



Spotlight: Episode 3 Podcast Transcript

Emma Storey: Welcome to Spotlight, the podcast for the domestic abuse sector. I'm Emma Storey, from the SafeLives Knowledge Hub and this is the third and final podcast in our Spotlights series on older victims of domestic abuse. But our work on this hidden demographic continues and over the next two weeks, we'll be publishing blogs, hosting webinars and having a live Twitter Q&A on August 31st. To stay up to date, follow us on twitter at SafeLives underscore or on Facebook.

Emma: So I've come to Cheshire this morning to meet with Jane who is an Idva based in a hospital and Mel who is the adult social care rep for one of the Maracs in this area. I've come to chat with them both to get their views and ideas on how we can support older people who are experiencing domestic abuse, so what services can do to identify people who are experiencing domestic abuse and how we can break down the barriers for individuals being able to access support. So my first question to you both is what do you think the challenges are that services face in relation to identifying and offering support to older people who are experiencing domestic abuse?

Jane: I think for the Idva service, the main problem we have is we just don't get the referrals. Whereas I'm now based in the hospital and I'm starting to see some of these cases coming through, in the community, unless there was a big police incident, they simply weren't coming through to the unit.

Mel: From an adult social care perspective, most of the concerns around older people come into the teams via safeguarding, and not necessarily specifically around domestic abuse. So I think with reporting, although it has improved, people still aren't identifying that there is domestic abuse issues for older people, they are treating them rather as safeguarding.

Emma: So what do you think are the reasons why people aren't identifying? Is that the fact that people don't recognise domestic abuse in older people?

Mel: I think a lot of it is around recognition, I think people have the idea that domestic abuse affects younger women or women with young children or children of any age, and that it doesn't really affect people over 65. And what we're finding more is that if people have had abusive relationships all the way through their marriage, obviously if they fall into our services at a later age, of course they're still going to be experiencing those relationship difficulties so we're seeing probably a generational thing as well where people have lived in these relationships for a long long time and have never maybe made a disclosure until much later.

Jane: I think the other thing is it's not just not recognising the abuse it's not realising that anything can be done about it and I think that's both from the victims point of view and from perhaps a social care point of view, and that's just the status quo. They are thinking that we have to accept it and just work with it rather than potentially changing the whole situation and even removing one of the members out of the relationship.

Mel: The other thing we experience in adult social care is if we have other complications such as things like dementia or physical disabilities, they are more of a barrier because it tends to take away the seriousness of any incidence, especially from a police perspective because they have to look whether it's in the public interest to remove people from houses or relationships where they've got a diagnosis of dementia or Alzheimer's, even though that perpetrator may have always been abusive and the abuse has been exacerbated by a mental health diagnosis. So it's about those extra complications for older people I'd say.

Jane: One of the cases I was involved in where the police did remove someone and put them on a domestic violence protection order, she described that as the worst 28 days of her life, because he was her carer, and she was absolutely high and dry, she had no proper care during that period and one of

the big issues always is the cost of care, and the reluctance of the perpetrator to pay for care or the reluctance of the victim to pay for care because always that's going to impact on the perpetrators inheritance at the end of the day and that's a massive massive issue for people not getting the help that they need.

Mel: I think something that also people become familiar with is a situation maybe between a couple where either of them has been the perpetrator and then for whatever reason they're physical or mental health deteriorates and we sometimes see a kind of change of responsibility in that relationship, so a perpetrator may become a main carer for somebody which has its difficulties. But equally if a victim becomes a carer, and that cared for person has previously been a perpetrator we can sometimes pick up that there is sort of a revenge situation going on where this perpetrator who has always been the strong person in the relationship is quite vulnerable and weak and situations have turned where the victim has become the perpetrator.

Jane: Yes, I've had a number of cases quite recently at the Marac where that situation has happened. It hasn't been a particularly violent situation in the past but has become very violent and in both cases the victim has got quite serious mental health problems and is literally abusing the perpetrator on a daily basis. In those cases the perpetrators are both men have been very reluctant to ask for help and support, it is only when there are quite serious injuries that they come forward for support.

Emma: So have you got any thoughts about what services can do to be able to get better at referring or identifying people who are experiencing domestic abuse and get them support?

Mel: I think one of the first things is that I think as professionals we don't ask that question about domestic abuse as we possibly would with someone who's younger. I think GP's need to get better at recognising periods of depression, isolation - GP's are very good at referring to services people who are isolated but there's other reasons but they don't ask that question. And I think as professionals in social care we need to get better at asking that question about domestic abuse. I think one of the difficulties for older people, I think it is a generational thing, I think lots of older people have lived with domestic abuse all the way through quite a long marriage and obviously times have changed we are much more proactive at looking at domestic abuse now than we were and I think that maybe if somebody in a relationship had made a disclosure years ago, thinking about the values around marriage, it was more or less marriage is for life until death do us part. And very much I've had people say to me 'I did mention it to my mother or my father years and years ago but was told to put up with it', and the thought that you've made your bed you have to lie in it and that you must not be a very good wife or mother therefore you need to up your game. And I think the whole generational thing has changed now, and that people want the opportunity to make a disclosure and they don't feel as bad about making that disclosure. In social care where we look at domestic abuse in relationships where the marriage has come to a situation where one of the people has become a carer which puts extra pressure on that house and extra demands on that individual, and it can obviously raise anxieties and tempers can flare, and whether you've been quite a passive person in the past those extra pressures of caring for somebody can bring about quite controlling behaviour. For example we've had situations where perpetrators have withheld fluids because that means that people are going to the toilet less so it's less mess, or where they have held medication back because medication affects the individual. And obviously these things have come to us under safeguarding but on the basis of things it is domestic abuse about control. And although they think they're controlling situations in peoples best interests, that's not necessarily what the outcome for that person is because obviously if you withhold fluid from somebody they become dehydrated, if you withhold medication that's got different impacts as well so it's quite a complicated situation to be in.

Emma: So Jane you've given quite a lot of examples of clients that you've worked with that are older. Have you noticed a difference in the type of victims who are referred to you from the hospital – so are you noticing any more or less people who are older being referred to you through that route?

Jane: Definitely we get more older people and more people who are in caring relationships who may be not older but in caring relationships at middle age. I guess they fall into different categories, there are carers relationships where perhaps the perpetrator is the partner and sometimes that partner may or may not have mental health problems, there are cases where the victim is the carer of the perpetrator or the perpetrator is the carer of the victim, also we get clients where the perpetrator is the carer who's the son or the daughter of the victim, and there is a big issue there where any money that is spent on care in that relationship, whether that's residential care or bringing carers in, is going to impact very much on that persons inheritance. Quite literally care packages will be set up and then they'll go home

and literally the adult child will phone up the next week cancelling the care package and stopping all those people from coming in, possibly saying the victim doesn't want that care to happen, and the whole thing will stop just so that the money isn't going out. And the other thing is they can become quite threatening - the carer themselves and the perpetrator to district nurses or social care staff coming into the home, so then they have to say well we have to send people in too so that impacts again on the cost of the care and they say 'well we're not having 4 people coming into the house' so again they'll stop the care. So it's a constant kind of battle with finances often when the carer is the son or the daughter, and it's also a massive pressure on the son or the daughter, probably it wasn't their life plan to be looking after their 80 year old mum or dad or in some cases both of them, and so they can become very neglectful. And sometimes the solution is about working with the carer persuading them that they do need the support so that they can have their own life as well because they're lives become very small as well. It's not as simple as the normal victim / perpetrator relationship because some of the work is about supporting the perpetrator to take some of the weight off them because they can become quite bitter about what's happened to their lives really, which have ended to a certain extent; they can't go out they can't socialise and meet new people.

Mel: I think from the social care point of view obviously the introduction of the care act last year allowed us to look more closely at carers needs and I think as part of that we need to be involved as professionals in asking carers about the pressures placed on them and about their caring role, does that effect the way that they think about their loved one whether that be mother, father, brother sister etc. The pressure on carers is huge and we rely on that support so much that sometimes we forget that it is a really demanding job and it can ignite domestic abuse in that kind of situation because the pressures are so high. And it may be that there has never been domestic abuse in that relationship until that point where that person becomes a carer for looking after somebody close to them. I think we are very good as professionals at looking at safeguarding but not specifically at identifying that support that domestic abuse services can provide specifically.

Emma: And what do you think are the barriers for the people themselves or the victims themselves being able to access support. So say we solved all the problems on enabling professionals to be able to identify and refer properly, then what are the issues for victims themselves being able to engage with support.

Mel: I think older people don't identify themselves as being victims of domestic abuse at all, I don't think until maybe as professionals we mention it to them directly they even realise that they have any choices, that they identify themselves as being in a domestically abusive relationship. I think there are lots of barriers around support and accessing services just in itself. Maybe people have mobility issues and physical/mental issues that affect them getting out of the house and if they do have a carer at home that might be identified as a perpetrator then how do we get services in when that person may not leave the house either, it's very difficult to even make a telephone call to somebody who is in that relationship because more often than not the perpetrator is there all the time and there is no way of making contact with that victim.

Jane: Yea they are the problems I've had in contacting the victim as an Idva; it's just the fact that where I can see someone in a hospital, it's almost impossible once they've gone home. I'll be at a Marac meeting a couple of weeks later and I just won't have spoken to them since they left the hospital because it has been impossible. And also sometimes the landlines are disconnected because that is seen as too expensive, or because the perpetrator said well if the landline is there then she will phone the police and he doesn't want her to do that so disconnects the landline, and he holds the mobile phone so victims don't have any means of communicating with the outside world. Sometimes they'll have a pendent alarm but that's only if the perpetrator was willing to pay the money for it. But I think the biggest barrier is the fact that people don't think they can change anything, they think this is my life and there's nothing I can do about it. And there is a fear that if people do start to say I want things to change and then they get sent home and then the cat is out of the bag and the perpetrator is going to have a field day with them when they go home. There is nobody to protect that victim when they go home, and often they are completely immobile, sometimes they're in bed and they can't move. I've had cases where very frail people have been threatened physically with literally a fist in the face on a daily basis. But you're not going to pick these things up unless they're coming into hospital and unless there is somebody there to recognise it, whether that's somebody on the medical team or social care team. So I know I'm only touching the surface of what's actually coming through the hospital. And then when you see the victim it's then persuading them that there actually are options.

Mel: I think from my point of view working in a couple of recent cases with older women in domestically abusive relationships, one of the big fears was that they would have to move from their home. One lady in particular who had a lot of physical disabilities, the property she was living in had been adapted there was a lot of equipment in there but we persuaded her that there were options to move out. Unfortunately, those options were very limited and it meant that rather than us accessing somewhere like a refuge or any independent housing it was residential care, and that's a massive thing for people. Residential or nursing care really has to be the last option, but it really shouldn't be an option to move out of a violent relationship. And her concern was that if she moved out into residential care even if it was short term she would never have the option to either move back into the property that was adapted specifically to her and was in her name or into another property – she saw that moving from that house was going into care. And really she didn't need to be in care but for us as a service provider it was our only option.

Jane: And refuges don't generally have the support available to be able to cope with the kind of care needs that these victims tend to have. Or the social needs, because refuges generally have younger people.

Emma: So what have you done or what can you think of that has been done to break down these barriers? So to improve the rate of people who are being referred and to be able to enable older people to access support once they are referred?

Mel: Well Jane and I have been involved in pulling together some training from adult social care and domestic abuse for all professionals including adult social care staff, police, all health staff and specifically designed around looking at adult safeguarding and domestic abuse in that forum as well. We rolled that training out last year and the response has been very very successful and the funding has enabled us to roll it out again for another year. I think it's less of a training session but more a discussion and identification session, allowing people to think a little more outside of the box when they are dealing with people. And I think it's been quite an eye opener for people and given them more confidence in asking the question and looking at domestic abuse as an option rather than just under the umbrella of adult safeguarding.

Jane: And I think it's fair to say that the adult social care just don't think in terms of domestic abuse at all and think very differently to the social workers working with children. And so I think we are certainly starting at a lower base really in looking at recognition, and accepting that there is abuse in these relationships, so we are certainly starting from a lower level I think.

Mel: We are and I think the big difference between children's social care and adult's social care is that we look at domestic abuse in children's services around protecting children but what we have to look at in adult social care is definitely mental capacity. And with the Care Act we had making adult safeguarding personal to make people as safe as they want to be. So people who have capacity to make decisions, even if it be unwise ones, they have the support of us helping to make them as safe as they want to be, not necessarily rescuing them or removing them from situations but absolutely supporting them in the decision making process and supporting them to continue, even in a relationship that on the surface doesn't look very good for them. So we have the difficult job in adult services of obviously looking at capacity as well as adult protection. So I think that the difficulty we have sometimes between looking at children's social care and adult social care.

Jane: Yes, I've been in professionals meetings where it's incredibly frustrating because we are just looking in from outside and people want to stay in those relationships whatever reason it is, that there is literally nothing you can do. And I've been in professionals meetings before where the police are saying 'if this was kids we'd just take them out' and we can't do that- unless we have capacity as an issue. And suddenly the moment somebody doesn't have capacity then you are able to take somebody out and make actions in people's best interests and you can be involved and there could be a deprivation of liberty safeguarding done for that person so that they can be taken out of the situation.

Mel: I would say 90% of the cases of Marac are younger women and women with child protection issues; we have very few cases presented at Marac where they are older people. And I think sometimes it's difficult for everybody at that table to start throwing out options to be worked on because it's about that individual wanting to be part of the process.

Jane: Because people are so difficult to contact, the actions are often reliant on the care team that are going in, perhaps the district nurse, so they are very different actions to the actions we have in our other

Marac cases. Because those are the only people that have a lead into the house who are the eyes on the ground and can see what's happening. And those people themselves are also put at risk, I've been involved in cases recently where the health care staff have been threatened or harassed by the perpetrators.

Mel: It's very difficult to follow Marac actions up following a case where people have capacity but don't want any support, and I think as professionals we feel quite uncomfortable about that. But I think it's rights to say that as professionals we've had open and honest discussions round the table, especially at Marac with the high risk cases, that those discussions are noted down somewhere, so that should anything go wrong in the future we have evidence that we have tried and we have supported people. But like you say unfortunately we just don't have the same weight in our laws that the children's act has about preparing and making children safe.

Jane: By the same token though, most of the victims in the older adult cases probably only just beginning to get their heads round themselves that it is an abusive situation. So in the same way that with younger people you're often sowing the seeds and it's the next time or the time after that. It's about as long as people know that there is support out there, perhaps the next time that they come into hospital they will want to do something about it, or perhaps the next time the district nurse sees something or tries to speak to them about it they will want to do something. So in many ways those parallels are there with younger people it's just that we're only just starting to see those repeat Maracs coming through really, I've only had a few repeat Maracs so far.

Mel: And I think as professionals we just need to get better at asking those questions, they're quite difficult questions and I think it's very different asking an older lady or an older gentleman towards the end of their life if they're having difficulties in this area than it is asking a younger women or younger man. And I think it can be seen far more intrusive into older people's lives. But the more we ask the questions the more opportunity people have got to make disclosures and ask for support, so it's really really imperative that as professionals we look at it as an option.

Jane: Because for lots of people they think 'well we've been together for 60 years I'm not going to change anything now' or for one person I worked with for a long time used to keep saying 'I know when the time will come, you just keep on ringing me and eventually the time will come where I will ring the police but I'm not there yet. My decision is I want to stay in this situation because for me even though he's an awful carer and he's abusive and he's violent sometimes, sometimes he's lovely and he is my carer and I don't get any love or support off the carers I pay for who come into the house'. So she was very much saying 'I'll know when the time comes when I've had enough'.

Emma: Thank you for listening to this podcast. All the Spotlights content can be found on our website at www.safelives.org.uk