Supporting people with social care needs who are experiencing coercive control

Guidance Sheet Three: What works? Evidence based interventions to prevent and respond to domestic abuse

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Factors in the wider culture and community

Ecological models of domestic abuse propose that individual resilience to domestic abuse is supported by aspects of culture and social infrastructure that increase a woman's 'space for action'. For example, most women in the UK were only able to open a bank account or obtain a mortgage with the signatory of their husband or father before the Sex Discrimination Act in 1975 made that practice illegal. Not being able to control one's own money had placed huge limitations on women's ability to resist financial abuse and to leave abusive relationships. Social and religious beliefs, for example, that marriage is a sacred bond, are other factors that may support a woman's belief that she has to remain in an abusive partnership and 'keep trying' to make the relationship work.

The enactment of the crime of coercive control aims to influence public perception by increasing understanding of the reality of domestic abuse, as well as increasing women's real options for using the criminal justice system to achieve safety.

Media, including soap operas, social networking sites such as *Mumsnet* and contact with friends and family can be important source of reflection to a person that their relationship is an abusive one. However, a key behaviour within coercive control is isolation. Behaviours that prevent the survivor making contact with others and others from

(wanting to) make contact with her are key to reducing her sources of information and support. Evaluations of public awareness campaigns about domestic abuse and adult abuse find that they increase public understanding and the reporting of abuse (Fraser and Solomon, 2009; Pike, 2015).

Co-ordinated Community Response model

Feminist models propose that services are offered to survivors and interventions made with perpetrators within the context of a Co-ordinated Community Response (CCR). A CCR includes the criminal justice system, police, health, social services, community groups, specialist voluntary sector agencies and advocates alongside a public message campaign to decrease social acceptance of domestic abuse.

Research into the impact of the Co-ordinated Community Response suggests that they have a long term cumulative impact on decreasing the levels of violence towards women (Post et al, 2010). This is supported by evidence from safeguarding adults' work where Safeguarding Boards have adopted a similar approach (Pike, 2015).

The CCR approach was pioneered by the Duluth Model Minnesota as a whole systems approach.

The key activities of the Duluth Model fall under one or more of eight objectives:

1) Creating a coherent philosophical approach which centralizes victim safety

2) Developing 'best practice' policies and protocols for intervention agencies

3) Reducing fragmentation in the system's response

4) Building monitoring and tracking into the system

5) Ensuring a supportive community infrastructure

6) Intervening directly with abusers to deter violence

7) Undoing the harm violence to women does to children

8) Evaluating the system's response from the standpoint of the victim.
(Pence and McMahon, 1997).

The CCR approach was adopted by the UK Home Office in 1996 and underpins current policy (Home Office, 1999; CCRM 2010). This approach has led to multi-agency domestic abuse partnerships and forums being set up in local authority areas as part of their Safer Community Partnerships. Many areas have domestic abuse strategies which co-ordinate improvement in the response by agencies (e.g. through training programmes) and the commissioning of specialist services for survivors and perpetrators. Current government strategy also promotes early intervention with children and young people to promote 'healthy relationships'. Berry et al, (2014) categorise interventions to stop domestic abuse and other forms of gender violence in Figure 1 below.

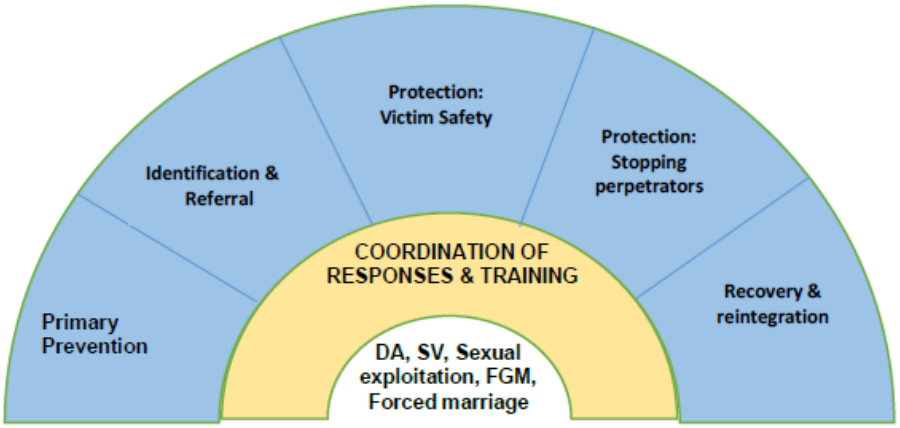
Whilst the lead agency for community safety work is the local authority there is commonly a lack of contact and communication between adult social care and/or

Safeguarding Adults Boards and local domestic abuse strategies. This can mean that the role of adult social work in reducing crime and disorder in general and specifically our role in decreasing domestic abuse is not specified or communicated to practitioners.

Work with individuals: Evidence based interventions

There is a lack of research of a sufficient standard with large enough samples to draw many conclusions about how to achieve effective outcomes for women (and men) trapped in relationships that feature domestic abuse. There are similar gaps in relation to identifying the forms of support that enable survivors to recover or improve their wellbeing (Berry et al, 2014; Mallender et al, 2013; Kelly et al, 2014; Wathen and MacMillan, 2003). There is a similar lack of robust research as to which interventions produce good outcomes in relation to elder abuse (Nelson et al, 2004). There is some evidence about programmes aimed at reducing the use of coercive control by perpetrators (NICE, 2014; Kelly and Westmarland 2015).

Figure 1: Typology of interventions (Berry et al, 2014)



Second level: At the second level of the typology a further set of more detailed classifications assess:

1. Recipients of the service: female victim; male victim; perpetrator; family; professional.
2. Type of help offered: information; advice; advocacy; befriending; education; finance; recreation; treatment; care/tending; practical assistance; legal support; accommodation; training; assessment; action planning; personal safety and coordination.
3. Sector of delivery: (1) statutory, private or voluntary; 2) education, social care, criminal justice or health; or 3) combination.
4. Specialised or generalist services.
5. Geographic reach: rural, urban or both.
6. Setting of delivery (community, clinic, refuge, home, school, online, other)
7. Amount of intervention: duration and frequency of delivery
8. Theoretical basis, use of research evidence

Supporting survivors

Qualitative research into disabled and non-disabled women's experience of specialist domestic abuse services gives consistent messages about what they find to be the most valuable forms of support. These are:

- an unconditional, holistic approach
- an orientation to 'the whole person'
- being listened to and believed
- being validated and affirmed and supported to live free from abuse
- combined with expert knowledge of domestic abuse, the services available and being pro-active (Kelly et al, 2014; Berry et al, 2014; Allen et al, 2013; Mandl et al, 2014; Coy and Kelly, 2011; Mullender and Hague, 2000).

I felt like I could trust her… I gave her [personal information], stuff that you just don't give to people, but since I knew… what she was doing, I don't know, I felt comfortable… Because she talked to me like a person rather than a project… She's caring; she actually cares about the details. She wants to know the details. She wants to know what's going on and she wants to help. (Allen et al, 2013: 7)

…it was nice to have someone to talk to that didn't have to give you their opinion on crap they don't know anything about. (ibid: 9)

There was a working relationship with her… most people that I've tried to deal with, they don't really take the time to listen or to understand what you need. Either you fit into the right little holes, if you're a square peg not fitting into a round hole, they don't wanna come up with a square peg set or a square hole somewhere for you. (ibid: 6)

Being non-judgemental and not blaming the survivor for the strategies that she has used to survive counteracts the shame experienced by a survivor. For example, passivity and not attempting to leave the relationship may be criticised or misunderstood when viewed from the outside of the controlling and coercive relationship, or pathologised as a symptom of 'learned helplessness'. However, it can in fact be the best strategy for decreasing risk of serious injury to oneself or others (Stark, 2007; Dutton et al, 2005). Survivors living within abusive relationships are constantly vigilant and constantly making decisions as to how best to avoid harm whilst at the same time preserving their sense of self and agency (Pain, 2014). Working from a stand point that validates the survivor's strengths in the present and those she exercised to survive within an abusive relationship have been found to enable her to rebuild her sense of self and take steps to establish safety (Stark, 2007; Berry et al, 2014).

Survivors also value having a single point of contact so that they are able to access support without have to explain their full circumstances or re-tell their experiences on each separate occasion and, especially when they are at risk, 24 hour availability of specialist advice and support (Berry et al, 2014; City of Westminster Council 2007).

Identification and referral

There is evidence that training GPs and other health workers improves the identification of domestic abuse and referral to specialist advocacy (Feder et al, 2011) and is cost effective in circumstances where women (and men) are referred to specialist domestic abuse advocates or to psychological support via a dedicated referral pathway (Norman et al, 2010; Devine et al, 2012).

There is a debate as to whether or not professionals should ask every person they come into contact with whether they are experiencing domestic abuse. NICE guidance (NICE, 2014) recommends that routine enquiry should be established in Accident and Emergency, antenatal services, health visiting, sexual and mental services whether or not there are signs of abuse or coercive control. Studies have found that some professionals are in favour of this approach whilst others strongly disagree. Some women would not like to be asked but the majority would (Trevilion et al, 2014; Trevillion et al, 2012; Ramsay et al, 2002; Mallender et al, 2013; IRIS, 2014). Older women in particular report that they would not disclose unless they are asked but they welcome that opportunity (Scott, 2008). Studies also suggest that women with learning disabilities are more likely to report abuse when asked directly about their experience (McCarthy et al, 2015).

Increasing a professional's confidence to identify domestic abuse and coercive control is of little value unless they are able to intervene effectively themselves or they are able to enable the survivor to be in contact with those that can.

Not all survivors come into contact with services at the same stage in their recovery from domestic abuse. One project using Judith Herman's model of three stages of recovery has designed a set of questions to create a pathway for practitioners to identify the level of support they should offer. The stages do not always follow a strictly linear course but they may be a useful guide to practitioners working with an adult at risk to establish the priority outcomes at the each stage in her path to safety and recovery. These are summarised in Figure 2 (Greater London Domestic Violence Project, 2008).

Figure 2: What level of support should be offered? (Greater London Domestic Violence Project, 2008).

General questions	Stage 1 questions (still at risk/ establishing safety)	Stage 2 questions (remembrance and mourning)	Stage 3 questions (reconnecting with normal life)
Can I help her?	Acute health/injuries?	Is she safe?	Chronic health issues?
If I can't, can someone in my team help her?	Physical safety - from further abuse?	Does she want to begin therapeutic work?	Permanent housing?
If no-one in my team can help, can another agency?	Emotional safety - from self/others?		Education/training/ employment issues?
			Community activism/ involvement?

Protection/ victim safety

Being and feeling safe is the cornerstone for individual survivors building a new life (Kelly et al, 2014; Mandl et al, 2014). Whilst she is still at risk her attention will be focused on negotiating the abuse she is experiencing. Survivors have been found to make accurate assessments of the level of risk they face and understand the potential consequences of taking action**;** for example to leave a relationship (which has been evidenced to be a time of high risk to the survivor and her children) (Cattaneo et al, 2007; Pain, 2014a).

Perpetrators of high-risk domestic abuse continue the abuse after they and the person they are abusing are no longer living together (Howarth et al, 2009). This evidence is reflected in the law around coercive control which applies to people who have been in intimate relationships and who are not (and may never have) lived together. The most dangerous time for a woman leaving an abusive relationship is at and shortly after the time of separation. Separated women are more likely to experience physical attack and it is more likely to cause serious harm, or death (Stark, 2007; Howarth et al, 2009). This risk must be taken seriously.

Models of coercive control explain this increased risk as the perpetrator increasing their use of power to counteract the woman finding and demonstrating her own autonomy. Recognition by the perpetrator that contact with practitioners may be supporting her to do this can lead to actions that isolate her from the support (e.g. phone calls to cancel appointments) or even to actual risk towards a practitioner who is actively seeking to reduce the perpetrator's level of control (Agnew-Davis, undated).

Working with someone who is still at risk requires understanding that their actions (and those of the perpetrator) may only make sense in the specific context of the abuse she is experiencing. Her behaviour may not match practitioners' assumptions about how a survivor will behave and her support needs may not fit neatly into organisational boundaries.

Research provides evidence for the cost effectiveness and benefits to the safety and wellbeing of survivors of services from specialist advocates (Berry et al, 2014; Wathen and MacMillan, 2003; Mandl et al, 2014; Sullivan and Bybee, 1999; Bybee and Sullivan, 2002; Mallender et al, 2013; British Colombia Centre of Excellence for Women's Health, 2013; Coy and Kelly, 2011; Kelly et al, 2014). These advocates are able to support survivors to navigate the often complex systems of criminal justice, access to housing, social security benefits, social and health care (Wathen and MacMillan, 2003). In some instances this is due to services not being responsive to direct contact from their customers or understanding of their needs. An evaluation of four independent domestic violence advisor (IDVA) services concluded that 'IDVAs are islands of consistent and ethical practice, in a stream of turbulent and often inadequate responses from other agencies' (Coy and Kelly, 2011).

It's got me more able to get in contact with the housing and get them to actually listen to me. So before, I literally would call them, call them, call them, call them, left messages - nothing and then as soon Solace Women got involved that was it. (72, W1) (Kelly et al, 2014: 36)

And, she amazed me, the amount of information that she would find, because . . . I thought how in the world are they going to give me an advocate that hasn't come up with all the resources that I've already come up with? But she did, and it was great, and would give me websites to check out on my own, um, so that I could pick out of it what I might find best for myself. (Allen et al, 2013: 11)

The evidence suggests that survivor-centred advocacy, co-production and empowerment are effective in achieving better outcomes; e.g. being less likely to return to abusive partners. A strengths based approach allows someone who has been abused to relearn how to use their own power and enables to learn skills that increase their 'space for action', for example personal skills such as decision making and information skills such as navigating services that they may need in the future, as well as new sports and leisure interests (Allen et al, 2013; Berry et al, 2014).

"What should I do"? And then he would ask in return, "what do you want to do? This is your body, you control it". No-one had said that to me before, you know. It didn´t occur to me that it was my body and that I controlled it, it would never have occurred to me. So it was, you know, a bit of a shock for me. Of course, I understood as soon as he said it, and of course it was so. But even so it was somehow, it was new information to me'. (Snæfríðar-Gunnarsdóttir and Traustadóttir, 2011)

Research has also found that those needing support due to domestic abuse do not, in general, find statutory services supportive.

Considerable time and energy was spent battling "the system", and over the course of the study, women began to comment that their lives were now constrained by structural barriers. With the exception of some thoughtful, aware and sympathetic individuals, what women reported was poor practice characterised by victim blame, delay and misinformation. Being under the scrutiny of social services was an additional burden to some, especially given the inconsistency in the recognition and understanding accorded to the impacts of domestic violence. This became a glaring contradiction for those who were pressured to leave to protect their children, yet offered no support in doing so. (Kelly et al, 2014: 5)

Some women do not feel confident that statutory services will maintain confidentiality and only share information with their informed consent whilst others fear that seeking help will be interpreted as a sign of 'not coping' (Berry et al, 2014: 28).

Research available about disabled women with experience of domestic abuse also found that whilst women identified practitioners who were particularly helpful, it was the helpful individuals who were singled out, rather than any profession as a group. This suggests that good practice is not supported by organisational culture and structures (Mandl, 2014). For disabled women the ability of the practitioner to understand the impact of disability as well as domestic abuse and how they interact on issues such as self-esteem and body image is also important (Rich, 2014). Physical, educational and attitudinal barriers also prevent disabled women benefitting from services (Snæfríðar-Gunnarsdóttir and Traustadóttir, 2011).

Recovery

Judith Herman's study of women who had experienced domestic abuse and other traumas (Herman, 1992) identified a three stage process of psychological recovery. The first stage is the establishment of safety, the second remembrance and mourning, the third is reconnection with everyday life. She does not propose that the stages are experienced as a simple linear progression.

Research using interviews with 100 women who had experienced abuse identified eight foundation stones that help facilitate the building of a new life (Kelly et al, 2014: 5).

These were:

- having opportunities to explore domestic violence and its legacies through counselling, but also with trusted family and friends
- being and feeling safe
- becoming settled and able to make a new home
- improved health/ability to manage health conditions
- children in new schools and less anxious, able to make and see friends
- (re)entering employment and/or education and training
- a tight, but trusted, network of family and friends
- financial security.

Of the 65 women interviewed three years after leaving an abusive relationship many had most of these elements in place but none of them had all elements in place.

There is evidence that specialist counselling services are effective in decreasing the amount of abuse experienced and increasing wellbeing (Berry et al, 2014; Wathen and Macmillan, 2003; British Columbia Centre of Excellence for Women's Health, 2013). There is also some evidence that many survivors find their wellbeing is improved by attendance at support groups of women who have all experienced abuse (Mandl et al, 2014; Berry et al, 2014; British Columbia Centre of Excellence for Women's Health, 2013).

(The) programme has made me see that I'm normal and it wasn't me or anything I did. It made me see how nasty he was and how damaged he was. Also I have started to live again and had to rebuild my life over after I lived it around him and now I can start again… I'm safe now and my kids have got me now instead of taking him back. The course has saved me in all ways from a dark hole and made friends too and I can see I did everything I could to protect them. (DAIT, 2015: 6)

Some disabled women prefer to share mutual support with other disabled women who understand disability as well as abuse, others value being part of a wider group of women domestic abuse survivors (Rich, 2014).

Interventions with perpetrators

There is a lack of systematic research that can evidence a relationship between interventions made with perpetrators of domestic abuse and outcomes (Akoensi et al, 2013).

There is some evidence that criminal justice sanctions such as arrest, injunctions and restraining orders do prevent some perpetrators from repeating their violent behaviour.

There is evidence that professionally run group work with perpetrators of domestic abuse can be effective in reducing abuse. Physical abuse decreases more than coercive control but this is still reduced considerably (Howarth et al, 2009; Kelly and Westmarland, 2015). Some men are mandated to attend courses as part of a sentence for a criminal offence others cater for men who seek support to change. Groups certified to Respect accreditation standard (Respect, 2012) enable men to learn to understand the reasons they use power and control in intimate and domestic relationships and the impact that this has on their partners and children (Respect, 2011). Other studies suggest that perpetrator programmes are most effective when they are personalised. Approaches using CBT and attention to drug and alcohol misuse may also be effective (Guy et al, 2014).

Current guidance in relation to engaging with perpetrators emphasises the potential risk of workers who act outside a clear joint framework with other professionals increasing risks to survivors and children (Agnew-Davis, undated).

Behaviours of survivors and perpetrators may appear to have benign meanings to those outside the relationship (including professionals)**,** but may indicate specific risks and coercion and control for the survivor. Without understanding the details of the coercive and controlling strategies used in a relationship it can be easy for a professional to collude with them – for example, by taking a carer's account of a survivor at face value. A safety plan should include how the professional engages with the survivor and the perpetrator.

Many Domestic Violence Perpetrator Programmes (DVPPs) also work with women whose partners are attending the programme. Some include individual work with men. The Project Mirabal evaluation of these programmes describes how some men's attitudes and behaviours change (Kelly and Westmarland, 2015). Their accounts add evidence to theories that domestic abuse is the use of power and control over the behaviour of (usually) women and children within intimate and domestic relationships.

Never even crossed my mind that (sighs) – the impact of my behaviour and the effect it has on other people, because again I always had this thought that king of the castle type person. And it never really crossed my mind until now… I was probably aware of it in the back of my head somewhere, but chose to ignore it. (Sebastian, Time 2). (Kelly and Westmarland, 2015: 27)

Similar interventions with perpetrators of 'adult abuse' would add understanding to whether coercive control is used in the same way within intimate relationships where one or more person has care and support needs. It could also elucidate whether coercive control is used to exert power and control in other family and carer relationships.

Conclusion

If a safeguarding enquiry is needed in relation to an intimate or family relationship the safest course of action is to assume that coercive control is taking place and ensure safe enquiries are made. The survivor can then, given time and following the building of trust, be enabled to describe any coercive control that they are experiencing. If after such enquiry no coercive control is evident then intervention can be made on the basis of a different assessment for example of 'situational abuse'. However, practitioners should be aware of the high risks associated with coercive control and ensure they have consulted with peers, supervisors and sources of expert advice before making interventions. Practitioners should not intervene directly with a perpetrator of coercive control or address the issue of coercive control with the couple together unless they have appropriate expertise. The Respect phone line can offer guidance (www.respectphoneline.org.uk).

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