Italy.**

After reporting, specialised public prosecutors are responsible for investigating and prosecuting the perpetrator. With the support of the judicial police –if applied-, public prosecutors should gather all the evidence of the committed actions, and if there is sufficient evidence, public prosecutors will bring

charges against the alleged perpetrator and initiate court proceedings. Public prosecutors may request precautionary measures for the victim, such as restraining orders, to maximise her protection. Judges' role is to preside over trials and maintain order in the courtroom, having received tailored training to hear domestic and gender-based violence cases, especially in larger courthouses. They make decisions or judgments based on facts, evidence, and applicable laws. They may refer victims to support services or recommend precautionary measures to maximise victims' safety and well-being throughout the legal process. Legal mechanisms that allow for the timely exchange of information between criminal and civil courts when the relationship between the victim and perpetrator is relevant to both are required (e.g. domestic violence occurring in the context of divorce).

## 5.2.2 Ensuring coordinated Multidisciplinary Collaboration

To be able to provide coordinated assistance to individual victims, professionals and services involved should have a common understanding about DV and GBV in general and violence against older women per se. All professionals should co-construct mutual philosophy, language, understanding, and perception about the phenomenon of violence against older women. Mutual, ongoing, and specialised training would lead to sharing a common definition and understanding of the phenomenon; awareness of the risk factors in general and in regard to age; of the tools and interventions being available and effective when working with this population.

Professionals should be familiarised with Intersectionality and the impact of gender on socialisation and on gender diversity on cooperation. Professionals must approach each case with sensitivity to intersectionality taking into consideration the layered identities (e.g. age, gender, race, class, sexual orientation, disability) to avoid assumptions or oversimplified solutions.<sup>75</sup> Training in intersectionality equips professionals to assess risks holistically, considering how overlapping oppressions affect a victim's safety and access to help. Gender socialisation refers to how societal norms and expectations about gender roles are installed throughout an individual's life. Professionals themselves are not immune to gender biases; their perceptions of older women's needs may be shaped by their own gendered assumptions and stereotypes. Therefore, training in gender socialisation is significant for

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<sup>75</sup> Veenstra, G. Race, gender, class, and sexual orientation: intersecting axes of inequality and self-rated health in Canada. *Int J Equity Health* 10, 3 (2011). <https://doi.org/10.1186/1475-9276-10-3>

professionals to recognise and challenge their own biases and avoid paternalistic attitudes. Understanding how socialisation shapes victim responses encourages empathy and creates space for empowering interventions. Professionals must develop inclusive practices to accommodate diverse gender experiences, ensuring that language used in documentation and interviews is respectful and affirming, and that services are accessible and non-discriminatory. Cooperation requires all professionals to have a shared understanding of gender diversity, avoiding conflicts or inconsistencies in how cases are handled.

Coordinated assistance involves the implementation of common and standardised practices such as risk assessment tools, safety planning, case management, and referral pathways. These tools should be used with a shared understanding among all stakeholders to prioritize victims' protection, rights, and safety, while ensuring perpetrators' accountability and engagement in perpetrator-focused interventions. To achieve this, corresponding protocols and procedures must be established to provide consistent and comprehensive support to older victims of abuse.

Strong collaboration between all services is critical, under a multidisciplinary framework of coordinated action. Following a victim-centred approach, professionals of various disciplines, can work together to ensure that older victims receive the support they need to continue their lives, regardless of whether or how judicial proceedings unfold.

Such cooperation protocols should be, first, governed by gender-sensitive and trauma-informed approaches, taking into account at the same time the factor of age. They should stipulate the procedures according to which professionals from all agencies (hospitals, services for older people, psychiatric units, social services, VSS etc.) need to share data and share information in a formal and protective way towards the victim, respecting confidentiality issues. Empowerment and protection of victims and preventing secondary re-victimisation should be a basic principle for all those working with this population. Data sharing would be ensured by multilateral confidentiality agreements ensuring the safety of the victim.

Clear and comprehensive referral pathways are crucial and must be firmly established as part of the overarching protocols and integrated into the policies of each agency involved. These pathways

should outline the processes for identifying, reporting, and managing cases of abuse, particularly those involving older women and older perpetrators.

When abuse against older women is detected, frontline services such as health and mental health providers, as well as victim support organisations, must have clear procedures for referring survivors to the police and the criminal justice system (CJS) or to other services depending on their needs. This ensures that incidents could be addressed through appropriate legal channels. Conversely, the CJS should have equally robust mechanisms to refer older women to specialised support services designed to address their unique needs, ensure their safety, and provide assistance throughout the criminal process. This dual-referral system is essential for delivering holistic and survivor-centred care.

Similarly, perpetrators, including those involved in Perpetrator Programmes, should also follow designated referral pathways to ensure they receive interventions that promote accountability and behavioural change. This integrated approach fosters a coordinated response to DV.

However, the relationship between VSS and the CJS is inherently complex for all cases of DV. These challenges become even more pronounced when dealing with older women and older perpetrators due to additional factors such as age-related vulnerabilities, health issues, and societal perceptions about violence against older women. Older survivors may face unique barriers, including a lack of awareness about available resources, feelings of shame or dependency, or challenges in navigating the legal and support systems. Similarly, older perpetrators may require distinct interventions that account for generational attitudes or health considerations.

If this manual aims to specifically address older women and older perpetrators, it is essential to provide a detailed and nuanced discussion of these issues. This should include tailored recommendations for effective collaboration between agencies, the integration of age-sensitive practices, and strategies to overcome specific barriers faced by this demographic in both support services and the CJS.

The methodology established and followed by all actors should be clear to the other professionals involved, as well as their roles and limits.

De-stigmatisation of older victims of abuse should be a priority for all professionals engaged during all phases of the procedure. Their needs and risk should also be assessed regularly at predetermined

times. The results of the mutual risk assessment should guide the future steps, including the case management and safety planning, and should be decided within regular (preferably monthly) multi-agency meetings with the involvement of all stakeholders (no exception for lawyers and police). Stipulated by the protocols, these meetings would assist high-risk cases and enable flexibility in communication and decision-making. All professionals taking part have clear roles and responsibilities and formal paths of cooperation are engraved, on behalf of the victims. They also have stable structure and supervision, encompassing the different contact and cooperation that may exist with each agency.

In Italy, although it is considered a good practice that public prosecutors and judges may appoint technical experts, normally psychologists, to deal with domestic and gender-based violence, however, without adequate training, these experts may misinterpret power-and-control dynamics characteristic of domestic violence as "mutual conflict" or "relationship problems." Over time, these experts have taken on an ever-increasing importance in this matter that is expressed not only in carrying out specialised investigations (technical assessment or expertise), but also in assisting the judicial police, the public prosecutor or the defence lawyer, in gathering information from offended persons in a particularly vulnerable condition. However, the misunderstanding risks minimizing abuse and even misrepresenting victims as complicit or equally culpable. Many experts lack a firm grasp of the patterns and consequences of coercive control, economic abuse, and other forms of non-physical violence common in gender-based cases. Without specific training, assessments might inadvertently reinforce stereotypes, such as blaming victims or underestimating the danger posed by perpetrators.

### 5.2.3 Ensuring better coordination, based on an integrated policy approach

Mutually shared policies based on evidence-based collaboration models and good practices, such as CCR and MARAC, depending on the strengths, resources, weaknesses and opportunities available at local level enable better coordination among agencies. Clear professional roles, clear boundaries between services and clear coordination guidelines and roles are basic preconditions towards this direction. All stakeholders should acknowledge intersectionality and be aware of all intervention procedures and steps followed by their own and other agencies. Above all it is essential to cultivate a trust *relationship* between all professionals involved, even coming from different fields.

Communication, interaction and coordination among primary and secondary care services are also required; while conquering competence in methodology, procedure and cooperation.

Professionals from different agencies should implement and take part in tracking monitoring procedures while constantly revising and updating their processes, protocols and interventions based on data collection and victims' feedback.

### 5.2.4 Undertaking the necessary acts related to prevention, protection, and victims' safety

In order to secure victims' safety professionals should have the same understanding and perspective on the phenomenon of violence against older women. They should use standard risk assessment tools and corresponding procedures; share their results when meeting all together and agreeing on a common case management and safety planning. Towards this end, they should cooperate to take all necessary legal measures, including protection order and safety housing, to ensure overall safety and reduce any secondary victimisation risk. At this point, cooperation and coordination with the local associations is necessary.

### 5.2.5 Improving the capacities of professionals

Mutual and ongoing training focused on DV and GBV in general is needed, as well as training explicitly focused on violence against older women. Professionals should be trained on gender and trauma

sensitive approaches. They should also learn how to cooperate with each other, overcome the difficulties deriving from different philosophies, and bridge the gaps between their perspectives. They should be aware of cultural issues and receive training on setting up the corresponding procedures. Focused training on the existing law and available services and their role is needed, as well as on how to work under a multidisciplinary approach within the institutional system locally.

## 5.2.6 Ensuring updated information, analyses, and research.

In terms of ensuring updated information, analyses and research a systematic and official data collection and the creation of a corresponding database with information by all agencies involved is required. Apart from quantitative data, qualitative data regarding cases of violence against older women is needed.

In addition, in terms of implemented protocols, tools and interventions, checking their effectiveness, as well as the effectiveness of the provided services, are required. Professionals and services should ask their beneficiaries for feedback in a structured and official way, in order to gather this data.

## 5.2.7 Roles of Professionals

Engaged front line professionals from various disciplines need to work upon a multidisciplinary approach to address any issue of older woman abuse, as older women can face unique risks and challenges due to age, potential isolation, dependency, and societal attitudes toward both ageing and gender.

Front line professionals could be defined as the ones working at the following agencies, which constitute the *response, and operating ecosystem* since they interact with each other according to the specificities of each case and within each institutional framework at regional and national level.

- Victim Support Services (VSS)
- Police
- Social Services
- Perpetrators Work Programmes
- Health Services at any level
- CJS

The role and positioning of each agency within the “operating ecosystem” is described as follows:

**VSS/NGOs:** When risk has been assessed or violence identified through the police, professionals at VSS or any other professional or service (health and social services, including dependency and home visitation), referrals to VSS should follow. VSS provides survivors of domestic violence (DV) or intimate partner violence (IPV) with psychological support services such as counselling, therapy, and the creation of safety plans, following a thorough risk assessment, taking into account all the possible risk factors, and especially factors relating to age and gender. They offer case management, support for accessing shelters, referrals to welfare services, advocacy, and peer support. VSS either provide integrated legal services —including legal support, criminal prosecution of perpetrators, protection orders, and child custody arrangements— or refer survivors to legal professionals. Additionally, VSS can offer survivors financial assistance for relocation, finding accommodation, opening bank accounts, and/or making referrals to access these services.

Professionals engaged in VSS services, along with healthcare professionals, such as geriatricians and nurses, should also address the health impacts of DV on older adults. They also work on increasing awareness of educators and programme coordinators who work on public awareness campaigns and prevention programmes; and advocates and policy experts who focus on legislative reforms, research, and advocacy to create broader systemic changes that protect survivors and prevent DV.

VSS mental health professionals and counsellors’ role is to assess the general mental state of people and are frequently the first ones to identify whether there is a deriving from abuse trauma, getting led to assess the situation in order to identify the violence and assess the risk, either on their own or working closely with VSS. After that, VSS takes charge of the case, maintaining close contact with the police and CJS to report high-risk cases, develop safety planning and case management, and make appropriate referrals, when required.

When VSS participate in coordinated collaboration meetings, their priority is to represent survivors of DV or IPV, after they have given their consent for sharing their information, support their goals, rights, and concerns, work collaboratively with them, and most importantly, avoid re-victimisation.

In terms of multi-agency cooperation, VSS works closely with the police and the law enforcement agencies. More specifically, police, law enforcement agencies, or the CJS are often referring survivors of DV and/or IPV to VSS to receive specialised help and support. Vice versa, when complaints to the police or the CJS have not been made by the victims, survivors are being referred to the police or the prosecutor by the VSS to report the abuse. In both cases, VSS and police and/or CJS are exchanging information and working closely in order to defend victims' rights, continue the criminal procedures, ensure victims' safety, prevent recidivism and secondary victimisation, and hold the perpetrator accountable for his violent actions. VSS services are also cooperating in a systematic and regular base with Perpetrator Programmes (PP) to assess the risk from the part of both the survivor and the perpetrator and manage the case, including conducting follow ups, in terms of maximizing victim's safety, prevent recidivism, end the violence and hold the perpetrator accountable. VSS collaborate and exchange information and views regarding the case with Child Welfare Services, when minors are being involved, to address all possible victims and keep them safe and secure. To respond to all the possible needs DV survivors may have, VSS are working closely with Health and Mental Health Units. Especially for older people, the cooperation between the aforementioned agencies and with social/ specialised services for Older People is much more essential and intensive, due to the multiple and / or severe –linked to the age- needs of this group and the specialised help and support they need. For instance, VSS may refer older victims to doctors or psychiatrists for diagnostic and/or treatment reasons, while ongoing communication between these professionals should be implemented to effectively address the issues older people are facing. Multi-agency cooperation among VSS and Social services for older people ensures that they receive the specialised help and support they need by experts, while all their needs are being met in compliance with their age. For instance, social services for older people may, as a response to the information being received by the VSS, visit survivors at their homes to assess the environment they live in and provide them with the adequate services. Conversely, Health and Mental Health Units and Social/ Specialised services for Older People may refer survivors to VSS or to turn to VSS themselves to receive specialised DV and/or IPV guidance and advice. The same applies to Social Services in general and Shelters or Housing Institutions.

**Domestic Violence Services:** play a central role in ensuring safety, support, and long-term recovery for victims, while also contributing to perpetrator accountability and broader prevention efforts.

Operating across social services, healthcare, the criminal justice system, and specialist NGOs, these services provide coordinated interventions that address the complex and interconnected needs of victims, including psychological support, legal assistance, housing, financial stability, and access to health care. They assist in the early identification of abuse—through police responses, healthcare encounters, social service assessments, and direct disclosures—and ensure that cases are referred promptly to the appropriate agencies for further action. DV services also contribute to risk assessment by offering specialised expertise on patterns of coercive control, escalation, and factors affecting victim vulnerability. In addition, they support multi-agency safety planning by sharing information, aligning institutional priorities, and ensuring that victims receive consistent and holistic care.

Importantly, DV services are also involved in interventions for perpetrators, helping to reduce violent behaviour through structured programmes linked to judicial processes. Beyond case management, these services engage in public awareness and prevention campaigns that challenge harmful norms, encourage reporting, and promote community responsibility. Through this combination of direct support, coordinated intervention, perpetrator work, and societal education, domestic violence services form a critical pillar of an effective multi-agency response to violence in the home.

**Perpetrator Programmes (PPs):** PPs focus on diminishing the violent behaviour of the perpetrator, frequently through investigating the underlying conditions, attitudes, or beliefs that initiate such behaviours and by figuring out the inner triggers that set off violent acts. PPs engage multiple professionals such as psychologists, social workers and psychiatrists that work on implementing behavioural change interventions targeting perpetrators of DV and IPV, through individual and group counselling. PPs have programme coordinators that work on public awareness campaigns and advocacy to prevent DV. PPs work closely with VSS and police and the CJS, as well as with other services if they are involved, to make sure that survivors' needs, and safety are given priority, prevent re-victimisation and foster perpetrators' accountability. More specifically, PP collaborates with VSS and Child Welfare Services to address all possible victims, meet their needs and assess the risk so as to proceed to safety planning and case management with the goal of maximising survivors' safety, end violence, prevent recidivism and secondary victimisation and hold the perpetrators accountable. Regarding the perpetrators per se, cooperation with other specialised services, such as Addiction

Rehabilitation Programmes, is required to meet all their needs and assist them in being sober and non-violent. Close cooperation with the police and the CJS, provides PP all the necessary information (e.g. perpetrator's criminal record) and fosters the criminal treatment of perpetrators in cases of ongoing and/or additional abuse, adding as well to keeping them accountable in all levels and processes. PP collaborates also with Health and Mental Health Units to address the health and mental health issues of perpetrators, which are being maximised while talking about older perpetrators. In the same line, the cooperation between PPs and Social/ Specialised services for Older People is crucial. By this way, accountability and behavioural change is being fostered since health, mental health and socioeconomic issues may exaggerate the perpetrated violence.

The role of PPs in coordinated collaboration and in the corresponding meetings is to present high-risk cases, in compliance with the beneficiaries' consent. Based on the risk assessments conducted by PP professionals, they suggest appropriate actions such as conducting social inquiries, psychiatric evaluations, issuing a prosecutor's order for a restraining order, and other necessary measures that are going to ensure the survivors' safety.

**Social Services:** Generally, Social Services are involved in the whole process, carrying out a preliminary assessment and examination to verify the maltreatment, and offer continuing psychological support to carry out a treatment plan. Social Services include financial support, case management, counselling and mental health aid, housing, police engagement, and coordination of external referrals. More specifically, social services are compiled from a multidisciplinary team that involves social workers, occupational therapists, nurses, psychologists, and administrative staff. Their work looks alike with the work of VSS, missing however, the appropriate expertise, and focus on survivor work. They usually fill the gap in absence of VSS. That being said, Social services exchange information and cooperate with VSS and PPs in terms of assessing and minimising the risk; with VSS and Social/ specialised services for Older People for referrals and receiving themselves specialised guidance and advice; with police and the CJS for reporting the abuse and proceed in the following criminal procedures; and with Health and Mental Health Units to make referrals and exchange information regarding the case so as to meet survivors' needs and treat any possible (mental) health problems.

**Social Services for older people:** Social Services for older people specialise in treating older people and responding to their focused needs. Their role in multi-agency collaboration meetings is to talk with the survivor, assess the risk and accordingly, introduce the case to the team. They are also responsible through their assessments to inform the multi-agency meeting about cases of survivors who deal with health and/ or mental health issues (dementia, depression, suicidal thoughts etc.) or accordingly cases of perpetrators who are dealing with psychiatric problems, which might be related to their aggressive and abusive behaviours.

Social services professionals are also responsible for assessing the social and emotional needs of the older people, by conducting home visits and specific social inquiries ordered by prosecutors to understand the living conditions, social networks, and the overall well-being of the older participants. They are responsible for assessing the possible risk of abuse if they have noticed appropriate signs and refer the older person to the multi-agency meeting. Additionally, they create personalised care plans for everyone based on their needs.

Social/ Specialised services for Older People are being engaged when survivors are old and cooperate with all the aforementioned services, making and receiving referrals, in order to provide them with specialised services, help and support. The same applies to the Health and Mental Health Services described below.

**Healthcare Services:** They provide basic healthcare services, such as monitoring vital signs, administering medications, wound care, and other essential medical tasks that do not require hospitalisation. They regularly assess the health status of older people, identifying potential health risks and coordinating with doctors or hospitals when more intensive medical care is needed.

In Health Units doctors' (in general and specialties) role is to provide medical care and treatment, by making diagnosis, providing treatment, prescribing medications, and monitoring patients.

Geriatricians are the most noteworthy specialty related to older people since they specialise in the care of older people, focusing on the prevention, diagnosis, treatment, and management of diseases and conditions that commonly affect older people. Their role is essential because they also provide support and guidance to families and caregivers, helping them manage the special needs of older people. Additionally, geriatricians deal with the prevention, diagnosis, and treatment of conditions that primarily affect older adults, such as dementia, osteoporosis, cardiovascular diseases, arthritis,

and other chronic illnesses. They also focus on issues related to polypharmacy (the use of multiple medications), frailty, falls, mobility problems and are specialists in managing multiple chronic conditions simultaneously, which is common among older patients. Finally, geriatricians provide comprehensive care to patients by collaborating with other specialists (nurses, physiotherapists and social workers) and they similarly provide support and guidance to families and caregivers, helping them to manage the demand of caring for an older person.

In addition, other relevant doctor specialties mainly addressing older people are neurologists, psychiatrists, physiotherapists, occupational therapists, social workers and nurses (general or geriatric).

Neurologists diagnose and treat disorders of the nervous system, such as Alzheimer's disease, Parkinson's disease, strokes, and other neurodegenerative conditions that are common in older adults. They often work closely with geriatricians to manage cognitive and movement disorders.

Physiotherapists work with older patients to maintain and improve their physical mobility and function. They help with rehabilitation after surgeries or injuries and assist in managing conditions like arthritis and balance issues to prevent falls.

Nurses are the primary caregivers in hospitals and health centres, providing day-to-day care such as medication administration, wound care, and monitoring of vital signs. Geriatric nurses specialize in the specific needs of older adults, including managing chronic conditions and end-of-life care.

Health care providers like nurses, doctors and geriatric specialists, have a very essential role in DV and GBV concepts by identifying and recognizing risk factors, signs, and patterns of coercive controlling behaviours related to DV. Furthermore, healthcare providers often are the first line of support for survivors by diminishing the harmful consequences, granting support and assistance, preventing further harm, trauma, and damage and being capable of sensitively responding to disclosures and thoughtfully recognizing when to refer individuals to specialised treatment. In a coordinated collaboration concept, health care professionals can directly file complaints in cases recognising that DV or GBV is taking place and/or refer survivors of DV or GBV or to the police or the criminal justice system, to VSS, social services and to forensic pathologists if the survivor needs an immediate examination. Furthermore, they can provide several affirmations of their examinations from survivors to the multi-agency meeting.

**Mental Health Units (Psychiatric Hospitals):** Mental health professionals evaluate whether cognitive issues, such as dementia, contribute to or complicate the risk of abuse. Psychiatric hospitals and specialised psychiatric units focusing on addressing the unique mental health needs of older patients. This population often faces complex mental health issues that can be linked to ageing, chronic illnesses, cognitive decline, and social factors such as isolation and loss. Psychologists, psychiatrists, and mental health counsellors can assist survivors with emotional support, counselling, therapy and conduct psychological evaluations to determine the effects of abuse. These professionals, and specifically psychologists, are attributed to assess the mental health of the older women, identify signs of depression, anxiety, dementia, or other cognitive issues, and provide counselling and therapy to address emotional and psychological needs, helping the older people cope with issues like grief, loneliness, or cognitive decline.

Their role in coordinated multi-agency collaboration meetings is the same as Social Services noted above. (To talk with the survivor, assess the risk and accordingly, introduce the case to the team. They are also responsible through their assessments to inform the multiagency meeting about cases of survivors who deal with psychiatric problems (depression, suicidal thoughts etc.) or accordingly cases of perpetrators who are dealing with psychiatric problems which give rise to aggressive and abusive behaviours.)

Psychiatrists in geriatric settings focus on mental health issues that commonly affect the older people, including depression, anxiety, dementia-related behavioural changes, and late-life psychosis. Geriatric psychiatrists are especially trained to understand the interplay between physical and mental health in older patients and can provide multi-agency meetings with evaluations of both survivors' and perpetrators' mental health.

**Rehabilitation centres:** They accept referrals from prosecutors for perpetrators dealing with addiction issues. In terms of coordinated multi-agency meetings, they are responsible for updating the team about the perpetrators' progress, recommending further appropriate actions to address the specific needs of each case and informing if the beneficiary leaves the programme or experiences a relapse.

They can also support survivors with substance use issues. Also, they can play a role in detecting situations of violence and abuse in their older service users (potential survivors and perpetrators).

**Police:** Police is often the first respondent to incidents of DV and GBV, responding in emergency situations, conducting investigations and applying preventive measures. The core role of police is to assist victims / survivors for filing the report, collect evidence and organise a file for prosecution. The mission of police as at any call for report is to immediately respond to the call, ensure protection and maximise survivors' safety from further harm. Police collect evidence related to the DV and GBV incident and then fill out detailed reports, documenting the victim's statements, injuries, and any other relevant information that can support the case in court. Police work with prosecutors at first instance, so to ensure that evidence is properly handled and that the case progresses through the legal system. As part of the Initial Support, police provide information on available support services (VSS, PP, Social/ Specialised Services for Older People) and legal options, providing information or in cases refer them to shelters, medical care, and counselling services; while at the same time they refer survivors to specialised support services and survivor advocacy organisations for ongoing assistance. Police also assess the risk of further violence and, when appropriate, recommend or implement protective measures such as restraining orders or emergency intervention.

Under a coordinated multi-agency collaboration, the role of police would be considered as a more “proactive” front line entity, conducting thorough risk assessments, contributing on risk minimisation of cases together with other front-line agencies, working in coordinated mode, with either the Prosecutor's Office or with Support Services or medical entities. Especially for older women, the role of police is to ensure the risk minimisation by reacting to any violation of protection order.

**Law Enforcement Agencies:** Law enforcement professionals receive the dully-filed case by the police, organise the legal enquiry of the case and investigate allegations of abuse, evaluate the evidence, and support prosecutors in building cases against perpetrators.

At parallel, attorneys, including those specialising in law regarding older people or DV, help older women understand their rights, file protective orders, and seek justice through civil or criminal proceedings. Law enforcement professionals collaborate with other agencies to create safety plans

and provide protective measures, including restraining orders if necessary. Prosecutors determine the appropriate charges based on the evidence collected. Cases of violence against older women may be prosecuted under a variety of charges, depending on the type of abuse, and in some jurisdictions, violence against older women carries enhanced penalties. Many prosecutors' offices work with victim advocates to provide support to older victims throughout the legal process. This includes explaining court proceedings, offering protection during testimony, and helping with any special needs the older adult might have. Prosecutors may work closely with social services and health professionals to build a case that reflects the complexity of violence against older women and to ensure the survivor's holistic needs are met.

Under the concept of coordinated collaboration, prosecutors have to work closely with police, social and victim support services, as well as perpetrator programmes, to ensure that the survivors' needs are addressed and that the case is pursued effectively. In addition, they issue prosecutor's orders to the authorised services for the conduction of a social investigation, referral for psychiatric/child psychiatric evaluation - under the scheme of involuntary hospitalisation-, the establishment of a criminal case file and anything else related to their prosecutorial duties.

Judges, in DV cases, are responsible for overseeing court proceedings and making evidence-based legal decisions. Towards Presiding over Cases, they manage the courtroom, ensure legal procedures are followed, and make rulings on motions, evidence, and legal arguments. In terms of Evidence Evaluation, they assess the evidence presented by both the prosecution and defence, including testimonies from the victim, witnesses, and expert reports; while in Case Management judges may refer victims to support services or recommend measures to protect their safety and well-being throughout the legal process.

**Occupational Therapists:** Occupational therapists work with older individuals to help them maintain or regain their independence, focusing on adapting the home environment to make daily tasks easier and safer (e.g. installing grab bars, suggesting adaptive equipment).

**Administrative Staff:** Administrative staff ensures the smooth operation of the programme by managing schedules, coordinating between different team members, and handling the logistics of service delivery.

## 5.3 Flows and interactions among professionals – The role of data sharing

Undoubtedly, when referring to DV cases, networking of actors, including public agencies, non-profit organisations, and private companies is crucial.<sup>76</sup> In many situations, complex social services are required, since they can address issues that cannot be solved easily by single organisations acting alone.<sup>77</sup> Complex networking and cooperation are both significant and challenging, because coordinated cooperation between multiple agencies/organisations who must work together without any authority over each other to compel action is needed. However, working together often leads to conflicts due to questions of jurisdictional boundaries. For instance, in some cases, two agencies wish to have primacy in a particular area (for example, a social department of a local government vs. a prosecutor's office), leading each agency to defend their 'turf', which can result in a lack of cooperation and/or redundancy or even counterproductive services.

In addition, agencies may oppose taking responsibility for an area, leading to service gaps. This happens mainly when challenging and/or resource intensive groups are involved, such as the homeless people. In this line, it may be the result of organisations, which often compete with each other for the same or scarce resources, such as shares in a municipal budget or lines in the state budget. Moreover, they may lack experience in collaboration, or even worse, they may have experienced problematic interactions due to different priorities, cultures, or expertise – such as when they are staffed by professionals whose ethics, standards, and practices differ from each other. For instance, in collaboration between CJS and rehabilitation programmes, the police may treat substance

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<sup>76</sup> O'Toole, Laurence J., Jr. 1997. Treating Networks Seriously: Practical and Research-Based Agendas in Public Administration. *Public Administration Review* 57 (1): 45 – 52.

<sup>77</sup> Agranoff, R., & McGuire, M. (2003). *Collaborative Public Management: New Strategies for local Governments*. Georgetown University Press.

users as threats to public safety who should be held accountable if they commit crimes, whereas a treatment centre is more likely to see them as patients needing help in treating the addiction.

When rightly implemented, multi-agency cooperation can help in addressing the difficulties described above. Generally, this occurs at either the **client level** (through service coordination) or at the **system level** (which is sometimes referred to as service integration):

- At the client level, agencies work together to align their services and activities for specific individuals to address their unique needs and achieve better outcomes. The results of this effort may or may not be used to try to improve system performance. These approaches often involve more rapid, sometimes ad hoc actions responding to actual client needs in almost real time.
- At the system level, agencies providing services within a specific sector (like education) or serving specific types of clients in a shared region (such as serving the homeless in a city) seek to unify or align services to reduce service fragmentation, fill gaps, and create a continuum of services for clients. Other goals are to increase efficiency by reducing the duplication (and cost) of services and to decrease inappropriate service use. System approaches tend to involve a great deal of planning, often consider resource allocation issues, might promote shared guidelines or protocols and make administrative changes across agencies to foster long-term collaboration.

Although these two levels of practice are often carried out separately, they are not mutually exclusive and could reinforce each other. For instance, system wide approaches could foster implementing client-based coordination by eliminating or reducing institutional barriers; while client-based approaches can help to fill gaps or address barriers. Addressing the system or specific clients, multi-agency cooperation approaches can identify who provides services, where and how often they are provided, and create mechanisms for communication between professionals as well as ways of sharing data.

The professionals involved in the different phases addressing violence against older women form a network of interconnected roles, with a structured flow of information, referrals, and support aimed at ensuring a cohesive and effective response.

### Initial Reporting and Identification

Often, a case of abuse to an older woman would be first reported by family members, caregivers, or community members who suspect violence or neglect. Sometimes cases of abuse of older people are noticed by people from the Social Services visiting the residence of older people. These individuals typically contact law enforcement or social services in their areas to initiate intervention. Healthcare providers may identify signs of abuse during routine exams or emergency care. If abuse is suspected, they report it to the social services in the hospital or in their areas or law enforcement, following mandatory reporting laws in many countries. Finally, initial reporting and identification could happen by social workers in home care agencies or community centres who detect abuse and report directly to the police.

### Initial Response and Assessment

Initial response and assessment could be conducted by social workers to confirm suspected abuse and determine if immediate intervention is required. If there's evidence of violence against older women, social workers coordinate with law enforcement for a criminal investigation. Sometimes, social workers may also reach out to healthcare providers to assess physical or mental health impacts. If law enforcement responds to a report and finds immediate physical injuries, they may refer the victim to emergency healthcare services. Conversely, healthcare providers may notify law enforcement if the victim's injuries are consistent with abuse.

### Investigation and Evidence Gathering

During an investigation, law enforcement may work with healthcare providers to collect physical evidence of abuse, such as photographs of injuries or forensic exams. Once evidence is collected, law enforcement compiles the case information and refers it to the prosecutor's office. Prosecutors review the case details and determine whether charges can be filed.

### Legal and Protective Action

Prosecutors collaborate with victim advocates and social workers to support the victim through the legal process, offering guidance on legal rights and protective orders. Victim advocates may also

coordinate with social services to address housing, safety, and other needs. If protective orders are issued, judges coordinate with victim advocates and social workers to ensure that victims understand and can enforce these orders. Advocates and social workers help monitor compliance and report violations to the court.

### Ongoing Support and Services

After the immediate crisis is addressed, social workers often refer survivors to mental health providers for counselling and trauma support. Mental health professionals provide therapy and ongoing support to help the survivor cope with the psychological effects of abuse. For long-term health management, healthcare providers may work with social workers to create care plans that include regular check-ins, ensuring that any future abuse signs are quickly addressed. Social workers often connect survivors with community resources, such as housing assistance, financial support, or peer support groups, facilitated by non-profit organisations. This support is essential for survivors needing long-term assistance or relocation.

### Monitoring and Follow-up

Law enforcement should follow up with social services to ensure that the survivor remains safe and receives ongoing support. If the victim remains in a potentially risky environment, regular welfare checks from law enforcement or social workers may be requested. If the perpetrator is placed on probation, probation officers may monitor compliance with protective orders and check in with social workers or law enforcement to ensure the perpetrator is not violating court orders. In cases where the survivor has ongoing health concerns, healthcare providers maintain communication with social workers to monitor the survivor's condition and alert all involved services if any new concerns arise.

### Feedback and Improvement

Insights from law enforcement, healthcare, and social services are feedback to researchers and policymakers to inform new policies, training, and resources to improve intervention in cases of violence against older women. This feedback loop is essential for strengthening systemic responses to violence against older women.



The flow between these professionals creates a layered support system that addresses the survivor’s immediate and long-term needs. Each professional role builds upon the others, ensuring that no aspect of the survivor’s well-being is overlooked while maximising safety and reducing the likelihood of future abuse. This coordinated approach is crucial for navigating the complexities of violence against older women and supporting the unique needs of older women.



# 6. Operation for cases of violence against older women including Coordinated Multi-Agency Response

## 6.1 Introduction

This chapter describes the procedures and the steps to be followed by professionals under a coordinated multi-agency collaboration, useful tips and recommendations for their work; how to communicate with older women, where to pay special attention etc., and instructions to follow in case of an emergency.

This chapter is inextricably linked to the **Case Management & Risk Assessment Development Tool / Checklist<sup>78</sup>** to ensure efficient interventions to the greatest extent possible. The overall aim of this chapter together with the Case Management & Risk Assessment Development Tool (MARVOW 2.0 Risk Factor Checklist & Case Management Tool) is to ensure that all the involved and frontline professionals in positions where the abuse against an older woman may be suspected, witnessed, or disclosed, will be able to identify abuse, assess the survivor's safety and provide support to the older woman and refer the incident to the appropriate agency/professional/stakeholder based on the form of violence.

It is important to understand that to implement the following steps some preconditions need to be in place:

- The willingness for collaboration of all frontline agencies under a coordinated multi-agency collaboration at local / regional level. Intensive training of professionals needs to be carried out for multiagency collaboration and data management.
- The collaboration, following the MARAC methodology, needs to be coordinated; coordination of the MARAC teams would be decided following the institutional mandate, or following a “rotation system” unanimously agreed upon by agencies at local – regional level.

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<sup>78</sup> MARVOW 2.0 Riskfactor Checklist and Case Management tool for cases of violence against older women. See: [https://marvow.eu/wp-content/uploads/2020/05/MARVOW2\\_Riskassess\\_EN\\_251112\\_web.pdf](https://marvow.eu/wp-content/uploads/2020/05/MARVOW2_Riskassess_EN_251112_web.pdf)

- Filing of the work of the multidisciplinary collaboration needs to be in place, with a decision / agreement for data sharing strictly among collaborating partners.

## 6.2 Main Steps for Frontline Professionals

The process followed by professionals engaged needs to be structured based on specific steps provided by the MARAC model (see Figure 2). According to the MARAC, the professional flowchart includes seven steps:



Figure 2: Basic Steps for Professionals

## 6.2.1 Step 1 Identify Abuse

The Professional needs to ask questions and gather information regarding older women's daily life and (mental & physical) health. The professional is best placed to recognise any possible change in daily life, health behaviour, and habits of the older woman.

### Tips for the professional<sup>79</sup>

- The victim's recognition of violence can vary depending on the "cycle of violence" (tension building, eruption of violence, reconciliation)<sup>80</sup>
- Provide comfort to the survivor by being warm, calm, and open to effectively build rapport with her.
- Explain confidentiality.
- Explain the Case Management Process and your role.
- Explain older women's rights.
- Be sure that she feels fine, safe, and comfortable talking at the moment you are there.
  - ✓ *Are you comfortable talking right now?*
  - ✓ *Are you fine talking now?*
  - ✓ *Do you feel safe and have enough privacy for our conversation?*

### Open questions: used to initiate conversations.

- How are things at home?
- How do you spend your days?
- How do you feel about the amount of help you receive at home?
- How do you feel your carer/family is managing?
- How are you managing financially?
- How do you feel when a carer/family member does/says (name behaviour noticed)?
- Lots of women put up with abuse and it can be hard to talk about. Does this sound like your situation?
- What is happening now/how can I support you?

### Direct questions: use when abuse is strongly suspected.

- Are you feeling safe?
- Are you afraid of anyone at home?
- Has anyone close to you tried to hurt or harm you recently?
- Are you often sad or lonely?
- Are you helping to support someone?
- Has anyone touched you without consent?
- Has anyone shouted at you or threatened you?
- Has anyone taken anything that was yours without your consent?
- Have you signed any documents that you didn't understand?

<sup>79</sup> Anami, G., Farhat, A., Mortada, Z., (2021). Remote GBV Case Management during emergencies; Guidelines for GBV Case Workers.

<sup>80</sup> Walker Lenore, E. (1979). The battered woman. *New York*, 270.

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| <ul style="list-style-type: none"> <li>→ I noticed a bruise on your arm today. How did this happen?</li> <li>→ You seem a little upset – what’s happening to you?</li> <li>→ How are you managing at home? (Or how is your carer managing?)</li> <li>→ What would you like to do about your situation?</li> <li>→ You seem anxious about your finances. What would it be like if I arranged for someone to assist you with your banking etc.?</li> </ul> | <ul style="list-style-type: none"> <li>→ Has anyone failed to help you when you needed help?</li> <li>→ Is there someone you can talk to about your situation?</li> <li>→ Would you like me to talk to someone who can help or advise you?</li> <li>→ Would you like to have a visit from one of our social staff?</li> <li>→ Has anyone tried to hurt you recently?</li> <li>→ Do you know about a free telephone service called the NSW Elder Abuse Helpline – would you like the number?</li> </ul> |
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Figure 3: Effective Questions<sup>81</sup>

### Forms of Violence<sup>82</sup>

- Financial Abuse
- Neglect
- Emotional/Psychological Abuse
- Physical Abuse
- Sexual Abuse
- Institutional abuse

### Indicators for forms of violence<sup>83</sup>

- Delays between injury or illness and assessment.
- The history of victim and perpetrator differs.
- Implausible or vague explanations.
- Frequent visits for illness despite a plan of care and adequate resources.
- Functionality-impaired patient presents without caregiver.
- Lab or X-ray results inconsistent with history.

<sup>81</sup> NSW Elder Abuse Helpline & Resource Unit (EAHRU), (2016). Identifying and Responding to the Abuse of older people, p.21.

<sup>82</sup> TISOVA Project (2020). *How to Identify and Support Older Victims of Abuse: A training handbook for professionals, volunteers and older people*. Available at: [https://wave-network.org/wp-content/uploads/Tisova\\_Training-handbook\\_ENG.pdf](https://wave-network.org/wp-content/uploads/Tisova_Training-handbook_ENG.pdf)

<sup>83</sup> Bomba, P., (2002). Principles of Assessment and Management of Elder Abuse; NSW Elder Abuse Helpline & Resource Unit (EAHRU), (2016). Identifying and Responding to the Abuse of older people; the 5-step approach.

## Specific Indicators for Each Form of Violence<sup>84</sup>

<h3>Financial Abuse</h3> <ul style="list-style-type: none"> <li>→ Unexplained disappearance of belongings</li> <li>→ Unauthorised use of banking and financial documents</li> <li>→ Inability to pay bills</li> <li>→ Significant bank withdrawals</li> <li>→ Change to Wills</li> <li>→ Inability of a person to access bank accounts or statements</li> <li>→ Stockpiling of unpaid bills</li> <li>→ Insufficient food in the fridge</li> </ul>	<h3>Neglect</h3> <ul style="list-style-type: none"> <li>→ Inadequate clothing; complaints by the person of being too cold or too hot</li> <li>→ Poor personal hygiene; unkempt appearance</li> <li>→ Lack of medical or dental care</li> <li>→ Injuries that have not been properly cared for</li> <li>→ Absence of required assistive technologies</li> <li>→ Exposure to unsafe, unhealthy or unsanitary conditions</li> <li>→ Unexplained weight loss; dehydration; and malnutrition</li> <li>→ Poor skin integrity, e.g. pressure sores</li> </ul>
<h3>Emotional/Psychological Abuse</h3> <ul style="list-style-type: none"> <li>→ Feelings of helplessness, shame and powerlessness</li> <li>→ Changes in levels of self-esteem</li> <li>→ Sadness or grief at the loss of important relationships</li> <li>→ Depressions, withdrawal or listlessness due to a lack of social interaction</li> <li>→ Worry or anxiety after a visit by a specific person</li> <li>→ Confusion, agitation and social withdrawal</li> <li>→ Unexplained paranoia or excessive fear and anxiety</li> <li>→ Disrupted appetite or sleep patterns</li> </ul>	<h3>Physical Abuse</h3> <ul style="list-style-type: none"> <li>→ Internal or external injuries (sprains; dislocations and fractures; pressure sores; unexplained bruises or marks on the body; pain on touching or injuries at different stages of healing)</li> <li>→ Broken or healing bones</li> <li>→ Lacerations to mouth, lips, gums, eyes or ears</li> <li>→ Missing teeth and eye injuries</li> <li>→ Evidence of hitting, punching, shaking or pulling (e.g. bruises, lacerations, choke marks, hair loss or welts)</li> <li>→ Burns (e.g. rope, cigarettes, matches, iron, or hot water)</li> <li>→ Discrepancies between an injury and the explanation of how it happened</li> </ul>
<h3>Sexual Abuse</h3> <ul style="list-style-type: none"> <li>→ Unexplained STD or incontinence (bladder or bowel)</li> <li>→ Injury and trauma (scratches, bruises, etc.) to face, neck, chest, abdomen, thighs or buttocks. Trauma including bleeding around the genitals, chest, rectum or mouth</li> <li>→ Torn or bloody underclothing or bedding</li> </ul>	<h3>Institutional Abuse</h3> <ul style="list-style-type: none"> <li>→ Repeated or regular abuse in any institutional environment where service users are engaged with professionals (outside their own home)</li> <li>→ Unsafe or unsanitary living conditions</li> <li>→ Overcrowding, leading to compromised privacy and dignity</li> </ul>

<sup>84</sup> NSW Elder Abuse Helpline & Resource Unit (EAHRU), (2016). Identifying and Responding to the Abuse of Older People; the 5-Step Approach.; Perttu, S., Laurola, H., Blank, K., Solohub, O., & Lind, M., (2020). *How to Identify and Support Older Victims of Abuse A training handbook for professionals, volunteers and older people*. TISOVA Project. Available at: [https://kakopoiisi.gr/wp-content/uploads/2023/05/02\\_TISOVA\\_Training-handbook\\_ENG.pdf](https://kakopoiisi.gr/wp-content/uploads/2023/05/02_TISOVA_Training-handbook_ENG.pdf).

- Human bite marks
- Difficulty walking, sitting or pain when toileting
- Anxiety around the perpetrator and other psychological symptoms
- Fear of being touched

- Absence of recreational or social activities, leaving residents isolated and unstimulated
- Lack of staff training on specific needs of older people, including gender-sensitive approaches

Figure 4: Specific Indicators for the different forms of violence and abuse

## 6.2.2 Step 2 Assessment/ Support Provision

The professional needs to understand the survivor’s situation, difficulties and problems and identify immediate needs to ensure the maximisation of her safety. Therefore, determination of the level and urgency of safety is identified as a priority. Risk factors regarding both, the older woman and the possible perpetrator, need to be evaluated based on the regularly used Risk Assessment Tool. The professional needs to provide emotional support to her and needs to give her information regarding the procedure, especially in case of an emergency.

### 1. Provide Support

- Listen to the older woman.
- Acknowledge what she tells you.
- Validate her experience.

### 2. Assessment to Identify Problems and Needs <sup>85</sup>

History:	Psychological History:	Results of abuse against older women:
<ul style="list-style-type: none"> <li>→ Comorbid medical and surgical conditions.</li> <li>→ Cognitive status: mentally retarded, developmentally disabled, Alzheimer’s. Disease &amp; related memory disorders.</li> <li>→ Functional status: ADL’s &amp; performance status.</li> <li>→ Trajectory of decline in status.</li> </ul>	<ul style="list-style-type: none"> <li>→ Depression, anxiety, PTSD, suicide risk.</li> <li>→ Longstanding relationship problems between victim and perpetrator.</li> <li>→ Quality of life.</li> <li>→ Caregiving and social support.</li> <li>→ Financial resources.</li> </ul>	<ul style="list-style-type: none"> <li>→ Unnecessary suffering, injury, pain, decreased quality of life, loss or violation of human rights.</li> </ul>

<sup>85</sup> Bomba, P., (2002). Principles of Assessment and Management of Elder Abuse

→ Medication history & compliance.  
 → Alcohol & Substance use.  
 → Vague references to sexual advances.  
 → Past neglect, abuse or DV  
 → Order and evaluate appropriate diagnostic labs & X-rays.

→ Patient, family, and caregiver's cultural and spiritual beliefs.

### 3. Risk Assessment

Professionals need to identify and evaluate the risk factors and red flags that put older women at risk. To do this, they need to use the Risk Assessment Tool, which they already use. Additionally, the MARVOW 2.0 Risk Factor Checklist, developed for this project, should be used as a standardised tool whenever a woman affected by violence is over 60 years old.

The MARVOW 2.0 Risk Factor Checklist is a complementary instrument designed to work with other established RA framework tools and methodologies. It is not intended to function as a standalone tool, but rather as part of a comprehensive approach to risk assessment. This integration ensures a more holistic understanding of risks, particularly in complex and dynamic environments where multiple factors need to be considered.

The MARVOW 2.0 outputs feed into broader assessments, enriching them with context-specific insights and ensuring alignment with organisational objectives.

Some risk factors for older women that should be taken into consideration are:<sup>86</sup>

- Social isolation.
- Confused about their property, belongings and/or surroundings.
- Vulnerable to other persons taking advantage of them because of deteriorating health, cognitive decline, dementia, and capacity issues.
- Physically or verbally violent/aggressive because of progressively worsening conditions such as dementia.
- A history of family dysfunction, domestic and family violence and abuse.

<sup>86</sup> NSW Elder Abuse Helpline & Resource Unit (EAHRU), (2016). Identifying and Responding to the Abuse of older people; the 5-step approach.

- Insecure accommodation.
- Substance abuse and gambling.
- Financial difficulties.
- Personality and/or behaviour changes due to illness and/or other progressively worsening condition/s.
- Relative powerlessness because of diminished ability to advocate effectively for themselves or to modify their environment.
- Experience of (often unreported) DV for many years.
- Cultural issues and dependency, e.g. for all financial and communication matters.

Some of the risk factors for people who abuse older people that should be taken into consideration are:

- Domestic and family violence involving violent, abusive, or intimidating behaviour carried out by a partner, carer, or family member to control, dominate, or instil fear.
- Carers and family members play a crucial role in caring for older people and while not all perpetrators of abuse are carers, carers may become abusive in certain situations.
- Cultural/settlement issues (multiple carers, over-dependency, and lack of understanding of resources, services and systems, refugee background, isolation from cultural activities or interaction).
- Other variables such as mental health, a history of drug and alcohol abuse, gambling, or other behaviours.

### 6.2.3 Step 3 Referral to the Case Management Meeting

The agency that identified the case refers it to the Case Management Meeting coordinator and all professionals involved are being informed. Support is being provided to the victim by the VSS or other agency and further risks and fears, as well as resources and strengths are being identified.

### 6.2.4 Step 4 Research

All agencies receive a Case Management Meeting agenda and discuss all cases on the agenda. Other professionals involved are being contacted to gain further information, explaining the purpose of the

meeting. VSS represents the victim – having obtained her consent-, having all the background information required. During this phase, the MARVOW 2.0 Case Management Tool is being used in order to assist participating professionals to address the cases, in terms of a coordinated multi-agency cooperation.

### 6.2.5 Step 5 Case Action Plan/Management

If no immediate danger exists, then the professional needs to advise and discuss with the older woman and arrange a follow-up. Depending on the role of the professional, a referral may be necessary to social services to advise older women. (ANNEX: Case Management Tool). Inform the Case Coordinator and organise the appropriate referral (Step 3).

The professional needs to obtain the informed consent of the older woman: <sup>87</sup>

- Explain the case management.
- Explain confidentiality.
- Explain client information.
- Explain older women's/survivor's rights.

However, when an emergency arises, informed consent is not necessary. In case of an emergency a professional needs to act <sup>88</sup>:

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<sup>87</sup> Anami, G., Farhat, A., Mortada, Z., (2021). Remote GBV Case Management during Emergencies; Guidelines for GBV Case Workers.

<sup>88</sup> NSW Elder Abuse Helpline & Resource Unit (EAHRU), (2016). Identifying and Responding to the Abuse of older people; the 5-step approach.

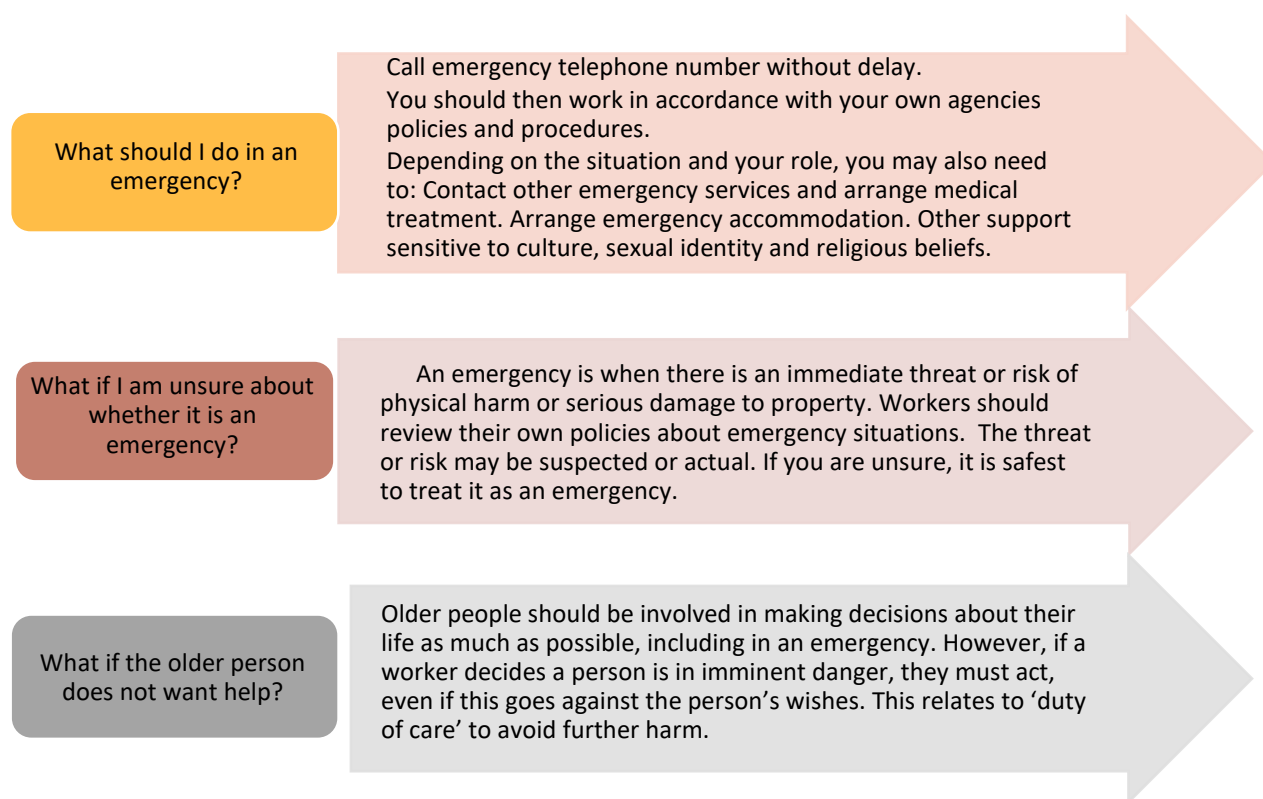


Figure 5 What to do in case of an emergency?

## 6.2.6 Step 6 Inform the Older Women and Make an Appropriate Referral <sup>89</sup>

The professional needs to ensure that the older woman is informed about her options and the procedures. They need to ask her what she wants to do about the situation and in case the older person lacks capacity, the professional should include the substitute decision-maker (if this person is not the abuser) in the conversation. The referral options need to be discussed and the professional needs to conclude and make the appropriate referrals (see 5.3. Flows among professionals). In case

<sup>89</sup> NSW Elder Abuse Helpline & Resource Unit (EAHRU), (2016). Identifying and Responding to the Abuse of older people; the 5-step approach

the older woman refuses assistance, the professional needs to respect that and leave information (if safe to do so) and keep the lines of communication open.

### 6.2.7. Step 7 Case Follow-up

The professional needs to ensure procedures are in place for coordination and/or monitoring, and follow-up as required. Follow-up is important to assist older women to feel connected and not alone. The follow-up will create the possibility of discussing again with her and allow her to feel more comfortable and express herself. The professional needs to ensure that the older woman has incorporated the action plan, to schedule the next meetings and re-assess her safety.<sup>90</sup>

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<sup>90</sup> Anami, G., Farhat, A., Mortada, Z., (2021). Remote GBV Case Management during Emergencies; Guidelines for GBV Case Workers

## 7. Case Study

Case study regarding the implementation of the Manual and the coordinated Multi-agency Meetings and operation.

### Common Case

Ellen is a 72-year-old woman. She has been a widow for many years and lives alone with her son, George, who is 49 years old. George has been diagnosed with schizophrenia and is now under medication. His mother, Ellen, has taken full care of him, trying to provide him with everything and "avoid clinic hospitalisations", despite the long-term psychological and verbal abuse she is suffering. More specifically, his son shouts at her, calls her names, underestimates, blames and threatens her by saying "you are useless and an idiot; you are responsible for my illness - you had always been a bad mother and you are going to pay for this; you deserve suffering, and I will punish you and leave you alone to die". Mrs Ellen is also physically victimised by her son. She has several health issues and receives disability allowance, as 3 years ago in a tantrum of her son, George hit her so hard that she lost her ability to see out of one eye. George has many episodes in which he becomes very violent and beats his mother. In the later one, he attempted to run her over with his car, also destroying the entire yard of the house. Then, George was arrested –after his mother called the police, being both frightened for her and anxious about him- and all legal actions were taken. At first, he was imprisoned, but then, due to his psychiatric issues, he was moved to a psychiatric hospital, where he remained for a one-month period in order to get stabilised. On leaving, he returned again to the house where he lives with his mother. George has been appointed by the prosecutor's office to receive his treatment, visiting the local hospital accompanied by the police. He does it himself many times and on his own. Due to his imprisonment and mental health issues, he can't find a job, and Ellen feels guilty for his condition and for putting him in prison –even indirectly-. For this reason, although she has disclosed that the abuse hasn't stopped, she is very reluctant to hear about victim support services or legal aid.

Ellen receives specialised help from "House Social Services" and speaks to the Social Worker, expressing her distress and love for her son, justifying his aggressiveness and for whom she feels she must endure and help, as she is the only person he has. She claims that prison and medication have

helped him a lot and he is not violent anymore. However, the “House Social Services” staff often sees several things broken in the house during their visits, but Ellen always finds a way to justify what they observe (“I fell down, and I broke them because I can’t see very well”). Still, there are times when she changes the staff visits by giving various excuses. A few days ago, the Emergency Police Department received a call from a ‘third individual’ (witness) reporting violence at Ellen's home (e.g. shouts, threats, cries and things being hit and broken). Police arrived at the home, but nobody opened the front door. The next day, Ellen reported to the police that she was not even in the house. The same day, she asked the “House Social Services” staff to change their appointment. At the next appointment, three days later, the staff of the “House Social Services” found her quite depressed and sleepy/ catatonic, while they observed some bruises on her arms, as well as bruises around her neck looking like a struggling attempt, but she claimed that she fell down when waking up. Her vision has deteriorated, and she admitted sleeping many hours due to some changes in her prescribed medication for anxiety and depression, done by her son because she was feeling extremely sad, and she was crying a lot.

## Case Management

### 1. IDENTIFY ABUSE AND INDICATORS

#### A. Type of abuse and Indicators.

First, professionals should assess the type of abuse the older victim is suffering, taking into consideration all the important indicators by asking questions and gathering information regarding older women’s daily life and (mental and physical) health. To achieve this, warmth, openness and rapport building are required. More specifically, in this case, Ellen is suffering from psychological, verbal, and physical violence for many years, since her son is being aggressive against her and objects in the house. There is evidence of broken things and physical harm at the victim’s body, while in one incident her life was threatened. Moreover, professionals should notice the postponements of the appointments and the deterioration of Ellen’s physical and mental health, as well as the possibility of over-medication. Gathering all information together, it is evident that not only the violence has not stopped –as the victim claims-, but also, she has taken a distance from the Services and professionals supporting her, possibly in an attempt to hide the continuance of the abuse and protect her son.

Regarding indicators, the professional should recognise any possible changes in her daily life, health behaviour and habits; delays between injury or illness and assessment; whether the history of victim and perpetrator differs; implausible or vague explanations, and how the functional impairment of the patient presents with or without the caregiver.

## 1. ASSESSMENT/ PROVISION OF SUPPORT

### A. Needs of the individuals

In regard to the assessment of the needs of the individuals involved in the case, professionals should understand the survivor's situation, difficulties and problems and identify immediate needs to ensure the maximisation of her safety, focusing on the social, health, legal and financial issues, as well as on the system response to them. Special attention should be paid to the isolation and the support system of the individuals, both in social and service context; on the physical/ psychological and economic/ practical dependency issues of both parts on one to another, namely from the mother to the son and vice versa; to the economic, social status and unemployment and the feelings of fear and guilt they are suffering from. The health condition and the disabilities of Ellen, as well as the mental health issues of her son, including his compliance with the medication, need to be assessed. Lastly, his past imprisonment and future legal steps required should be examined, especially in cooperation with the survivor, to ensure her safety and provide him the support he needs, preventing in this way further abuse, escalation of violence and/ or recidivism.

Taking into consideration all the above indicators there are signs, frequent Emergency Department (hospital) visits for illness despite plan of care and adequate resources, as well as lab or X-ray results should be conducted in order to reveal inconsistencies with survivors' history.

### B. Risk Factors – Risk Assessment Tool

As part of the aforementioned steps and the Risk Assessment *per se*, and in terms of the general management of the case, professionals need to investigate social history in order to receive all the required information about their life, strengths and needs, as well as to investigate, the survivor and perpetrator's relationship dynamics, risk factors and living conditions. First of all, it is important to create a framework of openness, empathy and active dialogue, in which Ellen will feel that she can express all her thoughts, acknowledge the current situation and make use of the options available to

her, that meet both, her needs and her interests, fully ensuring her safety and the improvement of her relationship with George.

- **Social History:** In social history, it is important to discuss with the survivor all the information concerning the living conditions, the mental, psycho-emotional, social and economic situation of the beneficiary, as well as possible dependencies of the beneficiary and/or her son. Furthermore, when taking the social history, it is necessary to explain the roles and responsibilities of Ellen and George, the history of past incidents of violence, highlighting the most recent incident of violence against the beneficiary. At the same time, in taking the social history, it is important to explore possible perceptions of the beneficiary and the husband regarding violence, patterns of interaction and the relationship as it develops between them. Finally, the social background highlights possible goals and encourages the free expression of the beneficiary's future vision and how she envisages "the next day".
- More specifically, indicators to be investigated in the Social History:
- Demographic data (e.g. age, number of children, etc.)
  - Physical & Psychological Condition of the survivor and the perpetrator (e.g. previous hospitalizations, medical conditions, etc.)
  - Medication for health and mental health issues; prescribed or not
  - Employment Status, Financial Resources, & Financial Independence
  - Potential Reference Persons & Social Support
  - Start of incidents of violence - last incident of violence - forms of existing violence
  - Previous possible assistance received (if so, where from?) - Possible support from other services and/or institutions
  - Relationship with the perpetrator
  - Family History & Relationship with other family members

### **Risk assessment (the MARVOW 2.0 Risk Factor Checklist & Case Management Tool):**

Risk assessment is important so that professionals can discern the level of risk to which Ellen is exposed in order to take immediate action to ensure her safety. During the risk assessment, specific risk factors are assessed and evaluated, according to which the individualised safety plan is developed. For this to be achieved, the Risk Assessment tool provided in this Manual is required to identify and

evaluate risk factors and red flags that put the older women in danger. In this case study (Ellen’s case) multiple risk factors are present and could be assessed by the use of the corresponding Risk Assessment Tool. For instance, Ellen has a variety of health issues and disabilities, making her more vulnerable. At the same time, she appears to be distinguished by perceptions and stereotypes that discourage her actions. In addition, she seems to deny and reduce the danger of the existing violence. At the same time, George's psychiatric illness and the medication he is taking are another risk factors. In addition, there appear to be several incidents that remain unreported and unrecorded, while at the same time there is deterioration in Ellen's health. There are also barriers for the professionals to get involved, as well as social and economic issues and dependency by both parties.

Below there is an example of a filled in MARVOW 2.0 Risk Factor Checklist based on the content of the Case Study.

RISK FACTOR	AREAS TO EXPLORE	YES / NO / NO INFORMATION AVAILABLE / N.A.	COMMENT ON WHAT RISK FACTOR(S) HAS BEEN OBSERVED BY YOU AS A FRONTLINE PROFESSIONAL	COMMENT ON WHAT RISK FACTOR(S) HAS BEEN REPORTED BY THE OLDER WOMAN	COMMENT ON WHAT RISK FACTOR(S) HAS BEEN REPORTED BY ANOTHER PERSON AND WHOM	COMMENT ON WHETHER THERE IS AN INCREASE IN FREQUENCY AND/OR SEVERITY OF RISK FACTORS OBSERVED OR REPORTED
<b>PSYCHOLOGICAL OR MENTAL HEALTH ISSUES RELATED</b>	<ul style="list-style-type: none"> <li>• Psychiatric treatment, medications</li> <li>• Changes in sleep, appetite, concentration, memory problems or difficulty communicating</li> </ul>	Yes	Depression. More sleepy/ catatonic (reported by Social Worker – Staff of “Help at Home”)	Depression, Anxiety, Symptoms of depression and anxiety (deteriorated – increasing the last period), fear, isolation. Increase of symptoms and prescribed drugs by her son – without	Depression, Anxiety. Psychiatric treatment, medications (reported by her health/ hospital history & the drug prescription). More sleepy/ catatonic (reported by Social Worker –	Increase in severity of depression. More sleepy/ catatonic

				doctor consultation	Staff of "Help at Home")	
<b>FUNCTIONAL DEPENDENCY/ DISABILITY</b>	<ul style="list-style-type: none"> <li>• Poor mobility</li> <li>• Physical impairment, needs for special medical equipment (wheelchair, walker, etc.) or medical products</li> <li>• Changes in vision</li> <li>• Changes in hearing</li> </ul>	Yes	Visual Impairment	Visual Impairment - vision deterioration	Visual Impairment (according to her health/ hospital history)	Vision deterioration
<b>MEDICAL ISSUES</b>	<ul style="list-style-type: none"> <li>• Illness</li> <li>• Lack of medical treatment</li> <li>• Limited access to medical examination</li> <li>• Perpetrator /Carer not reporting serious symptoms or changes in condition</li> </ul>	Yes		The perpetrator hasn't informed the doctors about his mother being more anxious and depressed	Multiple health issues (reported by her health/ hospital history & the drug prescription)	Multiple Health Issues. Perpetrator hasn't informed about changes of prescribed drugs

<b>ENVIRONMENT</b>	<ul style="list-style-type: none"> <li>• Tensed atmosphere in the home</li> <li>• Damaged objects in the victim's home/room</li> </ul>	Yes			Verbal, psychological & physical violence continue and maybe there is an escalation (Social Worker – Staff of “Help at Home” reported bruises on her arms and around her neck looking like a struggling attempt + Witness called the police reporting shouts, threats, cries and things being hit and broken)	Tensed atmosphere in the home. Shouts, cries, threats and objects being hit and broken
<b>HYGIENE AND MEDICAL ASSISTANCE</b>	<ul style="list-style-type: none"> <li>• Use of physical and chemical restraint</li> </ul>	Yes (?) - probably		Increase of and prescribed drugs by her son – without doctor consultation – the victim being more sleepy and catatonic		Increase of and prescribed drugs by her son – without doctor consultation – the victim being more sleepy and catatonic
<b>FINANCIAL DEPENDENCY</b>	<ul style="list-style-type: none"> <li>• Victim does not have access or not able to manage her finances, e.g. pension, other source of income, property rights</li> <li>• Lack of adequate income or finances</li> </ul>	Yes - by the perpetrator		No by the older woman – the son is financially depended on his mother		the perpetrator is financially depended on his mother

<b>FINANCIAL ABUSE</b>	<ul style="list-style-type: none"> <li>• Disappearance of valuable items from the home (jewellery, objects...)</li> <li>• Unpaid bills</li> </ul>	No				
<b>LACK OF SOCIAL/FORMAL SUPPORT FOR THE VICTIM</b>	<ul style="list-style-type: none"> <li>• None or low involvement in social services</li> <li>• Controlled access to phone and electronic devices.</li> <li>• Erosion of bonds between generations in the family</li> <li>• Not close to her children or siblings.</li> <li>• Family does not identify, minimises or justifies the abuse, does not support the older woman in related needs and / or is allied with the perpetrator</li> </ul>	<p>Not Addressed (informal) social support (except from Social Services – “Help at Home”)</p> <p>needs to be assessed</p>				<p>Unwillingness to contact with Victim Support Services. Unwillingness / reluctance to cooperate with the Police</p>
<b>INAPPROPRIATE / INCONVENIENT HOUSEHOLD LIVING ARRANGEMENTS</b>	<ul style="list-style-type: none"> <li>• Shared housing with perpetrator, other family members (no privacy, safety)</li> <li>• Inappropriate conditions (accessibility, special needs)</li> </ul>	Yes				Living with the perpetrator
<b>ADHERENCE TO TRADITIONAL SOCIAL GENDER NORMS</b>	<ul style="list-style-type: none"> <li>• Victim does not recognise/identify the violent behaviour</li> <li>• Victim minimises violence or justifies it as normal</li> <li>• Victim unaware of the situation because it has been going on for a long time</li> <li>• Victim unwilling</li> </ul>	Yes				

	to change anything					
<b>CHANGES IN RELATIONSHIPS</b>	<ul style="list-style-type: none"> <li>• Sudden appearance of a distant relative she vaguely knows who wants to take care of her, live in her home</li> <li>• Sudden appearance of a new friend or romantic interest - this usually happens with the recent death of a spouse/partner</li> </ul>	No				
<b>PERPETRATOR</b> — Can be the partner/husband/younger perpetrator (e.g. sons), member of the family, please specify: Son						
<b>DIFFICULTIES / STRESS ADJUSTING TO AGE RELATED CHANGES</b>	• Stress and/or frustration related to (new) role as care giver (inadequate caring and/or coping skills, etc.)	No				
	• Distress related with dependence, illness, cognitive impairment, etc.	Yes – Mental Health Issues (Schizophrenia)				
	• Frustration of not being able to cope	Needs to be assessed				
	• Distress and or frustration related to retirement (loss of social role, prestige, occupation, etc.)	No				
	• Being at home full time	Yes – Unability to work due to mental health issues and imprisonment.				
	• Loss of driving licence	Needs to be assessed				

<b>ONGOING HISTORY OF PERPETRATING DOMESTIC VIOLENCE</b>	• Previous criminal charges/ convictions					
	• Chroni-fication of the abuse					
<b>LACK OF SOCIAL/ FORMAL SUPPORT FOR THE PERPETRATOR</b>	• No social network (family, friends)					
	• None or low involve- ment in social services (home visits by social workers, regular check-ups, senior care)					
<b>ADDITIONAL RISK</b>	• Weapons or guns in the home	Needs to be assessed				
	• Death threats	Needs to be assessed				

Figure 6: Case study

## 8. Database

The formation of a database for case collection in the limits of this Manual of Operation involves designing a centralised and secure platform that enables efficient tracking, reporting, and analysis of DV cases against older women in the 6 different countries involved. This database serves as a shared resource for all participating agencies, ensuring accountability, improving communication, and facilitating comprehensive case management.

The implementation of a centralised case collection database brings several key benefits. Improved coordination is one of the most significant advantages, as it allows agencies to work more effectively together by accessing up-to-date case information. This ensures that all stakeholders, from victim support services to law enforcement, are aligned in their responses and can collaborate seamlessly. Enhanced survivor support is another critical benefit, as the database enables consistent and timely interventions. Survivors are more likely to receive the help they need when case details are readily available and shared among relevant agencies. The system also promotes accountability by tracking the actions taken by each agency, helping to identify any gaps in response and ensure that all parties fulfil their responsibilities. Finally, the database supports data-driven policy making, providing valuable evidence that can be used to shape more effective policies and allocate resources where they are most needed. This data can guide decisions about service provision, highlight trends, and ensure that interventions are based on real-world information.

Case	Health	Age	Country	Relation to Perpetrator	Situation	Type of Violence	Substance Use	Onset	Living situation	Support	Risk High/M/Low	Previous conviction	Agencies involved	Barriers or gaps
Please provide only the name of the survivor	Please describe the health situation	Please provide the age of the survivor		Please provide the relationship with the partner	Please describe briefly the situation	Please provide the type of violence	Please provide information related to substance use	Please provide when the violence started	Please describe the living situation	Please provide who supports the women	Please provide the level of the risk	Please provide whether there is any previous conviction for the perpetrator	Please provide all the agencies involved	Please describe briefly the barriers and gaps in the case management

Figure 7: Case collection data base



The core features of the case collection database are designed to ensure effective case management and coordination among agencies. The data collection fields are comprehensive, capturing essential details such as survivor's information (age, gender, nationality, health and mental health status, and support needs), perpetrator details (relationship to the survivor, and history of violence), issues related to both of them (living, financial situation, substance abuse) and incident information (nature of abuse, severity, frequency, and location, agencies involved, etc.). Additionally, the database tracks interventions provided, such as counselling, legal assistance, and housing support, along with any referrals made and the outcomes achieved. It also records the agencies involved, documenting their actions and follow-ups to ensure coordination and accountability.

## 9. Annex



### Risk Factor Checklist for cases of violence against older women

This Checklist was established within the Coordinated Multi-Agency Response to Violence against Older Women European project (MARVOW 2.0). Its aim is to support frontline professionals in assessing age-specific risk factors in cases of violence against older women (60+). It is to be used alongside pre-existing domestic violence risk assessment tools. Please note that it is not suitable for individuals with severe cognitive impairment or psychiatric conditions.

#### ■ STEP 1. COMPLETE YOUR USUAL RISK ASSESSMENT TOOL

The first step is screening for violence with pre-existing specifically designed tools, e.g. your usual risk assessment tool.

If a high risk case is identified in Step 1, proceed directly to Step 3.

#### ■ STEP 2. COMPLETE THE MARVOW 2.0 RISK FACTOR CHECKLIST

Name and capacity of frontline professional completing the checklist:

Identification of the woman (name, age, situation, any relevant details, in line with Data protection):

Name of the pre-existing risk assessment tool used:

Date and place of completing the MARVOW2.0 Risk Factor Checklist:

Timeframe:

RISK FACTOR	AREAS TO EXPLORE	YES	NO	no information available	not assessed - N/A	Comment on what risk factor(s) has been observed by you as a frontline professional	Comment on what risk factor(s) has been reported by the older woman	Comment on what risk factor(s) has been reported by another person and whom	Comment on whether there is an increase in frequency and/or severity of risk factors observed or reported
PSYCHOLOGICAL OR MENTAL HEALTH ISSUES AGE-RELATED	<ul style="list-style-type: none"> <li>Psychiatric treatment, medications</li> <li>Changes in sleep, appetite, concentration, memory problems or difficulty communicating</li> </ul>								
FUNCTIONAL DEPENDENCY/ DISABILITY	<ul style="list-style-type: none"> <li>Poor mobility</li> <li>Physical impairment, needs for special medical equipment (wheelchair, walker, etc.) or medical products</li> <li>Changes in vision</li> <li>Changes in hearing</li> </ul>								
MEDICAL ISSUES	<ul style="list-style-type: none"> <li>Illness</li> <li>Lack of medical treatment</li> <li>Limited access to medical examination</li> <li>Perpetrator/carer not reporting serious symptoms or changes in condition</li> </ul>								
ENVIRONMENT	<ul style="list-style-type: none"> <li>Tensed atmosphere in the home</li> <li>Damaged objects in the victim's home/room</li> </ul>								
HYGIENE AND MEDICAL ASSISTANCE	<ul style="list-style-type: none"> <li>Use of physical and chemical restraint</li> </ul>								
FINANCIAL DEPENDENCY <sup>1</sup>	<ul style="list-style-type: none"> <li>Victim does not have access or not able to manage her finances, e.g. pension, other source of income, property rights</li> <li>Lack of adequate income or finances</li> </ul>								

1 "Financial independence requires financial ability, reflecting financial literacy and self-efficacy, combined with financial resources (financial capability) and decision-making power and control over those resources. Financial independence is noted to provide individuals with the resources, opportunities and agency to lead fulfilling lives, irrespective of their background or identity." cf. [https://eige.europa.eu/newsroom/news/whats-gender-equality-got-do-financial-independence?language\\_content\\_entity=en](https://eige.europa.eu/newsroom/news/whats-gender-equality-got-do-financial-independence?language_content_entity=en) p.20

RISK FACTOR	AREAS TO EXPLORE	YES	NO	no information available	not assessed - N/A	Comment on what risk factor(s) has been observed by you as a frontline professional	Comment on what risk factor(s) has been reported by the older woman	Comment on what risk factor(s) has been reported by another person and whom	Comment on whether there is an increase in frequency and/or severity of risk factors observed or reported
FINANCIAL ABUSE	<ul style="list-style-type: none"> <li>Disappearance of valuable items from the home (jewellery, objects...)</li> <li>Unpaid bills</li> </ul>								
LACK OF SOCIAL/ FORMAL SUPPORT FOR THE VICTIM	<ul style="list-style-type: none"> <li>None or low involvement in social services</li> <li>Controlled access to phone and electronic devices</li> <li>Erosion of bonds between generations in the family</li> <li>Not close to her children or siblings</li> <li>Family (especially children) does not identify, minimises or justifies the abuse, does not support the older woman in related needs and / or is allied with the perpetrator</li> </ul>								
INAPPROPRIATE/ INCONVENIENT HOUSEHOLD LIVING ARRANGEMENTS	<ul style="list-style-type: none"> <li>Shared housing with perpetrator, other family members (no privacy, safety)</li> <li>Inappropriate conditions (accessibility, special needs)</li> </ul>								
ADHERENCE TO TRADITIONAL SOCIAL GENDER NORMS	<ul style="list-style-type: none"> <li>Victim does not recognise/identify the violent behaviour</li> <li>Victim minimises violence or justifies it as normal</li> <li>Victim unaware of the situation because it has been going on for a long time</li> <li>Victim unwilling to change anything</li> </ul>								

RISK FACTOR	AREAS TO EXPLORE	YES	NO	no information available	not assessed - N/A	Comment on what risk factor(s) has been observed by you as a frontline professional	Comment on what risk factor(s) has been reported by the older woman	Comment on what risk factor(s) has been reported by another person and whom	Comment on whether there is an increase in frequency and/or severity of risk factors observed or reported
<b>CHANGES IN RELATIONSHIPS</b>	<ul style="list-style-type: none"> <li>Sudden appearance of a distant relative she vaguely knows who wants to take care of her, live in her home</li> <li>Sudden appearance of a new friend or romantic interest – this usually happens with the recent death of a spouse/partner</li> </ul>								
<b>PERPETRATOR – Can be the partner/husband/younger perpetrator (e.g. sons), member of the family, please specify:</b>									
<b>DIFFICULTIES / STRESS / ADJUSTING TO AGE RELATED CHANGES</b>	<ul style="list-style-type: none"> <li>Stress and/or frustration related to (new) role as care giver (inadequate caring and/or coping skills, etc.)</li> <li>Distress related with dependence, illness, cognitive impairment, etc.</li> <li>Frustration of not being able to cope</li> <li>Distress and or frustration related to retirement (loss of social role, prestige, occupation, etc.)</li> <li>Being at home full time</li> <li>Loss of driving licence</li> </ul>								
<b>ONGOING HISTORY OF PERPETRATING DOMESTIC VIOLENCE</b>	<ul style="list-style-type: none"> <li>Previous criminal charges/convictions</li> <li>Chronification of the abuse</li> </ul>								
<b>LACK OF SOCIAL/ FORMAL SUPPORT FOR THE PERPETRATOR</b>	<ul style="list-style-type: none"> <li>No social network (family, friends)</li> <li>None or low involvement in social services (home visits by social workers, regular check-ups, senior care)</li> </ul>								
<b>ADDITIONAL RISK</b>	<ul style="list-style-type: none"> <li>Weapons or guns in the home</li> <li>Death threats</li> </ul>								

### STEP 3. MANAGE RISK

- If high or extreme immediate risk is identified (i.e. possession of weapons or guns, death threats), take immediate action for the protection of the older women, including calling the police and/or relevant services in your context.
- If the risk factors identified in the MARVOW 2.0 checklist (in combination with the result of the standard risk assessment from pre-existing tools) indicate a level of risk, proceed with the MARVOW 2.0 case management tool.
- Ensure that all cases are closely monitored through the multi-agency protocol and therefore the case management tool.
- Follow-up assessments should be carried out to monitor fluctuations in risk – as risk is dynamic and can change rapidly.

Deliverable 2.2: MARVOW 2.0 Risk Assessment Methodology and Risk Assessment Development Tool

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