Supporting people with social care needs who are experiencing coercive control

Guidance sheet four: The experience of people with care and support needs

Ruth Ingram, RiPfA Associate

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Overview:

Introduction

Women and men with health and social care needs experience high levels of domestic abuse. As described in the evidence scope (Ingram, 2016a) the reason for this may include the additional physical and attitudinal barriers faced by disabled people in gaining help to stop abuse. These barriers together with levels of dependency on others create situational vulnerability.

Some survivors have a very high level of dependence on others. Where the perpetrators of coercive control is also a 'carer' they may control issues of life and death on a daily basis, such as preparing food and supporting the person to eat, personal care and access to health care and medication.

'*He would purposefully give me the strongest painkillers when my friends were coming, and they couldn't come then obviously because I was asleep. He would cancel care shifts, he would then say that I'd cancelled them, because again when you've had them tablets you're not good at remembering anything - even what your name is*.' (University of Glasgow, 2015:7).

Control of these vital aspects of wellbeing have to be 'won' from non-disabled victims, however, the 'space for action' for people with care and support needs may already be comparatively small due to physical and social barriers.

Creating further disability by withholding aids and adaptations is a simple way that a non-disabled perpetrator can reduce a disabled person's 'space for action'. Similarly, 'taking over' activities that a person can do for themselves but perhaps with some effort impacts on self-esteem and competence.

'*I don't even think he did. The taking over with the cooking and stuff, he thought he was being helpful. Not controlling. I don't think he acknowledged the fact of making me feel about this big. I think he thought that he was just having his opinion, and that I wouldn't be affected by his opinion, that I wouldn't feel bad and I wouldn't feel affected*.' (Grace, Time 1)(Kelly and Westmarland, 2015)

Disabled women report that they internalise social stigma of not being fully female. There is evidence that perpetrators exploit this existing psychological vulnerability. For example, studies concur that abusive partners commonly use disabled women's internalised shame at not conforming to societal norms of appearance, telling her that her appearance was unacceptable which had the impact of lowering her self-esteem, inducing guilt, and instilling a fear of abandonment that can be exploited for purposes of control (Rich, 2014; Mandl et al, 2014; Thiara and Hague, 2015; Walter-Brice et al, 2012). 'Wanting to belong' and have sexual partners and other friends is a reason disabled people, especially those with learning disabilities, give for not giving up relationships with those who abuse them (Pestka and Wendt, 2014).

CPS guidance in relation to domestic abuse (Crown Prosecution Service, 2014) covers a range of relationships and recognises the unequal levels of power and control created in relationships by older age and frailty/disability. However, a defence against the crime of 'use of coercive control' is a 'belief of acting in the person's best interests' and that the behaviour in all the circumstances was reasonable. A 'legal' use of coercive control should not be reasonably foreseen to create serious effects however, there is little guidance as to how the distinction between control used in the different circumstances will be made. The evidence suggests that many perpetrators of domestic abuse report that they do not realise that they are causing harm and that they were acting in the best interests of their partner and family (Kelly and Westmarland, 2015). However, evidence is increasing that coercive control plays a significant role in forms of elder abuse that were previously categorised as 'carer stress'. The fact that domestic abuse of older women has been subsumed within the definition of 'elder abuse' has been described as age discrimination. Distinguishing between abuse that can be successfully stopped for example, by providing carer respite and training and that which is underpinned by coercive control is of vital importance for the safety of the survivor (Spangler and Brandl, 2007; Scott et al, 2004).

A key gap in the evidence base is whether the experience of and impact on the well-being of a person with support needs in a domestic abuse relationship is different from that of a person being supported by an over stretched carer who uses coercion to control and manage daily routines and who has a 'short-fuse' that can lead to 'rough handling' and/or verbal abuse.

Safeguarding adults and coercive control

Knowledge about safeguarding adults work has been complicated by grouping the abuse of a diversity of adults with different health and social care needs, experiencing abuse in a wide range of situations and within a wide range of relationships together (Kalaga, 2007). It might be supposed that there are some differences between the causes, intent and impact of abuse by the group of staff at Winterbourne View towards people with learning disabilities and a nephew coercing his aunt into giving her all of her considerable savings. However, there is a lack of relevant theory and research to underpin understanding of the different forms of adult abuse (Norrie et al, 2014). This includes a lack of knowledge about the role of power in the relationships between those being abused and those carrying out the abuse.

Reports from the national data collection (NHS Digital, 2016) similarly do not disaggregate abuse by family from other abuse within the home and so this category can include abuse by family carers, abuse by paid carers as well as abuse by intimate partners and family who do not take a caring role. The format does not enable separating violence from family and partners towards people with health and social care needs into 'situational violence' and 'domestic abuse' or any other categories (see Ingram, 2016a). Whilst some safeguarding procedures have specified distinct approaches to abuse of people with health and social care needs within intimate partnerships and by family members compared to abuse by paid carers and provider organisations this has not been underpinned by a theoretical base (Ingram, 2011).

The Crown Prosecution Service is attempting to disaggregate this picture. They have created five categories of crimes against older people:

1. Offences which appear to be in part or wholly motivated by hostility based on age
2. Offences (such as a distraction burglary or a scam) specifically targeted at the old person because they are perceived as being vulnerable or an 'easy target'
3. Offences that are not initially related to the older person's age but later become so, for example a burglary where the burglar does not know the age of the householder but later exploits the situation on discovering that the householder is an older person
4. Offences where the age of the victim is irrelevant to the offence and
5. Offences perpetrated by a person who is in a relationship with an expectation of trust, for example assault/theft by a carer or family member some of which will now be categorised as domestic abuse (Crown Prosecution Service, 2014).

There is very little research that describes the use of coercive power and control in family relationships between adults where one or both have care and support needs. However, as described in the evidence scope (Ingram 2016a), there are emerging accounts about the experiences of people with care and support needs living with domestic abuse.

Evidence from Domestic Homicide Reviews concerning older women supports the theory that some older women are at significant risk from domestic abuse. The Home Office reported that 23.7% of victims of Domestic Homicide were over the age of 60 and the website 'Counting Dead Women' records the names of 126 UK women who were killed during 2015 (Smith, 2013). Of those, thirty-nine (31 per cent) were over the age of 50. Eighteen had been killed by their husband or male partner, ten by their son and three by other men from their extended families. The oldest of the women killed was aged 93.

There is growing evidence that perpetrators of sexual and financial abuse of older women (and men) use coercive behaviours to gain and maintain power and control over them and that this may be the main form of elder abuse by other family and household members (Spangler and Brandl, 2007).

The characterisation of elder abuse within households being primarily caused by 'carers stress' is being challenged (Ramsey-Klawsnik, 2000).

There is no theoretical model of the causes of adult safeguarding issues and therefore of how best to intervene in different circumstances.

Older women and men

Awareness of the experience of domestic abuse by and toward older people has been slowly growing (Scott, 2008).

A UK-wide study of abuse and neglect of older people in 2007 found that of those experiencing maltreatment, 51% experienced it from a partner, 49% from another family member, 5% from a close friend and 13% from a care worker. Women were more likely to experience maltreatment than men (3.8% of women and 1.1% of men in the past year), and the majority of perpetrators of 'interpersonal abuse in domestic circumstances' were men, most of whom were themselves older people (O'Keeffe et al, 2007).

Data collected about referrals made to adult safeguarding teams within Local Authorities for 2012–13 in England shows that 2,509 referrals were made about abuse of older women (aged over 65) by a partner and 8,085 about abuse by other family members. These 10,594 referrals will all relate to allegations of abuse falling within the previous government definition of 'domestic violence' but the data does not give information about how many people were experiencing coercive control.

A review of Domestic Homicide Reviews (mandated when a person is killed in circumstances of domestic abuse) found that more older women are killed in those circumstances than would be expected from their proportion in the population. One study of 32 DHRs found that a quarter of the reviews (n=8) were about the killing of older women, six involving an ex/current partner who also was the carer of the victim (SafeLives, 2016a).

The report also showed that older women represented 16% of those experiencing domestic abuse who were referred to MARACs. There were more referrals of older women than of older men but the figure for older men (4%) is higher than it is for younger men (SafeLives, 2016b). Half of the older women referred to MARACs had a disability. The abuse of older people appears to be more hidden than that for younger adults with many of those experiencing domestic abuse who have been referred to MARAC not being engaged with services other than the one that referred them (SafeLives, 2016b). Further study is needed to establish if those that were killed would have been eligible for care and support.

There is a gap in evidence about the specific impact of coercive control in the lives of older women (and men). One study found that controlling behaviour towards older women was consistently associated with physical and mental health issues (Stockl and Penhale, 2015). Levels of shame and embarrassment are high and older women report that this is a barrier to them seeking help (Scott et al, 2004).

The impact of domestic abuse for older women has been found to be similar to that for younger women, including impacts on physical and mental health (Morgan Disney and Associates, 200; Devaney, 2013; McGarry and Simpson, 2011).

'*Oh God… but obviously, it affects you in a horrible way… you feel worthless, you feel useless, and you feel like you don't get anything right… your confidence and your self-esteem… you don't have any… and it impacts you on many levels… many levels'* (Participant 1: 63 years) (McGarry and Simpson, 2011: 296).

'*And your self esteem… and you just feel that you are totally and utterly stripped of any identity so it is like building another self when you finally get* away' (Participant 4: 76 years) (ibid).

Some survivors reflected that domestic abuse had been more socially accepted and therefore hidden with more barriers and less support to leave abusive relationships in their early married lives

'*It was behind doors a lot, you know what I mean, like mine was, and in them days, years ago, there was nothing at all for us to turn to, you know'* (Participant 8: 76 years) (ibid: 297).

Partly due to demographic factors (men tend to be the elder of the couple and men die at a younger age than women) older women who are living with their husband are very likely to become his carer. There is evidence that women who are carers are at greater risk than those who are not (Scott, 2004). Men who are living with dementia who have been perpetrators of domestic abuse earlier in their married lives continue to abuse and may increase the level of violence they use against their wives after the onset of dementia (Knight and Hester, 2014; Penhale, 1999).

Other issues that have been identified for older people experiencing domestic abuse include:

- The abuse survivor may be providing care to the perpetrator or vice versa meaning that alternative care may be needed to interrupt the abuse
- The abuse may have been going on for decades and the survivor may fear that disclosure will disrupt other relationships e.g. with (adult) children
- Survivors may fear losing their home and potentially the results of many years of homemaking
- Fear of losing independence and expected to live in a care home
- Older women are one of the poorest groups in society. Survivors may fear losing financial support

'... the stories (from 250 Australian women) also illustrated the unique difficulties faced by older women leaving a violent relationship. Foremost among their concerns was being unable to survive financially and being plunged into poverty or being inappropriately placed in residential care and losing their homes, families, and social networks' (Mears, 2003).

Current barriers include lack of awareness on the part of practitioners and lack of services, and that refuges and other services are not aimed at older women. Despite some refuges now having made specific provision for older and disabled women they may not be perceived as suitable for older women and may not be accessible. Additionally, practitioners may hold ageist views that there is little point in an older person starting again – however these should be challenged, as exemplified in the quote below form an older woman:

'I did meet someone else. A beautiful man. And I'm having a lovely life. And I'm having everything I never had before [laughs].' (Scott, 2004).

Women and men who are disabled

As stated above disabled people experience high levels of abuse compared to non-disabled people of the same gender.

Fifty per cent of disabled women may have experienced domestic abuse (Magowan, 2004). Disabled women are twice as likely to experience abuse as other women and are likely to encounter specific issues of power and control as well as isolation and dependence due to their disability (Hague, 2008; Mandl et al, 2014; Thiara and Hague, 2015). Perpetrators often use forms of abuse that exploit, or contribute to, the abused person's social care needs; for example not recharging hearing aids or wheel chair batteries and many abusers deliberately emphasise and reinforce dependency as a way of asserting and maintaining control.

'I'm disabled. He takes my mobility equipment so I can't go out to my friend's house for a cup of tea.' (Howard and Skipp, 2015).

Evidence from such interviews demonstrate how social care needs are used as part of coercive control to humiliate and belittle women (University of Glasgow, 2015). A study with 19 women with physical impairments who had experienced abuse found that women's experience of discriminatory attitudes towards them were used and compounded by perpetrators (Rich, 2014).

'Nick… wanted me to sleep with other men to bring in a little extra money; I said 'come on, how can you expect me to do that when nobody else would want me?' He said, 'You're wrong, there are plenty of perverts out there who'd get a kick out of sleeping with you . . . I was shocked. I started to wonder if he was a pervert too—or some kind of criminal mind.' (ibid: 5)

The impact of domestic abuse is often especially acute where the abusive partner is also the carer; the carer has considerable power and control and the victim relies on them.

'He would not get me the food I was meant to have, and when I said I'm not meant to have this he would start swearing at me saying 'eat it'. There were a couple of occasions where the food was all over the tray and I'd say I can't eat it off the tray and he'd say 'You're so difficult. You're such a bitch, I'm cooking for you'. He was warming up a ready meal.' (Howard and Skipp, 2015: 20).

However, abuse within the context of 'caring' can be more subtle. For example, care can be used as a rationalisation for surveillance:

'He seemed so romantic at the time. Never wanted me out of his sight, even to go run a small errand. He thought I would trip and die or something. Maybe break a hip. And I thought I was the luckiest gal in the world' (Madeline, 62) (Rich, 2014: 10)

'He had this idea that he needed to check my blood pressure every 30 min, so I couldn't go very far. No exceptions, even when my daughter came to visit and we wanted to go out. It got in the way, but I thought—you know, he really cares' (Elaine, 72) (ibid: 10).

The context of caring and dependency can also mask abuse:

'People pity him because he is taking care of you and so noble. So people are reluctant to criticise this saint or to think he could be doing these terrible things. And possibly as well as that there's… an idea… people don't really 'see' disabled women. And people don't easily see a disabled woman as a wife, partner, and mother. So I think for some people it's hard to think well this might be a woman who's being sexually or physically abused by her partner,… because disabled women don't have sex, do they?' (Thiara, 2008).

Financial abuse of disabled women has been found to be common and may be a motivation for some perpetrators targeting disabled women (Plummer and Findley, 2012) e.g. to access their benefits.

'I have only very recently escaped; I was terrified I wouldn't have enough to buy food, to live. He had full control of my disability benefits and my car. He wouldn't even allow me to have my own mobile phone.' (Howard and Skipp, 2015: 20)

Power over finance can be used to create humiliation

'He refused me money for sanitary supplies, so I couldn't buy any.' (ibid: 20)

Disabled women face additional barriers to seeking support (University of Glamorgan and Welsh Women's Aid, 2011; Mandl et al 2014). Some of these arise from physical barriers to accessing services (for example very few refuges being able to accommodate Guide Dogs or personal assistants), and to communication (e.g. lack of information in braille and BSL), some from the attitudes of friends, family and professionals who seem not to understand or believe that disabled women experience abuse, or that it is acceptable. Specific issues affect disabled peoples' recognition of and/or hope that they can live free from abuse, including a lifetime's experience of power and control used over them (Snæfríðar-Gunnarsdóttir and Traustadóttir, 2011) and lack of accessible information about abuse and services available.

'Joe… used his wooden leg to hit me… similar things happened to me in the group homes. The inmates used canes and hooks and chairs… The staff would refer them for counseling. So they'd go sit in a room with some nice person nodding at them. Meanwhile I'd be hiding in a closet, scared out of my mind… So being with Joe was like a kind of deja-vu… (Claire, 57) (Rich, 2014: 9)

'When the slapping started, at first I was shocked. No boyfriend ever lifted a hand to me before. But… I've been through more than that from my doctors. One physical therapist used to torture me and you should have seen what it was like in rehab… If I was a whiner I'd 've been dead a long time ago. So I just… let God take care of it. (Mindy, 39) (ibid)

These barriers stop disabled women from seeking help from DA service providers and that puts the disabled women at risk of enduring long-term abuse;

'What emerges is that many services that provide support to women who report domestic abuse are not always responding appropriately to women with a physical or sensory impairment, learning difficulty or mental health condition. This may vary from access to a refuge, personal assistance, communication support or information provided in appropriate formats.

Similarly, many services that provide support to disabled women are not always identifying domestic abuse victims and therefore not able to signpost to appropriate domestic abuse services.'
Bowen-Davies (National Adviser for Violence against Women Wales) (University of Glamorgan and Welsh Women's Aid, 2011).

There is an evidence gap in relation to disabled men's experience of domestic abuse by men or women and disabled women's experience of abuse from other women e.g. partners or carers. One source of information about the increased risk faced by disabled men comes from the Forced Marriage Unit. A forced

marriage takes place without the valid consent of one or both parties, where duress is a factor, and is illegal in the UK. 2015 statistics show that 12% (141 cases) of cases reported to the Forced Marriage Unit involve people who had a physical or learning disability 62% of whom were men and 48% women; in contrast, statistics for the general population show that of 1220 cases reported in 2015, only 20% concerned male victims. (Home Office and Foreign and Commonwealth Office, 2016, in Pike and Norman, in press).

Women and men with learning disabilities

Women and men with learning disabilities also experience abuse from partners and family members.

Many of the barriers that people with a learning disability face could be assumed to be similar to those faced by people with other social care needs e.g. lack of recognition, lack of accessible information and lack of accessible services. However, there are specific challenges in relation to communication for people with intellectual impairments and the historical lack of recognition of the intimate relationships of people with learning disabilities (Walter-Brice et al, 2012). There is an evidence gap in relation to the prevalence of domestic abuse and its specific impact on women and men with learning disabilities. Two small scale studies (Walter-Brice et al, 2012; McCarthy et al, 2015) that interviewed women survivors of domestic abuse in England found that the levels of physical violence they had experienced were particularly high and of high risk (e.g. use of weapons, threats to kill).

Women described how their learning disability was specifically used to humiliate them;

He used to take the piss out of me because of my learning disability. He used to show me up in front of his mates if I couldn't work something out. He'd say, 'you're useless, you can't do nothing' (McCarthy et al, 2015: 6).

Women with a learning disability appeared to be targeted. Their loneliness and sense of being 'different' but wanting to be 'normal' was used to groom or 'cuckoo' them into accepting a relationship. In many cases this was intended, on the part of the perpetrator, to exploit the women and their resources (e.g. housing, benefits) (McCarthy et al, 2015).

Women and men who use mental health services

Domestic abuse and poor mental health are related. There is a higher prevalence of domestic abuse among people who experience poor mental health (Trevillion et al 2012; Scott et al, 2015) but the reason may be because the experience of domestic abuse causes symptoms of and/or mental ill-health.

Nevertheless, women who use mental health services report that this is used as part of coercive control against them.

He gave me wire and told me to strangle myself. He wanted me to suicide myself. He wanted me to die (McCarthy et al, 2015: 6).

Other examples include:

- Saying the victim couldn't cope without them.
- Saying the victim is 'mad', and is 'making it up'.
- Not allowing them to go anywhere alone because they are the 'carer'.
- Speaking for the person: 'You know you get confused/you're not very confident/you don't understand the issues'.
- Telling them they're a bad mother and cannot look after the children properly.
- Forcing a woman to have an abortion because 'she couldn't cope'.
- Threatening to take the children away.
- Threatening to 'tell Social Services' - the implication being they will take the children away.
- Telling the children 'Mummy can't look after you'.
- Deliberately misleading or confusing the person.
- Withholding medication or over medicating.
- Undermining you when you disclose the abuse or ask for help: 'You can't believe her - she's mad'. (Women's Aid, 2009).

These issues have been compounded by the low levels of awareness and expertise about domestic abuse and the impact of coercive control within mental health professions (Hegarty, 2011; Trevillion et al, 2014). For example:

- Not recognising or not providing effective services for trauma.
- Focusing on the woman's mental health in isolation from the abuse she is experiencing.
- Blaming her.
- Offering medication and not effective talking therapies.
- Using stigmatising labels and the medical model (Greater London Domestic Violence Project, 2008).

The role of the social worker

The Care Act places social workers in a key role in assessing and arranging support to people with care and support needs to improve their well-being, including safety from abuse. Social workers are amongst the health and care professionals who are in a strong position to be able to notice signs of coercive control, to make safe enquiry and to provide relevant information and support.

In addition, social workers will also be charged with making statutory safeguarding enquiries. An important skill is establishing whether the enquiry

relates to a situation of coercive control or whether it relates to other forms of family violence.

The Professional Capabilities Framework for social workers includes transferable attitudes and skills that have been evidenced as effective in the work of specialist domestic abuse advocates. The principles of working within a strength based approach, supporting the empowerment of the person at risk is consistent with best practice and guidance in safeguarding adults (Department of Health, 2014). Logically social workers should be able to work effectively to support adults at risk from domestic abuse, particularly where they are in the best position to provide that support within a specialist understanding of the person's other care and support needs (SafeLives, 2016b).

Despite these synergies, research with adult social workers has found that practitioners are uncertain of what their role is (McLaughlin et al, 2014), and are confused with the need to operate a parallel domestic violence and adult safeguarding approach, which is further complicated by issues of mental capacity (McLaughlin et al, 2016). Training for those entering the profession as well as opportunity for work place training in this area was found to need improvement (Heffernan et al, 2012).

A social worker supporting an adult at risk from domestic abuse can be a key person in building trust and safety to enable that person to take steps to free themselves from coercive control, gain information about local services and mobilise other parts of the 'Co-ordinated Community response' to support her. Where organisational constraints do not enable the worker to work in this way, ensuring the person has made a relationship with a specialist advocate is an effective intervention. (Ingram, 2016b).

Mental capacity

A key role for adult social workers is likely to be an assessment of whether the adult at risk from domestic abuse has mental capacity to make relevant decisions about their safety and the support that they want. This is particularly complex in situations where a person may have 'a disturbance of mind or brain' due to the impact of the abuse they are experiencing affecting their ability to weigh up the risks and benefits of a particular decision. There may also be situations where there is no disturbance of mind but:

'A vulnerable adult who does not suffer from any kind of mental incapacity… is, or is reasonably believed to be, incapacitated from making the relevant decision by reason of such things as constraint, coercion, undue influence or other vitiating factors' (Munby, 2005).

In a Court of Protection judgement (A Local Authority v DL, RL & ML [2010] EWHC 2675) and a subsequent judgement by the Court of Appeal it was agreed that 'inherent jurisdiction' could be used in such a circumstance. The case that was before the court was one in which the elderly parents of a 50 year old man referred to as DL were constrained from exercising their decision making capacity due to his coercive and controlling behaviour towards them (DL v A Local Authority & Others [2012] EWCA Civ 253).

Local Authorities can therefore apply for relevant orders to protect people who are not able to make decisions due to the level of coercion and control being exercised over them. See Pike (2016a) for an outline of available legal remedies, and Pike (2016b) for further discussion of capacity and coercion.

The Crown Prosecution service also recognise the impact of coercive control on the ability of witnesses with physical, or learning disabilities, or mental health problems to give statements about the abuse they have experienced. 'Special measures' such as screening the survivor from the perpetrator in court or using video evidence can be used to support people to give 'best evidence.' Similar measures can be applied for in relation to non-disabled 'intimidated witnesses'.

The issue of making a best interests decision for a person who has lived with coercive control for many years and has subsequently lost capacity to make key decisions about their well-being is very complex. For example; an older woman with dementia may never have had the opportunity to disclose, reflect on her experience of abuse and make her wishes known. She may have been isolated from her family and friends or have successfully kept the abuse hidden. This leaves the professional unable to discover from others who have known her before she lost capacity about her views about the abuse she has experienced. Establishing other evidence from old health records, for example, is also likely to be challenging.

In summary, working with coercion where capacity is in doubt is a challenging area of practice, and legal advice should be sought where necessary.

Conclusions

This briefing has outlined the evidence of the experience of coercive and controlling behaviour for people with care and support needs. It shows that people with social care needs are likely to be at higher risk of coercive control and domestic abuse than the general population, reiterating the importance of social workers and social care practitioners being able to appropriately recognise and respond to it.

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[11] Information provided to Steve Bartley - Older Peoples Commission Wales by Home office (direct communication)