

Hampshire

Domestic  buse

Forum

"The false barriers between elder abuse, vulnerable adults and particularly domestic violence should be removed to ensure greater joint working across all agencies and sectors, both statutory and non statutory."

(Action on Elder Abuse, 2007)

Domestic Abuse & Safeguarding Adults

A discussion paper investigating the links between domestic abuse and safeguarding vulnerable adults in Hampshire and implications for practice and strategic development.

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1. PURPOSE

- 1.1. The purpose of this report is to investigate the links around vulnerable adults, safeguarding adults procedures and domestic abuse.

It aims to:

- Inform practice and strategy
- Assist in decisions as to appropriate responses to situations which include elements of domestic abuse and of safeguarding vulnerable adults from abuse.
- Link domestic abuse and safeguarding adults strategies / boards / groups into broader crime and disorder and health and wellbeing agendas.

2. INTRODUCTION: WHAT IS DOMESTIC ABUSE?

- 2.1. **Domestic abuse is a term that is used to describe a wide range of violent and abusive behaviours.** These include many forms of physical violence (biting, kicking, punching, beating etc) but also include many forms of sexual abuse (including rape), emotional and psychological abuse (including threats and intimidation, humiliation, isolation, belittling and constant criticism) and other varieties of abuse such as financial control and deprivation.

- 2.2. **Domestic abuse is a crime that primarily affects women.** One woman in four experiences domestic abuse at some stage in her life and it is estimated that one in ten women experience domestic abuse in any one year (Home Office, 2000). Women aged 16-29 years are the age group at greatest risk of domestic abuse (British Medical Association, 1998) and pregnancy is a time of increased risk. However, domestic abuse is something that affects all ages and all classes of women, and which has devastating physical and psychological consequences for those who are its victims. For example, British homicide statistics tell us that two women are killed every week by their current or former partner. Of these, one has already sought to escape their violent partner only to be pursued and ultimately killed by them. Indeed the number of female homicides that can be attributed to domestic abuse can range from 1 in 2 to 1 in 3 each year. The number of men killed by their partners or ex-partners is approximately 1 in 12.

- 2.3. **Domestic abuse is a crime that can affect men.** During the British Crime Survey of 1996, for example, fifteen percent of men aged 16-59 said they have been physically assaulted by a current or former partner at some point in their lives. As the government researchers employed on this survey pointed out, however, a deeper analysis of the data offered revealed some important differences in the violence used by women and men in their intimate relationships. In terms of purpose, for example, women's violence against men was reported to be largely reactive and protective, rather than pro-active and offensive. In terms of its nature, the violence that women used against their partners was also less likely to result in injury, less likely to result in the need for medical treatment. In terms of

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consequences, very few men reported being afraid of their partners; a finding that may explain why it is women, not men, who seek refuge in safe houses and why it is women, not men, that come to the attention of crisis intervention services such as the police and the local A&E department.

2.4. The definition of domestic abuse adopted by The Hampshire Domestic Abuse Forum (HDAF) seeks to acknowledge these differences and states that:

Domestic abuse is any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. This includes issues of concern to black and minority ethnic (BME) communities such as so called 'honour based violence', female genital mutilation (FGM) and forced marriage (FM). Domestic abuse frequently co-exists with child abuse.
(HDAF definition, 2009)

This definition can be broken down and expanded on as follows:

<i>Any incident of threatening behaviour, violence or abuse</i>	This can also involve the misuse of power and control
<i>(psychological, physical, sexual, financial or emotional)</i>	Also, movement restriction and imposition of social isolation. It is most commonly a combination of all of these.
<i>between adults</i>	An adult is defined as any person aged 18 years or over
<i>who are or have been intimate partners or family members,</i>	Family members are defined as mother, father, son, daughter, brother, sister, and grandparents, whether directly related, in laws or stepfamily
<i>regardless of gender or sexuality</i>	Also, age, race, wealth, and geography
<i>This includes issues of concern to black and minority ethnic (BME) communities such as so called 'honour based violence', female genital mutilation (FGM) and forced marriage (FM).</i>	Also, other groups such as older people, men, same-sex relationships and people with disabilities
<i>Domestic abuse frequently co-exists with child abuse.</i>	And should always be considered as a child protection issue.

2.5. This definition is not intended to deny the existence of other forms of relationship violence such as abuse of men by woman or abuse within lesbian and gay relationships. The forum believes that everyone experiencing abuse regardless of gender, sexuality, ethnicity, ability or age deserves respect, understanding and support. They also believe that we have to deal with the facts, as we know them today.

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3. WHAT EVIDENCE IS THERE THAT DOMESTIC ABUSE AFFECTS VULNERABLE GROUPS?

3.1. Introduction

The broad definition of a vulnerable adult referred to in the 1997 Consultation Paper *'Who Decides?'*, issued by the Lord Chancellor's Department is someone who: *'is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'*.

3.2. Vulnerability is not a rigid concept, however, and in considering whether safeguarding adults procedures should be used in an individual case, staff are generally advised to assume relevance unless and until the information collected suggests that this is not the case.

3.3. Such a presumption in favour of relevance should also hold true in relation to domestic abuse. **If one or both adults involved can be regarded as a vulnerable adult(s) as defined above and/or by the definition of a vulnerable adult then the safeguarding procedures should be used.** If vulnerability, as defined above or by the safeguarding definition, is not involved then these guidelines will not normally apply.

3.4. If safeguarding adults procedures are to be implemented, the Lead Officer must ensure that there is appropriate representation from the field of domestic abuse at all necessary meetings during the investigation. Joint working with professionals in the field of domestic abuse during safeguarding adults investigations will be crucial to the investigative process and to the outcome of the investigation itself. All avenues open to the victim and/or the perpetrator will need to be fully explored and this can be accomplished most successfully using the advice and information from a trained professional in the area of domestic abuse.

3.5. Research into both the presence and the impact of domestic abuse on people who are vulnerable by virtue of mental ill health, disability, age etc. is still in its infancy, but even a cursory look at some of the general factors that increase vulnerability to violence and abuse can begin to highlight the connections that can and should be made. These factors include:

- **Being chosen by a perpetrator to be a target of their abusive behaviour**
- **Having been victimised by the perpetrator before (repeat victimisation)**
- **Lack of information about and/or experience of exercising one's human rights**
- **Lack of information about or access to sources of protection and support**
- **Being dependent upon others for basic needs being met – e.g. for money, care, equipment, practical tasks etc.**
- **Being subject to discrimination on any grounds – e.g. race, sex, sexuality, disability, mental health, age**
- **Discrimination that means it is assumed that you do not tell the truth**

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- **Discrimination that means that it is unimportant that you are abused or unacceptable for others to intervene**
[R. Ingram, 2002]

3.6. In addition, research in 2007 (O'Keefe et al.) into the abuse and neglect of older people highlighted a considerable number of factors that inherently link the abuse and neglect that some vulnerable adults are experiencing to domestic abuse. This was not only demonstrated by the types of abuse (psychological, physical, sexual and financial abuse) people were subjected to, but also by the vast majority of 'victims' being abused by either a partner, spouse or family member, which is in keeping with the definitions and nature of domestic abuse.

3.7. **Links between domestic abuse and vulnerable adults who may be the subject of safeguarding adults investigations.**

There is a significant body of research which clearly indicates ways in which the impact of domestic abuse may result in the "victim" becoming a "vulnerable adult" (particularly in the context of mental health). Given that this is true it is clear that significant numbers of domestic abuse victims are vulnerable adults and vice versa. This demonstrates the importance of joined up thinking and practice across the two disciplines of "domestic abuse" and "safeguarding adults".

In this context it is important to:

- Draw on knowledge and expertise from both disciplines
- Raise awareness of the need to practice in ways which avoid retraumatisation and mitigate against the risk of mental illness (including ensuring involvement in social networks; building self esteem; attention to environmental factors).

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4. LINKS BETWEEN DOMESTIC ABUSE & VULNERABILITY IN A MENTAL HEALTH CONTEXT

VICTIMS OF ABUSE & MENTAL HEALTH

- 4.1. **An individual's mental health can be affected by their exposure to violence and abuse.** Indeed, there is now a relatively substantial body of research which links women's experience of child sexual abuse and domestic abuse with long term mental illness and also with physical and sexual health problems. This research suggests that violence and abuse against girls and women is more common than is generally realized, can have a significant impact on physical and mental health, and is often not disclosed (Dept of Health, 2002).
- 4.2. In its investigation of domestic abuse as a health care issue, for example, the British Medical Association (BMA) noted that there *'...is little doubt that psychiatric illness, particularly PTSD, depression and anxiety is greater among women who have experienced domestic violence compared to those that have not'* (BMA, 1998, p31). In relation to domestic abuse, common features associated with Post Traumatic Stress Disorder include anxiety, fear, flashbacks, nightmares, sleeplessness, exaggerated startle responses, difficulty in concentrating and feelings of shame, despair and hopelessness.
- 4.3. In exploring the impact of abuse, Stark and Flitcraft (1996) also found that victims of domestic abuse were 15 times more likely to **abuse alcohol**, 9 times more likely to **abuse drugs**, 3 times more likely to be **diagnosed as depressed or psychotic** and 5 times more likely to **attempt suicide**. They also found that 1 in 7 victims were institutionalized in psychiatric hospitals or received a psychiatric referral, yet no incidence of domestic abuse was recorded on their referral notes.
- 4.4. There seems little doubt, therefore, that **domestic abuse is a risk factor associated with mental ill health**; but it is one that has traditionally been neglected in mainstream research. For example, the research exploring the impact of (other) risk factors has demonstrated that there is **a clear link between social isolation and mental ill health**. It has also demonstrated that women are more vulnerable to social isolation than men because of higher levels of poverty, lone parenthood, lack of mobility and longer life expectancy (DoH, 2002). What is less frequently acknowledged, however, is that isolation is a common control strategy exercised by abusive partners who seek to limit their partner's involvement with those who might seek to challenge the abuse and/or support the victim.
- 4.5. The same is true of the **well-established link between sexual violence and mental ill health**. Findings from the British Crime Survey 2000 indicated that around 1 in 10 women have experienced some form of sexual victimisation, including rape, and approximately three quarters of a million women have been raped on at least one occasion. In this context, however, it is important to note that 'strangers' are only responsible for approximately 8% of rapes. Women are most likely to be sexually attacked by men they know, including current and ex partners. This risk factor also has clear links to domestic abuse.

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- 4.6. Research into the various **protective factors** that can mitigate against the risk of mental ill-health is in its infancy, but the role of family ties, positive parenting experiences, social networks, self-esteem and environmental factors (such as housing) are all seen to play a part in protecting an individual's mental health. In this context, however, it is important to note that a woman who is being controlled by a violent or abusive partner will find their ability to maintain family ties, to parent how they want, to develop social networks and to maintain their self-esteem severely impaired. They will also experience difficulties engaging with mental health practitioners and their therapeutic interventions whilst sharing a home with their abuser.

RESEARCH BASED IMPLICATIONS FOR PRACTICE

- 4.7. Indeed, research into the needs of women who are experiencing mental ill health as a result of ongoing domestic abuse have highlighted a series of issues and a series of demands for the future. These are outlined by the Department of Health (2002) and include the demand for services that:
- **Place importance on the underlying causes and context of women's distress in addition to their symptoms** – research suggests that women using mental health services often have histories of violence and abuse in child and/or adulthood. Although many of the studies are small, figures of over 50% are not unusual. In secure settings this figure is even higher. In contrast, however, the level of awareness of violence and abuse appears low amongst mental health professionals. As a result, women are rarely asked about such histories, an omission that can:
 - a) Reinforce their belief that they should keep their abuse hidden
 - b) Leave a significant factor affecting both their mental health and their ability to recover unexplored
 - c) Allow practitioners to unwittingly engage in practices that retraumatise rather than help the victim of abuse (DOH, 2002).
 - **Promote empowerment, choice and self-determination** – when asked, women who have experienced mental ill health as a result of domestic abuse express an overwhelming sense of 'not being listened to'. They feel that their life experiences, views and needs have not been validated. Women say medication is often the only option on offer with little information about side effects. In contrast, they want greater access to 'talking treatments', complementary therapies and opportunities to learn new strategies and develop new skills. They also highlight the importance of being able to choose the gender of their key worker, doctor and/or therapist, to access women only therapy groups and social activities and to develop '*sensitive, appropriate relationships*' with staff committed to partnership (DOH, 2002).
 - **Address women's wider fears and concerns** – the DoH (2002) also underlines the need to explore a victim's fears regarding their:

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- a) **Parenting or caring responsibilities** - since the real or anticipated loss of their children, for example, may lead many to avoid seeking help or to underplay their symptoms
- b) **Level of social and economic support** - since addressing such needs can be a prerequisite for engaging some service users who can see no alternative to living with their abusive partner
- c) **History of substance abuse** - because many victims hide their addiction, due to social stigma and/or fear of loss of children
- d) **Fears regarding professional intervention** - especially where an individual's race, disability or age, for example, may lead to fears regarding stigmatisation or institutionalization
- e) **The level of risk they face as well as pose** - since intervention should reduce rather than enhance risk to a victim of abuse

PERPETRATORS OF ABUSE & MENTAL HEALTH

- 4.8. Under the Domestic Violence, Crime and Victims Act 2004 victims of certain sexual and violent offenders have certain rights to receive information over the course of the offender's sentence and to make representations about any conditions to which the offender should be subject on release.
- 4.9. These rights have applied since 1 July 2005 to victims of offenders who are detained in hospital under Part 3 of the Mental Health Act 1983 (the 1983 Act) and who are subject to special restrictions (restricted patients), including those who have been conditionally discharged.
- 4.10. From 3 November 2008, these rights were extended to victims of offenders detained in hospital under Part 3 of the 1983 Act who are not subject to special restrictions (unrestricted patients), including those who are then discharged from hospital onto supervised community treatment (SCT).
- 4.11. To enable victims to exercise those rights, there are new statutory duties on:
 - providers of probation services to identify eligible victims and, with their consent, to pass on their details to hospital managers;
 - hospital managers to give information to victims and to pass on any representations they make;
 - responsible clinicians to inform hospital managers if they are considering discharging relevant unrestricted patients and if they make certain decisions relating to those patients. They must also consider victims' representations when deciding what conditions to include in the community treatment order of an unrestricted patient they discharge onto SCT;

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- approved mental health professionals to consider victims' representations when deciding whether to agree to the proposed conditions to be included in a community treatment order for a relevant unrestricted patient being discharged onto SCT; and
- NHS bodies, if they are considering using their powers under section 23(3) of the 1983 Act to discharge relevant NHS patients who are detained in independent hospitals, or who are SCT patients for whom an independent hospital is the responsible hospital.

(Mental Health Act 2007: Guidance on the extension of victims' rights under the Domestic Violence, Crime and Victims Act 2004. Ministry of Justice, 2008.)

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5. LINKS BETWEEN DOMESTIC ABUSE & VULNERABILITY IN THE CONTEXT OF OLDER PEOPLE

- 5.1. **Domestic abuse is frequently seen as a problem experienced only by younger women or as something that ceases as women grow older.** Although Hampshire Adult Services Department does not as yet collect data specifically around domestic abuse incidents and older people, statistics from April 2007 to March 2008¹ show that 75% of cases with older people involved either physical, sexual, psychological or financial abuse and of these cases, 46.9% occurred in the victim's own home. Further data on the alleged abuser showed that 36.7% were either a partner or relative and this figure rose to 44.9% when friends and neighbours were added to the equation^{2,3}.
- 5.2. **Many older women have lived with abuse for years,** often because they lived during an era where they were expected to keep the family together regardless of their own victimisation. Today, however, attitudes are changing, as are the responses of individual services like the police, but older women may have given up trying, may feel that it is too late for them or may simply not know what services they could rely upon if they decided to leave.
- 5.3. **Older women may also experience abuse at the hands of a more recent partner,** or may find their long-standing partners becoming more abusive as they themselves become emotionally or physically frail and hence more vulnerable to victimisation.
- 5.4. The **UK Study of Abuse and Neglect of Older People** (O'Keefe et al., 2007) surveyed over 2,100 people in the UK, with the following key findings:
- Four main types of abuse were highlighted: psychological, physical, sexual and financial abuse – all consistent with types of domestic abuse.
 - 2.6% of people aged 66 and over reported that they had experienced mistreatment involving a family member, close friend or care worker during the past year, which equates to about 227,000 people.
 - Mistreatment and abuse by partners/spouses in the last year involved 51% of cases, other family members at 49% and carers and close friends making up 18% (respondents could mention more than one person), with 53% of perpetrators living in the respondent's household.
 - 80% of interpersonal abuse perpetrators were men and 20% were women.
 - The implication, allied with the data on living arrangements, is that they are either experiencing domestic violence in later life, or that they have a condition, for example dementia, that sometimes gives rise to aggressive or challenging behaviour – or both.
 - Only a small proportion of cases currently come to the attention of Adult Services.

¹ It should be noted that these statistics were not collected specifically in relation to domestic abuse and should therefore be interpreted accordingly within this context.

² Statistics taken from total number of all cases recorded.

³ For similar statistics from Hampshire in relation to mental health and disability, see Appendix 1.

RESEARCH BASED IMPLICATIONS FOR PRACTICE

- 5.5. As a result of this study, Action on Elder Abuse (AEA) called for specific action⁴ which includes:
- An end to 'silo working'
 - Further research, especially in relation to BME communities
 - A need a greater focus on domiciliary care
 - Work around the misuse of medication
 - Greater support for family members who provide care to older people
 - Prosecutions where it is justified by the evidence
 - A major publicity campaign on adult protection
- 5.6. **Regardless of when the abuse begins, however, older women may feel a great deal of discomfort in talking about their experiences.** Sexual abuse is a case in point. In a youth orientated society, older people are often stereotyped as sexless meaning that professionals may fail to spot sexual abuse where it is occurring and older women find it difficult to even begin to raise the subject.
- 5.7. **Professionals may also overlook many other forms of abuse that are raised by older women.** For example, in her research on the needs of older women experiencing elder and other forms of abuse (including domestic abuse) Jacki Pritchard (2000) noted that the workers she spoke to most frequently identified physical abuse as the main problem for victims, whereas the victims themselves gave greater prominence to financial and emotional abuse.
- 5.8. **Not only this, but the physical evidence of abuse can often be attributed to falls or physical frailty.** As Mullender noted in 1996, older male partners may appear particularly plausible and harmless when they give such accounts to cover their actions, when their own physical frailty masks the domination that they continue to exercise through psychological and emotional ploys or when they seek to blame their abuse on the stresses of caring.
- 5.9. **As such, all assessments of older women (including those conducted at the point of discharge from hospital, respite care etc) should be conducted away from the partner and include abuse by that partner as a possibility to be explored.** In this context it is interesting to note the experiences of Pritchard (2000) who found that 'victims were eager to talk about their experiences because they had the researchers permission to do so..[whereas] there was evidence that some workers inhibit disclosures, either because these do not fit worker's pre-set plans, or because they dread the consequences of further demands'. Pritchard also notes that whilst most professionals felt it was essential to build

⁴ For further action that AEA have already committed to, see Appendix 2.

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as good relationship with a service user based on trust, many victims found it easier to disclose abuse to a kindly stranger.

- 5.10. Having received a disclosure of domestic abuse, however, we should not be surprised when a victim finds the idea of separating from their partner extremely daunting.** Older women have the same right to make their own decisions at their own pace as any other victim of domestic abuse, and the need for both practical advice and emotional support is likely to be paramount. This does not mean, however, that workers can afford to be complacent about a disclosure of domestic abuse. Writing in 1993, for example, McWilliams and McKiernan report on women who had not only been abused for 40 or 50 years, but also found their ability to physically and mentally recover declining whilst their partners opportunities to abuse (because the women needed help with medication, mobility, transport or to gain access to pensions/savings) increased.
- 5.11.** There are two discreet points here:
- that it is daunting to leave the perpetrator and the implications of that for practice; and
 - the effects in terms of recovery ability and opportunities to abuse created by increasing frailty.
- 5.12. So what are the needs identified by older women who have experienced domestic abuse?**

These are many and varied but seem to revolve around the need for:

- a) **supportive discussion of earlier or current experiences** – but this was only productive if the story was told once to one person. The need to keep repeating personal information to different service providers is seen as unhelpful and can be potentially retraumatising;
- b) **practical advice and information** – women need to know what will happen if and when they leave an abusive relationship . In particular they need to know about places of safety, the choice and availability of housing, entitlements to benefits, access to joint bank accounts, legal entitlements and procedures (e.g. in planning ahead for a divorce);
- c) **appropriate housing** – that comes after the immediate crisis of leaving home and that takes account of their social isolation and their emotional need for company and safety as much as their physical needs;
- d) **ongoing support** – covering periods of decision-making and of adjustments in personal circumstances;
- e) **attention to the long-term effects of abuse and trauma** – typical health problems include permanent internal injury resulting from physical attack, chronic eating disorders, self harm/neglect, suicidal tendencies, nightmares and flashbacks;
- f) **long term access to a variety of practical resources including those that recognise their concerns for safety** – such as personal alarms, house alarm systems, CCTV,

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door and window locks, access to a telephone, access to crisis telephone numbers etc.

5.13. Family Group Conferencing (FGC)

It should be noted that FGC has been used in Hampshire over the past two and a half years in elder abuse and there has been some success in terms of achieving some of the recommendations in 5.10 and 5.11 by employing this method of intervention. This should be considered in any further practice recommendations that are made.

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6. LINKS BETWEEN DOMESTIC ABUSE & VULNERABILITY IN THE CONTEXT OF PEOPLE WITH DISABILITIES

"Because I can't feed myself and he would go out in the evenings deliberately and I wouldn't have eaten anything for a twenty-four hour period or more. So that wouldn't have happened to anybody that could feed themselves."

"What he liked to do was to hold the chair down just as I was trying to move in it somewhere -- or, this is a great one, move it away just at the very moment I was shifting myself into it..."

WOMEN WITH DISABILITIES: LINKS WITH DOMESTIC ABUSE

- 6.1. Women with disabilities are particularly vulnerable to abuse. Research has shown that disabled women experience abuse at least twice as often as non-disabled women. Abusers - including personal assistants (P.A.s) and carers - may exploit a woman's particular condition or impairment. There are also additional barriers that a disabled woman must overcome when she seeks help⁵.
- 6.2. The prevalence of domestic abuse amongst women in the general population has been fairly well documented, but **very few studies have examined the prevalence of such abuse amongst women with disabilities**. Little is known, for example, about the incidence of domestic abuse amongst women with learning impairments, although Carlson (1998) reports a consensus amongst experts from the field of developmental disabilities and domestic abuse that domestic abuse is both a common and a serious problem for such women.

THE NATURE OF THE ABUSE WHEN LINKED TO PEOPLE WITH DISABILITIES

- 6.3. Likewise, an American study undertaken by the Centre for Research on Women with Disabilities (CROWD) indicates that **domestic abuse against women with physical disabilities is also extremely common**. Involving both qualitative interviews with 31 women with disabilities and a national survey of 946 women, (504 of whom had physical disabilities and 442 who did not have physical disabilities) this research indicated that the prevalence of abuse (including but not limited to partner abuse) was the same for women with or without disabilities but that **women with disabilities reported significantly longer durations of abuse compared with their able-bodied peers** (3.9 years on average versus 2.5 years on average).
- 6.4. **Whilst women with disabilities are vulnerable to the same types of abuse experienced by women without disabilities it is nonetheless important to realise that such abuse may be experienced in very different ways**. For example, disability related physical abuse may include being handled roughly, being restrained, being made to stand for an intolerable

⁵ www.womensaid.org.uk

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length of time etc. Disability related emotional abuse may include threats of abandonment, belittling or accusations of faking. And disability related sexual abuse may include demanding or expecting sex in return for help or being left naked and exposed.

- 6.5. **In addition, research suggests that women with disabilities are at risk of experiencing abuse that is specifically related to their disability support needs** – such as medication abuse, refusing to provide essential care and the deliberate disabling of equipment. Removing the phone of someone who is house-bound, for example, can be a very effective way of isolating them from the outside world.
- 6.6. **When seeking to prevent or escape abuse in the home, women with disabilities can face many of the same barriers faced by their able-bodied peers.** Shame, for example, can prevent a woman from reporting abuse, regardless of whether she is disabled or able-bodied. Likewise fear of reprisals from the abuser can keep any victim silent.

RESEARCH BASED IMPLICATIONS FOR PRACTICE

- 6.7. **Women with disabilities can nonetheless also face additional barriers to escape that are not experienced by others.** Primary amongst these is the shortage of qualified and dependable people to support them in their own homes and the absence of emergency back-up support. This shortage, combined with the low number of accessible refuges and support groups, can create a situation where the only 'choice' that a woman with disabilities has is to stay with an abusive partner or to enter a nursing home or other institutional setting. Women's Aid research (Hague et al, 2008) also found that a variety of surveyed disability organisations which had encountered the issue of domestic violence during their work highlighted the general shortage of accessible refuges and domestic violence services generally. Such choices, combined with the risk of losing children and/or pets as well as personal autonomy, can make the decision to leave an impossible one to make.
- 6.8. **All of the above means that it is not only important to ask questions about domestic abuse but to ask the right questions;** questions that are sensitive to the unique risks and barriers that women with disabilities may face. Hague et al also found that 87% of responding domestic violence organisations monitored referrals for disabled women, with 70% routinely asking questions about disability. Conversely, in of the 73 disability organizations that were surveyed, only 5.5% monitored for domestic abuse. Therefore it is necessary for staff to have accessible resources to respond to domestic abuse.
- 6.9. **It also means recognising that many women with disabilities will be afraid to disclose the abuse they are experiencing** - fearing that they won't be believed or that professionals will take control of their lives rather than supporting them in dealing with the abuse. In this context, reassuring the victim that she is not alone, that you will support her to decide the best way to manage the problem and that you will help her to identify her strengths and the resources she may need can be an important intervention in and of itself. It is

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therefore necessary to ensure that there is heightened awareness of domestic abuse in disability organizations.

- 6.10. It also means recognising that women with disabilities may need particular support in exercising their rights and choices.** In a society characterised by stigma and discrimination, where those with disabilities are encouraged to be compliant, obedient and passive to the wishes of others, those who seek to support abuse victims must accept that the process of change may be very slow. This highlights the need for empowering and supportive interventions.
- 6.11. It also means recognising that many perpetrators will perceive individuals with disabilities as easy targets for victimisation.** Individuals with physical disabilities may be less able to defend themselves or to escape a violent situation. Individuals with speech impairments may have limited communication abilities that can make disclosing abuse difficult. Above all however we need to recognise that the wider discrimination experienced by people with disabilities can also add to their vulnerability; allowing professionals to attribute the actions of partners to the pressures of 'caring' rather than to the desire to exercise power and control. All of these issues need to be addressed in appropriate service responses in order to overcome any issues of discrimination and to ensure that appropriate protective measures are made available.

7 THE PRACTICE IMPLICATIONS

So what are the implications of the above research for developing an approach that deals effectively with domestic abuse in the context of safeguarding adults?

These are likely to include the need to (in summary):

1. Raise awareness of staff in Domestic Abuse and Safeguarding Adults services regarding each others' specialisms;
2. Develop the assessment of vulnerability;
3. Develop victim focused interventions;
4. Make clear strategic links;
5. Make clear practice links between MAPPA, MARAC and Safeguarding Adults meetings/boards; and
6. Ensure attendance at each others' meetings.

Further information

7.1 Raise Staff Awareness Of The Possibility / Range Of Adult Abuse

This is clearly the first stage in the process and one that has been on the government agenda for some time. Much has already been achieved in raising the possibility of abuse, particularly where abuse is occurring within an institutional setting. However, more work is needed if staff are to be alert to the full range of abusive possibilities. For example, the early documentation on adult abuse appeared to assume that the partner of a vulnerable adult would invariably be their carer and further assumed that any abuse which occurred would be largely due the pressures of caring. This is not the case and this was evidenced in Action on Elder Abuse research into calls to their helpline. Such an emphasis nonetheless has the disadvantage of:

- **Reinforcing common stereotypes** – e.g. the perception that a service user with mental ill health is being abused because they are unwell, rather than unwell because they are being abused; and
- **Obscuring the evidence** - that some abusers target and develop intimate relationships with vulnerable people simply because they are open to exploitation and abuse.

7.2 Develop The Assessment Of Vulnerability

Having trained staff to recognise a broad range of abuse scenarios, the impact of safeguarding adults will be severely impaired if the victim's level of vulnerability is assessed in a limited or mechanistic way. For example, early definitions of vulnerability revolved around the need to demonstrate a physical **'dependency on another for meeting basic needs'**. If someone needed assistance with getting out of bed, for example, then they could be classed as an adult who was vulnerable enough to qualify for statutory intervention

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under safeguarding adults procedures. With the publication of the 'No Secrets' document, however, this emphasis on physical dependency has been supplemented by additional grounds for intervention that revolve around '***an inability to protect oneself from abuse***'.

This is now demonstrated in the No Secrets definition of a vulnerable adult:

"a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

In terms of domestic abuse, it is therefore important that professionals are aware of and work to this latter definition, as it is likely to prove more important than the former. For example, an apparently low number of safeguarding alerts made on behalf of those with mental ill-health may be explicable, at least in part, by an inability to demonstrate vulnerability on the grounds of physical dependency alone. Women can experience depression, for example, but still care for their children and partner. In addition, current practice in relation to domestic abuse acknowledges that victims experience very real practical and emotional barriers to help-seeking, barriers that are generally compounded by such as mental ill health, sensory impairment, learning difficulties etc.

As such, a broader assessment of vulnerability is required; one which moves beyond assessing an individual's ability/inability to meet their own basic needs to investigate the full history and dynamic of the abusive relationship and to identify the factors, such as control and isolation, that are acting as barriers to self-help.

In addition, the need for effective referral pathways is evident, both for safeguarding adults professionals and for domestic abuse professionals. It is imperative that the most appropriate interventions and routes of referral are used, on a case-by-case basis. In order to develop the most effective referral pathways for Hampshire, it may be necessary to undertake a mapping exercise of existing services, resources, pathways and responses.

7.3 Develop Victim Focused Interventions

Whilst developments within the safeguarding literature have generated the need for change there has, as yet, been very little (if any) central guidance on how to perform these more detailed assessments or on how to ensure that the information and insights gathered inform both the care planning and the care delivery process. Writing for the field of child protection in 1994, however, O'Hara identified some key elements of effective professional practice that could be used to shape developments in the area of safeguarding adults. These key elements include:

a) **Consulting victims** – practice here could include:

- explore the history and dynamic of abuse
- listen to and validate experiences
- explore barriers faced
- explore what is wanted and what is not wanted (avoiding retraumatisation)

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- consult on preferences re key worker, interventions etc,
 - address wider fears and concerns
 - assess risks faced as well as risks posed etc
- b) **Confronting abusers** – The need to ensure that both the abuse and the abuser that prompted the initial alert is not allowed to disappear from view has been highlighted within the child protection literature and is equally applicable to the field of safeguarding adults. Work in this area may involve using local police services but where a victim is living with their abuser then other professionals must also find ongoing opportunities to address the abuse and the risk that it poses to the victim. Practice here could include:
- being clear about the unacceptability of abuse and where responsibility for the abuse lies
 - remaining aware of the possibility of collusion - especially where the abuser is seen to experience vulnerabilities of their own.
 - using the legal powers available to a service to create cooperation
 - asking abusers questions about their abuse and exploring its impact on the victim
 - assisting abusers in the development of safety plans that address the risk they pose to their partners etc
- c) **Developing safety strategies for staff** – these strategies should include practices that:
- take likely gender differences between worker and abuser into account
 - are directly overseen by a senior member of staff
 - ensure that workers, whether male or female, are not expected to deal with potentially violent cases alone
 - involve the allocation of two workers whenever possible.
 - ensure that home visits and meetings with abusers do not take place without another worker present
 - ensure that standard safety measures are always remembered –including signing in/out, waiting for late workers to return, providing mobile phones etc.
- d) **Forming alliances with non-abusing others** – An exploration of abuse and its impact on the victim is likely to raise issues regarding both the physical isolation and the emotional vulnerability of the victim. In these circumstances, a variety of options can be explored with the victim including:
- the involvement of friends and/or family members in the wider process
 - of protection planning
 - finding ways to tackle the isolation
 - finding ways to develop self-esteem etc.
 - utilizing relevant legislation (e.g. the Domestic Violence, Crime and Victims Act 2004)

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- engaging with relevant and specialist services

7.4 Strategic links

In order to most effectively link and address the combined issues of domestic abuse and safeguarding adults it is necessary to focus on strengthening the strategic links. For example, recognition of both issues in policy and strategic developments such as the Crime and Disorder Reduction Partnership (CDRP) agenda, the Local Area Agreement (LAA), the Health and Wellbeing Partnership, the Safeguarding Adults Board, the Hampshire Domestic Abuse Forum and specific strategic documents such as the Hampshire Strategy Against Domestic Abuse.

In addition, clear links need to be established between initiatives such as MARAC (multi agency risk assessment conferences), MAPPA (multi agency public protection arrangements) and safeguarding adults case conferences.

7.5 Practice links

Practice links need to be made and established as general practice. For example:

- training and awareness of all relevant issues amongst frontline practitioners;
- development of champions and specialists in domestic abuse and safeguarding adults;
- referral pathways;
- policy and guidance to include both issues and their respective links;
- consideration and action on recommendations resulting from case reviews / critical incident reviews; and
- ensure all key organisations are clear about their responsibilities in both DA and Safeguarding Adults.

7.6 Meetings

In order to achieve the above, it is necessary as part of making and maintaining the links to ensure appropriate representation and regular attendance at meetings for both issues, be that at strategic or practice level.

FURTHER READING AND USEFUL RESOURCES

Bowstead, J. (1999) **Mental Health and Domestic Violence**

BMA (1998) **Domestic Violence: A Health Care Issue?**

Dept of Health (2000) **No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse**, DOH

Dept of Health (2002) **Women's Mental Health: Into the Mainstream**, DOH

Herman, J. (1997) **Trauma and Recovery**, Pandora Books

Ingram, R (2002) **Women with Mental Health Issues Experiencing Violence**- paper to Wearside Domestic Violence Conference, November 2002

Kemshall, H. & Pritchard, J. (1995) **Good Practice on Working with Violence**, Jessica Kingsley Publishers

Kingston, P. & Penhale, B. (Eds.) (1995) **Family Violence and the Caring Professions**, Macmillan

Ministry of Justice (2008) **Mental Health Act 2007: Guidance on the extension of victims' rights under the Domestic Violence, Crime and Victims Act 2004.**
www.dh.gov.uk/publications

Mullender, A. (1996) **Rethinking Domestic Violence: The Social Work and Probation Response**, Rutledge

O'Keefe, M et al. (2007) **UK Study of Abuse and neglect of Older People: Prevalence Survey Report.** National Centre for Social Research / King's College London. Prepared for Comic Relief and DoH.

Stark, E. & Flintcraft, A. (1996) **Women at Risk: Domestic Violence & Women's Health**, Sage Publications

Williamson, E. (2000) **Domestic Violence and Health: The Response of the Medical Profession**, Policy Press

Hague et al (2008) **Making the links: disabled women and domestic violence**, Women's Aid
<http://www.womensaid.org.uk/domestic-violence-articles.asp?itemid=1722&itemTitle=Making+the+links%3A+disabled+women+and+domestic+violence§ion=00010001002200080001§ionTitle=Articles%3A+disabled+women>

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APPENDIX 1

Hampshire Adult Services Department statistics from April 2007 to March 2008⁶

	Learning and physical disability	Mental health	Older Person
Physical, sexual, psychological or financial abuse	79.8%	84.7%	75%
Occurred in victim's own home	33.8%	50%	46.9%
Alleged perpetrator is partner or family member ⁷	36.7%	36.7%	36.7%
Alleged perpetrator is partner, family member, friend or neighbour	44.9%	44.9%	44.9%

⁶ It should be noted that these statistics were not collected specifically in relation to domestic abuse and should therefore be interpreted accordingly within this context.

⁷ Statistics taken from total number of all cases recorded

APPENDIX 2

Action on Elder Abuse's (AEA) call to action following the UK Study of Abuse and neglect of Older People: Prevalence Survey Report (O'Keefe, M et al., 2007).

1. **An end to 'silo working'**: The older person experiencing abuse by family members should be given access to whatever systems, processes or legislation increases the potential for their protection. The false barriers between elder abuse, vulnerable adults and particularly domestic violence should be removed to ensure greater joint working across all agencies and sectors, both statutory and non statutory.
2. **Further research** needs to be commissioned by the Scottish Executive and the Welsh Assembly: We need to understand the cultural and social differences that cause these two nations to experience abuse at a higher level or differently. We need further UK research into the experiences of BME communities, and the extent of abuse within residential and hospital settings.
3. We need a **greater focus on domiciliary care**: Nearly one tenth of abusers are home helps, and 20% of all thefts are by those staff. We need a greater focus of attention by regulators and others on the management and control of such services if we are to ensure that they all provide support instead of abuse.
4. **Medication**: Misuse of medication continues to be identified as a serious issue by regulators in Wales, Scotland and England. It was the subject of a series of recommendations by the Health Select Committee Inquiry into elder abuse (House of Commons Health Committee, 2004b, page 60) and these recommendations now need to be re-visited as a matter of urgency.
5. We need **greater support for family members who provide care to older people**: 62% of those identified as neglecting older people are partners and this merits further research and consideration. We need to understand what gives rise to such abuse and what support people need to continue in such roles.
6. We need **prosecutions where it is justified by the evidence**: In two thirds of cases older people told someone about the abuse but there is no indication of what was done in response. We need a major awareness campaign to raise the profile of the issue among the public, the criminal justice system, care providers and health and social care services. We need maximum use of special witness measures to increase older people's access to justice. Agencies need to adopt a positive action approach toward the crimes reported in the study, with a review of the thresholds for investigation. Further criminal sanctions should be introduced to protect older people from neglect.
7. We need a **major publicity campaign** on adult protection: Older people need to know about the systems available in each local authority, and how these can be accessed. The evidence from the Prevalence Study suggests people either do not know about such services or are wary about accessing them.

AEA direct actions following the UK Study of Abuse and neglect of Older People: Prevalence Survey Report (O'Keefe, M et al., 2007).

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1. **New Leaflets**, supported by Richard Briers, giving older people information on what to do about financial abuse and about neglect;
2. **A two year programme**, in conjunction with Women's Aid in Ballymena, to provide specific training on the links between elder abuse and domestic violence
3. **A two year programme** in England working with adult protection and domestic violence teams to improve collaboration and cooperation
4. The development of a **new training programme** for domiciliary care services, focusing on how to prevent abuse.
5. A **joint policy guidance/tool kit** for domiciliary care agencies written by AEA and the United Kingdom Home Care Association giving guidance on how to write an adult protection policy
6. A **Major Conference (*Cradle to the Grave*) in Northern Ireland**, in conjunction with Women's Aid in Ballymena, bringing together child protection, domestic violence, elder abuse, Mental Health, and Learning Disabilities, to share knowledge and experiences.
7. **Survivors Network**: The launch of a peer group support network in England, in conjunction with Age Concern, to provide opportunities for older people who have experienced abuse – and their families – to share experiences and support.