



Older People's Commissioner for Wales  
Comisiynydd Pobl Hŷn Cymru

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# Crimes against, and abuse of, older people in Wales

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Access to support and justice:  
working together

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**January 2015**

# The Older People's Commissioner for Wales

The Older People's Commissioner for Wales is an independent voice and champion for older people across Wales. The Commissioner and her team work to ensure that older people have a voice that is heard, that they have choice and control, that they don't feel isolated or discriminated against and that they receive the support and services that they need.

The Commissioner and her team work to ensure that Wales is a good place to grow older, not just for some but for everyone.

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## Glossary of terms

AAPC	Area Adult Protection Committee Report
APCA	Adult Protection Committee Annual Report
ATJ	Access to Justice
CJS	Criminal Justice System
DMS	Data Management Systems
IDVA	Independent Domestic Violence Advocate
IMCA	Independent Mental Capacity Advocate
MARAC	Multi-Agency Risk Assessment Conference
NHS	National Health Service
POVA	Protection of Vulnerable Adults

## Research team

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This report contains information on adult protection, domestic abuse and hate crime and is an independent audit of data management systems which is provided for general information only. It is not intended as a source of legal advice applying to any specific circumstances. Whilst Aberystwyth University, its employees and students have taken reasonable care to ensure the accuracy of the data contained in the report at the time of going to print, the data used is third party data and the University cannot and do not accept liability or responsibility for its accuracy, adequacy or completeness, nor is any warranty, either express or implied, given in relation to the report.

# Foreword

In June 2013, I published my Framework for Action<sup>1</sup> which outlines my priorities and how I will, over my term of office, discharge my statutory role as laid out in the Commissioner for Older People (Wales) Act 2006.

One of my key priorities is to work with the wider criminal justice system, safeguarding agencies, colleagues across police services and others to increase awareness of the nature of abuse faced by older people and ensure they have access to support and justice. I wish to ensure that, where they fit the legal definition, older people are recognised as victims of domestic abuse and have access to the full support available to them under domestic abuse legislation and domestic abuse support services, and that the abuse of older people is recognised and treated as a criminal act.

Whilst we have some good practice across Wales, it is not consistently being applied in all areas. There needs to be greater commitment and a joined up approach if we are to safeguard many older people who experience abuse.

To support my work, I commissioned Aberystwyth University to look at how we identify, record and transfer data and cases between agencies and I asked the researchers to suggest how we can do this better in Wales. As adult protection in Wales is about to go onto a statutory footing through the Social Services and Well-being (Wales) Act, this is an opportune time to consider how agencies can work better together to prevent older people falling through the 'gaps' that exist between services.

Unlike the majority of my reports, which are specifically intended for older people, this report is targeted at professionals who have a role in adult safeguarding and protection and domestic abuse services. Following publication of the report, it is my intention to bring together a working group that will look at the recommendations of the report and map out a way forward to address the issues it raises.

On 9 December 2013, I held a seminar at which I shared the initial findings of the report with many key leaders in Wales, such as Police and Crime Commissioners, adult safeguarding experts and those providing frontline services for domestic abuse. The feedback I received was positive and the research rang true with them in many ways; I look forward to working with these people and others to make sure that older people have access to the support and justice that is theirs by right so that Wales is a safe place to grow older, not just for some but for everyone.



**Sarah Rochira**  
**Older People's Commissioner for Wales**  
January 2015

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<sup>1</sup> [http://www.olderpeoplewales.com/en/news/news/13-05-23/Framework\\_for\\_Action.aspx#.U0aPSfldVe8](http://www.olderpeoplewales.com/en/news/news/13-05-23/Framework_for_Action.aspx#.U0aPSfldVe8)

# Executive summary

## Effective data management

From an analysis of the interviews with practitioners involved in case management, there appeared to be considerable variation in practitioners' understanding of domestic abuse in older people. However, interviews with practitioners from authorities that had invested in extensive staff training demonstrated a more sophisticated and nuanced understanding of abuse in older people; for other authorities it was evident that further training in this area was necessary.

### **1. Aggregate data sets**

Currently, most cases of domestic abuse appear to be broken down into separate categories that record the different types of abuse. Thus, domestic abuse is subsumed into other abuse which might be singular incidents of abuse carried out by people who were not related to the victim and, therefore, the domestic abuse elements may be lost.

### **2. The different types of abuse and the nature of the abuse**

Practitioners stated that they were uncertain about the type and level of information they could record. Numerous practitioners mistakenly held the view that detailed information about an alleged perpetrator could not be collected unless they had been convicted of a crime. There was awareness amongst some local authorities that often, to end the abuse, POVA practitioners must recognise and address the needs of both the perpetrator and the victim.

### **3. Financial abuse**

Financial abuse was not always perceived as a potential indicator of other forms of abuse, nor was financial abuse by a relative of the victim recorded as domestic abuse by agencies in some cases. The possibility that some practitioners do not recognise a case as domestic abuse may lead to an inaccurate risk assessment of the situation and thus an inappropriate response.

### **4. Contact with the perpetrator**

The time when the alleged perpetrator was not with the victim provided opportunities for further disclosure from the victim and opportunities for practitioners to refine safety planning.

### **5. Detecting and recording domestic abuse**

There appears to be a disparity between practitioners' knowledge of the definition of domestic abuse and the extent to which their knowledge of the definition informed their actual practice.

### **6. Location of the Domestic Abuse**

There was an erroneous perception amongst practitioners that in order for an incident to be regarded as domestic abuse the perpetrator had to be living in the

same household as the victim. It is the relational factors that define domestic abuse, not necessarily location.

## Protection of Vulnerable Adults (POVA) process

### 1. Threshold decisions and application

Across the twenty-one local authorities (out of twenty-two) who participated in the research, there was some variation on how 'significant harm' was interpreted and applied. Whilst small variations were understandable, practitioners felt that current practice had led to wide variations in threshold decisions. There was an uncertainty as to how to address these fluctuations in the threshold test. Knowledge of the threshold decision was felt to be dependent on how effectively agencies shared information and how the data management systems were utilised.

### 2. Sharing Information

Practitioners felt that, at times, highly relevant data was not being passed on to key agencies, which resulted in limited support being provided for older victims at critical periods. Some agencies commented that other organisations did not use the Data Protection Act 1998 and information sharing protocols to their full advantage and that this impacted on the quality of the risk assessment and safety management processes.

There was evidence of 'silo working' in some instances and a sense of concern that current information sharing between agencies was not as effective as it could be. Furthermore, external agencies either took too long to respond or certain agencies did not respond at all to requests for information so that an accurate assessment could be made.

### 3. Knowledge of the POVA process

Police knowledge of the POVA process and threshold varied both within and across forces. Professionals felt that POVA training needed to be mandatory because, currently, some agencies' knowledge of the process and threshold test was inadequate.

'Agencies that need more training and information on threshold would be police. Other agencies ring us and discuss the incident before making a referral whereas the police just refer to us.'

(POVA Coordinator: 2)

### 4. Knowledge and level of training amongst health services staff

There was also a perception that health services staff's knowledge of the POVA threshold was highly dependent on the role of the health care professional. Practitioners believed that General Practitioners (GPs), given their level of contact with older people, had an ideal opportunity to identify abuse and safeguard the individuals; however, there was a concern that these opportunities are missed. POVA practitioners stated that there was a real need for GPs to initiate a more meaningful dialogue with older people in order to either seek further advice or to



specify how they had taken steps to safeguard the individual. Greater involvement by GPs was felt to be vital, especially during the time between making a referral and before an initial Strategy Meeting (to decide how to deal with the referral) was held.

It was commented that GPs need to have mandatory training to increase their knowledge and understanding of the POVA threshold. When such input by health agencies was provided it proved to be invaluable to GPs, given they often have good access to older victims on a regular basis.

## **5. Quality of referral**

POVA practitioners often commented that frontline workers often do not provide sufficient detail on the referral form. The need to seek further clarification and to request further information was felt to be a time-consuming task for POVA practitioners.

## **6. Frontline workers, consent and opportunities for referral**

Whilst there were some excellent examples of client empowerment and integration into decision-making, especially in the good practice areas, where consent is not sought from service users this can act as a barrier to developing an individually tailored response:

‘I would say that is where the first failing seems to be when I have had referrals, that they [frontline worker] haven’t involved the individual. It’s almost that they need to report it and that is forefront in their minds. It’s stepping back and saying, what do I need to do? Who do I need to involve? What do I need to capture?’

(POVA Coordinator: 8)

A top-down approach rather than a client-led approach was felt to be counter-productive both in terms of reducing risks to the service user and increasing the likelihood of developing unrealistic and impracticable action plans.

## **Coercive control, consent and intervention**

Research by Hoyle and Sanders (2000) shows victims of domestic abuse are not often in a position to give consent because they are unduly influenced by perpetrators who control their access to external support.

### **1. Recognising coercive control**

Police and social care agencies were aware that face-to-face contact was more effective than a telephone conversation in establishing whether a victim’s refusal to give consent was the result of undue influence by a perpetrator. Home visits also gave practitioners the opportunity to assess the victim-perpetrator dynamic and ascertain whether the victim was experiencing manipulation by the perpetrator. However, frontline practitioners implied it was not always possible to visit in person and expressed concerns that current resources often resulted in case management by telephone.



There were a number of practitioners who expressed a degree of frustration that co-workers and other external practitioners did not always recognise the levels of emotional manipulation, control and coercion that the victim could be experiencing from the perpetrator. Practitioners stressed the importance of using what they termed as 'emotional intelligence' to help decide if consent was free from undue influence.

## **2. Mental Capacity**

Assessing mental capacity is decision-specific not condition-specific, thus when assessing capacity practitioners should assess whether they have capacity to make a decision in accordance with the principles set out in the Mental Capacity Act 2005. It was felt practitioners were particularly unaware how to act in cases where when mental capacity was fluctuating. This is something that needs to be addressed as a matter of urgency in order to protect the human rights of the individual involved and to avoid an unnecessarily paternalistic approach.

## **3. Power to intervene**

'I am saying intervention...I would far rather we question and ask more in detail and intervene. I would be happier to be questioned as to why I poked my nose in than I would be in a Coroner's inquest saying why I didn't. That is fundamental.'

(Detective Inspector: 1)

Practitioners that understood the use of power, control and coercion by perpetrators towards their victims were supportive of developing far more interventionist approaches to reduce the risk for victims of domestic abuse. The expectation is that the new Social Services and Well-being (Wales) Act [not yet in force] will encourage a more interventionist approach in some instances, but the effectiveness of the new Adult Protection Supervision Orders (APSO) outlined in the Act in providing greater leverage for increased agency intervention has yet to be established.

## **4. Empowerment**

Some areas had excellent examples of client involvement at every stage in the process, even in strategy meetings, and the feedback was that this was beneficial in facilitating engagement and also resulted in fewer repeat referrals and a more tailored and efficient use of staff resources (see Good Practice section).

## **5. Attendance**

Attendance by professionals at POVA meetings varied across each local authority. However, there was a general perception that health services need to engage more with the process. POVA practitioners felt that attendance at strategy meetings should be a statutory requirement.

## **6. "Toothless tiger"**

Some practitioners saw POVA as a 'toothless tiger' in that the process resulted in recommendations to help individuals but there is no legislation to facilitate

practitioner compliance with the recommendation; this lack of legislation was felt to increase the likelihood of repeat referrals and possible on-going abuse:

‘I do feel POVA is like a pointless exercise ....I think if there was some sort of legislation there would be a bit more weight in what POVA can actually do.’

(Social Worker: 1)

POVA practitioners and other interviewees frequently made the comparison between the legislation that was developed to support the process in child protection and the contrasting gaps in the adult protection process.

## Multi Agency Risk Assessment Conference (MARAC)

### 1. The use of the Domestic Abuse, Stalking and Harassment Risk Indicator Checklist (DASH RIC) in cases of older victims

The ‘good practice’ areas saw the DASH RIC as vital because it is specifically designed for risk assessment in cases of domestic violence. The findings from the current study add further weight to findings from the Access to Justice evaluation (Clarke et al 2012: 24)<sup>2</sup> regarding adult services, where there appeared to be either limited knowledge and thus inadequate application of the DASH RIC, or an unwillingness to use the DASH RIC to assess older victims of domestic abuse.

Several of those interviewed were of the opinion that not employing the DASH tool could result in missed opportunities to detect domestic abuse and assess the level of risk.

### 2. Knowledge of the MARAC process

The number of referrals made to MARAC for older victims of domestic abuse was surprisingly low. It was believed that referrals for those aged sixty years and over were low because there is a lack of awareness of domestic abuse in older age groups and this lack of knowledge leads to reluctance by agencies to engage in the MARAC/IDVA process.

## Effectiveness and perceived limitations of POVA and MARAC integration

The MARAC process and the POVA processes can both be used when dealing with an individual. POVA professionals felt that the POVA process involved a more robust approach than the MARAC process when dealing with the individual because they had more time to discuss the case. The findings here further reinforce some of the findings from the evaluation of the *Access to Justice* study that further discussion at strategic and operational levels about POVA and MARAC roles and pathways is required to decide which cases may require more input by one process than the other and at what point a case may benefit from an integrated approach.

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2 <http://wales.gov.uk/statistics-and-research/evaluation-access-to-justice-pilot/?lang=en>

## **1. Mandatory training**

There was a strong suggestion that mandatory training, especially for POVA teams, in the MARAC/IDVA process was necessary so that a more nuanced approach can be applied based on the specific needs of the individual older victim rather than applying a blanket response to a diverse group of older people; such an approach is highly unlikely to lead to positive, individually tailored results. Although several practitioners thought a case by case approach was best, several had no understanding that a specifically tailored response for older victims of domestic abuse could bring real benefits.

## **2. Communication**

Clear communication between the MARAC and POVA processes was felt to be vital to avoid duplication of practice, monitoring which practitioner is responsible for specific actions. Currently, integration of the two processes is not nearly as effective as it could be.

## **The Role of Housing**

For victims of abuse who were local tenants, local housing authorities and housing associations could work with other agencies to provide safer positive outcomes, but for owner-occupied housing, the removal of the perpetrator was a more complicated and protracted task.

### **1. Supporting safeguarding**

In some areas, local housing authorities were actively involved in safeguarding, for example, abusive tenants were removed from the tenancy agreement, and permission was granted to change the locks on the doors. Other agencies recognised the benefits of involving housing and there were examples of good joint agency working. Agencies saw the potential for increasing the role of housing in cases of domestic abuse in older people, given that housing agents may be a regular contact point, especially in cases where an individual has a disability and may be housebound.

### **2. Re-housing perpetrators**

In areas where housing was involved, the safeguarding measures that could be employed were felt to be very effective. There was widespread recognition by social care professionals that there was a shortage of appropriate housing for the victim and a need to re-house the perpetrator to prevent further harm.

## **Attrition**

### **1. Client disengagement with the process**

The majority of practitioners noted that client disengagement was more likely in the initial stages of the process, often occurring at the first point of contact with the initial agency. The likelihood of the victim to engaging with practitioners depended on two factors:

- who made the disclosure; and
- how the recipient of this information responded to the disclosure.

Social care professionals observed that, for older victims of domestic abuse, the primary motive for calling agencies was not to seek help for themselves, but to request help for the perpetrator.

Reasons for non-engagement with justice processes were as follows:

- a fear of repercussion from the perpetrator;
- a fear of the negative family consequences, especially increased isolation, and further reprisals;
- the victim's feeling that they would rather live with the abuse than lose a family member, especially if this was the only person the victim had contact with;
- the victim's feeling that they were somehow responsible – directly or indirectly – for the abuse, especially if they were the parent or grandparent of the perpetrator.

Self-blame and a sense of responsibility often impacted negatively on the decision-making process when seeking help.

There were age-related factors that were also felt to influence older victims' decisions whether or not to engage with social care and/or justice options. According to frontline practitioners, victims expressed the view that they did not wish to be alone at that stage in later life, even if that meant accepting a level of abuse. Practitioners observed that once the perpetrator was removed and strategies put in place to make the victim safe, many older people readily engaged with services. There was a view that more strategies needed to be developed to help victims feel safe so they were in a position to disclose information about the abuse that they were experiencing.

## **2. A lack of knowledge about service provision**

Practitioners commented that older people were unaware of safeguarding processes and this lack of knowledge about the service provision was a deterrent to engagement. Therefore, ways of making them aware must be explored more actively.

## **3. For clients who did not meet the POVA threshold**

If a case did not meet the threshold for POVA, there was often felt to be a degree of confusion over which statutory agency had responsibility for case management. However, there was a perception that for cases that did not meet the threshold, victim referrals were not appropriately dealt with, and many cases were left 'between agencies and without clear support'. The majority of practitioners commented that currently too many cases 'fell through the net' and that this was not acceptable.

# Criminal justice proceedings

There appeared to be wide ranging differences across the local authorities as to the point at which social services involved the police in a case. It was felt to be important for all practitioners to explain to victims the nature of the police role and discuss all options available and not to make any ageist assumptions about decisions to pursue a justice outcome.

Police officers and CPS professionals identified three stages which impacted on criminal justice proceedings, these were: evidence gathering, withdrawal of witness statements, and court proceedings.

## 1. Evidence gathering

Criminal Justice agencies felt that evidence gathering was not as robust as it should be especially in cases where medical evidence was required to support allegations. Timing was crucial as the quality of the evidence was very time-dependent.

## 2. Witness statements

Police officers and the Crown Prosecution Service (CPS) stated that victims may sometimes choose to disengage because of a lack of understanding about the process. There were also concerns that increasing cuts in staffing levels were having a negative effect.

Older victims often felt particularly isolated between the point when bail was granted and the court case taking place. This was a key period when high attrition<sup>3</sup> rates were observed by practitioners. It was noted that an advocate from the third sector was often crucial to encouraging on-going engagement with the criminal justice process. Police officers recognised that, for older people, a lack of regular communication could increase anxiety and lead to disengagement.

## 3. Court proceedings

The CPS and police officers commented that older people were less likely to ask questions about the court procedure and may be more afraid of the formality of the court process than people at other stages in the life course. The adversarial process and robust methods of questioning were felt to have a negative effect on the older person. Police officers also noted that lengthy court processes could lead to an increase in attrition rates in older victims because of the negative impact on the victim's health and emotional wellbeing. It is not clear on what evidence this was based.

There was concern that Special Measures<sup>4</sup> were not being used when they could be and police officers and the CPS believed that older victims needed far more support than currently given before, during and after the court experience to increase the likelihood of a successful prosecution process and outcome.

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3 A decrease in the number of cases progressing

4 [http://www.cps.gov.uk/legal/s\\_to\\_u/special\\_measures/](http://www.cps.gov.uk/legal/s_to_u/special_measures/)

# Hate Crime

There was a perception amongst hate crime professionals that when older people experienced hate crime it was usually focused on issues relating to age or disability rather than other issues such as race or religion.

Specialist hate crime officers stated that police officers in general may have responded to a case of hate crime without necessarily identifying it as such, so many cases may be recorded as other incidents. In older people, there were parallels with under-recording of hate crime that were similar to the under-recording of domestic abuse.

Adult protection officers in the police were aware that additional training would be of benefit to their organisation. It was clear that social care practitioners' knowledge base of hate crime and how it could shape service provision was still in its infancy.

## 1. Age as a reporting factor

Interview data highlighted that the CPS has 'age' as a reporting category for hate crime but the police do not record statistics for age-related hate crime. There was a perception that a degree of ambivalence existed both across and within agencies as to whether 'age' should have a reporting category of its own. Some practitioners who held the view that 'age' should have its own reporting category, felt that perpetrators were very calculating in targeting who they could abuse.

## 2. Dealing with Hate crime

Social housing was seen in most instances to be proactive when tackling incidents of hate crime involving older people:

'Social Housing Providers... they are excellent... I use them and their Housing Officers and their Community Safety Team to put pressure on the perpetrator, threaten their tenancy, demote their tenancy, threaten eviction... Their understanding of Hate Crime and way of dealing with it is extremely robust.'

(Hate Crime Officer: 2)

Previous research findings on this topic area by Clarke et al. (2011), suggest that social housing and other housing associations need to raise tenants' awareness of hate crime and provide information to them on how to safely report incidents to housing officers. This awareness-raising information should highlight that the response given by housing officers must be discreet and confidential to ensure against any further repercussions



# Introduction

*‘Justice and empowerment, along with adult protection should lie at the heart of any comprehensive safeguarding service’*

*Care and Social Services Inspectorate Wales (2010)*

Accessing justice is not only a human right, but in some instances may be the only effective way of protecting the victims of abuse. The use of justice processes and the provision of welfare support can complement each other as long as an appropriate balance is achieved which acknowledges and responds effectively to the wishes of the individual. As part of this process, it is essential that service providers adopt a person-centred approach when discussing the criminal, civil and welfare options available.

The review of ‘In Safe Hands: Implementing Adult Protection Procedures in Wales guidance’ (National Assembly for Wales, 2000) emphasises the need for the early involvement of the police service and the Crown Prosecution Service (CPS) where a crime may have been committed. The CPS policy document on crimes against older people states that a ‘welfareist reaction to vulnerable adult abuse may lead to an assumption that no prosecution represents the ‘public interest’ as it avoids exposing victims to the criminal justice system, and provides a pretext for welfare intervention.’

At present in Wales, we do not have a law similar to the Scottish Adult Support and Protection (Scotland) Act 2007. However, there is currently a body of law that is relevant to the safeguarding and protection of older people from abuse; this is highlighted in the published guide by the Older People’s Commissioner, ‘Protection of Older people in Wales: A guide to the law’ (2014).

## The policy context

A significant number of older people experience domestic abuse (DA). In 2008, the Welsh Assembly Government’s Communities and Culture Committee undertook a review of domestic abuse in Wales. One of its many findings was that older people who were victims of domestic abuse did not receive appropriate levels of service provision and in some cases were not considered as ‘victims’ under ‘In Safe Hands: Implementing Adult Protection Procedures In Wales guidance’ (National Assembly for Wales, 2000). Abuse in older people is not only a social problem and a crime problem, but also a human rights issue.

Although domestic abuse in older people very often involves behaviour that is criminal in nature (Williams 2010), criminal investigations, and ultimately prosecutions, are rare. In Wales, over a twelve month period (2011-2012), only 2.4% of referrals resulted in a prosecution, and 1.2% resulted in a caution (Care and Social Services Inspectorate Wales, 2013: 21). Similarly, the figures for England are low, with 1% of all completed referrals resulting in prosecutions or police cautions for each of the age groups 65-74, 75-84 and 85 and over (NHS Information Centre



2013: 47).

The Social Services and Well-being (Wales) Act 2013, seeks to enhance the safeguarding and protection of adults at risk by placing it, for the first time, on a statutory basis. A key provision in the Act is the imposition of a duty on local authorities to make enquiries if they have reasonable cause to suspect that person is an adult at risk. The Act also contains limited powers to enter premises to interview in private an adult thought to be at risk. The changes in the Act will improve the ability of local authorities and other statutory partners to engage in preventative work, but also to intervene when necessary. With a better statutory framework, the potential for an increase in referral rates and limited powers of intervention, local authorities will be required to diversify the way they respond to abuse and neglect (Williams: 2013).

The research literature indicates that in cases of domestic abuse, victims may experience 'secondary victimisation' by some professionals, who may not be equipped with the necessary training and experience to respond appropriately to victims, especially when they have complex needs (Hoyle and Sanders: 2000).

The Care and Social Services Inspectorate's All Wales Overview of Adult Protection (2010) recognised that empowerment and issues of justice should lie at the heart of any comprehensive safeguarding service. For victims of domestic abuse, seeking justice via criminal and/or civil routes presents numerous, often insurmountable, challenges especially given the often complex dynamics that exist between victim and abuser (Clarke et al., 2012; Wydall and Clarke, 2011; Clarke and Wydall, 2010). This research aims to provide an insight into what stages in the referral process may lead to older victims disengaging with the criminal/civil and welfare agencies.

## Older people and domestic abuse

### **A definition of domestic abuse**

Domestic abuse is defined as:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for

independence, resistance and escape and regulating their everyday behaviour.

‘Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim’

(Home Office, 2012)

Currently, official statistics do not routinely record domestic violence as a ‘discrete crime’; domestic violence can be subsumed under a number of different categories, for example, common assault, actual bodily harm (ABH), grievous bodily harm (GBH), public order offences.

## **Meeting the definition and implications for practice**

Although the definition of domestic abuse in older people does not differ from that of other people experiencing abuse, various studies suggest there may be some differences not only in the nature and type of victim and perpetrator relations, but also in the way practitioners respond to older people experiencing domestic abuse. Findings from numerous UK studies indicate practitioners often do not record the abuse older people experience, which meets the definition, as domestic violence. Instances of domestic violence for those over sixty years of age may instead be classified under different descriptors, such as theft or neglect.

Also, older victims may have different priorities, which subsequently results in the need to develop practice to provide an appropriate service to reflect the diverse needs of individual victims.

## **Access to Justice Pilot Project 2011**

### **Findings from the Evaluation of the ‘Access to Justice’ Pilot Project**

In 2012, Clarke, Williams, Wydall and Boaler conducted an evaluation of the Access to Justice Pilot, which developed out of the Welsh Government’s six-year integrated domestic abuse strategy ‘The Right to be Safe’. The pilot was designed to address the needs of older, vulnerable people who were victims of domestic abuse, and facilitate their access to criminal and civil justice options. More generally, the pilot project sought to ‘reflect the UN Principles for Older People, to tackle discrimination against older people whenever it occurs, promote positive images of ageing and give older people a stronger voice in society’ (Access to Justice, 2011: 3). The evaluation of 131 detailed case studies highlighted numerous gaps that exist in current justice provision for older people, for example:

- a) two-thirds of the victim sample were not involved in the decision-making process when their justice options were considered;
- b) older people who participated in the research felt that victims of abuse were more likely to engage with a justice provider if they were given additional time with one worker to build a relationship, establish trust and develop a rapport. The participants felt that an advocate model of practice was more likely to

empower the older person than the current 'case management' model. This advocate approach was recommended to increase the likelihood of older people feeling central in the decision –making process;

- c) a significant proportion of frontline workers lacked sufficient training to be able to explore civil justice remedies with older victims;
- d) very few cases of abuse resulted in a criminal conviction, suggesting a pattern of attrition worthy of further investigation (Clarke, et al., 2012).

The study was valuable because it allowed for in-depth analysis of individual level data. The study focused on qualitative issues to provide rich and detailed understanding of agency perceptions of abuse of older people as domestic abuse. The research highlighted the contextual specificity of abuse in domestic settings. The research was particularly useful in reviewing inter-agency responses to individual victims, whereas aggregate data can hide variations in the data.

## **Risk assessment**

The referral patterns suggested that risk assessment processes were inaccurate and many cases were not identified as domestic abuse. Furthermore, cases were not referred into the appropriate multi-agency group/service when it was appropriate to do so. The findings from the Access to Justice evaluation suggested that cases that entered the Multi Agency Risk Assessment Conference (MARAC) experienced better support and improved outcomes. A common perception among both practitioners and older people was that services were reactive rather than proactive and there was a need to make services more accessible, user-friendly and person-centred.

## **Working together - Silo-working vs a multi-agency model**

The importance of developing a local multi-agency response to ensure effective action for victims of domestic abuse has been recognised by feminist activists as far back as the 1970s (Harwin et al., 1999). From an official policy perspective, inter-agency collaboration and multi-agency partnership working have been increasingly promoted and encouraged since the 1990s in England and Wales (Home Office, 1995; Home Office, 2003; Task and Finish Group, 2012). However, this multi-agency approach is **not** evident for victims not deemed high-risk.

This gap in provision for low risk – or seemingly lower risk - victims means that even if they are in a position to access a service, the approach is likely to involve a single agency response rather than a co-ordinated community response. Shepard et al., (2002) note that positive programme outcomes were more likely where there is a coordinated community response involving justice agencies, other statutory bodies and voluntary sector organisations working together both in terms of increasing victim safety and feelings of empowerment, whilst simultaneously addressing the needs of the wrongdoer. Whilst research into the dynamics of domestic abuse in older people is still in its infancy, there appears to be some differences in the nature and types of perpetrator behaviours in some cases (Clarke et al., 2012).

The variation in causality may call for further refinements to older people's support services; specialist domestic violence provision and generic service provision.

## **Data Management Systems**

Research suggests that in most professional settings, agencies will have a form of computerisation of records. Whilst some areas may have developed bespoke systems which allow data sharing between partners; in other areas individual partners maintain separate databases. There is also evidence from research that some service providers do not have computerised records but hard copies of documents held in filing cabinets or practitioners rely on personal knowledge. However, the lack of consistency in data collection across agencies may, on occasions, result in duplication of cases, case omission, gaps in support and ineffective case management. To facilitate understanding it is imperative that accurate information is collected, recorded and analysed so that services can be tailored to better meet the needs of older victims of domestic abuse. An integral element of this study was to ascertain the degree to which current data management systems facilitated effective practice and monitored service provision, both within and across agencies.

# 1. The Research

## Research Objectives and Methodology

### Scope of the Study

The research fieldwork began in mid-September 2013 and lasted for a ten week period. All 22 Local Authorities; four Police services and the Crown Prosecution Service Cymru were contacted across Wales. Primary quantitative data input forms and data gathering spreadsheets were sent to all local authorities and police forces. Two generic interview schedules were designed; one which focused on data management systems and one exploring perceptions of service user disengagement/ attrition (see Appendix B for template).

The research focused on two areas:

- A scoping exercise, to review the effectiveness of data management system by key agencies. The study analysed the quality of intra-agency and inter-agency data collection, record - keeping and data transferal processes by key statutory agencies. The study also explored practitioners' knowledge of information-sharing protocol and data protection guidelines.
- The second stage explored professional agencies' perceptions of the various stages in the referral process, from initial point of contact to case closure, to find out why and at what point clients /service users may disengage with services. The purpose of this stage was to learn about potential gaps in the process, and examine solutions that would help to reduce the attrition rates of service users from both welfare and justice services.

### Data Collection

In exploring practitioners' perceptions of service provision and data management systems, a multi-method research design was chosen, employing both quantitative and qualitative methods of data collection. Information was primarily obtained from two major sources: Adult Care Services and Police Services.

### Qualitative Data

Primary data from semi-structured interviews and documentary information:

50 qualitative semi-structured interviews were conducted with practitioners and managers from:

- 19 out of 22 Local Authorities
- 4 Regional Police Services
- 2 Crown Prosecution Service Cymru

Documentary information was extracted for analysis from 13 Area Adult Protection Committee annual reports (2012-13).

## Quantitative Data

Descriptive statistics were drawn from:

- 22 Welsh Government data returns (PVA2)\*
- 21 Data Management Systems data input forms
- 14 Data gathering spreadsheets completed
- 13 Area Adult Protection Committee Safeguarding reports for 2012-13

## Data Analysis

### Levels of Analysis

There were three types of analysis used, these were as follows:

- Content
- Thematic
- Quantitative

### Access Considerations

The research team conducted the Pan-Wales study over a three month period, and whilst agencies were very supportive of the research process, the tight time constraints had an impact on accessing the research data. The qualitative data collection process was very productive, however, gathering quantitative data proved to be more difficult. For example, there was limited data readily available from the four regional police services, although they did have the facility to provide data on cases where the victim / alleged victim was aged 60 years and over. Given the tight time frame, police services did not have the resources to manually extract the level of detail the researchers requested.

## 2. Research Findings

### The Efficacy of Data Management Systems

#### Effective data management

Qualitative and quantitative data analysis identified four key themes relating to data management. The themes were as follows:

- Collecting details about the client
- Recording detailed information about the alleged perpetrators
- Sharing information both within and across agencies
- Agency variations in their knowledge of data protection and data storage

#### Client details

Across the local authorities there were variations in what was documented regarding individual client details. Differences were observed when reviewing both demographic data and other information that would be relevant to effective case management.

When accessing DMS (Data Management Systems) to review a client's history, practitioners frequently stated that domestic abuse was not easy to identify. The individual practitioner would have to actively look through all the case notes to ascertain whether the abuse was domestic abuse.

In addition, information as to whether the alleged victim was 'unfriended' was not always captured on the DMS. If practitioners were unaware of the individual circumstances, this may prevent a client's access to resources (e.g. an advocacy service). For example the Independent Mental Capacity Advocate (IMCA) provides a service for individuals who lack capacity and is also available if an individual was 'unfriended'. Practitioners commented that documenting information about the clients' social contacts would benefit case management, improve the accuracy of risk assessment and increase the effectiveness of any subsequent action plans.

Interviews with practitioners indicated that limited staff resources and barriers to the easy electronic access of client information influenced whether practitioners examined case notes to determine whether the abuse was domestic abuse and whether the victim had previously experienced domestic abuse:

Interviewer:

'As part of your record keeping on the DMS when you describe an incident, is there a way to create a consistent use of categories on the DMS so repeat incidents can be easily monitored over time?'

Interviewee:

'No, unless you go back over the case notes for the involvement. With Mental Health, everybody flags up on our system as being under Mental



Health. With domestic abuse (DA), there isn't a category for DA on there so it will be under Mental Health Services and you would have to go through the case notes to see if there was any DA previously recorded. Which, for ongoing cases, can be a nightmare - trying to get all of the information together. It would be useful to have an easy way to identify DA.'

(Frontline Practitioner in Adult Mental Health: 1)

Whilst some local authorities used flags to highlight suspected DA in older people on their DMS, it appears that others did not have these systems in place.

## **Recording detailed information about alleged perpetrators**

In many cases, there was felt to be insufficient information on the DMS detailing the relationship dynamics between the victim and the alleged perpetrator. In cases where there was a degree of interdependency between victim and perpetrator it was felt that, in order to enhance the decision-making process, agencies may wish to document the follow factors:

The different types of abuse and the nature of the abuse;

- Identifying whether the alleged perpetrator is pro-active or reactive\* and monitoring any circumstances that may lead to increased risk;
- Substance misuse / mental health needs of the perpetrator;
- The level of contact the alleged perpetrator has with the victim;
- The level of contact, both formal and informal, the victim has with other people and the nature of these relationships;
- Establishing if alleged perpetrator is a vulnerable adult and, if so, how is data shared across both victim and alleged perpetrator case files.

## **Sharing Information**

On the whole agencies felt that multi-agency working had improved, partly as a result of better joint working with health services and partly as a result of a move towards improved integration of MARAC and Protection of Vulnerable Adults (POVA) processes. The data suggested that practitioners were at times uncertain about formal data sharing protocols and this could be a barrier to providing effective support for vulnerable older people. Practitioners felt that, at times, highly relevant data was not being passed on to key agencies which resulted in limited support being provided for the older victims at critical periods. There was a need, in some instances, to develop trust and formalise working partnerships including more effective information sharing especially between statutory and third sector agencies.

There appeared to be considerable variation in the nature and quantity of data that was shared between social care services and partner agencies. Time constraints and large caseloads were perceived to have an impact on the ability to update case files. Similarly DMS were sometimes updated by practitioners as soon as they received new case note material, whilst other practitioners stated that they updated information in blocks on a weekly basis.

‘I think the difficulty is you have to upload as a completed documentation because once its uploaded it is stored without the ability to be changed, therefore you have got to hold off on the system while you are working on documents. So prior to getting it uploaded there may be a time delay. I find that frustrating because you know you’re trying to make sure that your colleagues are aware you maybe uploading information. But it is down to the time pressure with the work at the moment.’

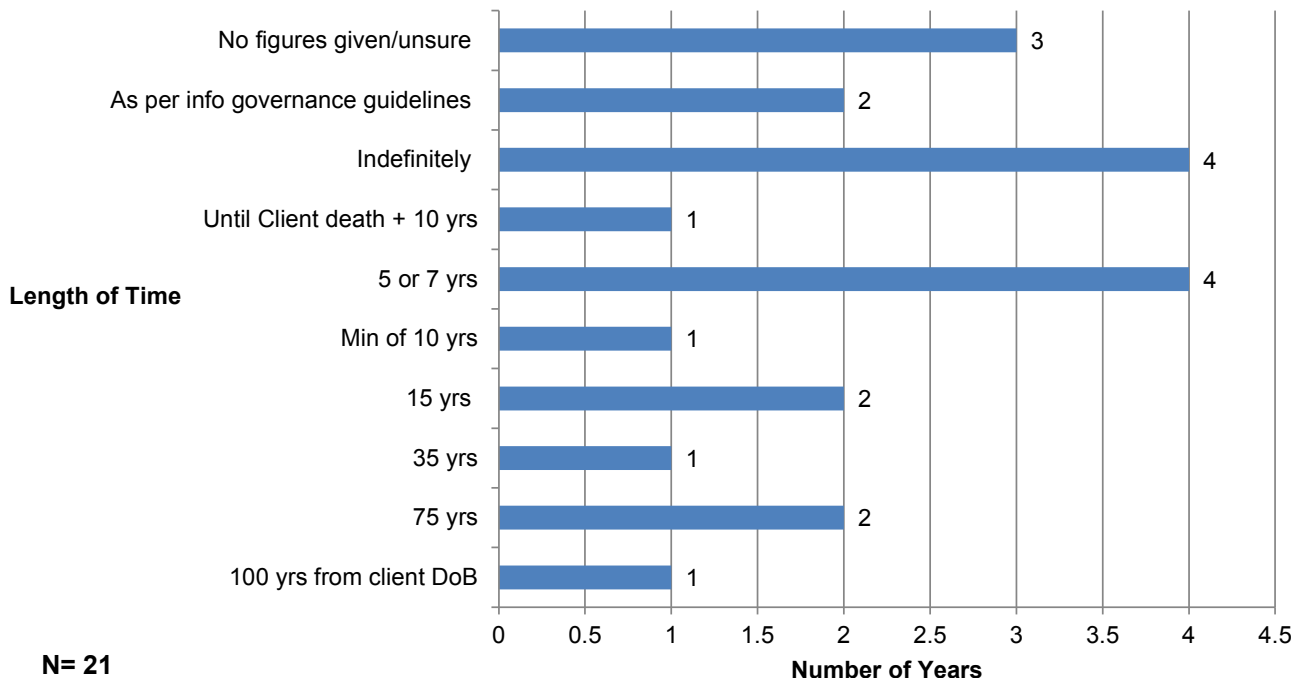
(Adult Protection Officer: 3)

Some agencies commented that other organisations did not use the Data Protection Act (1998) and information sharing protocol to its full advantage and this impacted on the quality of the risk assessment and safety management processes. In some regions it was felt that health authorities, particularly within primary care, were reluctant to share information and this could impede effective inter-agency working practices.

### Data storage policy on data management systems

The length of time personal data was stored on DMS varied considerably across local authorities. Practitioners who were directly responsible for data management were uncertain how long data should be stored in order to meet with Data Protection guidelines. The range of responses given for how long data should be kept on file after case closure varied, from five to seven years to an indefinite period.

#### Length of time client data is stored



This finding further reinforces the likelihood that training on data sharing protocol, data protection and data recording is required in some local authorities.

Qualitative data from interviews with practitioners who were directly involved with data input produced two themes: first, the majority of data management systems were inadequate as a tool to support the development of service provision tailored

to meet the needs of older victims of domestic abuse and, secondly, data gathering was mainly driven by the requirements of the Welsh Government annual returns.

## Detecting and Recording Domestic Abuse

### Definitional imprecision and the implications for practice

- Types of domestic abuse
- Perpetrators of abuse
- Recognising financial abuse as domestic abuse

As might be expected, generic practitioners and specialist domestic abuse practitioners differed in their knowledge and understanding of the incidence, prevalence and dynamics of domestic violence in older people. However, there were occasions where practitioners with dedicated domestic abuse roles did not appear to be aware of domestic abuse dynamics in older people, which was of some concern.

There also appeared to be a disparity between people's knowledge of the definition of domestic abuse and the extent to which an individual's knowledge of the definition informed their actual practice. For example, some individuals were aware that domestic abuse involved more than one type of abuse, others were able to quote the definition verbatim, but further discussion revealed considerable gaps in their knowledge on the nature and types of domestic abuse perpetrated against older victims.

### Perpetrators of Abuse

The majority of professionals were aware that domestic abuse could be perpetrated by someone other than an intimate partner. There was a view that, in some cases, practitioners saw only intimate partner abuse as domestic abuse. Thus some frontline workers did not recognise domestic abuse as a relational issue which may involve perpetrators who were related in some capacity to the victim, for example, sons, daughters, in-laws, grandchildren and ex-partners. There appeared to be a need for further training, so practitioners are more aware of the range of other types of victim-perpetrator scenarios such as mother-son or mother-daughters-in-law in older victims of domestic abuse:

'When I train if I say the alleged perpetrator could be the son or the grandson or daughter people don't see that as domestic abuse. I think it's because it's not an intimate relationship. I think it's perception and getting people retrained.'

(POVA Coordinator: 2)

The findings from the 'Evaluation of the 'Access to Justice' Study' (2012) provided an insight into the different relationship dynamics in which domestic abuse occurred in older people. The study indicated the most common type of perpetrator was not an intimate partner or ex-partner but a son. The study also suggested that a degree of interdependency existed which may have implications for how services developed their response in supporting clients.

The findings from the current study showed that whilst practitioners in some local authorities were aware of the different relationships common to domestic abuse, and the subsequent dynamics within a relationship, in other local authorities it was evident that practitioners were not aware of the nature and type of relationships classified as domestic violence.

Analysis of the Area Adult Protection Committee annual reports after the fieldwork was completed provided information on localities where intensive training and awareness-raising programmes were provided. The semi-structured interviews with practitioners in areas where training had taken place demonstrated a greater understanding of domestic abuse in older people, and a more nuanced response to clients than interviews in areas where training sessions had not been documented in the area adult protection committee (AAPC) reports.

## **Location of the Domestic Abuse**

There was a perception amongst practitioners that in order for an incident to be regarded as domestic abuse the perpetrator had to be living in the same household as the victim:

‘If they weren’t living in the same property I would probably think of it as more financial abuse from a relative rather than as domestic abuse.... Possibly more likely to think of it as domestic abuse, in the same household.’

(Adult Services Manager: 1)

‘...it is anyone living in the same household that perpetrates violence or intimidation against another person. They don’t have to necessarily be married for us in adult protection we get quite a lot where sons and daughters have gone back to live with parents, so children against parents or partners against each other.’

(Adult Protection Coordinator: 1)

However, perpetrators do not need to be living in the same household to be domestic abuse perpetrators; it is the relational factors that define domestic abuse, not necessarily location. Some practitioners were unaware that perpetrators of domestic abuse could live with the victim or away from the victim’s place of residence. In addition, practitioners were sometimes confused whether the case could be defined as domestic abuse when the abuse had occurred outside of the victim’s home.

## **Financial Abuse**

Financial abuse was not always perceived as a potential indicator of other forms of abuse nor was financial abuse by a relative of the victim recorded as domestic abuse by agencies in some cases:

‘In Adult Protection we have no category of domestic abuse, there is no specific category singling out domestic abuse. It is highlighted as part of the abusive situation so our abuse would be under a category of neglect,

physical, financial or psychological. We would tick the financial abuse box and then consider whether we would tick the DA box as an aggravating factor. From my experience I would be more likely to deal with it as financial abuse.'

(Adult Protection Officer: 1)

The quote above represented a common response by practitioners about their practice in a number of local authority areas across Wales.

## Asking the Questions

It was suggested that practitioners needed to have the confidence to ask further probing questions to establish the level of abuse the individual may be experiencing. It was important for practitioners to assess the impact of abuse on the individual's physical and mental wellbeing.

Interviewer:

'Overall to summarise, would you say there are any improvements or anything that can be strengthened in the process, from initial contact to case closure?'

Interviewee:

'As far as other agencies go, again asking the questions and being brave enough to say "Is there a problem? Tell me about it". Awareness around the area of DA is an on-going problem for all agencies really. It's not just a case of financial abuse because the impact could have psychological impact on the wellbeing of the individual so maybe that is a lack of insight of the person [conducting the assessment].'

(Detective Constable: PPU: 1)

The possibility that some practitioners did not recognise a case as domestic abuse may lead to an inaccurate risk assessment of the case and thus an inappropriate response. Some practitioners commented that if practitioners were not recognising that financial abuse could be an indicator of domestic abuse, then agencies would not be working effectively with the victim to reduce risk:

'Nothing is going to change if it is [the case] coming in as a straightforward manner, purely as a theft, realistically that victim is not going to have the proper advice and work done with them to reduce the risk of it [the domestic abuse] carrying on'.

(Detective Constable: PPU: 1)

## Problems with aggregate data and monitoring domestic violence

Managers and some practitioners commented that although the PVA2 forms were supposed to be purely for Welsh Government returns, some practitioners used the DMS information to gain a picture of abuse levels locally, sometimes misinterpreting aggregate data rather than analysing individual level data. The data from the twenty-two local authorities shows that there were a total of 2155 closed cases of abuse throughout the previous year (2012-2013). Of the 2155 closed cases 2551 types of abuse were recorded.

### Type of abuse and different measures of recording across different local authorities

	Six Authorities		16 Authorities		All 22 Authorities	
	Closed cases	Types of Abuse	Closed cases	Types of Abuse	Closed cases	Types of Abuse
Emotional		58		333		391
Physical		125		513		638
Financial		101		486		587
Neglect		175		674		849
Sexual		13		73		86
	<b>472</b>	<b>472</b>	<b>1683</b>	<b>2079</b>	<b>2155</b>	<b>2551</b>

Six local authorities recorded the same number of types of abuse as the number of closed cases i.e. only recording one type of abuse per case. The table above illustrates the number of closed cases by the types of abuse across the twenty-two local authorities.

More experienced practitioners felt that misconceptions about domestic abuse in older people were commonplace, they noted that some data recording and storage techniques may distort an individual's perceptions of domestic abuse in older people. Experienced practitioners felt that new practitioners and practitioners who were untrained in the area of domestic abuse were more likely to misinterpret data on the DMS.

### Detecting Domestic Abuse

Analysis of the data from the annual PVA2 returns for the Welsh Government (2012-13) suggested that across twenty two local authorities, only 297 recorded domestic abuse as an aggravating factor out of 2,155 closed cases for those individuals aged 65 years and over. It is interesting to note that eight of the 22 local authorities did not record any incidences of domestic abuse as an aggravating factor on the PVA2 forms. It was not clear why the Wales-wide figure was so low; however this data does not present a useful indicator of prevalence nor context in cases of domestic abuse across Wales. It is important that guidance is further refined and new data



categories are developed so that in cases of domestic abuse, a more accurate Pan-Wales benchmark can be developed.

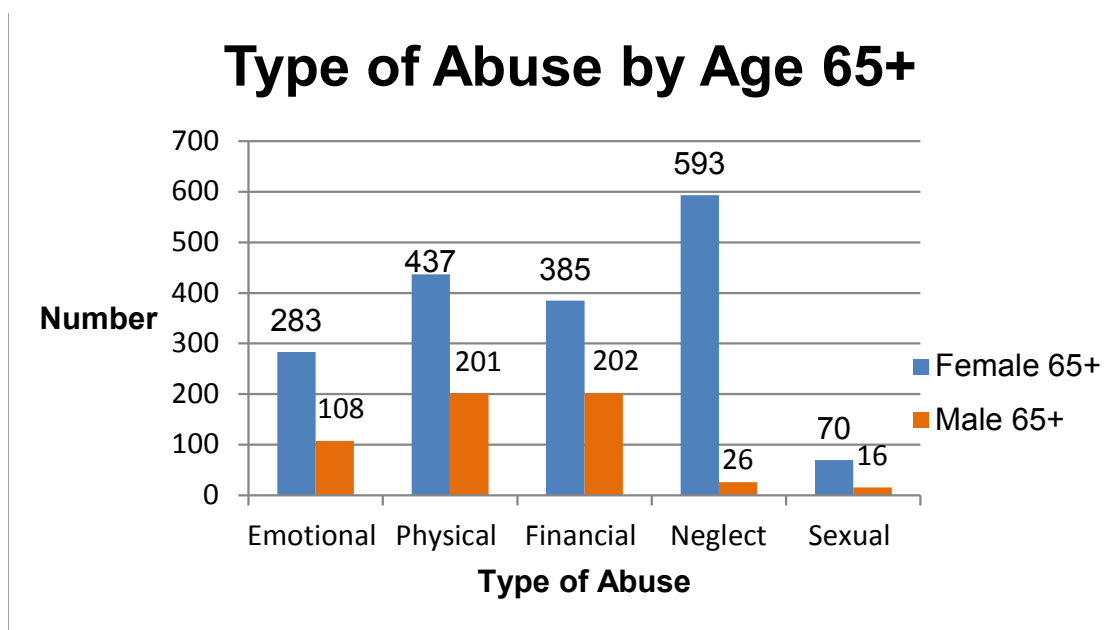
The PVA2 forms did not appear to have a separate section where domestic abuse was recorded unless domestic abuse was perceived as an aggravating factor.

‘When we look at abuse we look at the impact, financial abuse could be psychological, emotional abuse etc. Perhaps people become focused on one category, not realising that other types of abuse can also take place...It can vary and perhaps that’s what people do, lose sight of the types of abuse and the impact they have on people.’

(POVA Coordinator: 3)

Currently most cases of domestic abuse appeared to be broken down into separate categories that recorded the different types of abuse, thus domestic abuse was subsumed alongside other abuse which may be singular incidents of abuse carried out by people who were not related to the victim.

The graph below illustrates the number of recorded incidences involving the type of abuse by gender of the alleged victim. This graph does not highlight discrete incidences of domestic abuse; it merely provides an aggregate figure for all types of abuse.



From an analysis of the interviews with practitioners involved in case management, there appeared to be considerable variation in practitioner’s comprehension of domestic abuse in older people. However, interviews with practitioners from authorities that had invested in extensive staff training demonstrated a more sophisticated and nuanced understanding of domestic abuse in older people. For other authorities it was evident that further training in this area was necessary.



## The different types of abuse and the nature of the abuse

Practitioners stated that they were uncertain about the type and level of information they could record. The quantitative data indicated that some agencies recorded basic demographic information, such as the gender of the alleged perpetrator and their relationship to the victim, whilst other agencies recorded potential risk factors, for example, previous domestic incidences, substance misuse and mental health issues. Fear of breaching data protection guidelines and information sharing protocol were key areas that could inhibit detailed recording of perpetrator–victim dynamics. Numerous practitioners mistakenly held the view that detailed information about an alleged perpetrator could not be collected unless they had been convicted of a crime.

‘We don’t hold a lot of information about the perpetrator we might try and identify their sexuality, male or female, whether they are a relative, a paid worker or unpaid worker, volunteer...’

(Adult Protection Officer: 1)

‘People are cautious with what they are sharing. Got to make sure it’s relevant for what they are asking. I think people are nervous about that sort of thing in case they provide too much information or not enough. Hard decision to make... got to make sure you’re giving information to specific questions and only give information that is relevant to what has been asked.’

(Frontline Practitioner, Mental Health Services: 1)

The Data Protection Act (1998) outlines that the level of information recorded about an alleged perpetrator is based on professional judgement so long as the personal data is ‘adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed’ (Principle 3, Information Commissioner’s Office<sup>5</sup>).

The perception by practitioners was that clear training was required to clarify what data could be recorded relating to an alleged perpetrator.

### **Mental health needs of the perpetrator**

For cases of domestic abuse in older people, it was important to identify information about mental health and victim and perpetrator dynamics.

‘...police don’t need to know with mental health. For example, if you are looking at domestic abuse situation in someone’s home they don’t need to know the full background of the patient. It’s more about the risks of that situation’.

(Frontline Practitioner in Adult Mental Health: 1)

Practitioners were aware that where the victim may be solely dependent on the perpetrator for care, and if there was an allegation of abuse, the case needed to be handled very sensitively. Although POVA operated a victim centred focus, it was recognised that the perpetrator may be experiencing carer stress; have mental

5 [http://www.ico.org.uk/for\\_organisations/data\\_protection/the\\_guide/the\\_principles](http://www.ico.org.uk/for_organisations/data_protection/the_guide/the_principles)

health needs; and they may also be a vulnerable adult. There was awareness amongst some local authorities that, in order to end the abuse, POVA practitioners must recognise and address the needs of the perpetrator and the victim.

Agencies need to try to explore whether they are addressing a situation where proactive and reactive behaviour can occur, and build this information into their risk assessment. (For information on proactive and reactive dynamics see pages 21-24<sup>6</sup>)

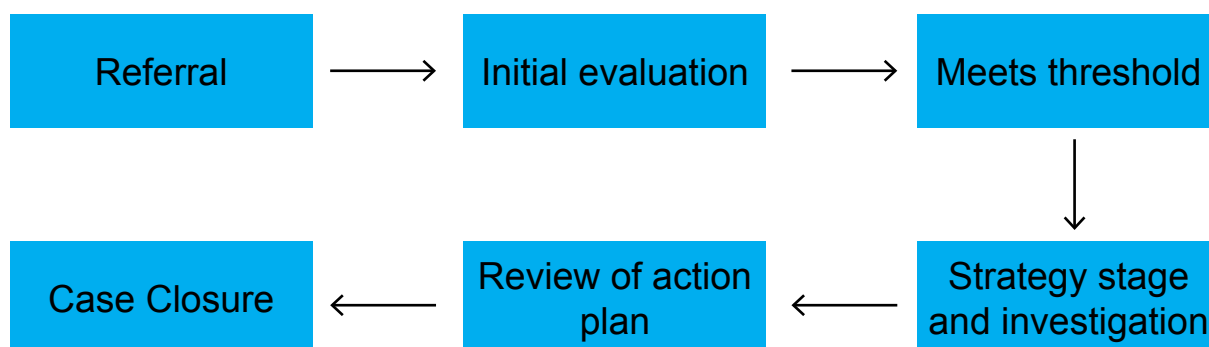
### **Contact with perpetrator**

The time when the alleged perpetrator was not with the victim provided opportunities for further disclosure from the victim and opportunities for practitioners to refine safety planning. Whilst some social care workers said they were aware of the possible need to monitor when and where the perpetrator was in proximity to the victim, many were worried about detailing anything about alleged perpetrators in the case files.

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6 <http://wales.gov.uk/docs/caecd/research/121220accesstojusticeen.pdf>

### 3. Protection of Vulnerable Adults (POVA) Process



Seven key themes emerged from an analysis of the qualitative and quantitative data.

These were as follows:

- Threshold, vulnerable adults and significant harm
- Seeking consent
- Quality of referral
- Attendance
- “Toothless tiger”
- Victims presence in strategy meeting
- Compliance

#### Adult protection referrals 2012-13

From the 21 authorities that provided full data sets for the 2012-2013 financial year:

Adult referrals received	7,333
Met POVA threshold	3,736
Percentage	50.9%

This suggested that just over half the number of referrals to POVA met the threshold.

Data gathering forms were sent out which requested 1) the number of new referrals received and 2) those that met the POVA threshold. The data provided broke down the referrals into two separate groups; the number of referrals for all adults and the number of referrals for older people aged 60 years and over. However, only eight of the twenty two local authorities provided a figure for the number of new referrals for people aged 65 years and over who met the POVA threshold.

From the 8 authorities that provided this data:

	All Adults	Aged 65+	Percent
Referrals received	2,315	1,529	66.0%
Met POVA threshold	1,288	869	67.5%
Percentage	55.6%	56.8%	

This showed a consistency of application of the POVA thresholds across the age ranges.

For the completed closed cases, during the same period, all 22 authorities provided figures for all adults and those aged 65+ as this was a requirement on the PVA2 return. This showed:

#### Completed POVA cases

All adults	3,575
Aged 65+	2,155
Per cent	60.3%

## Repeat referrals

Of the 2,155 cases in the 65 years and over age range there were 513 cases (23.8%), which had been referred previously to the authority, although the status and severity of these cases was not recorded on the PVA2 returns.

There was a wide variation between the local authorities, with one authority showing a figure of 52% repeat referrals and the lowest at 7.9%. Half of the authorities showed figures that fell within the 10-19% range but nine of them (40.9%) recorded over one-quarter of new referrals as having previously being referred. This would suggest that there are areas where the referral process and the subsequent response appeared to be more effective than in other areas. Please refer to the section on Good Practice for examples of strategies to reduce 'repeat victim' cases by POVA teams.

## Thresholds, vulnerable adults and 'significant harm'

### Threshold decisions and application

Across the twenty two local authorities who participated in the research, there was some variation on how 'significant harm' was interpreted and applied. Practitioners explained that interpretation can depend on the context of the abuse and the local authority conducting the threshold test. Some local authority practitioners commented that they had lower thresholds if the abuse occurred within a care home. Agencies said that recent media attention had led to increased sensitivity and sometimes an overly cautious response by practitioners:

‘Sometimes I think, particularly with care homes and hospitals the threshold is quite low because there is a higher public expectation for investigations to be carried out. I think at the moment it’s a low threshold [in an institution] but a lot higher [threshold] in the community, so for care homes it seems to me that every time two residents have a disagreement that’s being referred as a safeguarding case at the moment.’

(Adult Protection Manager: 2)

A common concern was the frequency of inappropriate referrals to adult protection. Practitioners commented that interpretations of ‘significant harm’ also differed considerably from both the referrer and those practitioners who screened the referrals. There was a perception from external agencies that the referral had met the criteria and then further confusion by these agencies when the referral did not meet the threshold test. Inappropriate referrals were felt to be a source of inter-agency tension across both statutory and third sector practitioners.

The ‘significant harm’ element to the test was based on an individual’s professional judgment. The element of subjectivity involved in assessing levels of harm increased inconsistencies of threshold testing and subsequent responses. Whilst small variations were understandable, practitioners felt that current practice had led to wide variations in threshold decisions. There was an uncertainty as to how to address fluctuations in the threshold test.

When initial information was requested, social care practitioners felt that gathering information in order to make an accurate decision about a case was often very difficult, especially if the alleged perpetrator was the only primary source of information:

‘It is often very difficult to get enough information to establish it [level of harm]. If they [the client] come into the service first time, there’s often limited information about that client. If a 70 year old woman is referred with dementia and they are reliant on the perpetrator for care it can be difficult to obtain that information [to make an assessment]. The knowledge about how we apply the threshold is widespread; how we actually apply it can be quite difficult because we don’t have the information.’

(POVA Coordinator: 7)

‘Significant harm’ may comprise a series of incidents which, when regarded in isolation, seem insignificant, but when frequent or continuous become serious’ (In Safe Hands, 2000). It was important that practitioners working with the individual were aware of previous referrals and other agencies that have been involved with the individual in order to apply the threshold. This knowledge was felt to be dependent on how effectively agencies shared information and how the DMS were utilised.

There was evidence of silo-working in some instances and a sense of concern that current information sharing between agencies was not as effective as it could be. Furthermore, external agencies either took too long to respond, or certain agencies

did not respond to requests for information so an accurate assessment could be made.

## **‘Vulnerable Adults’**

The Welsh Government Guidance defines a vulnerable adult as:

‘A person over 18 years of age 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 himself or herself, or unable to protect himself or herself against significant harm or serious exploitation.’

(In Safe Hands: 2000)

POVA practitioners felt that there was a need for training when identifying whether or not an individual qualifies as a vulnerable adult. Currently knowledge was limited in certain areas across Wales:

‘Even the issue of where they [referring agencies] are defining as vulnerable as well. We have got this unfortunate box on our list which says other, which I think is a bit of a ‘cop-out’ really. We do have difficulties with that.’

(Senior Practitioner Social Worker in the POVA Team: 1)

‘The title ‘POVA’ is unfortunate because in the common sense definition of the term every victim of domestic violence is vulnerable but under POVA criteria they may not be vulnerable.’

(POVA Coordinator: 7)

There were often conflicting interpretations of what was regarded as ‘vulnerable’ between police and social care professionals. Some social care professionals felt that there was a need for some police officers to have further training to recognise what qualified as a vulnerable adult in terms of adult protection policy:

‘Police have good knowledge on the whole. On the beat officers [specifically] aren’t fully aware of the process. Vulnerable adult term is bounced around too often by the police. They see adults as vulnerable if they have capacity. They see ill informed decisions such as alcohol and drugs as vulnerable. They are vulnerable adults but not from a POVA perspective.’

(POVA Coordinator: 4)

## **Knowledge of the POVA process**

Police knowledge of the POVA process and threshold varied both within and across forces. It was apparent that in areas where there had been a considerable amount of training on the POVA process, officers had a more comprehensive understanding of the POVA process and the issues relating MARAC /POVA integration in relation to older people and domestic abuse.

Interviewees stated that POVA training was currently optional with professionals actively opting to be part of the training. Professionals felt that POVA training needed

to be mandatory because, currently, some agencies' knowledge of the process and threshold test was inadequate. As with the MARAC it was felt that more training was needed on POVA processes to facilitate a more nuanced multi-agency response to victims. The police were often named as an agency that would benefit from a greater awareness:

'[The] police don't know anything about POVA and there needs to be more training on this. Police don't have the knowledge of what the POVA is and what it does.'

(Decision Maker for POVA: 1)

'Agencies that need more training and information on threshold would be police. Other agencies ring us and discuss the incident before making a referral whereas the police just refer to us.'

(POVA Co-ordinator: 2)

## Knowledge and level of training - Health

There was also a perception that health care services' knowledge of the POVA threshold was highly dependent on the role of the health care professional. There was widespread support for improving inter-agency working between GP practices and adult protection:

'I think it is fragmented in regard to health's [knowledge of the POVA]. I think District Nurses are aware with adult protection. We have a very good working relationship with District Nurses and they are aware of our process and refer through. GPs are a more complicated situation. We have some GP practices that engage but they are the exception rather than the rule. I find it is very difficult to get GPs on board, very fragmented [engagement] but in the majority of cases GPs have very little understanding of what we are doing but that is an improving situation.'

(Adult Protection Officer: 1)

Many agencies held the view that health services needed to become more involved in the safeguarding process and play a more integrated role in safeguarding adults. A common theme that resonated in the data was that supporting older victims was 'everybody's responsibility' but that only some agencies fully embraced this principle:

'Very rarely do you get a doctor in a strategy meeting. The higher up the chain you go, doctors, consultants the less the attendance. .. I understand their time is precious but they are consultants and they have to take the responsibility [attending meetings] that comes with that.'

(Decision Maker for POVA: 1)

Practitioners believed that GP's, given their level of contact with older people, had an ideal opportunity to identify abuse and safeguard the individuals, however there was a concern that these opportunities are missed.



'GPs when they are seeing people in surgeries need to be more intuitive in what they are seeing and see it as another opportunity... raising awareness with GPs because I think they are fundamental.'

(Detective Inspector: 1)

## Sharing information

Practitioners felt that health professionals needed to share more information with other agencies. Currently, the information sharing was felt to be one directional, with agencies passing details onto health professionals, however, there was a perception that health professionals did not reciprocate on occasion. Practitioners often expressed concerns in relation to a reluctance to engage in appropriate inter-agency information sharing.

'I find it amazing, ...with regards to reports from hospitals, doctors, consultants with regards to something they [health] want the police to deal with but then won't share the information with us [POVA] unless we get a court order to say we can have access to the hospital records. Now for me that is absolute nonsense, they are asking me to look at something and give my professional judgment without the relevant documents unless I get a court order. The bureaucratic train there is absolutely ridiculous... its time consuming, it's costly and its needless... they [health] are just frightened of being sued.'

(Decision Maker for POVA: 1)

When there was a disclosure of abuse it was felt that the GP's focused on the individual's wishes and didn't take into account the possible ongoing nature of the abuse, and the potential harm to the older person's health and well-being.

'But I think when you are looking at GP practices and you are looking at people who go in and talk to the Doctor and disclose they are in a domestic abuse situation and afraid of their Grandson/Granddaughter, or whatever the situation, maybe they [GP's] take on board the wishes of the person. Maybe they don't predict and look ahead what the possible consequence [potential risks] of not sharing the information is.'

(Adult Protection Safeguarding Officer: 2)

GP's appeared to be unaware of when it was acceptable for them to share information with other agencies, for example, when the level of abuse the older person was experiencing by a family member may put them at risk of serious harm.

It was commented that General Practitioners (GPs) needed to have mandatory training to increase their knowledge and understanding of the POVA threshold. POVA professionals often felt that GP's sometimes just automatically referred onward, without detailing whether, as GPs, they had taken direct action to support the individual. POVA practitioners stated that there was a real need for GPs to initiate a more meaningful dialogue with them, to either seek further advice, or to specify how they had safeguarded the individual:

'GPs tend to 'over' refer into the POVA, but POVA prefer to be 'over' referred into rather than 'under' referred. GPs do it to pass the buck though. They need to be provided with more knowledge and understanding of POVA threshold.'

(POVA Co-ordinator: 6)

POVA professionals felt that GP's should take on a more active role in the POVA process, taking necessary steps to safeguard the individual, especially during the time frame between making a referral and before a Strategy Meeting was held.

To summarise, social care professionals and police representatives stated that health practitioners, particularly GPs, needed to engage more in safeguarding procedures. When such input by health agencies was provided, it proved to be invaluable given both agencies often had good access to older victims on a regular basis. In order to better safeguard individuals' health, practitioners were sometimes unaware that they could share information. Health professionals were sometimes unsure under what circumstances they were able to override the wishes of the patient in order to protect them, this suggests further training is required on the Data Protection Act 1998 and Crime and Disorder Act 1998.

## Frontline workers, consent and opportunities for referral

Dignified Revolution (2008) outlines the importance of promoting practices amongst health and social care that prioritise dignity and respect for the older service user. One of the principles states that professionals involved in the adult protection process should give careful consideration and respect to vulnerable adults' wishes and preferences.

Whilst there were some excellent examples of client empowerment and integration into decision-making, especially in the good practice areas, not seeking consent from service users could act as a barrier to developing an individually tailored response. POVA practitioners commented that when frontline workers did not elicit consent from the client at the first point of contact, this resulted in missed opportunities for early client engagement with statutory and third sector agencies; furthermore, many referrals could not be made without consent. It was suggested at both operational and strategic levels that more time should be spent informing clients about the role of consent in facilitating access to services.

Practitioners should highlight to the potential client the benefits of information sharing, for example, reducing the likelihood of repeatedly discussing perpetrator activities and the subsequent negative experiences of the abuse. It was recognised that more time should be spent with the client, in person where possible, to explore in depth the individual's wishes and needs when making a decision to refer to other agencies:

'I would say that is where the first failing seems to be when I have had referrals, that they [frontline worker] haven't involved the individual. It's almost that they need to report it and that is forefront in their minds. It's

stepping back and saying, what do I need to do? Who do I need to involve?  
What do I need to capture?’

(POVA Co-ordinator: 8)

When referring, professionals who do not seek the individual’s consent make the safeguarding process more time consuming.

‘Have they got capacity? Yes. Are they aware of the referral? No. Have they consented to it? No. I think that is the difficulty sometimes that we have because it’s about going back to the referrer and saying they need to discuss with the person what their wishes and views are. What they want to do about this. I think that is the stumbling block, they had completed the referral without involving the individual. Doing it to the person [the referral] rather than involving the person in the process.’

(POVA Co-ordinator: 8)

A top-down approach rather than a client-led approach was felt to be counter-productive, both in terms of reducing risks to the service user and increasing the likelihood of developing unrealistic and impracticable action plans.

## Quality of referral

POVA practitioners often commented that frontline workers did not provide sufficient detail on the referral form. Social care providers and, in particular, health professionals meeting with service users did not always ask the right questions to be able to fully complete the referral form. POVA practitioners were unsure whether this was a consequence of limited knowledge and training to equip frontline workers to ask the questions, or whether frontline workers didn’t share the information because it was not ‘relevant’ or proven ‘true’:

‘You don’t have to fill out every section [of the referral form]. Just as much as you know. Obviously you don’t want to make up information. You have to be careful with information. You would put as much information on there as you knew and then it’s up to POVA if they want to take that[information] to a strategy meeting, which they would invite the referrer to attend. You can pass on any further information at that strategy meeting.’

(Frontline Mental Health Practitioner: 1)

When a referral to POVA was made, adult protection officers commented that they needed to respond promptly, however delays occurred when information was missing from the referral form. POVA practitioners had to go back to the referrer and gather the information. The need to seek further clarification and to request further information was felt to be a time consuming task for POVA practitioners.

‘...I think the other bit that is sometimes missing is they don’t give enough detail; they will sometimes forget to say which area they think the person may be being abused. That’s the other thing.’

(POVA Coordinator: 8)

## Coercion, consent and intervention

Three key themes emerged when examining how victims may refuse to give consent as a result of the coercive tactics used by domestic abuse perpetrators. These were as follows:

- Coercive control, consent and free will
- Using emotional intelligence
- Powers to intervene

### Coercive control, consent and free will

Establishing consent to share information and facilitating access to support services involved frontline staff agreeing to:

- establish whether the victim was competent ( capacity was assumed unless there was evidence to contrary);
- ensure the victim was suitably informed about the range of options available and that she/he was also aware of how any information they , or witnesses , provided would be used;
- establish the presence of any undue influence , for example fear of retaliation from the perpetrator;
- help create an environment to allow the victim to make a clear decision about her/his current circumstances and any actions they wished to take.

(Wales Interim Policy & Procedures for the Protection Of Vulnerable Adults from Abuse, 2013)

However, as research by Hoyle and Sanders (2000:12) shows, victims of domestic abuse are not often in a position to give consent because they are unduly influenced by perpetrators who control their access to external support:

‘These victims are, therefore, situationally coerced by their circumstances. The task ... is to help women [victims of domestic abuse] to change their circumstances, in order to alleviate this coercion and make different choices...’

(Hoyle & Sanders, 2000:12).

When asked to make a decision on intervention and safeguarding procedures, the victim should be informed of the consequences of accepting or refusing proposed actions from professional agencies:

‘If somebody isn’t consenting to a POVA referral and they don’t want it to go through the process it’s about risk management, risk strategies. It’s about doing that with the individual and highlighting to them that if they carry on with this behaviour or allow this behaviour to carry on these are the risks. So in other words, they are part of the process. So they understand they are taking risks really and actually looking at strategies they feel able to

implement to reduce those risks. If somebody doesn't want our involvement then that's fine but by saying they don't want the involvement or support, these are the situations they could put themselves in. Do you understand that? I guess that comes down to capacity as well.'

(POVA Coordinator: 8)

When a disclosure of domestic abuse was made, it was evident that a proportion of social care practitioners were willing to ask further questions to ascertain whether a victim was exercising their own free will in refusing help. Two differing perspectives were evident from interviewees when asked how agencies should respond to a situation when consent was refused: firstly, there were those practitioners who accepted consent was given freely, thus they took no further action in pursuing a case:

'Perhaps it's [the perpetrator] is a family member, that's why they weren't consenting. So literally that would be their decision so we would go no further.'

(Adult Services Manager: 1)

The response above implied that the victim was in a position to exercise free will; however this would be unlikely given the context of domestic abuse perpetration.

Alternatively, there were practitioners who were prepared to be more sceptical and questioned whether the victim was in a position to give genuine consent:

'The difference between what is words and what is being said [the underlying message]. If somebody tells me they are not the victim of DA that is quite open and shut. If they say they are not the victim of DA and don't need any police assistance but they are trembling and the house is in tatters, wreck and ruin.... It comes down to time and time again people say "They are saying they are happy". Listen to what they say and how they are saying it. Do they sound happy? That is where I am taking them back to, someone doesn't consent to abuse. Somebody is coerced and controlled and groomed.'

(Detective Inspector: 1)

A lack of understanding by clients about the role of statutory services and their links with the third sector also led to negative stereotyping about the consequences of disclosure to external agencies. Police and Social Care agencies were aware that face- to- face contact was more effective than a telephone conversation in establishing whether a victim's refusal to give consent was the result of undue influence by a perpetrator. It was widely accepted that visiting the older person in their home was the best way to facilitate engagement because face-to- face contact increased the potential for the older person to develop a relationship with the frontline worker based on trust. Home visits also gave practitioners the opportunity to assess the victim-perpetrator dynamic and ascertain whether the victim was experiencing manipulation by the perpetrator. However, frontline practitioners implied it was not always possible to visit in person, but expressed concerns that



current resources often resulted in case management by telephone. Perpetrators frequently used misconceptions about practitioner's motives to further silence victims:

'It's so easy [for the victim] to put a [brave] face on the phone. I appreciate it's necessary to smile on the phone to sound positive but people can do that, especially if they don't want to open up the scars and wounds that are so deep. They are so well groomed as to be frightened to explain to anybody...'

(Detective Inspector: 1)

'...The people in the safeguarding capacity have been demonised by the abuser. "These [statutory agencies] are the people that put you in a home." "You tell someone else and you will be put in a home." Everything that could be said, that is the opportunity to disclose can be minimised and used over the telephone and that is why it has to be personal contact. That is why we work best. Ensuring we go out and visit people to the reality of the services we are delivering, that is key. Managing the case by telephone, I think is a real problem.'

(Detective Inspector: 1)

There was evidence that some practitioners felt that seeking genuine consent from victims would be difficult, because over a prolonged period their ability to make decisions had been severely impeded by the actions of the perpetrator:

'...I would be looking at why they aren't consenting and coercive control, does that mean they have lost the mental capacity to make an informed decision? As part of the mental capacity assessment it's determining whether they have capacity or not... it's about making that professional judgement about whether they have been coerced to such a degree that they lack that mental capacity. Then I would look to see what the evidence is to support that. I would have to justify what actions I would take if there are issues around coercion. It's on a case by case basis that I would make the decision in assessing the information and coming up with an informed decision. I would rationalise that as part of the on-going investigation. It is difficult to say without the set of circumstances. As a practitioner it's about taking that all into account. This is where it's important to get as much information as you can to make the decisions you make.'

(POVA Coordinator: 3)

Practitioners often stated that if the individual had mental capacity and refused to give their consent then they had to respect the individual's decision:

'In a domestic abuse case if a person has capacity and doesn't wish to share their information with others then we cannot do anything. If person lack capacity then they would be in a different situation and dealing with it differently. But would be questioning if they lack mental capacity are they in a position to be believed?'

(POVA Coordinator: 4)

## Using 'emotional intelligence'

The Wales Interim Policy & Procedures for the Protection Of Vulnerable Adults from Abuse, 2013, states that consent should not be accepted at face value since some vulnerable adults need protection from emotional manipulation and exploitation (undue influence). There was a number of practitioners who expressed a degree of frustration that co-workers and other external practitioners did not always recognise the levels of emotional manipulation, control and coercion that the victim was experiencing from the perpetrator. Practitioners stressed the importance of using what they termed as 'emotional intelligence' to help decide if consent was free from undue influence.

'A large percentage is aspects of evidence, framing what someone has said and how they say it. The inflections, the tones the non-verbal communications that people make.'

(Detective Inspector: 1)

The Mental Capacity Act 2005 states that: '... a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or disturbance in the functioning of, the mind or brain.'

The decision for assessing mental capacity is decision-specific not condition-specific, thus when assessing capacity practitioners should assess if they have capacity to make a decision at that current time.

'I would say it's fairly limited although we do try to emphasise the importance around consent and capacity. Capacity can be a challenge for some because if you have got somebody with fluctuating capacity who may say they want something done and the next day perhaps has no recollection and says they don't want anything done, you will get challenges but you have to deal with those when they appear.'

(POVA Coordinator: 3)

POVA and adult care practitioners had a good knowledge of mental capacity; however, they often expressed concerns that a large number of colleagues had very limited knowledge of issues relating to mental capacity. It was felt that colleagues were unaware how to act in cases where when mental capacity was fluctuating.

## Power to intervene

There was a divide between police powers and adult services powers to enter and risk assess a situation when there was suspected domestic abuse. Police have powers to enter, intervene and assess a situation:

'I am saying intervention..... I would far rather we question and ask more in detail and intervene. I would be happier to be questioned as to why I poked my nose in than I would be in a Coroner's inquest saying why I didn't. That is fundamental.'

(Detective Inspector: 1)



Practitioners that understood the use of power, control and coercion by perpetrators towards their victims were supportive of developing much more interventionist approaches to reduce the risk for victims of domestic abuse. These practitioners wanted more powers to enter and assess the situation. Practitioners wanted a more interventionist approach so that they could go in and establish whether the victim was experiencing coercion by the perpetrator and the extent to which undue influence was impeding client engagement. A considerable number of interviewees within local authority services felt that they lacked sufficient power to enter and assess a situation. They believed that if they had legislative powers to enter it would be helpful:

‘One of the biggest issues we have with domestic abuse and elderly people is the ability to get into the house to assess what is going on. Often the aggressive person is gate-keeping. They are on the door and you have no authority to go in to see the other person there and assess the situation.’

(Adult Protection Officer: 1)

The new Social Services and Well-being (Wales) Act will introduce an Adult Protection Supervision Order (APSO). This Order gives professional agencies the power to enter an environment where abuse is taking place to allow social care practitioners to make an assessment of the situation. The professional will need to have reasonable belief that the individual is suffering from harm. However, when an assessment is made, it is not clear whether the proximity of the perpetrator in the house may impact on the quality of the victim’s disclosure. The expectation is that the new Act will encourage a more interventionist approach, but the effectiveness of APSO’s in providing greater leverage for increased agency intervention has yet to be established. The police have the legislative power to intervene and ask further questions. It is a concern that if adult services involved the police it would frighten and intimidate the client which could lead to rapid disengagement.

## **Empowerment**

Some areas had excellent examples of client involvement at every stage in the process, even in strategy meetings; the feedback was that this was beneficial in facilitating engagement and also resulted in fewer repeat referrals and more tailored and efficient use of staff resources. (See Section 5 ‘Good Practice’)

## **Attendance**

Attendance at POVA meetings varied across each local authority. However, there was a general perception that health services needed to engage more with the process. POVA teams felt that attendance at strategy meetings should be a statutory requirement.

## **“Toothless tiger”**

POVA was often regarded as a ‘toothless tiger’ in that the process resulted in recommendations to help individuals, but there was no legislation to facilitate compliance with the recommendations. The lack of legislation was felt to increase

the likelihood of repeat referrals and possible ongoing abuse:

‘POVA process in many people’s eyes doesn’t have any teeth, it doesn’t offer any more than support from a support worker and there is support available from the victim support which can be accessed through the police. It is something that needs to be strengthened and work needs to be done on gathering information from vulnerable adults who have been through the process and ask them how it was for them.’

(POVA Coordinator: 4)

‘If we had some sort of legislation to give some weight on it really. That would be a big, big help. Sometimes I think we have a process of all these meetings and it seems to drag it out and not really get anywhere. We have strategy meetings, decide what we are going to do then it takes ages to get everybody back together again to see what the outcome is. It’s just the process really.’

(Social Worker: 1)

It was felt by POVA practitioners that the parts of the process were robust and frequently provided good recommendations, however POVA practitioners frequently described the lack of leverage in the process as frustrating, resulting in a ‘revolving door syndrome’ for certain clients :

‘I sometimes call it the dog with no teeth. What we have is a situation, clearly our processes are not punitive, so invariably all that falls out of our process is the recommendations where there is no legislation to say that those legislations have to be carried out by any of the agencies that we have identified ... What becomes then is somewhat of a cycle where we make recommendations and we are chasing up and reviewing the recommendations but in six months we are back in the same situation.... We seem to be repetitive because we will have the recommendations from the review and we will follow them up but sometimes we end up back in the same situation.’

(Adult Protection Safeguarding Officer: 1)

## What does the POVA process offer the client?

When asked during the interview what the POVA can do for older people experiencing domestic abuse, practitioners held the view that the current system was not as effective as it could be:

‘To be honest not a lot. I do feel POVA is like a pointless exercise ....I think if there was some sort of legislation there would be a bit more weight in what a POVA can actually do.’

(Social Worker: 1)

There was evidence, however, from some areas - particularly in the good practice areas - where POVA practitioners felt that they were in a position to facilitate positive change and empower the older victim.

POVA practitioners and other interviewees frequently made the comparison between the legislation that was developed to support the process in child protection, and the contrasting gaps in the adult protection process:

‘With the Children’s Act and child abuse you have the weight and the legislation but we don’t have nothing really with the adults. If something goes major wrong there’s nothing, there’s nothing to hold up and say this is against the law there’s nothing you can do.’

(Social Worker: 1)

## Multi Agency Risk Assessment Conferences (MARACs)

Six themes emerged in relation to questions on the value of the CAADA-DASH<sup>7</sup> Risk Identification Checklist (RIC), the MARAC and the Independent Domestic Violence Advocate (IDVA) process. These were as follows:

- Domestic Abuse Stalking and Harassment Risk Assessment Checklist ( DASH RIC)
- Information sharing and over-riding consent
- Knowledge of the MARAC and recognising domestic abuse
- Attendance at meetings
- Effectiveness and perceived limitations
- An integrated approach

## The use of Domestic Abuse Stalking and Harassment Risk Indicator Checklist (DASH RIC) in cases of older victims

Agencies working with older people were not always aware of the prevalence and the nature of domestic abuse. Their knowledge was either limited in terms of procedures involved when tackling domestic abuse, or they chose not to follow procedures. The DASH RIC tool and MARAC processes were not used to their full advantage. For example, some practitioners mistakenly referred to DASH as a service not a risk assessment process for domestic violence:

‘Perhaps more information [is required by agencies], about the process of referring onto different agencies as well. MARAC and DASH, I am not sure what everyone’s knowledge of accessing these services is. I don’t come into contact with it [DASH and MARAC processes] very often, so I certainly think providing information for all the agencies would be useful.’

(Adult Services Manager: 1)

Interviewees from specialist domestic abuse services and the police expressed concern that some agencies did not use the appropriate risk assessment tool for domestic abuse cases. A large proportion of practitioners who were from adult services indicated that they did not use the DASH risk assessment tool in cases of domestic abuse. Others, especially in the good practice areas, saw DASH RIC as

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vital because it was specifically designed for risk assessment in cases of domestic violence:

‘When you receive a referral you are basing your assessment on the information provided in that referral form. The referral form is not necessarily going to give you all the information that the CAADA-DASH is going to provide. That is why I would be looking for more detailed information and I don’t think the Green Light [initial risk assessment recording sheet] adult services risk assessment tool gives you that opportunity.’

(POVA Coordinator: 3)

The findings from the current study add further weight to findings from the Access to Justice evaluation (Clarke et al., 2012: 24) regarding adult services where there appeared to be either limited knowledge, and thus inadequate application of the DASH RIC in cases, or an unwillingness to use the DASH RIC to assess older victims of domestic abuse.

## **Risk assessment procedures in Adult Protection**

The research findings suggested that the DASH RIC was not used as frequently as it could be, and in some local authorities it was not used at all.

When an adult protection case was referred to POVA an initial Risk Assessment Recording Sheet (RARS) was completed by the designated lead managers. The guidance for completing this risk assessment tool was found in the Wales Interim Policy & Procedures for the Protection Of Vulnerable Adults from Abuse, 2013. Although adult protection practitioners used this risk assessment, they also had to complete additional specialist risk assessments for some cases, including domestic abuse. If there was alleged or suspected domestic abuse, agencies were required to complete a DASH RIC assessment prior to submission to the MARAC. Adult protection officers often perceived the DASH RIC to be solely for police use, rather than a generic tool for risk assessing domestic abuse.

Key stakeholders were of the opinion that not employing the DASH RIC tool could result in missed opportunities to detect domestic abuse and assess the level of risk. If the DASH RIC was not used to its full advantage many victims of domestic abuse would not have access to specialist domestic violence services. For example, older people who are deemed high risk by DASH RIC may not be deemed high risk by the ‘traffic light’ risk assessment system used in adult protection; therefore the victim may not be referred into the MARAC/ IDVA process.

Specialist practitioners were of the view that whole agency training was required, emphasising the value of DASH RIC and the importance of an inter-agency response when responding to domestic abuse:

‘It frustrates me that [training] it’s not mandatory. Why safeguarding people has to be a mandatory thing to do for people to have to give up their time to do training begs a bigger question in my eyes. Child protection on the other hand is a mandatory training, DA isn’t mandatory and until such time as it

is a mandatory for people to see it, for them to consent to go through the training and it's a requirement, they are not going to see what is in front of them.'

(Detective Inspector: 1)

## Information sharing and overriding consent

The National Assembly for Wales has provided a single framework for all Welsh public sector, third sector and private sector service providers to share personal information safely and legally. This is outlined in 'Welsh Accord for the Sharing of Personal Information' (WASPI, 2013). Within the interim report, it states that the reluctance to share information between agencies is a challenge for all public services. Information sharing is of fundamental importance in adult protection. Good communication, co-operation and liaison between agencies are paramount to achieve the focus and collaboration across public services. (<http://www.waspi.org/>)

The guidance states that in exceptional circumstances, personal information can be lawfully shared without consent where there is a legal requirement or the professional deems it to be in the public 'best interests'. One of the exceptional circumstances is in order to prevent abuse or serious harm to others. In the current study, agencies' knowledge of when it was possible to override a client's consent appeared to be fairly limited. The qualitative data collection process revealed that the majority of agencies recognise that consent can be overridden if it is in the public interest to do so and if the individual lacked capacity to consent. Practitioners were often unaware that the MARAC process could allow for consent to be overridden if the risk of harm was high.

'In a domestic abuse case if a person has capacity and doesn't wish to share their information with others then they cannot do anything. If person lacks capacity then they would be in a different situation and dealing with it differently. But I would be questioning if they lack mental capacity are they in a position to be believed?'

(POVA Co-ordinator: 4)

The majority of agencies recognised consent can be overridden if it was in the public interest to do so and if the individual lacked capacity to consent.

There was a perception that some practitioners in social care lacked the sufficient knowledge of the DASH RIC, and how it linked with the MARAC and IDVA process. Some practitioners were not aware of the benefits for the client when engaging with an approach specifically tailored to the needs of domestic abuse victims.

## Knowledge of the MARAC process

During the course of the research study it became evident that statutory agencies' knowledge of the MARAC process varied considerably. The Police, in particular, and most POVA professionals were felt to have a fairly good understanding of the MARAC. However, there were gaps when responding to domestic abuse in older



people and this suggested more awareness raising and training is required within adult social care services.

In cases of domestic abuse in older people, the number of referrals made to MARAC for older victims of domestic abuse was surprisingly low. It was believed that the referrals for those aged sixty years and over were low because there was a lack of awareness of domestic abuse when it occurred in older age groups and this lack of knowledge and other factors led to reluctance by agencies to engage in the process. The reasons behind low referral rates are outlined below. It was felt that adult care services did not make many referrals because they did not recognise some forms of abuse as domestic abuse:

‘Adult services are few and far between making referrals [to the MARAC]. This is because they don’t recognise financial, emotional and manipulation as domestic abuse. Therefore they follow their own procedures. They need training.’

(POVA Co-ordinator: 5)

It was further believed that older victims of domestic abuse were often directed through the adult protection procedures because of their perceived ‘vulnerability’ rather than being treated the same as other victims of domestic abuse and diverted into the domestic abuse referral pathways:

‘...don’t get that many older people referred to the MARAC process... I don’t know if when it’s older people and they meet the threshold for adult protection that it is not being highlighted as domestic abuse and [the case] is being dealt with in adult protection, not referred on...’

(POVA Coordinator: 2)

There was a strong perception amongst interviewees that all public sector, third sector and private sector agencies that work with older people should have mandatory training regarding safeguarding issues:

‘Every agency that has contact with our elder community should be able to understand, recognise abuse when they see it and how to react. That is a role for everyone in our community that has contact with all ages, right through the spectrum of age.’

(Detective Inspector: 1)

## **Effectiveness and perceived limitations of POVA and MARAC integration**

The MARAC process and the POVA process can both be used when dealing with an individual. However, it was often felt that the processes did not marry well and there was duplication of work. Many practitioners felt that the processes performed a very similar if not identical function:

‘MARAC isn’t used because POVA does the same as what MARAC would do.’

(POVA Co-ordinator: 6)

POVA professionals believed that the POVA process provided a more holistic approach to dealing with the individual because they could address other issues including 'care packaging.' Some felt that the POVA process offered a more person-centred approach than the MARAC process could offer. In the MARAC it was felt that agencies dedicated only a minimal time to the case because the MARAC meetings involved working through multiple cases, rather than focusing on one case. POVA professionals felt that the POVA process involved a more robust approach when dealing with the individual because they had more time to discuss the case.

One practitioner commented that within the MARAC, cases involving older people were frequently left until towards the end of the MARAC meeting. By this point many professionals that attended would have left due to other commitments. This example highlights the perceived differences between MARAC and POVA meetings:

'At a MARAC they will probably get a fifteen minute discussion on the situation and come up with an action plan. Whether that is sufficient I don't know but our Adult Protection meetings are significantly longer - more in-depth and focused on the individual and their family. We are probably more robust in the time we have discussing the issues but the experts in the field of what is available in support are the MARAC team. From my point of view there is a complication that there is duplication [with MARAC/POVA processes].'

(Adult Protection Officer: 1)

Some adult protection workers felt that the MARAC process did not offer the individual any additional benefits:

'The MARAC meeting is huge and there are people around the table who are not involved with the individuals, they are just part of the process. It's not that I think it's not appropriate to older people, just that it's less 'person centred' than the adult protection process. I don't think it meets all the needs of an elderly person.'

(Adult Protection Officer: 1)

The findings from the Access to Justice evaluation, that examined process and outcome factors using individual level data, demonstrated that older people who were referred into the MARAC process had improved welfare and justice based outcomes. This was because the MARAC offered a more victim centred approach that facilitated greater client involvement in the decision-making process. The findings of this research further reinforce some of the findings from the evaluation of the Access to Justice study that further discussion at strategic and operational levels about POVA and MARAC roles and pathways is required to ascertain which cases may require more input by one process than the other, and at what point a case may benefit from an integrated approach.



## An integrated approach

- Mandatory training
- Communication

Practitioners should aim to adopt a model that ensures greater integration by POVA of the MARAC process in cases of domestic abuse to increase welfare and justice opportunities for victims.

### Mandatory training

There was a strong suggestion that mandatory training on the MARAC/IDVA (Independent Domestic Violence Advocate) process was necessary, so that a more nuanced approach could be applied based on the specific needs of the individual older victim rather than preconceived ideas about different processes. Applying a blanket response to a diverse group of older people was not likely to lead to positive individually tailored results. A case by case approach was felt to be the best approach according to some practitioners:

‘If there is violence... or control, which is the best way and fastest way of bringing safeguarding to that? If it is by POVA then so be it, that’s not a problem but to realise that [POVA] is not the only way to bring safeguarding through. It may well be that a case may be considered on a DA angle and in that a discussion is needed for it to be dealt with in a MARAC format.’

(Detective Inspector: 1)

### Communication

Clear communication between the two processes was felt to be vital to avoid duplication of practice and the monitoring of which practitioner was responsible for specific actions. Currently, integration of the two processes was not as effective as it should be:

‘Communication can be a problem if there is more than one process running. Sometimes actions from the MARAC can be to refer to adult protection which I wouldn’t say is the most helpful way. The actions that come out of MARAC should be actioned from the professionals with that individual. ..So there needs to be communication and there needs to be a necessity to process these alongside, because sometimes things get missed and for meeting sake there’s a lot of information sharing but nothing is happening. It needs to be clear who has actioned those specific tasks and who has followed it through.’

(POVA Co-ordinator: 2)

The research team sent out a data gathering table to twenty one local authorities. One of the specific questions was how many cases were referred to the MARAC process and to an IDVA. From the twenty two local authorities, only eight responses provided figures. The total number of referrals to the MARAC process amounted to one and none recorded reporting to an IDVA. The table below illustrates the

outcome for the alleged victim and any intervention that was sought. The graph demonstrates that not only is there a very low figure for those cases referred to the MARAC process but also to those cases referred to advocacy services (victim support, referral to an advocate, IMCA).

## The Role of Housing Services

### Housing

Two themes emerged in relation to housing practice:

- Opportunities to use local authority housing powers to protect older victims
- Re-housing the perpetrator

### Use of housing measures to address domestic abuse

There were limited housing options available to address domestic abuse victims in owner-occupied properties. Practitioners could not exercise the same legal powers as when dealing with disputes in other types of housing tenure. For victims of abuse who were local tenants, local housing authorities and housing associations could work with other agencies to provide safer positive outcomes, but for owner-occupied housing, the removal of the perpetrator was a more complicated and protracted task.

In some areas, local housing authorities were actively involved in safeguarding actions, for example, abusive tenants were removed from the tenancy agreement, and permission was granted to change the locks on the doors. Other agencies recognised the benefits of involving housing and there were examples of good joint agency working. Agencies saw the potential for increasing the role of housing in cases of domestic abuse in older people, given that housing agents may be a regular contact point especially in cases where individuals have a disability and may be housebound.

### Re-housing perpetrators

Practitioners suggested that increased legislative powers were needed to enable professionals to enter the premises and conduct a risk assessment with the alleged victim face-to-face. The most desirable outcome was the removal of the perpetrator from the proximity of the victim. However, given the interdependency in some cases between victim and perpetrator this was not always possible.

‘The other [option] is the powers to remove the aggressive person. There needs to be an offence committed so that the Police have arrested them [the perpetrator] and can perhaps [grant] bail with conditions. That has complications for the Police if you have got an elderly perpetrator, who may also be a vulnerable person, are you likely to get someone remanded into custody? If there were powers to remove and accommodate aggressive persons. We are talking huge civil rights issues here. I am trying to think

flexibly about these sort of things. If the victim can remain in their own home and form a complaint against someone, that's ideal.'

(Adult Protection Officer: 1)

Practitioners were concerned that certain societal shifts in family living arrangements and policy developments may lead to an increase in cases of domestic abuse in older people. Key areas of concern were a shortage in housing, an increase in house prices, and limited employment and education opportunities. All of these factors resulted in adult children living with their parents for a longer period than in previous decades. The new bedroom tax was perceived to be problematic in some instances, as it may encourage adult children to reside with their older parents, when perhaps living in close proximity was not in the best interests of the older person(s)/both parties.

'In that age group they [the victim] may be a carer for their partner as well, so they may live in an altered property, so sometimes what happens is that the perpetrator stays in that home, as it has been altered for them, and the victim has to leave. Again that [the victim leaving] doesn't make sense. So I think housing is a big issue and it is quite complicated for people to understand between the private sector renting and the local authority and the bedroom tax, all areas that cause people grief and make them think they should just stay here[in the home].'

(Detective Constable: PPU: 1)

Agencies felt that there was not appropriate accommodation for older people who were experiencing domestic abuse:

'We are here to keep people safe. I don't think it suits an elderly person to go into a hostel, like Women's Aid. It's about suitable accommodation. If the victim has to get out of a home and they have disabilities then is there suitable accommodation. At the moment emergency respite is one of the options we have used but it is not acceptable to a lot of elderly people whose worse nightmare is going into a care home. If we had the ability to say that we had reasonable accommodation that we could at least temporarily place them into.'

(Adult Protection Officer: 1)

In areas where housing was involved, the safeguarding measures that could be employed were felt to be very effective. There was a widespread recognition by social care professionals that there was a shortage of appropriate housing for the victim and a need to re-house the perpetrator to prevent further harm.

## Attrition

Interview data indicated that for victims of abuse, especially for older victims, trying to disclose domestic abuse to frontline workers was extremely difficult and took considerable courage. Interviewees suggested that if an older person was not believed by practitioners once they had talked about the abuse, this could compound the problem for the older person. There was a view that not being believed or listened to may prevent the older person from ever discussing their home situation in the future. Victims needed to be reassured that they would be made safe, that they would not be judged, and that their concerns will be taken seriously.

The majority of practitioners noted that client disengagement was more likely in the initial stages of the process, often occurring at the first point of contact with the initial agency. Motivation by the victim to engage with practitioners was contingent on two factors:

- Who made the disclosure;
- How the recipient of this information responded to the disclosure.

### If the alleged victim made the call

Practitioners stated that it was rarely the older victim who would make the initial call to agencies. Social care professionals observed that for older victims of domestic abuse, the primary motive for calling agencies was not to seek help for themselves, but to request for help for the perpetrator. Very often victims did not want to take criminal or civil actions out against their abusers because of a range of consequences which may result from such actions. Reasons for non-engagement with justice processes were as follows:

- A fear of repercussions from the perpetrator;
- A fear of the negative family consequences and further reprisals, especially increased isolation;
- The alleged victim felt that they would rather live with the abuse than lose a family member, especially if this was the only person the victim had contact with;
- If the victim was the parent or grandparent of the perpetrator, they felt in some way responsible for the abuse. Self - blame and a sense of responsibility often impacted negatively on the decision- making process when seeking help.

There were age-related factors that were also felt to influence older victims' decisions to engage either with welfarerist and/or justice options. For example, at this stage in the life course clients sometimes had to cope with a chronic illness or mobility issues. Therefore victims had to care for the perpetrator or alternatively, victims were reliant on the perpetrator for care. According to frontline practitioners, victims expressed the view that they did not wish to be alone at that stage in later life. In addition to this, a victim's mobility could make them more vulnerable or dependent and alternative options, such as living in a care home, were not

perceived to be attractive by the majority of victims.

## **A lack of knowledge about service provision**

Practitioners commented that older people were unaware of safeguarding processes; a lack of knowledge about the service provision was a primary deterrent to engagement. In areas of good practice, considerable work had been undertaken in the community to develop a dialogue with community groups to increase knowledge of the work of social services. However, misconceptions amongst older people about the role of statutory services in supporting them were felt to inhibit engagement in most local authorities.

For the older victim it was felt to be essential for practitioners from all statutory agencies to explain all the processes and explore all options, criminal, civil and welfare with the victim to ensure they were in a position to exercise informed choice and feel in control of the situation.

## **If a family or friend made the call**

When friends or family members made a call about the abuse of a third party, they often did so without seeking consent from the alleged victim. Professionals commented that they felt a sense of frustration when consent was not sought prior to contact because they wished to advocate 'a person at the centre' approach whereby their actions were governed by the consent of the alleged victim. The professional agency would often ask for the family/friend to seek consent (if they had mental capacity) and then request they call back, or if the alleged victim was deemed at high risk they would investigate. Practitioners stated that even in cases of high risk victims it was sometimes difficult to investigate if the friend/family member wanted to remain anonymous.

When a friend or family member called for assistance on behalf of the older victim, practitioners noted that it was quite common for victims to be unaware that they were experiencing abuse; for older victims of domestic abuse it could be perceived as a 'way of life' which they then had normalised over a period of time. In these instances, practitioners stated that the older victims often refused to co-operate, because they didn't feel there was a problem. Other reasons given for early disengagement were older victims' tendency to downplay the abuse and suggest that service providers may have more important work to attend to than dealing with older people. There was felt to be a general reluctance to engage because of the stigma attached to statutory agency involvement or because of mistrust in the provider agency.

Practitioners who had extensive experience of domestic abuse in older people commented that the main reason for disengagement was a fear of reprisals from the perpetrator. They observed that once this threat was removed, many older people readily engaged with services. There was a view that more strategies needed to be developed to help victims feel safe so they were in a position to disclose information about the abuse that they were experiencing.



## When another professional makes a referral

Members of the POVA team expressed concerns that not all agencies sought consent from the alleged victim or even spoke to them prior to making a referral which sometimes led to inaccurate assumptions being made about the older person's circumstances. POVA professionals stated that practitioners needed to be more proactive and ask appropriate questions relating directly to referral requirements.

'If a case doesn't meet the threshold they [POVA] inform the alerter if they are known and aren't anonymous. If a professional agency refers then they aren't anonymous. If case is appropriate they [POVA] ask for more information. Nurses make controversial statements about care at time and don't provide information to support it. What we ask is if they [external agencies] are making a referral then they complete our referral form. We then can deal with such matters in an appropriate way. If enough information wasn't provided then we would ask them to provide it, if they didn't know then we would fill in the gaps and find it out. If appropriate we will invite the initial refer to the strategy meeting.'

(POVA Co-ordinator: 4)

If professionals did not ask the right questions it was often difficult for the POVA team to effectively risk assess the situation and make informed decisions.

The POVA team felt that most external practitioners should take a more proactive approach with safeguarding procedures and develop a greater sense of ownership with the process. It was often suggested by POVA professionals that practitioners were too quick to make a POVA referral and transfer their safeguarding responsibilities to POVA without risk-assessing the situation and taking immediate and necessary safeguarding steps. The interview data revealed two main categories for referrer behaviours; the passive one-directional referrers that refer without any attempt to try and safeguard the individual and conversely; the proactive two-directional referrer where a referral was made and actions were taken to safeguard the individual.

## Practitioners' response to the disclosure of abuse

The way practitioners responded to a disclosure of abuse was a primary concern for POVA professionals. If the response was positive, sensitive and reassuring, the older victim was more likely to engage with support.

'Individual practitioners need a relationship of trust that can be developed with clients. Only when they [older victims] feel comfortable and confident that they can trust the individual, will they disclose. So it's about the support, the skills of communication, and positive trusting relationships.'

(POVA Co-ordinator: 7)

There was a view that certain specific groups in some areas, especially GPs and hospital staff did not always ask the questions and explore the situation at home in

more depth. It was felt that professionals needed to be more active in referring older people to support services rather than merely mentioning an agency or third sector organisation. Practitioners were unsure what to say to an older person to support them when they had experienced abuse and/or neglect. Practitioners did not wish to place themselves in a position of professional vulnerability because of their own perceived lack of training.

Other potential reasons for limited action were perceived to be that:

- Practitioners lacked the necessary information about local or national services that supported older people, or they felt that emotional support for victims was very limited in a local area and did not want to be seen to be unable to offer any solution;
- Practitioners often felt that they had limited time to spend addressing an individual's needs because of perceived capacity issues within their organisation;
- Practitioners were often unwilling to refer the victim /perpetrator onto relevant agencies because they did not feel the services available would ameliorate the family situation and may have adverse effects.

## POVA process

When POVA practitioners discussed clients who disengaged from the process, they made clear distinctions between when clients met the POVA threshold and when they did not.

### **For clients who did not meet the POVA threshold**

POVA were aware that 'vulnerable adult' was a term that could easily be misinterpreted. POVA professionals recognised and appreciated other practitioner's perceptions of vulnerable adult were often different to the criteria of a vulnerable adult outlined in 'In Safe Hands'. POVA professionals frequently commented that external practitioner's knowledge, both from statutory and third sector, of the criteria for a 'vulnerable adult' was limited. The police perception was that a victim of abuse would automatically fall into the category of vulnerable adult; however, POVA practitioners were governed by the policy and observed that there were often differences of opinion between the two agencies relating to the definition of vulnerable adult.

If a case did not meet the threshold for POVA, there was often felt to be a degree of confusion over which statutory agency had responsibility for case management. POVA professionals often stated that the case went back to the initial referrer accompanied with a set of recommendations. POVA teams stated that it was the initial agencies' responsibility to carry out the actions or make a referral elsewhere. Police officers or social care practitioners sometimes commented that once the referral had been made to the POVA team, they, as initial referrers, had little involvement with the case. If the case did not meet the POVA threshold, POVA would refer the case on. However, there was a perception that for cases that did not meet the threshold, victim referrals were not appropriately dealt with and many



cases were left 'between agencies and without clear support'. POVA practitioners and the police felt that there should be far greater clarity as to which agency had responsibility when a case had not met the threshold. The majority of practitioners commented that, currently, too many cases 'fell through the net', and that this was not acceptable.

## **Referring a case to the police service**

There appeared to be wide ranging differences across the local authorities as to the point at which social services involved the police in a case. In some areas, social care providers made automatic referrals to the police no matter how minor the incident of abuse was, whilst in other areas, practitioners only referred when the abuse reached a certain threshold (usually high risk). Often, social care providers will not make referrals to the police unless they had consent from the alleged victim. Social care practitioners and police officers provided a range of reasons why the alleged older victim was reluctant to engage with the police, these were as follows:

- A lack of knowledge about the role of the police and fear of further reprisals from the perpetrator;
- A sense of misplaced loyalty given the perpetrator- victim relationship, and an unwillingness to criminalise a family relation;
- The stigma that was attached to police presence in their community; service users did not want a police car parked outside their house.

Practitioners also appreciated that the victim could feel anxious about police involvement, mainly because they were unaware of the options available and the processes involved. It was felt to be important for all practitioners to explain the nature of the police role and discuss all options available and not to make any ageist assumptions about decisions to pursue a justice outcome.

## 4. Criminal justice & hate crime

Police officers and Crown Prosecution Service (CPS) professionals identified three stages which impacted on criminal justice proceedings, these were: evidence gathering, withdrawal of witness statements and court proceedings.

### Evidence gathering

Criminal Justice agencies felt that evidence gathering was not as robust as it should be, especially in cases where medical evidence was required to support allegations. Timing was crucial as the quality of the evidence was very time-dependent.

### Witness statements

Police officers and the CPS stated that victims may sometimes choose to disengage because of a lack of understanding about the process. It was also recognised that perpetrators would employ various strategies to encourage the victim to withdraw their statement, such as promising to change their behaviour or by increasing the level of threatening and abusive actions. There were also concerns that increasing cuts in staffing levels were having a negative effect on outcomes.

Older victims often felt particularly isolated between the point when bail was granted and the court case. This was a key period when high attrition rates were observed by practitioners. It was noted that an advocate from the third sector was crucial to encouraging ongoing engagement with the criminal justice process. Individual police officers now had less time to feedback to and update the victim on how their case was progressing through the Criminal Justice process. Police officers recognised that for older people a lack of regular communication could increase anxiety and lead to disengagement.

### Court proceedings

The Crown Prosecution Service and police officers commented that older people were less likely to ask questions about the court procedure and may be more afraid of the formality of the court process than people at other stages in the life course. If the perpetrator was the adult child of the victim, older people were concerned that they may be held responsible in some way for the abuse or that their parenting abilities may be called into question.

The adversarial process and robust methods of questioning were felt to have a negative effect on the older person. There was the view that older people did not make credible witnesses because they had problems recalling the details of an incident and the court atmosphere hampered effective communication for older victims. There was some concern that special measures were not being used when they could be.

Police officers also noted that lengthy court processes could lead to an increase in attrition rates in older victims because of the negative impact on the victim's health and emotional wellbeing. Police officers and the CPS believed that older victims

needed far more support before, during and after the court experience to increase the likelihood of a successful prosecution process and outcome.

## Hate Crime

Currently, there is no legal definition of hate crime, however there are legal provisions relating to individual aspects of hate crime which relate to an individual's characteristics including, race, gender, ethnicity, class, sexual orientation and disability. The Association of Chief Police Officers (ACPO) and the CPS have agreed a common definition of hate crime:

'Any criminal offence which is perceived by the victim or any other person, to be motivated by a hostility or prejudice based on a person's race or perceived race; religion or perceived religion; sexual orientation or perceived sexual orientation; disability or perceived disability and any crime motivated by a hostility or prejudice against a person who is transgender or perceived to be transgender.'

(ACPO, 2012)

In 2007 criminal justice agencies adopted a common definition of 'hate crime':

'any criminal offence which is perceived, by the victim or any other person, to be motivated by hostility or prejudice towards someone based on a personal characteristic.'

and identified 'five strands' that would be monitored centrally:

- race;
- religion/faith;
- sexual orientation;
- disability;
- gender-identity.

Crimes based on hostility to age, gender, or appearance can also be treated as hate crimes.

Home Office, Office for national Statistics and Ministry of Justice (2013), An Overview of Hate Crime in England and Wales, London, (p. 11).

Social care professionals were able to provide a definition of hate crime, yet it was not something they felt comfortable defining. Hate crime police officers stated that professionals were fairly good at identifying hate crime that was of a racial or religious nature, however cases of age-related hate crime and disability-related hate crime were often more difficult for generic practitioners to recognise and respond to:

'I think generally within society if you were to mention the race or religion aspect of hate crime everybody knows that, because for the past ten, [or] fifteen years we have grown up with that. I think we have reached the stage with disability or age-related hate crimes we need to do that work [focus on age and disability hate –related incidents] now as we did ten years ago,

we all could do with some sort of training package, sessions to raise that awareness.'

(Hate crime officer: 1)

There was a perception from hate crime professionals that when older people experienced hate crime it was usually focused on issues relating to age or disability:

'...older person [related] hate crime basically comes down to two issues, the older generation's attitude [reluctance to report] obviously, but also the capacity to report. With Hate crime [involving] the elderly, I tend to find it's less against [issues of] race and religion and more towards a person's physical and personal characteristics.'

(Hate crime officer: 2)

'Age discrimination? Yes we have a lot of that. We have people who are a little bit confused and they are labelled as having a dementing illness. I just feel older people don't have the support and care that they need.'

(Frontline practitioner: 1)

Agencies commented that that hate crime-related referrals or reports were rare. The hidden nature of hate crime targeting older people led to the perception amongst some practitioners that it is only experienced by the older population in exceptional circumstances.

'..not frequently [ do we get reports in older people] but we do have some aspects e.g. domestic abuse situations, threat of honour killings .... not something that's reported to us very frequently. Certainly not something we can look at and say [this type of] abuse is centred around that vulnerable group.'

(Adult Protection Officer: 2)

Within adult protection services in some local authorities, it was suggested by practitioners that some of their co-workers made the assumption that hate crime did not occur within their geographical boundaries. This misconception was more commonplace especially if the population demographic was not seen as a particularly diverse group. The perception that hate crime occurred elsewhere suggested that some practitioners only understood hate crime when it was motivated by racist or religious discrimination:

'Hate crime, if you talk to our colleagues here [they] will say that it is something that happens on the borders... have that problem we don't have it in [name of place] .... So it is something that happens in other areas and not here. But because I attend other forums I know that it is an issue here like everywhere else. I think it is something that is not that well known to individuals because they think it happens elsewhere'

(POVA Coordinator: 6)

Specialist hate crime officers stated that police officers in general may have responded to a case of hate crime without necessarily identifying it as such, so

many cases may be recorded under other incidents. In older people, there were parallels with under-recording of hate crime that were similar to the under-recording of domestic abuse.

‘If someone came to me and said there is no hate crime I would say yes there is. It would be fantastic if there wasn’t however, it is there, we need to deal with it and we need that information and people to come forward and give it to us. We need to explain to them what is that it is a hate crime.’

(Hate crime officer: 2)

However, the CPS held the view that there was a strong link between domestic abuse, abuse targeting older people and hate crime:

‘There’s a huge crossover between elder abuse and disability hate crime. Quite often when we look at issues that are flagged up as elder abuse the reason that person has been targeted is not necessarily because what it says on birth certificate but because they have a condition physical mental that runs as vulnerable. It maybe that that is a age related condition but the reason they are being targeted is because they have that disability or perceived disability and not necessarily because of their age.’

(Crown Prosecution Service: 1)

The research findings suggested that statutory and third sector practitioners’ understanding of what hate crime was currently quite limited and widespread training was necessary to help frontline practitioners identify and respond to incidents of hate crime.

When asked about other agencies’ knowledge of hate crime an officer provided a scale to demonstrate local authorities’ awareness of hate crime in older people, the response highlighted the need to substantially increase awareness of hate crime in frontline staff:

‘On a scale of 1 to 10 [ten being the highest], I would probably say [I rate the current level of awareness to be] about 2.’

(Hate Crime Officer: 2)

Adult protection officers were aware that additional training would be of benefit to their organisation. It was clear that practitioners’ knowledge base when tackling hate crime and current service provision was still in its infancy.

However, the desire by practitioners to broaden their understanding of hate crime was evident:

‘I would say I am less well informed about hate crime... it doesn’t feature highly enough in adult protection and I think we need some more learning around it...In terms of in adult protection we need to give it a little more thought on how it integrates into our work, how we are responding to it and what the best practice model is for managing it. I don’t think we have got that yet.’

(Adult safeguarding manager: 1)

## Reporting cases in older people

As mentioned previously, older people were perceived by practitioners to be more tolerant to abuse than other groups of the population unless the level of hate crime escalated. The unwillingness by older people to involve the police could lead to increased harm:

‘In the older generation there is perhaps a reluctance to call the Police unless it is a more serious issue. That is a phenomena that will disappear in time because today’s generation have got no problem with calling the Police and it’s never been easier to get hold of them by email, mobile phone. I have seen our capacity increase dramatically in the past few years because of the mobile phone. When I do awareness raising with older people a lot of the responses I get is that they didn’t want to bother us, or they did not perceive it as hate crime or I have heard it many of times in all characteristics ‘that doesn’t bother me’ response [being called names etc]’

(Hate crime officer: 1)

## Disengaging with services

There were concerns that older people may not seek further support after the initial police response. Fear of repercussions, or a sense of reluctance about statutory involvement may be possible factors in dissuading older people from engaging with services , but it was difficult to draw any firm conclusions given the limited information available to explain why older people were hesitant to work with officers.

## Age as a reporting factor

Interview data highlighted that the CPS had ‘age’ as a reporting category for hate crime whereas the police did not record the statistics for age- related hate crime. However, the police frequently liaised with the CPS to monitor age-related incidences and crimes in general. To qualify as an age-related hate crime incident, the age and vulnerability of the victim had to be identified as primary motivating factors leading to the offense.

There was the perception that a degree of ambivalence existed both across and within agencies as to whether ‘age’ should have a reporting category of its own. Some practitioners felt that age should be a reporting category for two reasons: first, because age discrimination was widespread and second, because potential perpetrators were aware that both old and young people were easier targets than other sectors of the population. Thus, practitioners who held the view that ‘age’ should have its own reporting category, felt that perpetrators were very calculating in targeting who they could abuse. This level of pre-meditation was felt to increase the seriousness of the offence when directing hate crime against certain ages due to the potential vulnerability of certain groups, e.g. the very old and very young.

‘Burglars target properties with handrails outside because that implies limited mobility. Our policy also talks about crimes that aren’t initially targeted towards age but become so later. The example that is given is



‘you have a burglar who breaks into the house just intending to grab the telly from the lounge and run out as fast as he can but having gone in he realises it’s [the house is] owned by an older person and he becomes a bit bolder and carries out a search and goes upstairs and so on’. So the crime becomes worse because he’s realised the victim is an older person.’

(Crown Prosecution Service: 1)

## Conviction Rates for Hate Crimes

Force Area	Number Court Cases	Successful Convictions	Percent	Unsuccessful convictions	Percent
Dyfed Powys	25	21	84.0%	4	16.0%
Gwent	36	34	94.4%	2	5.6%
North Wales	42	30	71.4%	12	28.6%
South Wales	114	92	80.7%	22	19.3%
All Wales	217	177	81.6%	40	18.4%

The chart above illustrates the number of hate crime cases that went to court against the percentage of successful and unsuccessful convictions. It shows that Gwent had a higher success rate with only 2 (5.6%) unsuccessful convictions, but far fewer cases than South Wales. Hate crime officers commented that the low number of court cases was not necessarily an indication that less hate crime offences occurred in that area because it could be a reflection of the training and knowledge of practitioners and police officers in that area.

There was some disagreement between what the police regarded as a ‘successful conviction’ compared to what the CPS regarded as ‘successful’. Police officers stated that they often felt disheartened when offenders were given what was perceived to be a ‘light sentence’ or lenient sentence relative to the severity of the case:

‘Sometimes you think that’s not enough. With all crimes as police officer we want to put people into prison if they do wrong, that’s not always the right thing prison but you want to feel that you have done the best job you can for the victim and they get some sort of satisfaction out of it knowing that that offender is having to pay for something that they have done and I’m not sure we always get that satisfaction’.

(Hate crime officer: 1)

‘The number of hate crimes in society is therefore entirely determined by how hate crime is defined, conceptualised and interpreted. The problem is that the definitions currently in use ensure that the majority of officially labelled hate crimes are not motivated by hate at all, but by prejudice, which is often an entirely different thing.’

## Sharing information

The interviewees stated that 'data protection' and 'information sharing' were terms that were sometimes used by practitioners as a barrier to disclosing information to the appropriate agencies:

'Sometimes you get people hiding behind the old data protection. That is nonsense, there is no such thing as data protection that allows somebody who is vulnerable to be exploited or carry on being targeted by perpetrators of Hate Crime. There is no amount of data protection that will stop you telling the Police that. The problem is the third sector.'

(Hate crime officer: 1)

The third sector was perceived to be reluctant to disclose client information on occasions. Practitioners who were hate crime specialists were concerned that information was sometimes withheld in cases where it was inappropriate to do so.

## Compliance

When hate crime officers were asked about other agencies' attendance at inter-agency meetings and their compliance with hate crime procedures, officers stated that because of the fear of negative media coverage and accusations of not treating a hate crime case seriously agencies were very responsive:

'99.9% of the time I don't have any issue at all [with agencies complying]. One we are the Police, people seem to listen when it's got the word Police on the end of it. Two it's Hate Crime and no-one wants to drop the ball on Hate Crime. Simply the point that if you drop the ball on Hate Crime you are in the Western Mail or worse. So people tend to sit and listen a bit.'

(Hate crime officer: 1)

However, hate crime officers noted that if the incident was not domestic abuse related or did not fall into their POVA threshold there was often reluctance for social care workers to engage in police meetings and the investigation process:

'Domestic abuse is their bread and butter. Family issues is more their bread and butter to be quite honest with you because it's their key areas of work. If an incident is a POVA then obviously they will pull out all the stops but when the incident hasn't quite reached the POVA or MARAC threshold then that's where you may struggle to engage with them.'

(Coercion Officer: 1)

Hate crime officers wanted social care workers to recognise the need for multi-agency working in incidents involving hate crime. They were of the view that social care professionals needed to integrate their knowledge of hate crime as a serious issue in their everyday working practice:

'It would be the same pathway [as all adult protection cases] but we are

probably not good at putting the hate crime tag on it [the incident].’

(Adult safeguarding manager: 1)

## Dealing with hate crime

Social housing was seen, in most instances, as very proactive when tackling incidences of hate crime involving older people. As with domestic abuse incidences, social housing could use a range of powers to increase perpetrator compliance and deter them from further incidents. In extreme cases, housing would use eviction to prevent ongoing hate crime against the older person. However, as with other examples, housing authorities were reliant on the disclosure of the incident by the victim and this was not always forthcoming:

‘Social Housing Providers... they are excellent... I use them and their Housing Officers and their Community Safety Team to put pressure on the perpetrator, threaten their tenancy, demote their tenancy, threaten eviction... Their understanding of Hate Crime and way of delaying with it is extremely robust.’

(Hate crime officer: 2)

Previous research findings on this topic area by Clarke et al. (2011), suggested that social housing and other housing associations needed to raise tenants’ awareness of hate crime and provide information for tenants on how to safely report incidences to housing officers. The awareness-raising information should highlight that the response given by housing officers will be discrete and confidential to ensure against any further repercussions.

Hate Crime officers commented that all agencies needed to recognise the importance of information sharing, attending meetings and complying with the appropriate procedures. Officers noted that inter-agency working was not as it should be, with misunderstandings around data protection issues often acting as a barrier to effective joint working. The majority of specialists stated that widespread training on hate crime was necessary, especially in relation to age-related and disability-related hate crimes.

## 5. Good Practice

Whilst there was evidence of good practice across all local authorities, there were four areas that were particularly innovative in their practice when responding to older victims of domestic abuse. These were Bridgend, Cardiff, Caerphilly and Carmarthenshire. The high level of training and awareness—raising on the MARAC, the IDVA, the IMCA and the Mental Capacity Act 2005 was evident. In addition, health boards were more integrated into referral pathways and processes. The practitioners interviewed in these areas had an extensive knowledge base, prioritised an early intervention approach and used a holistic response incorporating a multi-agency framework. These four areas also demonstrated an awareness of the need to address both victims' needs and support perpetrators in changing their behaviour. There were particular aspects of practice where the local authorities were excellent.

### Bridgend

A content analysis of the AAPC report and the qualitative and quantitative data demonstrated a very strong understanding of domestic violence specific to older people, where choice and empowerment for service users was prioritised. There was also evidence of excellent multi-agency action, good integration with health and recognition of the need to develop advocacy links in cases involving older people.

### Cardiff

Cardiff and Vale University Health Board had an impressive POVA training package including level one 'induction'; level two 'recognition and referral' and level three 'designated line manager' and higher level training. There was a mandatory training policy for all staff, GP training, monthly 'Public Protection Days' incorporating domestic abuse and POVA training by Safeguarding teams. There was strategic and operational level commitment to tackling domestic abuse, and evidence of learning from the user experience. Practitioners were aware of the interdependency and coercion issues in cases of domestic abuse older people, and prioritised a 'person centred' approach. The significant increase in referrals from Health (Area Adult Protection Committee, 2012 -2013) highlighted an increased awareness of domestic abuse in older people by frontline staff in detecting the abuse, asking the questions through routine questioning and making accurate referrals. There was a sound understanding of domestic abuse relationship dynamics. Cardiff understood that it was unlikely that an individual would suffer just one form of abuse and emphasised the need to explore the psychological impact of the abuse on the individual's wellbeing. There was also evidence of effective follow-up action - where cases fell under the threshold the referrer was contacted with advice on safety management.

### Caerphilly

Caerphilly were a well-structured and well managed team in post since 2008. Each member of the POVA team had specific background expertise in policing, probation,

housing and nursing experience which complimented the other team members skill set, thus the team felt they were in good position to incorporate both justice and welfare responses and challenge other agencies decision- making given their prior experience of the law and policy across different organisations.

## The multi-agency chronology model

The chronology model was based on a piece of comprehensive research undertaken by Caerphilly. The rationale was to examine referrals involving repeat victims and produce a more effective response in stopping the abuse of victims. The research involved looking at previous decision-making in a sample of case studies where people were repeat victims of abuse. The findings showed that each time a repeat referral had entered the process; the same actions were being taken each time with the same referral on each occasion it entered the process, rather than adopting a different approach to address the abuse. Thus there was a need to evaluate the success of the strategies previously employed with a repeat victim, and decide how to amend their current response accordingly.

‘The reason they [ service users] are back in the POVA process was because users hadn’t consented to the safeguarding process, people didn’t consent to what we as professionals thought would reduce the risk of further abuse.’

(POVA Coordinator: 9)

According to the Caerphilly team, chronology models were mandatory in child protection cases. It was felt that adopting a ‘chronology’ approach in vulnerable adults would increase the likelihood of a successful response, improve client engagement and reduce the number of repeat referrals entering the system.

Current practice was informed by the research and so when a referral entered the process, practitioners would scan the system and observe what had been previously tried in terms of the various approaches employed by POVA. These previous details were then available to the practitioners from initial risk assessment and at every successive risk assessment.

‘Initially if a report comes in and the allegation is neglect, I would be going through the chronology to see if there is a pattern of neglect involving the same person who was implicated in previous investigations, but also I would be looking at the bigger picture to establish the level of vulnerability, risk is mainly a dynamic process, but whatever I feel the level of risk is will determine what I do next at that specific moment in time... also in terms of the chronology we can find out what type of investigation there has been, what the outcome of the allegation was, any specific safeguarding measures was put in place.’

(POVA Coordinator: 9)

The team said that the chronology process was very useful at multi-agency meetings because other agencies could then assist in building up a detailed picture

of their own activities and the subsequent outcome of any actions. The Caerphilly team also, saw that the chronology approach was invaluable to victims of abuse who attended meetings and encouraged engagement with the POVA process:

‘So then when you take the chronology [information] to a strategy meeting it gives all the other agencies a holistic picture of what has been done before and what we need to do differently, so you can see, for example, maybe this is the fifth allegation of domestic abuse and a victim has fluctuating capacity and nothing has been done previously so we need to address this, so it gives you the opportunity to think more creatively to get that consent, to find a way in to stop the abuse. Other agencies can give their intelligence and add to what we know, and on occasions at meetings the vulnerable adult has been at the meeting and given input and the chronology has helped them, especially in domestic abuse, they may only think about the most recent event, so victims then can see whether the abuse has got more severe it maybe makes them realise that they need our support to stop the abuse...’

(POVA Coordinator: 9)

The research undertaken by Caerphilly also found that vulnerable adults stated that during the actual process there was considerable input by frontline workers, but vulnerable adults commented that once the action plan was in place, and the case was closed, there was no monitoring of the outcome nor contact with POVA practitioners, thus vulnerable adults could suddenly feel quite isolated. It was decided by the team that for repeat victims, there would be a follow-up six week review so see if the action plan was being successfully adopted by the service user. The criteria for a follow –up review was based on the victim’s request, the details of the case, any new measures that have been implemented, and the level of complexity and risk.

The Caerphilly team was also very innovative in informing vulnerable groups about the work of POVA in community settings. This was to dispel myths and stereotypes about statutory agencies and to increase communication between the public and Caerphilly local authority. Rather than employing a top-down PowerPoint presentation, more informal, dialogic approaches were adopted to facilitate a more tailored question and answer session relevant to the community group involved.

## Carmarthenshire

Carmarthenshire were perceived to be similar to Cardiff in their commitment to staff training, their joint working practice with health, and evidence of learning from their own and others practice.

Emphasis was given to the effectiveness of a co-ordinated and joined up approach to achieve good quality of service for users. Carmarthenshire was committed to raising awareness of safeguarding across partner agencies and the general public. Awareness training involved inviting both senior and junior members of staff to safeguarding meetings in order to familiarise them with the system process and outcome:



'I think it's inviting more people to meetings that are appropriate. For example, if we invited the Lead from the Hospital, we would also invite the Ward Sister and maybe somebody junior. So they all get to understand the process.'

(Adult Safeguarding and Improvement Team: 1)

Carmarthenshire adopted an open door policy where agencies could observe the daily workings of social care services and adult protection departments:

'It's an open door policy where people can come in and be involved in the process, sit in the office for the afternoon and see what's going on and talk through the process and talk through cases and ask for any information. It's the open door policy that's going to support that.'

(Adult Safeguarding and Improvement Team: 1)

It was believed that the open door policy allowed other practitioners to understand the process in greater depth and appreciate the workload of adult protection officers:

Interviewer: 'In your opinion what do you think other practitioners knowledge of the POVA threshold is like?'

Interviewee: 'I think it is getting better. I don't think other professionals appreciate the amount of work involved unless they come and sit in. At every strategy meeting now, as part of the process, we invite other professionals. Health for example, Ambulance, Police, Case Managers, it could be the provider agency, any of those. They have a better understanding of the process because they are involved from start to finish.'

(Adult Safeguarding and Improvement Team: 1)

There was emphasis on victim empowerment. The POVA team actively went out into the local community and ran a series of local publicity events to raise awareness of the POVA process.

Carmarthenshire demonstrated excellent knowledge of domestic abuse and the relationship dynamics. They recognised that, in some circumstances, individuals maybe experiencing coercion when they are providing consent. They actively explored whether or not consent was given under duress and if it was they would override consent and share information with other agencies if it was deemed to be in the person's best interests:

Interviewer: 'If we look at the issue of consent what happens if the client refuses to give consent for you to share information?'

'Interviewee: 'It depends. If there is criminal activity we can override that. If there is undue influence we can override that because if a vulnerable adult is capable of giving consent, then obviously we must seek that consent from them. If the consent to abuse was given under duress you are looking at exploitation, pressure and fear of intimidation, then we can disregard that consent. We can share information in any way with third parties as we do.'

(Adult Safeguarding and Improvement Team: 1)

# 6. Recommendations

## Data Management and Information Sharing

### **1. There is a need for more accurate detection and recording of domestic abuse and violence in cases involving older people**

The research highlighted that, whilst the majority of practitioners were aware of the definitions of domestic abuse and violence, this did not always mean that they translated this knowledge into practice in cases of domestic abuse and violence in people sixty years and older. There was a common perception that cases of domestic abuse were not always accurately identified, nor were relevant details being recorded on data management systems. The fact that domestic violence may not be accurately identified has considerable implications for assessing risk (a largely dynamic process) at different stages in the adult protection process. For example, missing or inaccurate information could influence client engagement; a lack of appropriate information would also have an impact on decision-making in a multi-agency context as to whether, when, and at what stage the individual victim was transferred from the POVA to the MARAC process.

Moving towards more individual- based data collection rather than focussing on aggregate data sets would greatly benefit local data collection and subsequent responses to cases of domestic abuse which is often highly complex issue, and rarely involves only one form of abuse. Aggregate data can provide a snapshot of the types of abuse of older people face, however there was a view that the current techniques use may distort or hide important variations about domestic violence and abuse. Individual level data provides a richer understanding of victims' experiences of referral routes and service provision. For example, individual level data can answer questions such as:

- Does the nature of domestic abuse vary according to the relationship between victim(s) and perpetrator(s)?
- Are face-to face visits coupled with telephone contact more likely to improve engagement than just relying on telephone contact?
- Does the involvement of an Independent Mental Capacity Advocate (IMCA) or independent advocacy increase the likelihood of more timely and appropriate support to victims by both justice and social care agencies?

Aggregate data cannot answer these questions, however individual level data sets would if they are accurately and regularly utilised as part of practice.

### **2. The collection of accurate and complete data need to be improved, and its use in case management and decision making needs to be strengthened**

In some areas, the data management systems were used quite effectively to inform the decision-making process; however, in other areas it was felt that a number of steps could be taken to improve the quality of data collection and data recording for the day-to-day management of cases, information sharing purposes

and communicating good practice. There was a perception by some practitioners that even some of the better designed data management systems, as practice evolves, will decrease in value if careful management of quality control processes are not kept in check. There also may be, over time, an erosion of the quality of data if frontline staff or data management staff do not monitor the accuracy or completeness of information updated on DMS.

The research indicated that many local authorities could strengthen their collection of information for individual victims/clients by:

- Improving the mode of data collection and storage;
- Whole agency training on information sharing;
- The creation of unique, individual identifiers for victims;
- Collection of both standardised and non-standard data for alleged perpetrators;
- Recording accurate information on timing of incidences and agency responses.

**3. Data Management Systems must be clear and consistent in stating what data is required and such systems need to be easy to use. It must also be made clear to practitioners how they can use that data to best effect to benefit older victims of abuse.**

There appeared to be numerous methods of data storage used both within adult protection and across other statutory and third sector groups. The quantitative data collection sheets indicated that there was widespread uncertainty as to how long adult protection officers could store information on their DMS.

There was a general perception that the mode of data storage systems mainly involved some form of computerisation of records, however, practitioners were not positive about the utility of their data management systems and many expressed the view that adult protection services should revisit their current data collection systems and ensure that a) more attention was given to the type of information stored and b) that data retrieval processes were less cumbersome and time-consuming.

The lack of consistency of data collection, even within agencies, was also of key concern to practitioners. Practitioners felt that more guidance was required on what information should be standardised and what additional information may be of use.

The extent to which systems functioned effectively was not only contingent on the design of the system and the quality of regular monitoring for accuracy, the process was also dependent on the skills that practitioners brought to the process and their awareness of the importance of good data collection for risk management. For example, some practitioners were highly computer literate and had made significant contributions to improving the design of the DMS whilst others could not see the value in the process of DMS and avoided using the system preferring to use ad hoc methods and their own individual recording systems.

#### **4. All agencies involved in adult protection require further training in, and clarification about data sharing in accordance with, the Data Protection Act 1998 and the Crime and Disorder Act 1998.**

Information sharing remains a contentious issue, for example, police officers commented that POVA were reluctant to share information with the police. Furthermore, there was largely unwillingness to share information about alleged perpetrators. Responses from local POVA professionals and police services suggested that for non-criminal justice agencies there was still uncertainty about the requirements of the Data Protection Act 1998 and the Crime and Disorder Act 1998 about levels of risk, informed consent, and the extent to which partners are legally free to share personal and/ or sensitive information with partner agents. Whilst such guidance is widely available, many local agents still felt unsure as to what constraints there were when sharing with partner agencies, thus sometimes they erred on the side of caution and merely chose not to share data with anyone at all. Further whole agency training is required on information sharing protocol and aspects of Crime and Disorder Act 1998 relating to risk and confidentiality.

#### **5. The use of unique identifiers for individuals would make data sharing more efficient and effective because there would be greater focus on individual-level data sets that could provide far richer data.**

Some systems may automatically generate unique case numbers but if they were case -based or incident-based they did not always have comparable identifiers for individuals.

Unique individual level identifiers would make data sharing much more effective and efficient. Unique identifiers for victims carry less risk in terms of data protection. The use of such methods would assist local areas in assessing their own practice because the focus is on individual-level based data sets, the process would also allow areas to share summaries about their work with other areas.

There are various methods that can be employed to act as 'data quality checks'. IT systems and data management systems can be designed to ensure that key aspects of information must be entered for a new or repeat case to be saved on the system.

Other information that could strengthen information collection for victims may be:

- Using date of birth rather than numerical age
- Recording ethnicity, as BME groups may require further sensitivity when handling domestic abuse especially in relation to incidences of honour based violence
- Mental capacity issues and on-going details of assessment processes in cases of fluctuating capacity
- Type of disability and details of chronic illness
- Use of advocate support (IDVA, IMCA or other)
- Informal links with community groups

**6. There needs to be better understanding of the circumstances that might lead to abuse and the complexities of an older victim's dependencies, family life and desired outcomes. Thorough records must be made that build a clear picture of the victim's and perpetrator's lives, how they interact and what support has previously been put in place.**

Given that circumstances that can lead to abuse are not always straightforward, it is important to have detailed information about individuals who abuse. There is often a level of interdependency between victims and perpetrators and links with other family members, thus, any decision made by the victim regarding engagement with both justice and social care options are often contingent on those they care about. Victims frequently ask for help and support for perpetrators so as to end the abuse. Sometimes the problem needs to be approached using a coordinated community response working in parallel with perpetrators and victims. Some practitioners and specialists in domestic abuse of older people recognised that much more information about the alleged perpetrator is required than is currently collected in order to properly assess and manage on-going risk, to promote engagement and produce an effective outcome for the older person, in line with their wishes wherever possible.

Practitioners felt that regular input on DMS of the following information would better inform the decision -making process when supporting victims of domestic abuse:

- Documenting all the different types of abuse and the nature of the abuse being experienced;
- Whether there is substance misuse present and whether the alleged perpetrator was seeking help for their substance misuse;
- The mental health needs of the alleged perpetrator;
- Alternative accommodation options;
- Establishing whether the alleged perpetrator is themselves an adult at risk and, if so, ensuring this data is shared across both the victim's and alleged perpetrator's case files;
- The level of contact the alleged perpetrator has with the victim and times when perpetrators were not in the family home;
- Identifying whether the alleged abuse may be due to the perpetrator acting in a more pro-active or reactive manner and monitoring or providing support for any circumstances that may lead to increased risk;
- The level of contact, both formal and informal, the victim has with other people and the nature of these relationships.

Agency partners also have a responsibility to implement adult protection plans, this links to the Social Services and Well-being (Wales) Act's requirement that recordings of the findings of an 'adult at risk' enquiry are placed on the care and support plan. Practitioners were of the opinion that on many occasions plans were not implemented. More discussion at senior level is required as to how to address non-compliance of action plans by agency partners.

Information on the level and extent of additional support provided to both victims and perpetrators by professionals is important in judging the effectiveness of the action plan and on deciding whether any further action is needed or for those individuals who may become a repeat victim. The collection of standardised details of previous actions, especially in relation to the response of external service providers to the action plan may be useful, for example, 'substance misuse treatment' or 'alternative accommodation'.

**7. Information on the timing of incidents and repeat referrals is valuable information in building a complete picture and should be accurately recorded. It is recommended that the Caerphilly chronology approach could be adapted across all local authorities, tailored to each POVA team's particular needs and in line with the available external service provision in the area.**

Whilst it may be quite difficult to record precise timings of incidents, especially where there has been a long history of domestic abuse, agencies should be encouraged to assign dates to events, times when contact has been made and cross reference this to times where there has been input by other agencies. This would allow local practitioners to keep a more accurate picture of individual victims and undertake analysis of the amount of time spent on previous and current protection plans and better ascertain at which points in time the perpetrator is in a position to change their behaviour and when the victim may require increased external support.

The Caerphilly multi-agency chronology model, where practitioners examine previous responses to a repeat referral to inform current risk assessment and decision-making, has proved to be a simple and yet powerful method aimed at improving engagement with the action plan and reducing the likelihood of the 'revolving door' syndrome. Whilst there were some good examples of similar techniques used in some local authorities, there was a view at the local level that more intelligent models were needed to address repeat referrals. It is recommended that the Caerphilly chronology approach could be adapted across all the local authorities, tailored to each POVA team's particular needs and in line with the available external service provision in the area.

**8. The nature of abuse and abusive relationships and their effect on older people needs to be better recognised when providing options for support and access to justice.**

Abusers often use a variety of methods to undermine the victim's confidence, isolate the victim socially and deny them a voice in any decision-making in the place where they live – either in their own home or in another setting. Thus, extensive support is required to help the victim feel empowered so they feel in a position to exercise genuine choice. Similarly, if older people are targeted by perpetrators of hate crime they are often have no support and fear and isolation can impede engagement.

Where the victim is the parent or grandparent of the perpetrator, training must be given to practitioners to avoid 'theories' or myths that the victim 'brought it on themselves' because they did not raise respectful children/grandchildren, and



victims need to be helped to resist a false sense of guilt or responsibility for their child's/grandchild's abusive behaviour.

The research shows concern amongst interviewees that, for adult protection cases involving people over sixty years of age and that may involve a criminal investigation, prosecution rates for both domestic violence and hate crime were extremely low compared to other age groups. There is a common misconception that older people will not make good witnesses, perhaps because of stereotypes about being 'forgetful' or 'frail'. This is not usually the case, and such perceptions should be challenged.

### **9. Practitioners in a variety of disciplines need further training in dealing with different types of abuse of older people, how these different types of abuse should be responded to and how they overlap.**

Interview data indicated that some practitioners were aware that for older victims, trying to disclose domestic abuse to frontline workers was extremely difficult and took considerable courage. However it was clear that client disengagement was far more likely in the initial stages, often at the first point of contact. Motivation to engage was often contingent on how the practitioner receiving the disclosure responded to the victim. Practitioners were concerned that some of their colleagues and partner agencies did not give an appropriate response. Some practitioners admitted that they were unsure what to say to an older person experiencing domestic abuse especially if it was the victim's adult child who was the perpetrator of the abuse. For victims of hate crime, there is the misconception that hate crime is very rare. Practitioners felt they needed more information on how to detect and respond to hate crime, as it is an area most agencies have not knowingly come into contact with.

There is a need for widespread training on how to respond appropriately to disclosures and further information is required how to advise older people what they need to do to keep themselves safe.

POVA practitioners also felt that external partners should take a more proactive approach to safeguarding procedures and develop a greater sense of ownership of the process. It was often suggested practitioners outside social services, e.g. health, were too quick to make a POVA referral without trying to seek consent from the individual victim; furthermore partner agencies sometimes did not take the necessary steps to safeguard the individual and provide details of their actions to POVA professionals. POVA practitioners felt that there was a lack of understanding about the referral process by many agencies and this is something that needs to be addressed by POVA teams who understand it better than most.

It is also clear that GPs in particular could take a far more active role in the POVA process and should all have mandatory training in the POVA and MARAC processes.

**10. There must be far clearer and consistent guidelines on adult protection thresholds, accurate risk assessment and the links between adult protection and domestic abuse so that older people do not ‘fall between the gaps’. This should be done in the guidance that accompanies the Social Services and Well-being (Wales) Act. Agencies should also be given clearer guidance on their role and responsibilities in the adult protection process.**

For older people who fall below the threshold, many cases are left ‘between agencies and without clear support’, thus it is suggested that clear guidelines should be drawn up outlining which statutory agency has responsibility for case management in cases that do not meet the threshold test. It must also be clear who has responsibility for case management where an older person is the victim of domestic abuse and also needs support from social services. Some areas adopt a system whereby if the referral does not quite meet the threshold on three separate occasions, they ensure that, if appropriate, the referral is entered into the POVA process on a subsequent referral. See section on ‘Good Practice’.

For individuals who meet the threshold, it is important that the initial referrer and any other partner agencies involved are far more pro-active in assisting POVA professionals in the information gathering process. Attendance at Strategy Meetings by referrers is crucial and many practitioners expressed the view that attendance should be mandatory. POVA professionals felt that, at times, they were not sufficiently supported by external agencies and this made the process time-consuming and unproductive.

**11. A person-centred approach should be central to any process designed to safeguard or protect older people, and processes should ensure that they proactively uphold the human rights of older people.**

To facilitate client engagement it is important that practitioners adopt a client centred approach, rather than a top-down approach. This entails involvement at each step of the process, and face to face contact with the individual client is preferable to case management by telephone. An increased use of independent advocates is recommended in order to ensure that older people have a voice. It was apparent from the data gleaned for this study that neither IDVAs nor IMCAs were used to their full advantage, nor were third sector agencies.

Given the nature of domestic violence, and the heightened levels of risk to victims by perpetrators when agencies become aware of the situation, engagement with victims requires very careful planning. Where appropriate the early involvement of the police in a case is crucial. In a ‘call-out’ situation the police can play an important role in establishing face to face contact with the victim, building trust, safety planning and discussing welfare and justice options with the victim whilst the perpetrator has been removed from the vicinity. Police also use the DASH RIC and engage in a follow up strategy to try to increase opportunities to engage with victims. Whilst this approach is not failsafe, the domestic violence process often can provide detailed information about both victim and perpetrators improving the likelihood of developing a more accurate response. The process also provides access to a range

of specialists in the field of domestic abuse.

Currently, POVA professionals are not in a position to intervene, and the new APSO's process especially in cases of domestic violence may be problematic given that the perpetrator may be in close proximity to the victim even if they are not in the same room, thus 'speaking freely' and talking 'in private' presents considerable challenges. On leaving the property victims may feel very vulnerable to repercussions by the perpetrator unless a comprehensive exit strategy has been put in place to safeguard the victim.

The Welsh Government has chosen not to adopt the Scottish adult protection model which, where coercive control is suspected, allows social services to remove an adult from their home without their explicit consent for a defined period of time in order to speak to them in private and put in support and protection measures to assist them.

There is the need to consider how to link APSOs with the use of domestic violence protection orders where the wrongdoer may be removed from the property, as a strategy to better protect older victims of domestic abuse. The increased use of civil orders to remove the wrongdoer from the property could also increase agencies opportunity to engage and support victims.

## **12. There should be greater integration of POVA and MARAC**

It is clear that for older victims the level and type of support they require will vary at different points in the process both in terms of social care and justice options. POVA practitioners are currently not tending to use the DASH RIC, MARAC and IDVA pathways for older victims when it would, in fact, benefit the victim to use services designed to respond to domestic abuse.

Current practice suggests that the DASH RIC tool for risk assessing domestic violence and referring into the MARAC process is also not being used to full effect by health and social care agencies and this is a cause for some concern. Integration across the both MARAC and POVA processes is vital to provide an appropriate response to individual victims and to draw on the specialisms of each pathway. A case by case approach is recommended with clear direction provided on practitioner roles and careful monitoring of outcomes. Regular and detailed communication across multi-agency pathways is crucial to avoid duplication.

Practitioners should aim to adopt a model that ensures far greater integration by POVA of the MARAC process in cases of domestic abuse to increase access to justice opportunities for victims and create further options for older victims in terms of third sector involvement and independent advocacy support.

## **13. Housing authorities and services should be given more training and be more actively involved in safeguarding older people.**

Housing authorities presented an ideal opportunity to access victims of domestic abuse and hate crime. In local authorities there were many ways in which housing could use their legal powers to provide safer positive outcomes. There

was widespread recognition that housing should be more actively involved in safeguarding actions. Where housing had been involved, it was said that in most instances the strategies employed had been very effective.

Whilst there is less leverage with owner-occupied housing, some housing associations had devised methods for their clients to report hate crime or domestic abuse that are less likely to arouse suspicion in perpetrators. The discreet marketing and promotion of safe ways to access housing support and report abuse would help increase the likelihood of victims reporting their experiences.

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# 8. Appendices

## Appendix A

### Example model of practice: adult protection and domestic abuse

The following table outlines the key steps to be taken when a victim of domestic abuse may also be a vulnerable adult, as defined in the Interim Wales Policy and Procedures, and when a vulnerable adult may be the victim of domestic violence [Richards, M. and Kaye, A. (2011) *Adult Protection and Domestic Abuse: Strengthening the Links*, Interim Report, Powys Pilot Project].

Domestic Abuse	Adult Protection
<p><b>Abuse disclosed or suspected</b></p> <ul style="list-style-type: none"> <li>If victim presents as a vulnerable adult all Agencies should refer to adult protection (regardless of whether the alleged perpetrator is a partner/ex-partner or otherwise related to the alleged victim or not).</li> </ul> <p><b>Completion of CAADA DASH Risk Identification Checklist</b></p> <ul style="list-style-type: none"> <li>Follow Domestic Abuse referral Pathway for completion of RIC.</li> <li>If RIC completed and it becomes apparent that alleged victim may be a vulnerable adult refer to adult protection (regardless of whether assessed as high, medium or low risk and regardless of assessment of capacity to consent to referral)</li> </ul> <p><b>MARAC</b></p> <ul style="list-style-type: none"> <li>Before the meeting Agencies check if any of those referred are already known to them. In the case of Adult Services inform the relevant Social Services Team Manager (this is currently undertaken by the Adult Protection Coordinator).</li> <li>A Social Services representative may attend MARAC.</li> <li>If the alleged victim or perpetrator is</li> </ul>	<p><b>Referral</b></p> <ul style="list-style-type: none"> <li>Should include information about whether the alleged perpetrator is a partner/ex-partner or otherwise related to the alleged victim.</li> <li>Referral should include information about any previous domestic abuse and any action taken.</li> </ul> <p><b>Initial evaluation</b></p> <ul style="list-style-type: none"> <li>If the alleged victim is not a vulnerable adult or does not meet threshold for adult protection the Designated Lead Manager must consider if there is domestic abuse and refer to the police or domestic abuse services or undertake RIC and then refer.</li> <li>If the alleged victim is a vulnerable adult determine if the alleged abuse meets the threshold for adult protection.</li> <li>If the threshold is met, assess the risks. At this stage the usual adult protection risk assessment tool should be used with the information immediately available.</li> <li>Take immediate protective action if required. If there is possible domestic abuse this may involve accessing domestic abuse services, eg refuge.</li> </ul>

a vulnerable adult a referral will be made to adult protection using the Wales Adult Protection Referral Form.

- If there are further discussions of the case at MARAC the DLM will attend (or identify an appropriate person to attend). Information will be shared about the adult protection case and about any actions taken under the MARAC Action Plan.

### **MAPPA**

- If cases referred to MARAC involve a perpetrator already being managed by the MAPPA, then the MAPPA takes precedence and all relevant information is relayed to the MAPPA co-ordinator for inclusion in the management plan.
- If the victim in a MAPPA case is a vulnerable adult and it is identified that he or she is known to Social Services the Adult Protection Co-ordinator or relevant Social Worker would be invited to the MAPPA meeting to contribute information.
- If the perpetrator is a vulnerable adult then the Adult Protection Co-ordinator or relevant Social Worker would be invited to the MAPPA meeting to contribute information.

### **Strategy discussion**

- If alleged perpetrator is a partner, ex-partner or otherwise related to victim identify the incident as domestic abuse.
- Identify if the alleged perpetrator is also a carer for the alleged victim (in this case undertake checks re carers' assessment and services and consider involvement of Powys Carers).
- Check if the alleged perpetrator has access to other vulnerable adults or children, eg through their work and share information as appropriate.
- Follow the domestic abuse referral pathway for completion of RIC checklist if not already completed by referrer (this may be within the timescale for strategy discussion or as an action arising from it. It may be undertaken by the DLM, a social worker or other worker who has received training. This could include a provider agency).
- Take immediate protective action if required. If domestic abuse identified this may involve accessing domestic abuse services, eg refuge.
- If domestic abuse identified as high risk make referral to MARAC. The Designated Lead Manager will attend and/or the alleged victim's care manager (if one has been allocated)
- If domestic abuse identified as medium/low risk contact Domestic Abuse Coordinator/services for advice.
- Arrange strategy meeting within usual timescale (MARAC meeting may not take place within timescale).

### **Strategy meeting**

- In all cases of possible domestic abuse invite IDVA/domestic abuse services/Domestic Abuse Coordinator as appropriate.
- Involve domestic abuse agencies in Protection Plan.

### **Investigation**

- Request specialist domestic abuse involvement as required – e.g. perpetrator risk assessment.

### **Final Strategy meeting**

- Domestic abuse representatives to attend and participate in determining status of allegation and outcomes.
- Domestic abuse services may be identified in outcomes for victim (advice, support, refuge) and/or for perpetrator (perpetrator assessment/programme).

### **Case conference**

(This is where information about the investigation is shared with the alleged victim and/or their representative and the Protection Plan is agreed).

- Domestic abuse professionals to participate in or lead case conference as appropriate.

### **Review of Protection Plan**

- Domestic abuse professional to participate if they have had continuing involvement or if it becomes appropriate for domestic abuse services to be involved.

If it is immediately apparent that the victim of abuse is a vulnerable adult then the accepted course of action is to raise the concern with Social Services and the DLM has a responsibility to consider if domestic abuse is also an issue. If domestic abuse is part of the circumstances of the case then the DLM must complete the CAADA DASH Risk Indicator Checklist and/or consult with the Domestic Abuse provider in

that area in order to ensure maximum safety is afforded that victim.

This could result in the case being taken to MARAC but in any case the dynamics of domestic abuse will be fully covered in any Safety Plan drawn up.

Where the victim of abuse is not immediately assessed as being a vulnerable adult but domestic abuse has been recognised, the domestic abuse procedures will commence as a matter of priority and if there are concerns about the vulnerability of the victim then the Support Worker dealing with the case will consult with Social Services to ensure maximum safety is afforded that victim.

## Appendix B

### Interview schedules

#### The 'All-Wales' Adult Protection, Domestic Abuse/Violence and Hate Crime Study - telephone interview schedule

#### Safeguarding, adult protection and domestic abuse

#### START INTERVIEW (TURN MACHINE ON)

##### A. BACKGROUND

What is your role/job title?

How long have been in your current role?

##### Knowledge of domestic abuse

- Can you explain to me the difference between safeguarding and adult protection?
- In your own words can you describe what domestic abuse is?

##### B. INTIAL POINT OF CONTACT

##### B.1 At the point of initial contact with social services, what could be the possible causes for client disengagement?

Prompt:

- Client perspective.
- Do you think practitioners could do anything at this stage to reduce client disengagement?
- Agency perspective. How do the assessments impact on the decision making process to take a case forward?
- If a case does not meet the adult protection threshold, what happens to the case? Who is the case signposted to and how is the decision made to signpost the case?

##### B.2 What do you think are the possible reasons for disengagement when the client has contact with the police and they undertake an investigation?

Prompt:

- Client perspective
- Do the way police operate effect attrition? Could this be improved? If so, how?
- What do you think is the decision making processes for the police to decide whether or not to refer a case? Do you feel they do this effectively? If not, how could they improve?



## **C. THIRD SECTOR INVOLVEMENT**

### **C.1 How involved are third sector agencies with your clients?**

- Do you receive many referrals from them?
- What is the quality of the referrals you receive?
- In your experience would you say the third sector agencies have a good working relationship with your agency? Could it be improved in anyway?

## **D. POVA PROCESS**

### **D.1 What support does POVA offer the client?**

- In your opinion what do you think practitioners' knowledge of the POVA threshold is? What agency refers to the POVA the most? Who needs to refer more?
- How do you decide if a case has met the POVA threshold? (Vulnerability? Age? Capacity?)
- If they don't meet the threshold what happens to the case? Whose responsibility is the case if it does not meet the threshold?

### **D.2 What areas of a case do you feel are important for agencies to identify when deciding whether or not to refer a case to your agency?**

- Relationship dynamic effect the type and level of support given? E.g. husband carers stress? Son conviction? Unfriended?
- Do these areas tend to be explored with clients?

## **E. CONSENT**

### **E.1 What happens if the client refuses to give their consent for you to share their information?**

- Can this consent be overridden? When? How?
- Are there any circumstances where you can refer a case without the victims consent? How often is this done?
- What is practitioners' knowledge of this?
- Is coerced consent considered? What do practitioners do to assess whether consent is coerced?

## **F. DASH RISK ASSESSMENT AND MARAC**

### **F.1 Can you explain to me, when you would complete a CAADA risk assessment and when you would complete a DASH?**

- How often is the DASK risk assessment used?

### **F.2 Referring into the MARAC**

- When would you refer into the MARAC?

- Can you talk me through your risk assessment and what criteria you have for the MARAC process? (DASH RIC- point score. What points score higher?)
- How many cases do social services refer into the MARAC? (if low explore why and how it could be improved)
- What purpose does the MARAC serve?

**F.3 Have you had any experience with clients over 60 years of age in that have been involved in the MARAC process?**

Prompt:

- How useful is the MARAC for older victims?
- How have they responded to the support?
- If they've not had much experience, why do they think that is?
- When would the MARAC not be appropriate?

**F.4 Who is usually in attendance at your POVA meeting and MARAC meeting? Who's not there that you feel should be?**

**F.5 When a case has been identified as domestic abuse, when would you choose to involve an IDVA?**

**G. CROWN PROSECUTION SERVICE**

**G.1 It has been established that a criminal offence has occurred and the client wishes to pursue a conviction. In your experience, what proportion of cases does the CPS choose to take forward and process for those who are aged 60 and over?**

- What are the case characteristics?
- What is the outcome of these cases?
- What do you think are the real reasons why the CPS reasons for not taking a case on?
- How could this be improved?

**G.2 Why might a client choose to withdraw their consent/witness statements?**

- Does an individual speak with the client to explore why they have withdrawn their consent/witness statement?
- What are the reasons? Can agencies do anything to improve this?

**G.3 If a client decides not to pursue a criminal conviction what other options are discussed with them?**

Prompt:

- Civil?
- Welfare?

## **H. HATE CRIME**

**H.1 What is your understanding of hate crime and how would you decide how to deal with older victims of hate crime? Is there a referral mechanism where attrition may occur?**

## **I. FUTURE DEVELOPMENT AND FINAL COMMENTS**

**I.1 Overall, what are the key areas for attrition in the process from initial point of contact to prosecution? What can agencies do to improve and reduce the attrition rates?**

**I.2 Are there any gaps in the referral process that could potentially be strengthened?**

**I.3 Do you have any other comments that you'd like to make that haven't already been discussed?**

**"Many thanks for your time and assistance."**

## **END OF INTERVIEW**

# **The 'All-Wales' Adult Protection, Domestic Abuse/Violence and Hate Crime Study - telephone interview schedule**

## **Data Management Systems**

### **START INTERVIEW (TURN MACHINE ON)**

#### **A. BACKGROUND**

What is your role/job title?

How long have been in your current role?

#### **B. Section on general case management and sharing of information**

##### **B.1 What data management system do you use?**

Prompt:

- Databases – are there any changes to your system you feel need to be made to fit in with the case management process?
- How do you share information with other agencies?
- Do you feel it is fit for purpose (when making a referral to police, POVA, third sector etc.)?
- How do you record and manage the information that you receive about a client?

## **B.2 Data Protection**

**What is your understanding of your other colleagues perceptions of data protection? Practice? Policy within your organisations?**

**What is your understanding of data protection systems? How do you know about data protection?**

Prompt:

- What are the constraints in relation to data sharing?
- What information would you hold about the victim and under what circumstances would you withhold it?

## **B.3 Information that is recorded**

**When you receive a call reporting a domestic abuse/hate crime incident what information do you record regarding the victim?**

**Is the information you input 'standardised' relating to victim(s) and alleged perpetrator(s)?**

**What are the main areas of interest to you that you record when taking a call? How is this recorded (prompt DMS, notes, file etc)?**

Prompt if necessary:

- What are your main areas of interest in relation to victim?
- What are your main areas of interest in relation to perpetrator? (Is it recorded from the victim's perspective or the perpetrators?)
- Are there similar identifiers for the victim or the perpetrator? (Substance misuse programme, how do they make them accountable)
- Are there codes that capture this on your DMS? Some of the main areas of interest?

**Is the type and level of the additional support (by family friends etc) given to the victim and the perpetrator monitored, if so where is this information stored?**

**When note taking about individuals' abuse where do you store the information?**

## **C. Reflect on recording process and referrals.**

**C.1 In your organisation, if a case that has already been identified as domestic abuse/hate crime and an onwards referral is going to be made by you, what information would you share with other agencies?**

Prompt

- For repeat victims is there anyway an agency can identify that they have received a call regarding the same victim?

- How do you tag a crime that you think could potentially become a repeat and how do you flag it up? If you don't, how do you think you could do it?

**C.2 As part of your record keeping on the DMS when you describe an incident is there a way to create a consistent use of categories on the DMS, so repeat incidents can be easily monitored over time?**

**C.3 Meeting the POVA threshold**

- Are the decision making processes recorded when a decision is made about POVA? Are these decisions relayed back to the initial agency and if so how?
- What happens with a case if it does not meet the POVA threshold and how is this recorded?
- How do you monitor the outcome if the referral is taken up by MARAC?

**C.4 How do you record the service users views and wishes in cases? On the DMS? Or separately?**

**D. FUTURE DEVELOPMENT**

**In terms of other agencies data management systems and the POVA MARAC process do you feel there are any improvements that could be made when referring a case?**

**E. FINAL COMMENTS**

**Do you have any other comments that you would like to make that haven't already been discussed?**

**Many thanks for your time and assistance.**

**END OF INTERVIEW**

# Appendix C

Don't have victims consent

Victim doesn't want the perpetrator to be trouble or anything to happen untoward

Vulnerable adults tend not to make the call themselves

Don't understand that they are victims of abuse

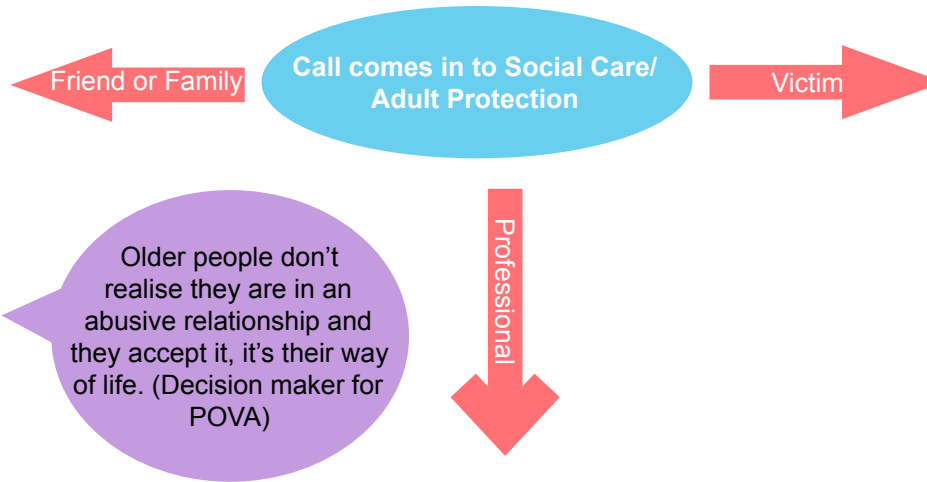
'Way of life'- the abuse is normal and acceptable for them

Don't want to bother social services

Stigma of agency involvement

Mistrust in services

Victim is reluctant to engage until removed from the situation



Want help for perpetrator

Fear of reappraisal

Sense of duty to care for the perpetrator or reliant on the perpetrator is their carer

Fearful of the unknown- rather live with the abuse than risk unknown consequences

Family consequences and repercussions

Rather 'put up' with the abuse than lose a family member

Want help but don't know what

Dependency issues- financially (no mortgage)

Mobility issues

Guilt- feel responsible for the abuse

Ashamed that their family member could be abusive

Vulnerable people won't call themselves

Depends how they are responded to by the professional. More will to engage if they are sympathetic, understanding and they feel they are being listened to

Don't understand the process

Not being believed

"I think people of that age are less likely to know where to get support from"

If the victim has had negative previous experience they are less likely to engage

If relatives or friends refer without discussing it with the victim or without gaining consent, the victim is more likely to disengage. (POVA Coordinator)

Often don't seek victims consent

Don't ask the right questions to complete referral

Assumptions made without speaking to the victim

'Passing the buck' – Professional shifting safeguarding responsibility

Professional doesn't take any action to safeguard alleged victim

If referral is made to social services they will want to speak with the victim ideally

As soon as they pick up the phone we are already battling the fact that they will be doubting themselves in that process. As soon as the phone is picked up at the other end we are on a knife edge as to how they react. If the person who picks up the phone is under a large caseload, demand, if they are negative in their tone and their voice, that could close down the individual and we won't get the disclosure. The way the person has answered the phone has impacted and maybe they are worthless and they shouldn't be mentioning. Certainly with elder abuse they wouldn't be bothering anyone who may be busy with far more important things, they would see it. (Detective inspector)

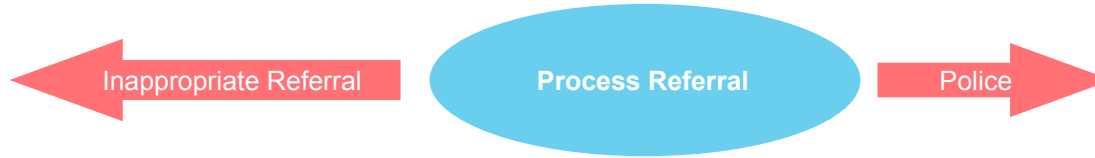
I think sometimes when we look at a case like financial abuse for example mother, father, whoever may realise they have been taken advantage of by a relative but they want that area to stop. What they don't want is for them to be prosecuted. That is where they may disengage and withdraw their consent for that investigation to go ahead. That doesn't stop you looking at safeguarding measure and moving things forward. (POVA Coordinator)

"I think people of that age are less likely to know where to get support from" (Adult Protection Officer)



**Active Approach**  
The professional will refer the victim onto another agency on behalf of victim

**Passive Approach**  
The professional will signpost the victim to another agency. It is the victim's responsibility to make further calls for help and support



Might disengage because of the loyalties to the family, they want you to just have a word with them. (POVA Officer in Public Protection Unit)

Didn't meet POVA threshold

Met POVA threshold

We rarely are. It goes into there [POVA] and then we almost take a step back then. That's yours to carry. That's your baton now and then we carry on with whatever else (Police Officer)

Lack of agencies knowledge of the POVA threshold  
The refer doesn't seek consent from the individual they are referring  
Not regarded as a vulnerable adult under the legislation "in Safe Hands" people don't get it  
Victim wants no involvement  
Agency makes referral and does not take steps to safeguard the individual (everyone's responsibility)

Seeking victims consent  
Referrals lack information and can take a long time to chase up the information from agencies  
If they meet the vulnerable adult criteria they have a duty to investigate incident no matter how minor (time consuming)

Some adult services departments make automatic referrals to the police no matter how minor the abuse incident. Others refer to the police only when they are a certain level of risk  
The individual may not want police involvement therefore the professional will not make a referral  
Refer to the police to decide if it meets MARAC threshold  
Some regard the police as a distant entity  
Trust  
Frightened of process and reappraisal  
Loyalty to perpetrator  
Embarrassment and shame- don't want a police car outside their house  
Stigma attached to police involvement  
Panic of what might happen  
Don't understand the process  
Depends on rapport with the police officer

Rational is provided as to why they didn't meet the threshold and recommendations are suggests. This is usually done via letter or can be a telephone conversation  
Suggestions are made but don't actively refer case on, it's the initial refers responsibility

They have got to be valued and supported for them to open up that box of horrific memories they have got of how they have been abused, as to what is going to happen next. (Detective inspector)

I think what can happen is a vulnerable adult could say they are happy to consent to POVA referral and they want that investigation. Where they might disengage is where you start talking about possible Police interaction, a criminal investigation.....They [alleged victim] just want the action to stop but they don't want prosecution. (POVA Co-ordinator)

Collaborative evidence isn't as robust as it should be (medical evidence to support allegations)

Not credible witnesses in terms of incident recall and communication skills

Quality of evidence

Evidence gathering

Process Referral

Witness statements

Some adult services departments make automatic referrals to the police no matter how minor the abuse incident. Others refer to the police only when they are a certain level of risk

The individual may not want police involvement therefore the professional will not make a referral

Refer to the police to decide if it meets MARAC threshold

Some regard the police as a distant entity

Trust

Frightened of process and reappraisal

Loyalty to perpetrator

Embarrassment and shame- don't want a police car outside their house

Stigma attached to police involvement

Panic of what might happen

Don't understand the process

Depends on rapport with the police officer

It's getting better, initially was because of poor evidence that was collected or the difficulty of evidencing abuse. (Decision maker for POVA)

Court proceedings

Psychological abuse that they have, that is being continually reaffirmed. "If you do report me, I will become a criminal and you will go into a home." (Detective Inspector)

Negative impact on their health  
Limited use of special measures  
They don't understand the modern CJ court process  
Individuals need support and empowerment to go to court

The CPS can only act on whatever evidence is presented to them by the Police. It is a dual role, not just the CPS but the quality of the investigation and what's presented to them. (Adult Protection Officer)

Even though there are special measures the courts don't like people to use them because they aren't as impactful. But courts shouldn't rely on impact they should rely on the facts. (Decision maker for POVA)

They may want the abuse to stop but they may not necessarily want to take a criminal route. It is possible to have an ex partner but it is not possible to have an ex son or daughter. (POVA Co-ordinator)

Certainly I feel there needs to be far more prosecutions and I don't think the most vulnerable are being given the opportunity to express their views in Court when they want to. (Adult Protection Officer)

