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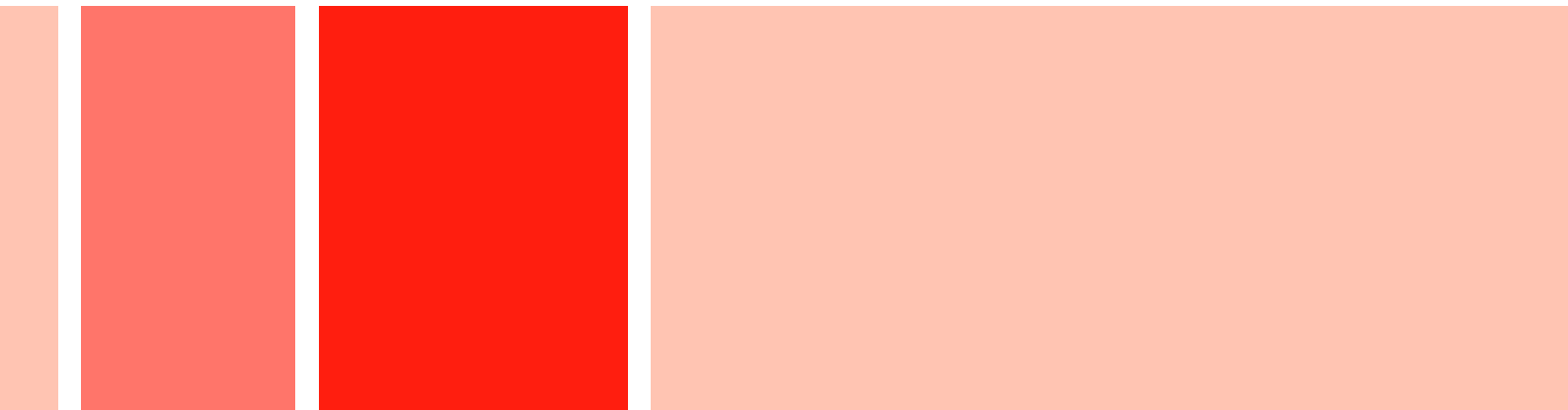
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An Evaluation of the 'Access to Justice' Pilot Project



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Views expressed in this report are those of the researcher and not necessarily those of the Welsh Government

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Glossary of Terms

BAWSO	Black Association of Women Step Out
BME	Black Minority Ethnic
CAADA	Co-ordinated Action Against Domestic Abuse
CMR	Case Management Record
CPS	Crown Prosecution Service
DASH RIC	Domestic Abuse, Stalking and 'Honour'-Based Violence: Risk Indicator Checklist
DLM	Designated Line Manager
GP	General Practitioner
IDVA	Independent Domestic Violence Advisor
IMCA	Independent Mental Capacity Advocate
LGBT	Lesbian, Gay, Bisexual and Transgender
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MCA	Mental Capacity Act
OPAN	Older People's Ageing Network
POVA	Protection of Vulnerable Adults

Executive Summary

1. Introduction

- 1.1. A principal objective of the 'Access to Justice' Pilot is to enable older, vulnerable victims of domestic abuse to access criminal or civil justice processes in seeking protection from further abuse.
- 1.2. This objective is founded on the need to ensure that the human rights of older people are protected. In *The Right to be Safe*, the Welsh Government noted that there are 'few more basic human rights than that of being protected from violence or exploitation' (2010: 4).

2. Aims and methodology

- 2.1. In evaluating the 'Access to Justice' Pilot both process and outcome issues were explored in examining how risk, capacity and consent are dealt with by criminal justice and civil agencies involved in providing services for older victims.
- 2.2. A multi-method research design was adopted, which employed both qualitative and quantitative methods of data collection and analysis. Data was collected from a variety of sources: case management records (CMRs); case file analysis; process maps; semi-structured qualitative interviews with managers and practitioners and older people; a focus group and police recorded incidents of domestic abuse.
- 2.3. Twenty semi-structured interviews were undertaken with managers and practitioners from eleven statutory and nine third sector groups. Twelve older people and one victim of elder abuse were interviewed, using anonymised scenarios drawn from the recurrent themes emerging from the content analysis of the CMRs.

3. Findings

- 3.1. Initially some statutory agencies were slow to engage with the Pilot. In addition, there was a perception amongst the practitioners interviewed that, in some instances, organisations did not always send the appropriate personnel to the training session to ensure that the information imparted was effectively disseminated throughout the organisation. There was a clear recognition of, and support for, the general ethos underpinning the 'Access to Justice' Pilot.
- 3.2. A total of 145 separate incidents, involving 131 individual victims, were recorded between 3rd December 2010 and 31st January 2012. Data was available for 127 victims (in four cases a second victim was identified as being present at the time of the incident).

- 3.3. Of the 131 victims, 95 were female and 36 were male. This is a higher proportion of male victims than usually found in younger age groups. Ages of victims ranged from 55 to 91 years. Nearly one-third of all victims had a disability. Ten individuals were recorded as lacking mental capacity.
- 3.4. When comparing male and female victims, a greater proportion of men (56%) than women (33%) experienced physical violence.
- 3.5. Of the perpetrators, 109 were men and 44 were women. There were 50 sons and 20 grandsons. Sons were more likely to have substance misuse issues than any other perpetrator. In only one case was there evidence that both the victim and the perpetrator were under the influence of alcohol at the time of the incident. This pattern of substance misuse appears to differ from that found in cases of domestic abuse in younger age groups.
- 3.6. When exploring the victim - perpetrator dynamic, two broad types of perpetrator behaviour were identified: reactive perpetrator behaviour and proactive perpetrator behaviour.
- 3.7. Spouses/ex-spouses displayed a proactive type of perpetrator behaviour and these cases had the highest level of physical violence in the whole sample. As a sub-group, intimate partners appeared to have the poorest outcomes.
- 3.8. Across all agencies Domestic Abuse, Stalking and 'Honour'-Based Violence: Risk Indicator Checklist (DASH RIC) forms were completed in 66 cases, of these the police completed 58 and social services completed six.
- 3.9. In at least 30 cases, given the gravity of the incident described in Section C of the CMR, the level of risk recorded in Section B was lower than one might expect. It was felt that the DASH RIC tool needed to be slightly adapted to meet the needs of older victims.
- 3.10. An adapted version of the DASH RIC was developed and social service personnel trained in its use. However, as only six adapted DASH RIC forms were completed by social services during the Pilot it is difficult to draw any firm conclusions as to whether the adapted tool provided a more accurate measure of risk in the context of elder abuse.
- 3.11. Where there was involvement from third sector organisations positive welfare outcomes were more likely.
- 3.12. In the vast majority of instances (70%), the CMR indicated that the original form did not show if consent had been obtained. The failure to record whether consent was given may affect the ability of the initial referring agency to involve specialist domestic abuse agencies and

other third sector groups in helping to ensure that the needs of victims are addressed.

- 3.13. Once a disclosure was made, there was a view that practitioners should be more proactive in establishing whether consent was genuine, and that the choice victims made were a true reflection of their wishes and not coerced choices brought about by their circumstances.
- 3.14. In 43 incidents victims were recorded as having capacity; there were 10 cases where the victim was found to lack capacity. Carer stress¹ featured in five of these cases. Eight cases involved physical abuse.
- 3.15. In a significant number of cases where the victim lacked capacity and abuse occurred, the victim was without friends, and the perpetrator was a close relative, either residing with the victim or living within close proximity. There was no evidence from the records that the involvement of an Independent Mental Capacity Advocate (IMCA) had been sought in any of these cases.
- 3.16. Interview data also raised concerns as to some misconceptions around the practice of delaying the involvement of an IMCA during the investigative process. The early involvement of an IMCA is critical as a range of decisions occur early in the investigative process that heavily influences the outcome.
- 3.17. In two-thirds of all relevant cases, criminal or civil justice options were not discussed with victims.
- 3.18. It was evident from the case files that the police responded sensitively and positively to victims of elder abuse. In some instances, the police paid regular visits to the homes of victims. These safety checks were considered to have a potential deterrent effect.
- 3.19. In terms of consent, options discussed, 'active engagement' (i.e. when a victim engages with an agency to which they had been referred) and legal and welfare outcomes, the cases referred to the Multi-Agency Risk Assessment Conference (MARAC) fared very well.
- 3.20. The data suggests that the quality of engagement with agencies varied considerably both in terms of ensuring that the victim was kept fully informed and that their wishes were central in the decision-making process.
- 3.21. It was recognised by a wide range of practitioners and managers that statutory agencies do not always have the necessary staffing resources to develop a strong relationship with their clients.

¹ 'Carer stress' is a term used to describe the physiological, psychological and emotional symptoms that can result from the ongoing strain of caring for a dependent adult.

- 3.22. Third sector involvement appeared to generate the best engagement by the older person and in the majority of cases where a conviction occurred there was evidence of third sector support. The general perception was that third sector practitioners could provide impartial, independent support that empowered the older person. Building a relationship was considered essential to enable victims to reflect on the range of options available and engage effectively with services.
- 3.23. Concern was expressed by practitioners that victims were being denied the opportunity to work with the range of agencies with a specialism in domestic abuse because the Protection of Vulnerable Adults (POVA) and MARAC were not well-integrated processes.
- 3.24. Where victims had consented to support, there did not appear to be any mechanism in place to monitor their route through the POVA and MARAC processes. In cases where consent was not given, but the level of harm was severe, it was in the best interests of the victim to override consent to share information and activate the MARAC process.
- 3.25. Eleven perpetrators were charged and ten were convicted. Of the convicted perpetrators five were grandsons, four were sons and one was a wife. Financial abuse was the most frequent type of abuse recorded in these cases. In eight cases, there was evidence of either illicit drug use and/or alcohol misuse.
- 3.26. There was a marked increase in the number of cases of elder abuse recorded by the police over the twelve-month period. Risk assessments were conducted in three-quarters of these cases, which represents an increase in the average figure for the three years prior to the introduction of the Pilot.
- 3.27. It was difficult from the data available to form a view as to whether the potential for using special measures was considered, and if so, by whom.
- 3.28. All of the decisions not to prosecute that were reviewed were supportable based on the information on the file. Typically, the reason for not proceeding was the lack of corroborating evidence and refusal on the part of the victim to testify.
- 3.29. There were very few examples where criminal and civil law options were pursued. There seemed to be a lack of awareness among practitioners about how the civil law could be used in cases of elder abuse.
- 3.30. There was limited information provided on the case management records by agencies to indicate whether the abuse had ceased or changed in severity at case closure.

- 3.31. The common perception was that 'Access to Justice' gave some impetus to increasing practitioners' knowledge about elder abuse as a form of domestic abuse. Although agencies supported the ethos of the Pilot, it was recognised that there still needed to be a shift in practice to address the needs of older people experiencing abuse.
- 3.32. Participants from the Older People's Ageing Network (OPAN) felt that successful outcomes should be highlighted and information on victims' positive experiences of using the civil and criminal law should be more widely publicised.

4. Recommendations

- 4.1. Consideration should be given by the Welsh Government to how domestic violence and elder abuse procedures, policies and guidance can be integrated more effectively.
- 4.2. 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.
- 4.3. Practitioners should record the basis for a conclusion that the victim has legal capacity to participate in the investigative process.
- 4.4. Practitioners need to ensure, when considered appropriate, that issues of capacity are considered throughout the investigative process.
- 4.5. In cases where a victim lacks capacity, there should be a presumption that an IMCA will be involved, and at an early stage rather than towards the end of the investigative process. This presumption should be rebuttable by, for example, evidence that some other suitable person is representing the victim's interests.
- 4.6. There should be an evaluation of statutory agencies responses to older victims who lack capacity. Particular attention should be given to the uptake of the IMCA service by adult services and health services and the impact of the IMCA role in supporting incapacitated victims of abuse.
- 4.7. The decision on whether to use special measures² in criminal proceedings should be based on assessments of the victim's vulnerability made throughout the investigative process. Practitioners should ensure that all information relevant to that decision is available to the Crown Prosecution Service (CPS).
- 4.8. Consideration should be given to extending the 'Access to Justice' Pilot for a further two years and this should include a pilot in a rural area.

² Special measures are available for certain categories of vulnerable witnesses appearing in court. They include the use of pre-recorded interviews, video link cross-examination, the use of a support person and assistance in communication.

- 4.9. Statutory agencies should be more aware of the support and services provided by the third sector and in appropriate cases, with the consent of the victim, that the third sector should be part of the interdisciplinary response.
- 4.10. Consideration should be given to providing resources to the third sector to fund support for awareness raising, training and advocacy support.

1. Introduction

(i) The wider policy context

Although precise figures are difficult to obtain, a significant number of older people living in Wales experience domestic abuse in situations where there is an expectation of trust from the abuser. 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 the *In Safe Hands: Implementing Adult Protection Procedures In Wales* guidance (National Assembly for Wales, 2000). The latter point has significant implications for the basic human rights of older people, not least the right to justice.

In its integrated strategy for tackling violence against women and domestic abuse, entitled '*The Right to be Safe*', the Welsh Government (2010) identified four key priorities for tackling domestic violence. They are:

- prevention and raising awareness of violence against women and domestic abuse;
- providing support for victims and children;
- improving the response of criminal justice agencies;
- improving the response of health services and other agencies.

One of the initiatives to arise out of this six year integrated strategy for tackling violence against women was a pilot study focussing on the support needs of older victims of abuse. This was undertaken with the support of the Crown Prosecution Service (CPS), Age Cymru, and other key stakeholders. The 'Access to Justice' Pilot Study commenced in 2010 and was based in Swansea. The aim of the project was to facilitate access to criminal and civil justice options for older vulnerable people, who were victims of domestic abuse.

Currently within Wales, there is no equivalent to the *Adult Support and Protection (Scotland) Act 2007*. However, this does not mean that older people who experience abuse are denied access to legal redress. A considerable number of criminal offences and civil law procedures should be available to the older victim in the same way they are available to other members of society. A key policy issue is whether older victims are in any way excluded, consciously or otherwise, from accessing justice. If so, what are the reasons and how can they be addressed?

The *In Safe Hands* guidance has been successful in raising awareness of the abuse of vulnerable adults and in putting in place an interdisciplinary response procedure. Quite rightly, a key component of this procedure is the need to provide appropriate welfare support for those who experience abuse. However, as the recent review of *In Safe Hands* identified, the guidance is no longer appropriate and is in need of revision (Magill *et. al.*, 2010). Any

revision, or indeed the introduction of new statutory powers, needs to address not only the importance of the welfare response, but also the need to ensure access to justice (both civil and criminal) in appropriate cases for victims of elder abuse.

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 and often insurmountable, challenges especially given the complex dynamics that can exist between victim and abuser. Victims may experience a form of 'secondary victimisation', which occurs not as a direct result of a criminal act but because of the inappropriate or negative response of individuals and institutions to the victim. For example, this may happen where professionals lack the necessary training and experience to respond appropriately to the needs of older victims, especially when these victims have complex needs. Furthermore, if a victim experiences an injustice there should be opportunities to address this; the 'Access to Justice' Pilot is designed to provide such opportunities for victims of elder abuse.

Key drivers of the 'Access to Justice' Pilot Study are human rights. In *The Right to be Safe*, the Welsh Government noted that there are 'few more basic human rights than that of being protected from violence or exploitation.' (2010: 4). The European Court of Human Rights has recognised the need for the State to be extra vigilant in protecting those in society who, for whatever reason, may be vulnerable. In *A v United Kingdom ((1999) 27 EHRR 611)* the European Court stated that: 'Children and other vulnerable individuals, in particular, are entitled to State protection, in the form of effective deterrence, against such serious breaches of personal integrity.'

This positive duty on the State is reinforced by the duty on public authorities under s.6 of the Human Rights Act 1998 not to act in a way that is incompatible with any of the rights in the *European Convention of Human Rights*. Elder abuse engages a number of different human rights under the Convention. These include:

- Article 2: right to have life protected;
- Article 3: right not to be subjected to inhuman or degrading treatment;
- Article 5: right to liberty and security of person;
- Article 6: right to a fair hearing;
- Article 8: right to a private life, family life, home and correspondence;
- Article 9: right to freedom of thought, conscience and religion;
- Article 10: right to freedom of expression

Article 14 states that the 'enjoyment of the rights and freedoms...shall be secured without discrimination on any ground' and this includes age. In applying human rights to cases of elder abuse, a careful balancing act must be performed. On the one hand, the protection and support of the victim is essential. Welfare support and therapeutic intervention is a right under, for

example, article 8. However, consideration must also be given to the provision of justice for the victim. For example, article 13 guarantees to everyone whose Convention rights have been violated ‘an effective remedy before a national court.’ Where the violation is of a fundamental right (for example, the right to have life protected or the prohibition of inhuman or degrading treatment), the European Court has held that this includes the right to ‘a thorough and effective investigation capable of leading to the identification of those responsible, including *effective access to the complainant to the investigative process.*’ (*Z v United Kingdom* (2002) 34 EHRR 97 para 109). Accessing justice, in addition to being a human right in itself, may be the only effective way of protecting the person. The provision of welfare support and the use of the criminal and civil justice processes are not incompatible or mutually exclusive. They do complement each other provided an appropriate balance is achieved in an individual case.

(ii) ‘Access to Justice’ Pilot

The ‘Access to Justice’ Pilot was developed for ‘older vulnerable people’ who are victims of domestic abuse. An older vulnerable person is defined as:

“A person who is 60 years of age or older who is not in a position to protect their own well-being, property, or other interests:

- because they are a disabled person **or**
- because they are ill **or**
- otherwise **and**
- is at risk of harm from domestic abuse that another person - or person’s conduct - is causing or is likely to cause.” (Access to Justice, 2011: 8)

A principal objective of the initiative is to enable victims to access criminal or civil justice processes in seeking protection from further abuse. In general terms, the Pilot scheme aims 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). An integral feature of the initiative is the establishment of a referral pathway for agencies involved in delivering services to support victims. The purpose of the pathway is to ensure that:

- elderly victims of domestic abuse have access to justice seeking options;
- professional practitioners understand and appreciate the significance of risk of harm to older vulnerable people who experience domestic abuse;
- disclosures of abuse are appropriately recorded and support measures implemented;
- statutory agencies and third sector organisations provide a co-ordinated response to protect victims;
- existing service provision is utilised to help victims make informed choices in seeking civil or criminal justice solutions.

The Pilot scheme provides guidance for agencies in the form of 'referral process maps' (which take into account capacity and consent issues) and risk assessment procedures. The various referral pathways are outlined in Appendix A. The multi-agency pathways are designed to enable more effective risk management, greater client safety and ensure more rapid and appropriate agency responses when elder abuse occurs.

(iii) Local context

The study was based in Swansea, an urban area in south west Wales, which has Carmarthenshire to the north and Neath Port Talbot to the east. Swansea has a population of around 231,300, a quarter of which consists of people aged 60 years and over. Given the high proportion of people in the older age groups, the 'Access to Justice' Working Group chose Swansea for the location of the Pilot scheme. In 2010 the Swansea Health, Social Care and Well-being Needs Assessment reported that during 2007/08 the Wales Domestic Abuse Helpline received 13,982 calls, with almost half of these (46%) originating from South Wales. The vast majority of callers were female (93%).

2. Research Objectives and Methodology

(i) Key Objectives

In February 2012, we were commissioned by the Welsh Government to conduct a process and outcome evaluation of the 'Access to Justice' Pilot and make recommendations for more effective all Wales implementation of the initiative. In addressing these principal aims we sought to:

- explore the relationship between the level of risk identified and the type and number of support services and criminal/civil agencies actively engaged in the referral pathway;
- ascertain how frequently the DASH Risk Indicator Checklist (DASH RIC) was employed in cases of elder abuse;
- identify the characteristics of those cases where a civil/criminal justice pathway was prioritised and explore the decision making processes involved;
- discover the extent to which multi-agency pathway requirements were observed;
- explore how the type of abuse and perpetrator-victim relationships may influence agency responses to the abuse;
- construct and examine 'process maps' to ascertain the direction taken by clients, paying particular attention to contextual factors and the specific needs of clients;
- analyse the effect of capacity issues in terms of the referral trajectory;
- determine the extent to which the initiative facilitates 'access to justice' for older people.

(ii) Data Collection

A multi-method research design was adopted, which employed both qualitative and quantitative methods of data collection and analysis. Data was collected from a variety of sources:

Case management records

Case management records (CMRs) were designed specifically to collect data during the Access to Justice Pilot. A quantitative content analysis of the CMRs was undertaken to provide descriptive statistics of the sample. A preliminary analysis of the CMRs informed the design of the qualitative, semi-structured interview schedules and the vignettes for the stakeholder focus group. A specimen CMR can be found in Appendix B.

Case file analysis

As information obtained from the CMRs only provided a limited insight into the impact and effectiveness of the Pilot project, a sub-sample of individual case files was taken and examined from a legal perspective. The primary objective

was to focus on cases considered to be successful in terms of criminal justice and/or civil justice sanctions and highlight instances of good practice. The intention was to compare these cases with a sample of cases where a criminal/civil justice remedy could have been pursued but was not, and to explore how consent and/or capacity issues featured in cases in the two samples.

Process maps

Process maps were constructed from information contained in the CMRs to illustrate the different routes through the referral pathway and the end points reached by clients. In analysing these process maps specific attention was paid to whether clients (a) had capacity and gave consent to share information, (b) had capacity but did not give consent, (c) did not have mental capacity to give consent.

Qualitative interviews

Primary was obtained by means of semi-structured, qualitative, telephone interviews with policy makers, practitioners and service managers. Twenty semi-structured interviews were undertaken with managers and practitioners from eleven statutory and nine third sector groups. The number of interviewees from each specialist area was as follows: health (5); adult services (1); criminal justice system (3); the Multi-Agency Risk Assessment Conference (MARAC) team (1); domestic abuse (4); older people (2); mental capacity (2); disability (1) and black and minority ethnic (BME) (1). Interview schedules can be found in Appendix C.

As user participation was essential to ensure the integrity of the research, the research team engaged with OPAN (the Older People's Ageing Network) to ascertain the views of older people. Thirteen older people (one of whom was a victim of elder abuse) were interviewed, using anonymised scenarios drawn from the recurrent themes from the content analysis of the CMRs. This was not intended to be a representative sample. However, it was felt important that the research would benefit from hearing the views of older people, who are the target group for the Pilot. The same applies to the interview with the male victim, which is used to illustrate one type of response to elder abuse.

Stakeholder focus group

The focus group comprised seven practitioners and managers. A range of methods was used to elicit individual perceptions of 'successful' cases. The group was asked to explore multi-agency responses to elder abuse in situations where there is a relationship between the perpetrator and the victim. The focus group facilitator used vignettes (informed by the data from the CMRs and the semi-structured interviews) to explore referral pathways and systematically analyse the different stages in service user routes through the referral process from initial contact to case closure. The use of this method enabled greater understanding of (a) the extent to which the individual characteristics of an older person and the contextual factors impact on the

referral route and the victim's entitled access to justice, and (b) how different agencies/practitioners have engaged with the Pilot project by examining perceived strengths and limitations of multi-agency practice in this area. At the end of the focus group session, individual participants were given the opportunity to reflect on their experience and/or add any further comments.

Comparative data

In order to explore the impact of the Pilot project, we sought access to police recorded data for the area covered by the Pilot (i.e. Swansea and Neath Port Talbot), over a three-year period, from January 2008 to the end of December 2010. While this dataset produced some useful information for comparative purposes, it was not sufficiently robust to support a retrospective, non-experimental before-and-after research design to assess the effectiveness of the intervention.

(iii) Data Analysis

Quantitative data from the CMRs and other relevant sources were coded and analysed. The qualitative data obtained from the interviews, the CMR forms and stakeholder focus group were recorded, transcribed and coded and then subjected to a systematic, thematic analysis using the computer software package NVivo.

3. The 'Access to Justice' Pilot

(i) Implementation and training

The 'Access to Justice' strategy was launched in March 2010 with the establishment of a Working Group with representatives from the following organisations: Age Cymru, Older People's Commissioner, South Wales Police, Crown Prosecution Service, Legal Services Commission, Victim Support, Disability Wales and Cardiff Women's Safety Unit. The Working Group produced an initial guidance document outlining the Pilot project. After consultation, it was agreed that Swansea, which was identified as having a relatively higher percentage of people over 60 years of age in comparison with most other urban areas, would be the site for the Pilot. A number of local statutory and third sector organisations were contacted to seek their participation and a training programme to support the delivery of the Pilot project was developed. The initial training session was held in November 2010 and was attended by over 30 delegates from 15 different organisations. Delegates were drawn from a good cross-section of statutory and voluntary agencies with both generic and specialist interests represented. Training on the use of an adapted version of the DASH risk assessment tool was delivered in two separate training sessions, to over 30 staff from social services, in June 2011.

Based on documentary evidence, feedback from training sessions and data from the qualitative interviews the following observations were made:

- the initial training was very well received and the launch of the Pilot was successful. Interviewees commented positively on the in-depth introduction to highly relevant information about elder abuse provided by a range of experts. Furthermore, they expressed how the training course had made them aware of the fact that some forms of elder abuse were very different, in terms of nature and context, from what was commonly understood by the term 'domestic abuse'.
- training on the adapted DASH RIC form was also well received by social services.
- there was a perception by some third sector and frontline staff that further 'booster' training sessions in relation to the use of civil legal actions, and more information about the respective roles of the MARAC, the Independent Domestic Violence Advisor (IDVA) and the Independent Mental Capacity Advocate (IMCA), would have been beneficial.³
- initially some statutory agencies were slow to engage with the Pilot. In addition, in some instances organisations did not always send the appropriate personnel to the training session to ensure that the

³ The respective roles of the MARAC, IDVA and IMCA are described in Appendix E.

information imparted was effectively disseminated throughout the organisation.

- There was a clear recognition of, and support for, the general ethos underpinning the 'Access to Justice' scheme and for the role played by the senior policy adviser in the whole implementation process.

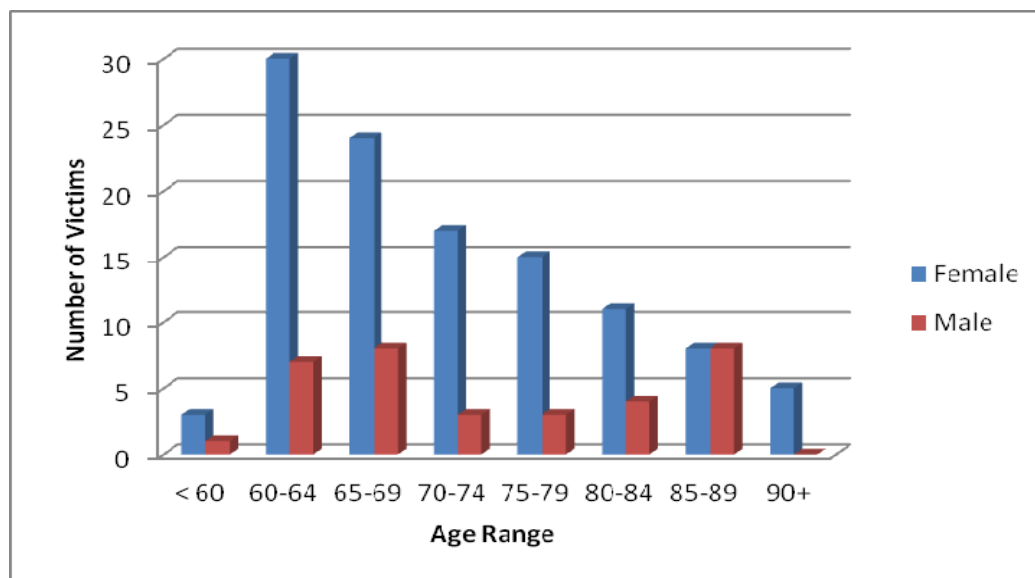
(ii) Profile of victims

A total of 145 separate incidents, involving 131 individual victims, were recorded between 3rd December 2010 and 31st January 2012. Data was available for 127 victims for whom CMRs had been completed (in 4 cases a second victim was identified in Section C of the record form as being present at the time of the incident, which means the Pilot dealt with a total of 131 victims).

Of the 131 victims 95 were female (73%) and 36 were male (27%). Information from the CMRs for the 127 victims revealed that:

- ages ranged from 55 to 91 years of age (see Figure1);
- five were recorded as BME (which represents 4% of all victims);
- one was recorded as lesbian, gay, bisexual and transgender (LGBT);
- nearly one-third (41) had a disability (32% of females [30] and 29% of males [11] were recorded as having a disability);
- 10 individuals were recorded as lacking mental capacity.

Figure 1: Age and gender of victims



The overall gender profile of older victims differs from that normally found in police recorded statistics for domestic violence incidents covering all age groups. It is estimated that in any one year, in over 90% of recorded cases of domestic violence the victim is female (Hester, 2009: 2). In contrast, in the sample of victims of elder abuse over one quarter (27%) were men. The

number of recorded incidents of domestic violence against older men is thus higher than expected, especially given the difference in life expectancy between men and women (78.44 and 82.47 years respectively) and the relative size of the female/male cohorts in each age band over 60 years of age. When comparing male and female victims, a greater proportion of men (56%) than women (33%) experienced physical violence. In a number of cases, male victims had suffered abuse over a prolonged period. There is the possibility that men may be reluctant to disclose because of the stigma of being a male victim of domestic abuse. When asked if he felt being a victim of domestic abuse was different for men than for women, our interviewee replied as follows:

'Well in some ways it is different isn't it and some ways it is the same. For men like myself, I think it's taken me a very long time to talk about it. They [men] are supposed to be the stronger ones aren't they, the idea is unless you are old and a silly old man like me you don't get fooled by other people, but unfortunately we do. At the start it was like ... she said "I shouldn't go out tonight, you are not up to it, I'll go". Gradually, I just sort of, over time, went into a corner and just hid myself. Basically ... I think you say less and put up with more perhaps.'

(Male victim)

The unwillingness by older men to admit to abuse suggests that the process of helping male victims disclose the extent of their experiences may take more time.

(iii) Number and types of victimisation incidents

Of the 131 victims, just over three-quarters had only one incident recorded during the twelve-month period. A total of 16 individuals (12%) were recorded as repeat victims. Of this group, the CMRs revealed that 14 individuals each had two separate victimisation incidents recorded, one victim experienced three incidents and one victim was recorded as being victimised on four separate occasions.

Figure 2 below illustrates the type of abuse experienced in those 104 cases where only one type of abuse was recorded on the CMR. The most common types of abuse found were emotional and physical. Where the victim was female, in over one half of the cases (53%) the abuse was emotional and in just under one-third of cases it was physical. For males, physical abuse was more prevalent than emotional abuse and accounted for 54% and 43% of cases respectively where only one type of abuse was recorded.

Figure 2: One type of abuse indicated on the CMR by gender

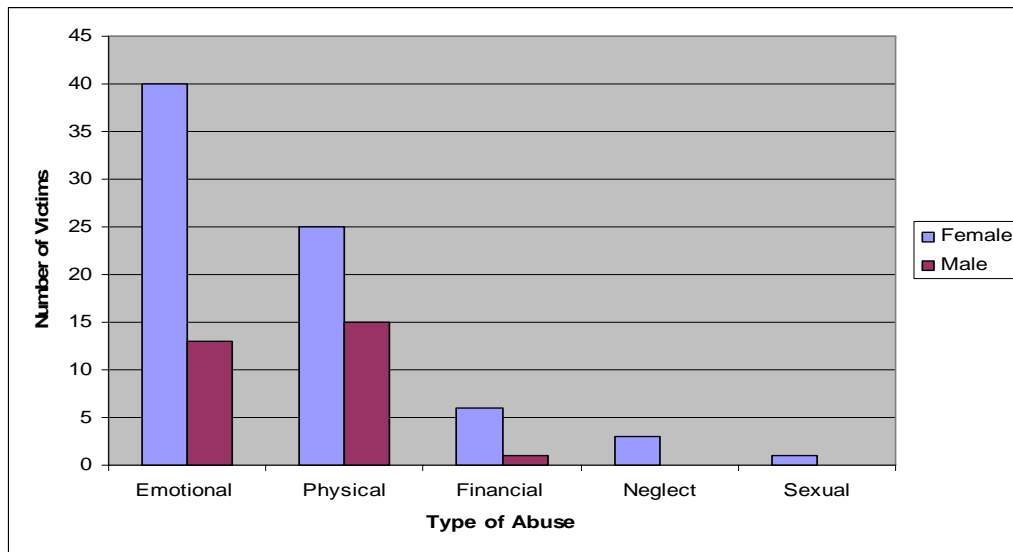


Table 1 shows the number of victims who experienced more than one type of abuse. This was the case for 27 individuals or 21% of all victims. When taking gender into account, 22% of females and 16% of males were victims of two or more types of abuse.

Table 1: Two or three types of abuse indicated on individual CMRs by gender

<i>Types of abuse</i>	<i>Female</i>	<i>Male</i>	<i>Total</i>
Two types of abuse			
Physical and emotional	7	2	9
Physical and financial	1	-	1
Physical and neglect	1	-	1
Financial and emotional	5	1	6
Financial and neglect	-	1	1
Total	14	4	18
Three types of abuse			
Physical/financial/emotional	4	2	6
Physical/financial/neglect	1	-	1
Emotional/financial/neglect	2	-	2
Total	7	2	9

Alcohol consumption by the perpetrator was identified as an aggravating factor in one quarter of all incidents; in nine of these cases illicit drug use was also indicated. In a total of 23 cases, the perpetrator was known to be a drug user. In only one case was there evidence that both the victim and the perpetrator were under the influence of alcohol at the time of the incident.

This pattern of substance misuse appears to differ from that found in cases of domestic abuse in younger age groups.

(iv) Perpetrator characteristics

In all but four cases, the gender of the perpetrator could be determined from information on the CMR: 109 were male and 44 were female, representing 71% and 29% respectively. This gender distribution is less pronounced than that found when dealing with domestic abuse in general, where it is estimated that over 90% of perpetrators recorded by the police are men (Hester, 2009: 2). In many of these cases, the violence is between intimate partners, with one partner seeking to exert power and control over the other. This was not the most common pattern found in the elder abuse sample when looking at the nature of the relationship between the perpetrator and the victim. Of the male perpetrators, 50 (46%) were sons and 20 (18%) were grandsons. A total of 27 (25%) were husbands and five (4.5%) were partners.

The data reveals the following:

- Where the victim was the mother, the perpetrator was more likely to be the son and the type of abuse primarily emotional, with financial abuse a secondary feature.
- Sons in the sample were more likely to have substance misuse issues than any other perpetrator.
- Where the victim was a spouse/ex-spouse or partner/ex-partner, the abuse tended to be physical.
- Where the victim was the father, sons were the most likely perpetrators and the abuse was more likely to be emotional, then physical.
- Where the victim was the husband or partner, the abuse was mainly physical by a female perpetrator; half of these cases were attributed to 'carer stress'.
- Where daughters (and daughter-in-laws) were perpetrators, in all but one case, they had a co-perpetrator.
- Of the ten perpetrators who were convicted, five were grandsons and four were sons.
- Cases where there was evidence of long-term intimate partner abuse were most likely to have the poorest outcome in terms of both welfare and legal interventions.

Perpetrator – victim relationship

When examining the data detailing the circumstances of the 131 victims in the Pilot study, there was evidence that some victims had requested help for the

perpetrator, especially if it was a son, daughter or grandchild of the victim. Many incidents highlighted the complex interdependency in the relationship between perpetrator and victim.

'They wish to see the relationship continue because they want to support their son. They are being victimised because their son needs to support his drug addiction. They think they are caring for their son. The mother is caught in this dilemma, wanting to support her son, and the dilemma that reporting her son will further criminalise him, and if they do highlight these abuses they are likely to suffer further abuse for having done so. So, when they say they are happy living this existence, are they saying it honestly and truthfully? You have to try and understand the motives of the mother. ... a solution needs to help both of them, because they are so interdependent.'

(Criminal justice manager: 2)

The data from the CMRs suggests that where the perpetrator of the abuse was experiencing carer stress, practitioners could quickly find a solution to ameliorate the situation. However, in situations where the abuse was not a consequence of carer stress, agencies tended to adopt a symptom-based approach, working only with the victim and often not attempting to engage with the perpetrator, who may have complex needs (such as mental health needs or substance misuse issues). It was felt by a range of practitioners that for the abuse to stop, a more holistic response was required, addressing the cause of the abuse, even if this meant finding ways to deal with hostile individuals:

'Dad has always been an overbearing individual, the son and daughter intimated that the family history has included him being violent to the mother, they kept it in the family. It is only in recent years that the abuse has come to the attention of health and social [services], this case has gone on for some time. This chap is a very threatening individual, a very forceful character, not without some degree of local influence. The police were involved on two occasions, charged him with assault but the case was dropped due to insufficient evidence. He is forceful, and this is something we have not yet learnt to deal with tackling people like him.'

(Mental health expert: 2)

When exploring the victim - perpetrator dynamic two broad types of perpetrator behaviour were identified: reactive perpetrator behaviour and proactive perpetrator behaviour⁴. These behaviour typologies were not mutually exclusive. There appeared to be a range of motivations which, according to the perceptions of practitioners, could alter in terms of a shift towards greater premeditated activity over an extended period of time.

⁴ These are similar to the reactive and proactive perpetrator motivations described by Davies *et al.*, (2011).

Reactive perpetrator behaviour

The qualitative and quantitative data suggest that abuse of an elderly relative can often be the result of perpetrators reacting negatively to their own general life circumstances and/or experiencing 'carer stress', that is being unable to cope with caring for the victim on a daily basis. Reactive perpetrators may also have mental health needs and/or substance misuse issues.

In our sample of 50 sons and 21 daughters, 48% of sons and 40% of daughters fell into the reactive category, often as a consequence of their addiction to alcohol or drugs. Sons and daughters were often reported as using verbal threats and emotional abuse to obtain money from their parents. There were also examples where the son or daughter had mental health needs and were unable to cope with their life circumstances, especially if this involved caring for an elderly parent.

In 49 cases where the abuser was a spouse or ex-spouse (33 male and 16 female), only 27 % were perceived to be reactive perpetrators who were experiencing carer stress. Only one carer was using alcohol and one was a drug user.

Grandchildren, of whom there were 21 in the sample, tended to be more reactive than proactive in terms of their perpetrator behaviour. When abuse occurred, it was often as a consequence of a breakdown in the relationship they had with their parents and they felt excluded in some way from their closest relations. Grandchildren would often physically attack property, rather than physically abuse the grandparent. Where the abuse was financial, grandchildren appeared to be opportunistic, rather than premeditated when it came to stealing money from their grandparents. There were examples in the case files where grandparents had physically intervened in a heated family argument and been accidentally injured as a consequence.

Proactive perpetrator behaviour

Where perpetrator behaviour was proactive, there was evidence that the abuse had taken place over a much longer period. Perpetrators may have initially been reactive but a change in the victim's or the perpetrator's circumstances could trigger much more premeditated behaviours. Practitioners perceived that perpetrators appeared to be much more proactive when victims had fluctuating capacity or lacked capacity. These perpetrators used a range of strategies to hide the abuse and isolate the victim from outside intervention such as avoidance of appointments, hostile and abusive behaviour towards practitioners and the threat of litigation.

The data shows that 36 (73%) of spouses/ex-spouses displayed a proactive type of perpetrator behaviour and these cases had the highest level of physical violence in the whole sample. Five of these cases were referred to the MARAC, (all police referrals). However, there were 18 cases out of the 36 where there was evidence of very limited intervention; adult services were the initial contact agency and no referrals were made to the MARAC.

Where perpetrators' actions were premeditated (as is the case with domestic abuse perpetrators in the younger age groups) the victims frequently withheld consent. Initiating the MARAC process, where consent to share information can be overruled, was not used as an option in these cases.

As a sub-group, intimate partners appeared to have the poorest outcomes and individual victims were unable to benefit from the wider range of safeguards accessed via the MARAC process. In a third of these cases, the victim had experienced abuse over a lengthy period of the relationship. Decisions taken by victims who have been subjected to abuse over a long period are of questionable effect. An essential component of decision-making is that the decision is made of the person's own free will; pressure exerted on the person, especially by somebody in a position of power and influence (which is typically the case in longer-term abusive relationships) can make the decision invalid. The Court of Appeal has recently reaffirmed that the inherent jurisdiction is available to protect people who may have capacity, but are prevented from exercising free choice by reason of undue influence (see *A Local Authority and others v DL* [2012] All ER (D) 211 [Mar]). Undue influence is invariably a feature of an abusive relationship, especially where the abuse has continued over a significant period.

4. Referral Pathways

In exploring the workings of the Pilot attention was focused on risk assessment, consent, mental capacity, referral pathways and active engagement. The research team adopted the latter term to define a situation where a victim actually engages with an agency to which they had been referred.

Of the 152 incidents of elder abuse recorded in the CMRs the initial contact agency was as follows: police (98), social services (48), local hospital (3), Age Cymru (2) general practitioner (1). The data suggests that domestic abuse (emotional, physical, financial, and sexual) and /or neglect was present in one or more forms in all but 12 instances. These 12 cases, all of which involved the police as the initial contact agency, included 11 very minor incidents and one spurious call-out.

(i) Risk assessment

Use of the DASH RIC by the initial contact agency

The Domestic Abuse, Stalking and 'Honour' Based Violence - Risk Indicator Checklist (DASH RIC) is a multi-agency tool used across the UK to assess risk in cases of domestic abuse (see www.caada.org.uk). The purpose of the checklist is to provide a simple and consistent tool for practitioners who work with adult victims of domestic abuse to identify those who are at high risk of harm. All frontline statutory agencies and third sector organisations that come into contact with individuals who may be experiencing domestic abuse are given the opportunity to receive DASH training on a regular basis in their local area.

Individuals who are assessed as high risk using the DASH RIC are referred into the Multi-Agency Risk Assessment Conference (MARAC). High-risk cases are closely monitored by the MARAC and measures are put in place to prioritise the victim's safety. Victims who are risk assessed by the DASH RIC as medium and low risk are referred to Victim Support and do not enter the MARAC process unless the level of risk increases. Victims deemed high risk are given the opportunity to engage with an Independent Domestic Violence Advisor (IDVA) who feeds back into the MARAC process. The IDVA works closely with the victim to ensure that all their welfare needs are met by liaising with a range of agencies on the victim's behalf. The IDVA explores justice seeking opportunities with the victim, so that the victim is sufficiently informed in terms of the range of civil and criminal options available to them. The IDVA also supports the victim through the court process.

The accuracy of the initial DASH risk assessment is vital in facilitating the victim's referral into the MARAC/IDVA pathway. Undertaking a DASH RIC provides victims, who are often isolated as a consequence of the abuse, with access to holistic support both in terms of welfare and justice remedies.

The DASH RIC is a generic form for assessing risk in cases of domestic abuse. The section which contains some questions on pregnancy and children may not be relevant for some victims such as women without children, individuals under 18 years of age and older victims. During the implementation of the Pilot, managers from social services stated that sections of DASH RIC tool should be adapted in cases of elder abuse to ensure greater reliability when assessing risk with people over 60 years of age. In response to this request, the senior policy advisor involved in the Pilot, in conjunction with a leading academic expert on domestic abuse, revised the risk assessment tool. Training on using the revised tool was provided for social services personnel. The other agencies involved in the Pilot, such as the police, were satisfied with the original generic tool and operated with this throughout the period of the 'Access to Justice' Pilot.

Completion of the DASH RIC

Across all agencies DASH RIC forms were completed in 66 cases out of 141 potential cases of elder abuse (excluding the 11 minor incidents): the police completed a total of 58 DASH forms, which represents approximately six out of every 10 cases where they were the initial contact agency (58 out of 96 cases). Social services, as the initial contact agency, completed a DASH risk assessment in only six out of a total of 43 cases (14%). One DASH RIC form was completed by a general practitioner and one at a hospital.

The perception from many frontline practitioners and specialist domestic abuse agencies was that there were likely to be missed opportunities by other agencies (both statutory and third sector) in detecting elder abuse and assessing risk.

'Obviously the whole thing centred on the DASH risk assessment, a number of organisations had never heard of or had never seen or used anything like it. The questions aren't easy in it, so it was a massive shift in the way organisations are being asked to work. Some organisations had already been using them for a while, so it wasn't such a big ask. Now [since the Pilot] all organisations know how they should be working if there is domestic abuse. It's a kind of self regulating thing going on as well. If I don't use this risk assessment other organisations are going to know now. We give them training on how important it is and how to use this - it's a route to the IDVA and other specialists, it gives victims more choice.'

(Domestic abuse service manager)

'... If a woman goes to A&E and they suspect abuse then they should ask the relevant questions and do the DASH assessment. I think health has not engaged, when it came to this project for some reason they found that more difficult to do [in]... acute, but also in community settings [such as] GPs, district nurses. I think it is really important that all of these people [practitioners] who have access to the vulnerable, some of the most isolated...they really need to understand their role in

this area more. I think there is a nut to crack there with health involvement.'

(Senior manager, older people's service: 1)

Data from the qualitative interviews suggests that some managers and practitioners did not feel that the current DASH RIC tool was always capable of accurately assessing risk in the context of elder abuse. Most practitioners and managers felt that the tool needed to be slightly adapted to meet the needs of older people:

'I don't think there should be a separate one [DASH RIC], I think it needs revising, it is well known, well respected. It's been in operation for a long time. I think it is just that the right questions need to be asked ... because older people's lives are very different, their needs are very different. What might be happening to them in terms of domestic abuse could be very different. I think that it is important that it is something that is recognised so that the tools are fit for purpose.'

(Senior manager, older people's service: 2)

It was the perception of social services representatives that their own risk assessment procedure was the preferred practice when assessing domestic abuse in older people and that practice had not improved since the inception of the Pilot:

'Not entirely convinced it's improved, in safeguarding we have a risk assessment tool, it's part of the test, under the Pilot we adopted the DASH adapted tool, but these are questions we are asking anyway. I wanted to look at whether this [DASH] brought us any more to our tool kit and I am not entirely convinced that there weren't mechanisms in place for properly identifying risk in older people.'

(Senior social worker)

However, not employing the DASH RIC could mean that older people assessed as high risk were not referred to the MARAC/IDVA process, which could have implications for their access to a range of support services and justice and welfare options.

An adapted version of the DASH RIC was developed and social service personnel trained in its use. However, as only six adapted DASH forms were completed by social services during the Pilot period, it is difficult to draw any firm conclusions as to whether the adapted tool provided a more accurate measure of risk in the context of elder abuse.

DASH assessment and the level of abuse

In at least 30 cases, given the gravity of the incident described in Section C of the case management record (CMR), the level of risk indicated in Section B was lower than one might expect. This could suggest that the assessment made by the initial contact agency did not always accurately reflect the actual level of risk.

Practitioners gave a variety of reasons as to why risk assessments may not always reflect the level of abuse. These included gaps in service provision, lack of knowledge and training about the diversity of domestic abuse experiences, and societal perceptions of older people.

'... maybe because it [elder abuse] is not so obvious as typical domestic abuse, the older person may not present in the same way. Also it's a kind of aversion by people that because the thought of a son beating the hell out of his own mother is a reflection of our society, the state of things, we would rather it isn't there. We would rather not see it. So is it that we are not asking the questions because we don't want to accept it is happening, or because if it's happening we have to do something about it? I am not sure that older people are priority, they are often seen as a drain on society, on resources ...'

(Criminal justice manager: 1)

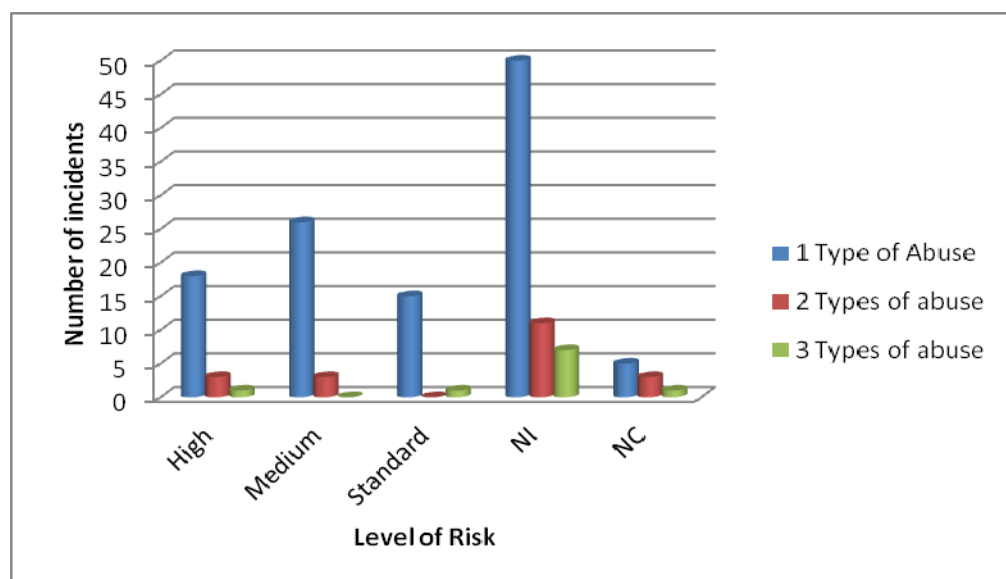
There was evidence that frontline staff felt uncomfortable asking questions that may affect the older person's sense of dignity and position in the family:

'I think practitioners may be, in a weird sense, ... embarrassed to ask the right question. There is a shame in admitting your own child does this to you, so that means we can't make an accurate assessment, it is really complex frontline I think.'

(Criminal justice manager: 1)

Figure 3 below highlights where there were one or more types of abuse and the relationship with the level of risk assessment. Where there was more than one type of abuse indicated, the abuse was more severe, and yet the individual practitioner's evaluation of the level of the DASH risk assessment did not always reflect the severity of the abuse. In addition, as indicated in the figure above, there were numerous cases where the level of risk was 'not indicated' (NI) and a proportion that were not completed (NC).

Figure 3: Level of risk assessment and number of types of abuse



NI = 'not indicated', meaning the level of risk was considered below a point where action was necessary; NC = not completed

In all nine cases where victims were recorded as experiencing three or more types of abuse, the abuse was often prolonged and severe. Seven of these victims were noted as having a disability. In four of the nine cases, the perpetrators were illicit drug users. The initial contact agency was as follows: social services (7); Age Cymru (1); local hospital (1). Further details of this group are presented in Table 2 below.

Table 2: The relationship between referral, consent, options discussed and agencies involved in cases where the abuse was severe.

Victim	DASH RIC	Consent obtained	Options discussed	Lacked capacity	Third sector	MARAC	IDVA	IMCA	Conviction	Welfare outcome
1	Yes	Yes	Yes	No	Yes	No	No	No	No	Positive
2	No	Yes	Yes	No	Yes	No	No	No	No	Positive
3	No	Yes	Yes	No	Yes	No	No	No	No	Positive
4	No	Not completed	Yes	No	Yes	No	No	No	No	Unknown
5	No	Not completed	No	No	No	No	No	No	No	Unknown
6	No	Not completed	No	No	No	No	No	No	No	Unknown
7	No	Not completed	No	No	No	No	No	No	No	Unknown
8	No	Not completed	No	No	No	No	No	No	No	Victim deceased
9	No	Not completed	No	Yes	No	No	No	No	No	Positive

In none of the nine complex cases were the police the initial contact agency. The DASH RIC was only used in one case and no cases were referred to

MARAC or had involvement from the IDVA. Where there was involvement from third sector organisations positive welfare outcomes were evident.

(ii) Consent

Consent must be based on the victim having a reasonable amount of information to make an informed decision of his or her own free will and not as a result of undue influence or coercion. When asked to decide, the victim should be informed of the consequences of accepting or refusing proposed actions.

Initially the contact agency has to secure the victim's consent to share information with non-statutory bodies in the third sector. When consent is obtained the information about the victim's circumstances can be shared with others who can then contact the victim and offer support. Thus, the victim does not have to keep repeating information about the traumatic event to each agency with which they have contact, thus avoiding having to re-live the experience and the shame and fear associated with it.

In the Pilot sample, a high proportion of the cases involved an emergency call out to the home of the older victim(s) immediately after a crisis incident had occurred. In such cases, the police have to react quickly to prioritise the health and safety needs of the individuals involved. To be able to talk to the victim safely police officers need to identify the perpetrator(s) and separate them from the victim(s). Victims may be traumatised and find disclosing the extent of the abuse to a police officer or other practitioner very difficult. Frontline staff should be aware that discussing confidentiality and establishing consent are crucial aspects of the referral process and vital when it comes to safety management and accessing welfare and justice agencies.

Gaining consent to share information and facilitate access to support services involves frontline staff undertaking to:

- establish whether the victim is competent (capacity is assumed unless there is evidence to the contrary);
- ensure that the victim is suitably informed about the range of options available and that she/he is also aware of how any information they, or witnesses, provide will 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 wish to take.

According to information recorded on the CMRs, victims only gave consent for information to be shared with other agencies in 18% of cases (24): 11% of victims (14) withheld consent. In the vast majority of instances (70%), the CMR recorded that the original form did not indicate if consent had been obtained. The failure to record whether consent was given may affect the ability of the initial referring agency to involve specialist domestic abuse

agencies and other third sector groups in helping to ensure that the needs of victims are addressed.

(iii) Capacity

Capacity is a central component of consent. One of the statutory principles in the *Mental Capacity Act 2005* (MCA 2005) is the presumption of capacity. This is important as it ensures that unwarranted assumptions are not made about vulnerable older people. However, it does not mean that capacity should only be addressed in the most obvious of cases, for example cases of late dementia. In 43 incidents victims were recorded as having capacity; there were 10 cases where the victim was found to lack capacity. This group consisted of four males and six females, and nine of these victims experienced two or more types of abuse. Eight of these cases involved physical abuse. Carer stress featured in five cases. The average age of this sub-group was 79.6 years.

In the majority of cases (92), it was not indicated on the CMR whether capacity issues had been assessed. Consent was recorded as 'not indicated' and the DASH RIC was recorded as 'not completed' for 42 of these cases. Upon analysing the qualitative data on the forms, where capacity was 'not indicated', it appeared that in some cases there was a lack of clarity about the basis of the assessment of the victim's capacity. There was no indication, from initial contact through to case closure, that these queries about capacity had been addressed. Failure to assess capacity, where appropriate, can lead to an older person being denied their right to a fair hearing and access to justice.

In a significant number of cases where the victim lacked capacity and abuse occurred, the victim was 'unfriended'⁵, and the perpetrator was a close relative, either residing with the victim or living within close proximity. There was no evidence from the records that the involvement of an Independent Mental Capacity Advocate (IMCA) had been sought in any of these cases.

As the findings suggest, where incapacity is identified, the victim is inevitably increasingly vulnerable. The best interest test, along with the guidance found in the MCA 2005 and the Code of Practice provide a framework within which best interests judgements can be made. Best interests assessments are complex; as far as is possible, the person must be involved in this process. A best interest assessment must also recognise the right of the person to justice and some kind of remedy, a point emphasised by the European Court of Human Rights in the case of *X v Netherlands*.

⁵ A person is regarded as 'unfriended' where there are no family or friends willing and able to advocate on their behalf; or it is not possible, practical and appropriate to contact anyone. The person who lacks capacity may also be unfriended if they have friends or family, but there are reasons why it is felt not to be practical or appropriate to involve them (for example, the person is the perpetrator, or at the other extreme is too frail).

IMCA referrals

Crucial to the involvement of the victim who lacks capacity, is the role of the IMCA. There is discretion on the part of the local authority or NHS body to appoint an IMCA in adult protection proceedings. The data suggests that there was very limited uptake of the IMCA role in cases of domestic abuse. Practitioners perceived that when the IMCA was used during the Pilot, it was relatively late in the process. The year of the Pilot was not felt to be an atypical year in terms of delayed uptake of the IMCA service by the agencies involved.

Only three cases were recorded on the CMRs as being referred to the IMCA; however, when the IMCA reviewed the records for the Pilot year only two referrals were actually received. The research team presented seven case files of victims who were incapacitated, but had not been referred to the IMCA; the specialist mental health manager confirmed that the seven case files met the referral criteria for the IMCA. These missed opportunities for referral demonstrate a lack of understanding as to when a referral to an IMCA is appropriate. Therefore, it would appear from the findings in the Pilot that the IMCA has not been incorporated to full effect in the POVA process.

The IMCA and the investigative process

Interview data also raised concerns as to some misconceptions around the practice of delaying the involvement of IMCA during the investigative process. There was a suggestion that statutory agencies postponed any such involvement until the investigative process had been completed. Many agencies perceived that the inclusion of an IMCA would compromise the process and risk accusations of coaching the witness, thus removing the possibility of a prosecution. This view must be challenged. The early involvement of an IMCA is critical as a range of decisions occur early in the investigative process that heavily influences the final outcome. The involvement of the IMCA during the investigative stage would guarantee that someone is advocating for the victim and that options are explored, for example, the use of special measures. IMCAs may also help in facilitating communication with the victim. Although lacking capacity, the victim still has rights and these include the right, if appropriate, to access the criminal or civil justice processes. IMCAs are a highly trained group of professionals and are sensitive to the restrictions imposed on them by the criminal justice investigative process; to deny victims access to an IMCA early on impacts on the rights of the incapacitated victim to communicate their wishes:

‘What I do feel is [practitioners] seem to be of the view that the IMCAs wouldn’t get involved while the investigation is going on for fear of us talking to people or inadvertently making some mess of it basically and get in the way of that process. We have all had training. ... I think we are all clear, everybody was of the view that they are all quite sensible people and professionals.’

(Mental health expert: 2)

The Mental Capacity Act 2005 and fluctuating capacity

Capacity is a dynamic and pervasive feature in all cases. Therefore, all agencies should be aware that identifying capacity at the point of the disclosure of the abuse should not necessarily determine an individual's capacity throughout the investigative period and beyond. Capacity may fluctuate, and there are a number of factors that must be considered when undertaking an assessment. Capacity is time and context specific; the venue, time of day, individual assessor and the nature of the discussion may all influence outcomes. It is essential that practitioners create an environment conducive to an individual's needs when exploring capacity issues.

All agencies (social services, health, voluntary sector and criminal justice) should be fully aware of the statutory framework in the MCA 2005, which requires that *everything* should be done to assist people to make a decision for themselves, rather than decide they lack capacity. As elder abuse may increase levels of anxiety, creating enabling environments for assessment is particularly important. When dealing with cases perceived as 'family matters' practitioners need to ensure that events within the family unit do not overshadow the needs of the victim.

A justification by practitioners not to test for capacity

Although 'mini-mental' capacity tests should not be routine, practitioners need to evidence why issues of capacity were not a consideration, and highlight during onward referrals that the process is sensitive to possible changes over time.

(iv) Options discussed

In all but 12 cases, (11 very minor incidents and one spurious call-out), we would have expected the 'initial contact' agency to discuss criminal and civil justice options with each victim as appropriate. However, this is not apparent from the CMR data. It is not possible to deduce whether options were not discussed or discussed but not recorded. In 21 cases (almost 14%) Section B of the CMRs indicated that a criminal and/or civil justice option was discussed with the victim. In half of these cases the police were the initial contact agency; social services, a hospital, Age Cymru and a general practitioner accounted for the other half.

On examining the contents of Section C of the CMRs there was evidence that options were discussed in a further 23 cases (19 police and four other agencies). This would suggest that options were *not* discussed with victims in approximately 66 % of all relevant incidents:

'To empower someone you have got to make that knowledge available to them to give them control and make some decisions for themselves. So I think they [the victim] should be aware of everything. I am not

sure that is happening either because people [practitioners] think on behalf of the older person, that it is better they [the older person] don't know, or people [practitioners] don't actually know what services, options are out there ... So yes, I think when we have that foot in the door, we need to seize the opportunity. I don't think these things are always thoroughly addressed....'

(Domestic abuse service practitioner)

The fact that there were only a relatively small proportion of cases in which it was reported that criminal/civil options were discussed may be due to a combination of factors. It was suggested in the qualitative interviews that in the case of civil justice options in particular, practitioners might not have the knowledge and training to enable them to advise victims accordingly.

'...there are a wide range of sanctions and I think there are enough civil sanctions to protect subjects of domestic abuse, elder abuse or whatever, but they are not being used. Frontline workers should know what the options are, they don't explore them with the victim; more training is needed. There is a perception that they are expensive, difficult, they are not.... The law is there, we just need to use it more'

(Senior criminal justice manager: 3)

There is also the possibility that practitioners may make a decision not to explore options with the victim out of a sense of paternalism and a desire to protect an elderly person they already perceive to be vulnerable. The interview with an older victim from the OPAN sample suggested that he was discouraged from pursuing a criminal or civil case because it was felt that the experience would be detrimental to his mental health.

'... it was at first so subtly done, but when it came to the crunch social services were called in along with other people, they wanted to call the police, but both my solicitor and my GP said no, because I wouldn't have got through it [the criminal justice process].'

(Male victim)

(v) Referrals

After addressing consent and capacity issues and undertaking a risk assessment, agencies should explore options with the victim and refer to the MARAC or other statutory agencies and third sector bodies and services.

Where active engagement was identified on the basis of information contained in the CMRs, the data suggests that the quality of the engagement with the agency varied considerably both in terms of ensuring the victim was kept fully informed and that their wishes were central in the decision making process.

'We really need to make sure that everybody is recognised; that the person is at the centre of the process. That has got to be the focus, it's about the wishes of the individual.'

(Senior manager, older people's service: 1)

A multi-agency, co-ordinated approach is an integral feature of the 'Access to Justice' strategy: 'It is nationally recognised that the statutory agencies need to work closely together with third sector organisations to enable delivery of comprehensive safety measures for people who are suffering domestic abuse. No single agency can achieve this goal by working in isolation'; (Access to Justice, 2011: 19). The case study below is a good example of a successful multi-agency response.

Case Study: Engaging with the victim through multi-agency working

Agency perspective:

A victim of elder abuse was referred by the police in the Domestic Abuse Unit to POVA, but the referral did not meet the POVA threshold. However because consent had been obtained at the outset, the lead in POVA contacted a third sector organisation, Age Cymru, who subsequently became the main point of contact for all agencies and acted as an advocate for the victim. The multi-agency group included the GP, the Drugs Project (who worked with other family members), the police and housing. Activities by the various parties involved helped to prioritise the victim for alternative accommodation. A strong trusting relationship was established with the advocate from Age Cymru, regular communication helped to address the needs of the victim and other family members. The abuse stopped and the victim was very satisfied with the support provided.

Client feedback:

The client felt supported by the fact that someone had shown an interest in her situation and how she felt. The information provided gave her more choices and options to think about. She was surprised at the services offered by Age Cymru Swansea and felt comfortable speaking to a non-statutory organisation. She stated she did feel pressurised (by the abuse) and for the first time had started to think about her own health and future. She stated she had always felt a sense of guilt in reporting her family to the police and the consequences of those actions but now realised that to move forward she must help herself by accepting advice and support from the parties involved. She was also pleased that the Police Domestic Abuse Unit and Age Cymru could support her housing assessment application.

There were some instances where the agency response was less than successful. For example, one victim avoided leaving the house because she was waiting for a telephone call from an agency that never came. Other examples included victims not being kept informed as to how their case was

progressing. The uncertainty created by experiences such as these may be more distressing for older victims.

Across all risk assessments, the most frequent number of referrals involved the initial agency referring to one other agency, all of which were statutory organisations. A total of 61 (42%) incidents led to active engagement with the victim.

There were 56 cases where the police referred victims to one other statutory agency; of these, active engagement was as follows: 11 involved the legal process (two of which also included welfare actions); one involved a civil action; and 6 cases involved welfare actions only.

In 24 cases where social services were the initial contact agency and one referral was made in each of the cases, active engagement was identified in 15 cases (this was primarily welfare action and in two instances included legal action).

It was evident from the case files that the police responded sensitively and positively to victims of elder abuse. In some instances, the police paid regular visits to the homes of victims. These safety checks were considered to have a potential deterrent effect.

MARAC

In terms of consent, options discussed, active engagement and legal and welfare outcomes, the cases referred to MARAC fared very well. A total of 16 cases were successfully referred to MARAC; one of these was not taken up due to a change in the victim's circumstances. Of the remaining 15 cases, 13 resulted in some form of active engagement with welfare agencies and 10 went down the legal route, of which five resulted in a conviction. Of the 13 cases where there was evidence of active engagement, 11 CMR forms indicated that options were discussed and all had contact from/or engaged with the IDVA.

Third sector involvement

Overall, the data from the interviews and the CMRs indicates that the voluntary sector was not used to its full effect. There were examples where victims had given their consent to share information held by the statutory agencies with the voluntary sector, and were willing to engage with the process, but this did not result in a welfare action. Practitioners gave a number of reasons for the limited referrals to the voluntary sector, these included:

- problems eliciting consent;
- partner agencies that were unaware of the type of provision available;
- agencies being unsure where to refer older male victims of abuse;
- their perception that certain agencies lacked knowledge about elder abuse and therefore might not respond in an appropriate way.

Third sector involvement appeared to generate the best engagement by the older person and where convictions occurred there was evidence of support from the third sector in the majority of cases. The general perception was that third sector practitioners could provide impartial, independent support that empowered the older person in a way statutory agencies could not:

'Why do capacitated adults say no to involvement? Because they are afraid of the authorities. Now the third sector give that person confidence, they don't feel they are being taken over. They are central to the decision making, they are an individual, not a case [...]. For an older person, being in control, knowing what is going to happen well in advance, is very important. With the statutory sector, it can feel, unless carefully handled, as though decisions are made without them. Their voice is not central to the process. You go rushing in there and they won't want to know.'

(Senior criminal justice manager)

The potential for third sector organisations to work directly with victims was also commented on in interviews with OPAN members. Age Cymru were frequently cited as adopting a victim-centred approach, which was seen as helping victims to talk about their experiences.

'... you need someone to sit down with that victim and befriend that person. With Age Concern this is what happened ... they [victims] need time so they can trust that person, it has to be something done sensitively. You may need to call and chat two or three times before they start talking. I can talk about it now quite openly but I couldn't at the time. The victim loses all power and you need to help them conquer that; there needs to be a plan set up with all agencies. It may be sometime later before the problem can be tackled...I think it is that one link [building a relationship] that is really missing with social services etc. ... it's that befriending side, it is vital, it really is...'

(Male victim)

A key theme across the OPAN interviews was how relationships between clients and service providers needed time to develop in order for trust to be established. Building a relationship was considered essential to enable victims to reflect on the range of options available and engage effectively with services.

Statutory Involvement

Statutory agencies have a duty of care to protect older people from abuse. The United Nations Principles for older persons, states 'Older persons should be able to live in dignity and security and be free from exploitation and physical or mental abuse' (Principle 17).

It was recognised by a wide range of practitioners and managers that statutory agencies do not always have the necessary resources to develop a strong relationship with their clients. This could mean that signs of elder abuse may not be identified. For adults who do not appear to fall into the *In Safe Hands* definition of a vulnerable adult, the problem of domestic abuse may not be addressed. The older person will then go on enduring abuse in an unsafe environment. Analysis of the process maps constructed from the CMRs suggested that a specific sub-group of victims in the Pilot sample were living in an environment where the abuse was ongoing. The group with the poorest referral rate and lowest level of active engagement consisted primarily of individuals in relationships where there was a history of domestic abuse by the husband/wife over many years. There was evidence that agencies were reluctant to act and intervene further due to threats of litigation by the perpetrator and in some cases members of the perpetrator's family.

'At one stage, they made the wife [the victim who lacked capacity] subject to a Deprivation of Liberty Safeguard while she was in hospital, to try and address some issues about him [her husband was a long term perpetrator of domestic abuse]. Conditions were attached whereby his visits to her had to be observed at all times, however it drifted when there was mention of legal action [by the perpetrator] towards them [the main agency] and the main agency backed off noticeably. Perpetrators know that they can do this and agencies quickly throw in the towel, the window of opportunity is lost and the door closes on that person [victim of elder abuse].'

(Mental health expert: 2)

There were many examples in the data where there seemed to be missed opportunities by all statutory agencies to refer to third sector bodies.

Adult Protection and Domestic Abuse

A key theme from the qualitative interviews and the focus group was the lack of clarity as to whether agencies should refer clients into the MARAC or the POVA process. The analysis of the process maps supported this finding and raised queries over the decision-making processes. A more structured approach, which integrated the POVA and MARAC processes, would improve overall outcomes for clients when dealing with cases of domestic abuse. When reviewing the process maps it was clear that tangible outcomes were evident when the MARAC had been incorporated into the process, and/or when a third sector agency was involved. There was a perception that some practitioners in social services, housing and health lacked sufficient knowledge of the DASH RIC, the MARAC and IDVA, the MARAC and Multi-Agency Public Protection Arrangements (MAPPA) process, the IMCA role and Victim Support and domestic abuse services such as Women's Aid and Black Association of Women Step Out (BAWSO).

There were real concerns that victims were being denied the opportunity to work with the range of agencies with a specialism in domestic abuse because the POVA and MARAC were not well-integrated processes.

‘... both the POVA and the MARAC process have their strengths and weaknesses; we need that cross pollination between the two. The MARAC has access to considerable resources in terms of third sector and statutory agencies. The POVA can be very responsive, so we take the individuals circumstances first and make sure the DLM [designated line manager] is at the MARAC, or the IDVA is at the strategy meetings. Currently it is like a ball bouncing back and forward and no one is willing to see the strengths in tackling it jointly ... to the detriment of the person [victim].’

(Criminal justice manager: 1)

Gaps in the referral pathway

It has already been noted that risk assessments did not always accurately reflect the gravity of the abuse and therefore could potentially act as a barrier to accessing resources in terms of justice options, welfare support and safety planning. There were however, examples where the risk assessment was accurate and an appropriate referral was made. However, when reviewing the process maps and the CMRs, and checking outcomes, numerous referrals that were considered high risk had fallen through the gaps in the referral pathway. These included:

- referrals to the MARAC that were not picked up by the MARAC process;
- referrals to POVA that did not meet the POVA threshold;
- high risk cases that were not referred into the MARAC process;
- high risk cases where the victim had not consented to share information, but were not referred into the MARAC process, (e.g. high risk domestic abuse cases where there was a long history of abuse between husband and wife);
- cases where individuals lacked capacity, were ‘unfriended’ and yet no referral was made to the IMCA.

Where victims had consented to support, there did not appear to be any mechanism in place to monitor their route through POVA and MARAC processes. Agencies need to develop strategies to track cases to prevent them from falling through gaps in referral pathways. The case files suggested that all avenues needed to be more thoroughly explored before assuming that victims did not want external involvement. In cases where consent was not given, but the level of harm was severe, it was in the best interests of the victim to override the refusal of consent and to share the information. In this instance, this could be done under the MARAC process.

Practitioners felt that older people often experienced high levels of abuse but were under undue pressure by the perpetrator to refuse any intervention. Once a disclosure had been made, there was a view that practitioners should

be more proactive in establishing whether consent was genuine, and the choices victims made were a true reflection of their wishes and not coerced choices brought about by their circumstances. Too much time was spent monitoring a situation rather than taking decisive action.

'Agencies need to step in and say, "We can't allow this to continue because we know you are being victimised, although I know why you [the victim] don't want to put your hand up and report things or go through prosecutions because you are fearful of things getting worse as a result of you having reported it." We have had ongoing cases where vulnerable adults have said "no" ... [for example, she says] ... she is happy to live with her son at this address and the abuse isn't that bad, but you know that ... you have spoken to a lady of seventy-nine years, who wouldn't open the door fully to speak to you, was that son present? She is scared to leave her home to speak to you for fear of her possessions being taken and sold for drugs. Is that true consent in that environment?'

(Criminal justice manager: 1)

Where neglect is experienced over a long period, and one agency perspective is allowed to dominate the decision-making process, this can be to the detriment of the older person. The case study below provides an example of such a situation.

Case Study: The need to take decisive action to prioritise victim's needs

The mother, who was the victim of abuse, was a very frail female in her nineties. The perpetrators were her two daughters, both of whom were chronic alcoholics. The case was well known to both the police and social services.

'Sometimes you get conflicts of philosophy [between agencies]. One agency saw their role as keeping the family together by putting carers in. However, over time it was clear this was not working. After a very lively debate [across agencies], the old lady was removed and actually lived three or four months of her life in a care home. I think she was denied a more comfortable life towards the end of her life by this "over the top" view of trying to keep this unit together. You have to know where to draw the line. These were two serious drinkers and sometimes they were in need of more care. They were incontinent on occasions. When the carers were coming in they had to step over them, the mess and all the rest of it. On a human rights issue, they are very fond of quoting article eight, which is the right to a family life, but it's one of the articles that is not an absolute right, it is a qualifying right. If there are serious issues like this, I think it is a misuse to keep emphasising article eight ... especially if the poor person hasn't got the capacity to express herself. That is where an IMCA is brought in, but their expertise is frequently not sought when it should be...'

(Mental health expert: 2)

5. Outcomes

(i) Legal remedies

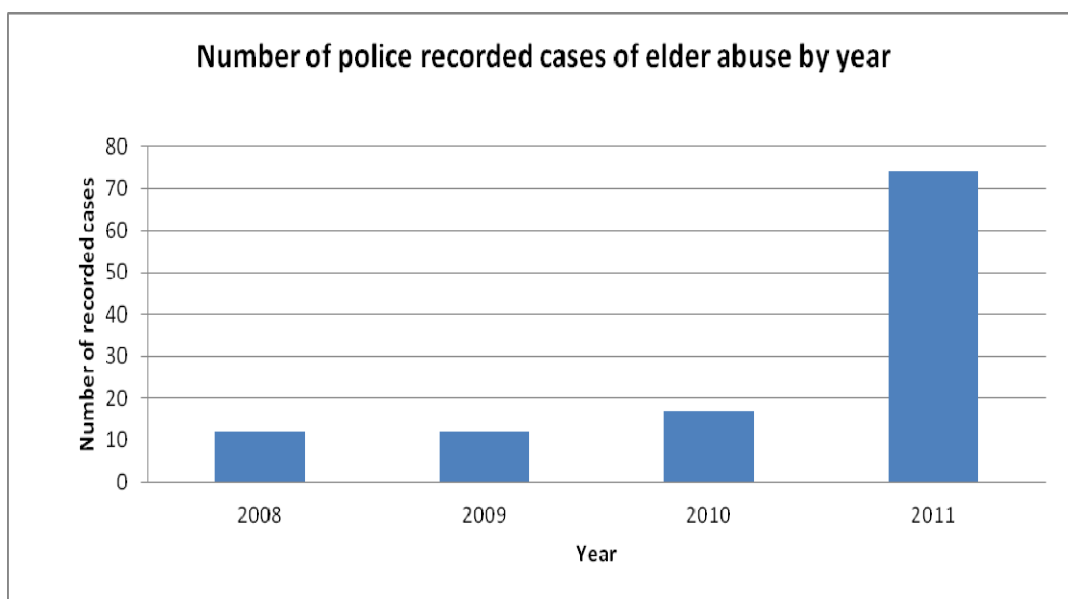
Within the criminal and civil justice systems, a number of legal remedies are available to victims of elder abuse. Both the criminal and civil law provide means by which vulnerable older people can be protected from the abuser. The use of criminal and civil law procedures in cases of elder abuse remains low. This is not to suggest that the use of the law is either always appropriate or always effective. However, legal redress is one way in which a victim can feel that they have obtained justice and that the State has fulfilled its human rights obligations.

Criminal justice outcomes

In the Pilot sample, 11 perpetrators were charged and went to court and 10 were convicted. One case was dismissed when the victim gave a different account of the incident in court. In seven of the 11 cases the DASH RIC was completed; three cases were classed as 'high' risk, two as 'medium' risk and in two cases the risk was considered below the threshold and recorded as 'not indicated'. Of the convicted perpetrators five were grandsons, four were sons and one was a wife. Financial abuse was the most frequent type of abuse recorded. In eight cases, there was evidence of either illicit drug use and/or alcohol misuse.

In order to obtain some indication of the impact of the Pilot initiative, comparative data were compiled for the area covered by the scheme over a three-year period prior to its inception. The data came from police recorded incidents and only covered cases where the victim was aged 65 years or over. The figures are presented below alongside comparable figures from the Pilot sample.

Figure 4:



As the figures in Table 3 illustrate, the Pilot year witnessed a marked increase in the number of cases of elder abuse recorded by the police over a twelve-month period. Risk assessments were conducted in three-quarters of these cases, which represents an increase in the average figure for the three years prior to the introduction of the Pilot scheme. With regards to those cases in which a perpetrator was arrested, when comparing the years prior to the Pilot with the year of the Pilot, there was no significant difference in the percentage of risk assessments undertaken. There was also very little difference in the percentage of cases leading to a charge being made; this was 34% and 37% of recorded cases respectively.

The comparative data also reveals that there was a significant *decrease* in the arrest rate and a significant *increase* in the conviction rate between the pre- and post-Pilot phases. In all ten cases of the Pilot where the victim was aged 65 years or over and a perpetrator was charged, a conviction was secured. Over the three-year, pre-Pilot period only two of the ten perpetrators charged were eventually convicted. This may suggest a more discerning approach to arrest and prosecution, and improved communication between the police and the CPS.

Table 3: Criminal justice outcomes pre-Pilot years and Pilot year

Year	2008 N=12	2009 N=12	2010 N=17	Total N=41	Pilot (2011) N=74
Arrested	9	9	11	29	27
Charged	3	4	3	10	10
Convicted	1	1	0	2	10
Not risk assessed (arrest)	1	3	3	7	7
Risk assessment (overall)	11	6	10	27	55

Access to the case files for the Pilot sample where prosecution was considered was limited. However, of those files that were accessed the basis of the decision not to prosecute was assessed. All of the decisions not to prosecute were supportable based on the information on the file. Typically, the reason for not proceeding was the lack of corroborating evidence and refusal on the part of the victim to testify. The evidential component of the Full Code test was not satisfied. The reasons for the refusal of the victim to testify are undoubtedly variable. The familial relationship may be one, especially if the abuser is a grandchild or close relative with a drug or alcohol addiction. Another reason why the victim refuses may be through fear, which raises the question as to whether their refusal is freely given.

A number of recommendations were made in the review of *In Safe Hands* in relation to access to justice. These concentrated mainly on the criminal justice system and included early involvement of the CPS, advocacy support, 'wrap round' support similar to the Safety Unit model for domestic abuse, and a positive prosecution policy in cases of alleged abuse. From the limited data available on the decision to prosecute, the guidance and policy contained in the CPS documents on crimes against older people (CPS, 2008a; 2008b; 2009) appear to have been followed. The policy and guidance provide a strong message on how the Full Code test should be applied in cases of elder abuse.

It is difficult from the data available to form a view as to when the possible use of special measures was considered, and by whom. Special measures may make a difference between a prosecution and non-prosecution.

Civil justice outcomes

As with the criminal law, the civil law does not offer a panacea but may provide some degree of protection (for example, an order under the Family Law Act 1996 or an injunction under the Protection of Harassment Act 1997). An additional advantage of using the civil law is that the standard of proof is on a 'balance of probabilities' rather than the stricter 'beyond all reasonable doubt' in criminal proceedings. In cases involving family members, the civil law may be less daunting for the victims than using the criminal law.

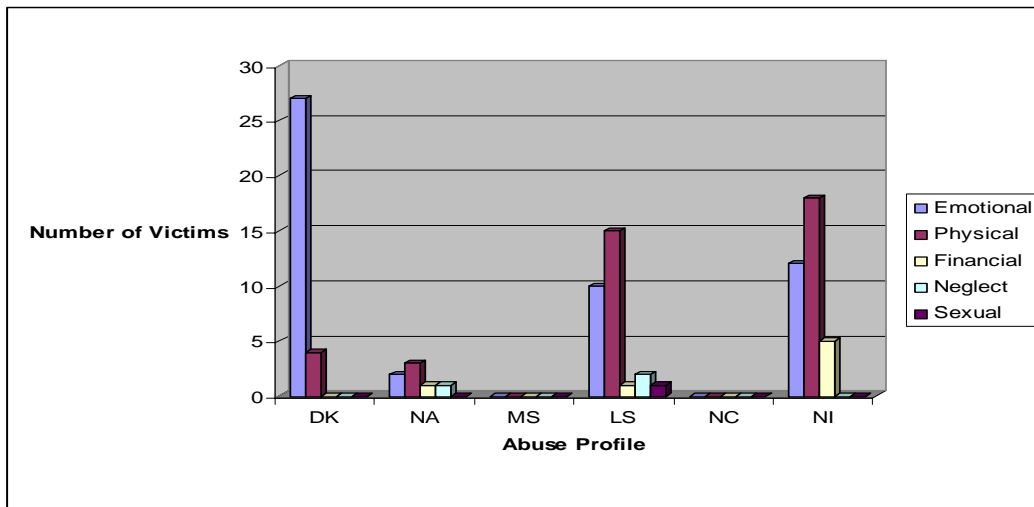
There were only four cases from the Pilot, all involving female victims and carer stress, where a civil remedy was sought. In three of these cases the son was the perpetrator and in one case it was the mother. There were successful outcomes in three cases: in one case an injunction was granted against the perpetrator and in two others an order of the public guardian was issued. From an examination of the CMRs and the case file analysis we identified a further 10 cases in which a civil justice solution could have been explored.

It is difficult to speculate why civil remedies were not used more. The general absence of any discussion of options (in both the pre-Pilot and Pilot samples options were not discussed in two-thirds of all cases) is undoubtedly a contributory factor. Added to this is the fact that there was also a cluster of records where it was not known if options were discussed. It could be that practitioners are unaware of what options are available or they assume that the person could not afford to take civil action. Awareness of the civil law and how to access advice and support needs to be raised amongst practitioners to ensure that, where appropriate, civil justice is pursued. If victims are not at least aware of the options, then they have effectively been disempowered. In cases involving incapacity the IMCA is well placed to make a valuable contribution to the discussion on whether or not to use the civil law.

(ii) Abuse profile at close of intervention

One possible outcome measure is the abuse profile recorded in the CMR at the close of the intervention. However, as shown in Figure 5, while no cases where there was only one type of abuse indicated were reported as 'more severe', only a relatively small number of cases were described as 'less severe'. Given the large number of 'not indicated' and 'don't know' responses, it is difficult to draw any firm conclusions concerning any changes in the pattern of abuse for this cohort.

Figure 5: Abuse profile at close of intervention (one type of abuse)



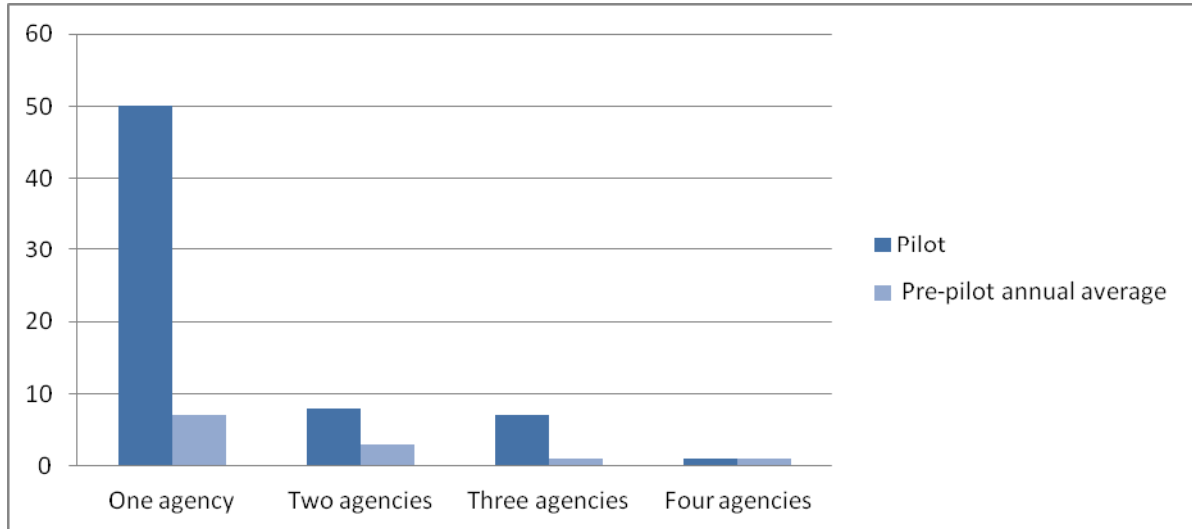
Key: DK= Don't Know; NA= Not Asked; MS = More Severe; LS= Less Severe; NC = Not Completed; NI= Not Indicated

Of the 16 cases where the victim experienced two types of abuse, four were recorded as being 'less severe' at the close of the intervention. However, in 10 cases the CMR stated 'not indicated' and two cases were recorded as 'don't know'. In the nine cases where victims were recorded as experiencing three types of abuse, four were reported as 'less severe'; four 'not indicated' and one 'don't know'. The limited information provided by agencies as to the abuse profile at case closure was a concern; this could be a reflection of increasing demands made upon resources.

(iii) Referrals

One of the primary aims of the Pilot was to promote a multi-agency response to elder abuse to enable victims gain access to justice seeking options and ensure that existing service provision is utilised. Figure 6 below compares the number of referrals made by the initial contact agency (in this case the police) during the Pilot period with the annual average for a three-year period prior to the launch of the 'Access to Justice' Pilot. An increase in referrals is shown.

Figure 6: Impact of the 'Access to Justice' Pilot on referrals



This increase in referrals does appear to demonstrate that the Pilot had some impact on raising awareness in response to incidents of elder abuse. The common perception was that 'Access to Justice' gave some impetus to widening the lens in terms of increasing practitioners' knowledge about elder abuse as a form of domestic abuse. Although agencies supported the ethos of the Pilot, it was recognised that there still needed to be a shift in practice to address the needs of older people experiencing abuse:

'I think there is just still a lot to do about getting to the appropriate people in those agencies to ensure the appropriate actions and pathways are actually undertaken but I think it [the Pilot] has made a huge step forward. For me it is bringing a whole new area of work, for me. It's widening my experience and definitely given me some new issues to deal with that I didn't even think last year before the Pilot.'

(Specialist domestic abuse manager: 3)

(iv) OPAN Participants

In order to gain an insight into the perceptions of older people themselves, a small sample (n=13) of OPAN (Older People's Ageing Network) members were interviewed and completed a short questionnaire. The socio-demographic details of respondents are presented in Table 4 below. This was not intended to constitute a representative sample, but it was felt that the study would benefit from being informed by the views of individuals drawn from the same age cohort as the user group. During the course of the individual interviews, it transpired that one interviewee was a former victim of elder abuse.

Table 4: Socio-demographic characteristics of respondents

Age	Gender	Education *	Ethnicity	Disability	OPAN **
Age range: 61-80	5 males 8 females	7 of the sample were educated to undergraduate degree level or above.	7 Welsh British	3 registered as disabled	13 in voluntary work, 5 also in full or part-time paid employment
Average age: 71 years			5 British 1 Asian British		

* Higher than national average

** Older People's Ageing Network

The questionnaire and interview schedule were designed to explore views and opinions regarding the use of justice and/or welfare options when older people experience domestic abuse. When respondents were asked what they felt older victims wanted, the following were frequently mentioned:

- the abuse to stop;
- treatment for the perpetrator;
- acknowledgement by the perpetrator of the harm caused;
- a voice;
- central involvement in, and support throughout, the process of seeking a criminal or civil justice remedy;
- injunctions to keep them safe;
- protection from retaliation/future victimisation;
- to feel safe.

From the interviews, it was clear that respondents were sensitive to the complex dynamic in relationships where the abuser is related to the victim. There was no evidence of victim-blaming stereotypes. The view was that any attempt by agencies to address the situation required a sensitive and holistic approach that supported all parties involved.

Many of the participants stated that if they were experiencing abuse they would be most likely to confide in a professional with whom they already had a trusted relationship, such as a GP:

'I would speak to my GP, my church group, a person I trusted, I don't want things taken out of my hands..., dignity and self respect are very important I think for older people. I think I would be very nervous about talking to a stranger, especially someone with an official tag ... it is the relationship you have with people like your doctor that is important, it's trust.'

(Female interviewee: 2)

When presented with a scenario that involved a son being abusive towards his mother, the majority of participants expressed concern for the parent.

Participants were sensitive to the dilemma the parent faced in terms of enduring the abuse, but not wishing to use a justice solution that could result in a criminal conviction for their son. It was perceived to be important to view the situation from a parent's perspective in terms of finding a solution to the abuse:

'We feel responsible for our children, right or wrong, we feel that we should be there for them when no-one else is. We will take more from them than we would from anyone else. So our role as a parent is to help our child, so in this case mum would need the agencies to help her help her son, otherwise the problem won't go away, it will probably get worse, it is very sad really'

(Female interviewee: 5)

Participants felt that the victim would primarily want help for the son to deal with his substance misuse issues. The perception was that addressing the son's needs would help to reduce the risk of further abuse.

Most participants stated that a civil order would be the most likely justice option that the victim would pursue, but it was felt that victims would only use this approach if the situation became unmanageable. There were also concerns about the cost of, and access to information about, civil orders.

'This information needs to be where old people go ... health settings, community groups, day centres. I know one old dear who went to Citizens' Advice on another matter; she turned up at 8 am and stood in the queue for two hours until she could stand no longer. Now why not have a special day once a fortnight, when older people can have a ten minute appointment either by phone or in person?'

(Male interviewee: 3)

When the scenario of carer stress was presented, many felt great sympathy for the male victim and the female perpetrator, given the relationship had only deteriorated later in the life course. All participants expressed concern that the male victim may endure a far greater level of abuse because a) conjugal roles in married life carried a social expectation that the male should adopt a protective role as the main provider, and b) men in society were not in a position to admit that they were being abused because of the negative stereotypes associated with male victims.

The general view was that agencies needed to be much more imaginative in terms of accessing older people in terms of both educating them about the nature of elder abuse and providing advice and support. Any support given was contingent on a strong and trusting relationship with one professional who would be proactive and sensitive to the needs of the individual.

'At the time you are not strong enough on your own to deal with it. I was very fortunate. I used to go to a particular church before I went into my shell, then when I went back, the church took me back, no

questions asked ... just looking after me all the time ... they did it that way, it was softly, softly, gently gently ...'

(Male victim)

The third sector was seen as key in developing opportunities for disclosure and therefore training in this field was seen as crucial. In contrast to statutory agencies, third sector service providers were perceived to be independent and better equipped to respond to individual needs.

'It's all about the relationship, and that is from people who work grass roots, your Age Concern, your volunteers at a community group. So in my opinion, it is those people who an older person will confide in, so it is those that need to be trained to know how to deal with them and not judge them. I think old people won't be pushed; they like to feel it is their choice; these relationships take time to develop.'

(Male interviewee: 1)

The participants felt that older people in general did not feel that they would achieve 'a sense of justice' by pursuing a criminal case. However, they felt that any successful outcomes should be highlighted and information on victims' positive experiences of using the civil and criminal law should be more widely publicised.

6. Recommendations

Recommendation 1: Consideration should be given to how domestic violence and elder abuse procedures, policies and guidance can be integrated more effectively.

Under its five-year legislative programme, the Welsh Government is committed to two pieces of legislation relevant to elder abuse. The first is the Social Services (Wales) Bill, which will most likely include a section on safeguarding and protecting adults at risk and impose duties and responsibilities on local authorities and other public sector bodies. The second is the Domestic Abuse (Wales) Bill. This Bill is likely to include a duty on public sector bodies to have a Domestic Abuse and Violence Against Women strategy and necessary support in place.

Evaluating the 'Access to Justice' Project has identified significant overlaps between domestic violence and elder abuse. Indeed the origins of the project, the Communities and Culture Committee's review and the Government's *The Right to be Safe*, are located in domestic violence. The desirability of having two pieces of legislation is a political judgment and beyond the scope of this report. However, it is important that the two initiatives are integrated and consistent. This can be achieved in a number of ways.

- a. The publication of a common code of practice covering the two pieces of legislation would represent a challenge to those charged with drafting the code and the legislation. The relationship between the code and the individual pieces of legislation would need to be identical in order to avoid different interpretations of the same provision in the code dependent upon which piece of legislation was being considered.
- b. The drafting of shared principles (achieved either by the use of common statutory principles on the face of each piece of legislation, or through common s.7 Local Authority Social Services Act 1970 guidance) across the two pieces of legislation would facilitate greater integration. Some of the problems noted in (a) above apply in the same way, but shared principles are more easily identified and applied (for example, autonomy and self-determination, dignity, safety, capacity, support in decision-making).
- c. Agreed protocols on how agencies will work within the two pieces of legislation would be a technical approach designed to minimise the risk of overlap and duplication.

No firm recommendation is made in respect of this matter other than it is something that needs to be considered as the two bills go through the legislative process.

Recommendation 2: 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. (See Appendix D for the model of practice proposed in the Powys Pilot Project [2011]).

The findings suggest that the MARAC process achieved higher rates of consent, greater 'access to justice' opportunities in terms of the range of options discussed with victims, and improved access and engagement with third sector organisations. Currently the DASH RIC/ MARAC process is not being used to its full advantage, especially by health and social care. The IDVA, IMCA and other advocates need to be regular attendees at POVA meetings so that they can convey the views of their individual clients.

Recommendation 3: Practitioners should record the basis for a conclusion that the victim has legal capacity to participate in the investigative process.

A full capacity test in every case, or indeed in most cases, is unnecessary as the Mental Capacity Act 2005 (MCA 2005) presumption of capacity is a strong starting point. However, practitioners, even in cases where capacity is not in doubt, should record the basis for that conclusion. Such a record need only be brief, but it would demonstrate that capacity has been addressed.

Recommendation 4: Practitioners should ensure, when deemed appropriate, that issues of capacity are considered throughout the investigative process.

In cases of doubt about capacity, an appropriate capacity test should be undertaken at whatever stage of the process it is considered necessary. Under the MCA 2005, an assessment of capacity is both time and context sensitive. The fact that the victim has capacity for one or more parts of the process does not necessarily mean that he or she has capacity for all parts, and vice versa. All agencies and voluntary organisations, including those in the criminal justice system, should be familiar with the provisions of the MCA 2005 and its possible relevance to their involvement with the victim.

Recommendation 5: In cases where a victim lacks capacity, there should be a presumption that an IMCA will be involved, and at an early stage rather than towards the end of the investigative process. This presumption should be rebuttable by, for example, evidence that some other suitable person is representing the victim's interests.

A presumption of involvement by an IMCA at an early stage is a guarantee that safeguards are in place for an incapacitated victim when making early decisions that could have a significant impact on the outcome of the process. To delay appointment until the investigative process is complete may significantly disadvantage the victim who lacks capacity.

Recommendation 6: There should be an evaluation of statutory agencies responses to older victims who lack capacity. The evaluation should examine the effectiveness of multi-agency practice to ensure it is victim-centred and that agencies can provide evidence of positive tangible outcomes. Particular attention should be given to the uptake of the IMCA service by adult services and health and the impact of the IMCA role in supporting incapacitated victims of abuse.

The findings suggest that there were cases that were unnecessarily protracted where victims were incapacitated. This delay in positive interventions is unacceptable in individual cases and potentially discriminates against the enjoyment of ECHR rights by those who lack capacity. Furthermore, article 6 ECHR refers to a fair hearing 'within a reasonable time'. Cases, which fulfilled the criteria for IMCA referral, were missed. There were also at least 30 cases where there were queries as to capacity and practitioners appeared to be unaware that they could seek the advice of an IMCA.

Recommendation 7: The decision on whether to use special measures in criminal proceedings should be based on assessments of the victim's vulnerability made throughout the investigative process. Practitioners should ensure that all information relevant to that decision is available to the CPS.

The decision to use special measures may determine whether a prosecution goes ahead. In making that decision, it is important that the CPS is aware of all relevant information including assessments of the victim by other practitioners.

Recommendation 8: Consideration should be given to extending the 'Access to Justice' Pilot for a further two years.

The evidence suggests that although there has been an increase in referrals overall and support for the general ethos of the Pilot, there needs to be a more effective integrated approach taken by statutory and third sector bodies when focussing on elder abuse. This should include improved joint working between statutory agencies, as well as closer collaboration between statutory and third sector organisations.

In extending the Pilot, consideration should be given to the following:

- a. further provision of resources for raising awareness of elder abuse as a form of domestic abuse.
- b. further dissemination of information on how consent and capacity issues can influence referral pathways and civil justice options.
- c. a review of health professionals' strategies for identifying elder abuse and of health's role in the POVA/MARAC processes.
- d. provision for the police to resource the continued use of safety checks.

- e. mandatory training on the use of the DASH RIC/MARAC and domestic abuse services for practitioners whose clients include those aged 60 years or over.
- f. social work training on the role of the IMCA, IDVA and dealing with hostile perpetrators.
- g. training for substance misuse teams regarding the nature of domestic abuse especially in recognising elder abuse as a form of domestic abuse.
- h. substance misuse teams acquiring a more central role in working with perpetrators (e.g. accessing perpetrators in custody suites).
- i. adopting the 'Powys model' to ensure better integration of the POVA/MARAC processes.
- j. holding regular meetings on the Pilot involving feedback and training sessions, at strategic and operational levels, between statutory agencies and third sector organisations.
- k. regular dip sample testing of the current DASH RIC tool by all agencies, and greater uptake of the adapted DASH RIC tool by social services to evaluate whether the adapted version more accurately measures domestic abuse in the context of elder abuse.
- l. increasing the use of advocates, especially but not exclusively, the IDVA and IMCA, given the importance of developing a relationship between client and practitioner in cases of elder abuse.

Recommendation 9: Statutory agencies should be more aware of the support and services provided by the third sector and in appropriate cases, with the consent of the victim, that the third sector should be part of the interdisciplinary response.

The expertise and support available in the third sector is a valuable resource that should be used more often. The findings suggest that older people engaged more in the process if a third sector body was involved. There was a perception that third sector practitioners provide impartial, independent support that empowered the older person in a way statutory agencies might not be able to do.

Recommendation 10: Consideration should be given to providing resources to the third sector to fund support for awareness raising, training and advocacy support.

Support and liaison

- a) The initiative would involve raising public awareness by targeting, for example, places older people congregate. It would adopt an outreach model engaging with older people in community settings (day centres, churches, leisure centres etc).
- b) The initiative would involve liaising with representatives of MARAC and the POVA to draw on their expertise, and identify referrals that currently get 'lost' in the process.

- c) The advocate support element would include providing advice and guidance for advocates on criminal and civil law options, and on effective record keeping using the IDVA approach as a template.

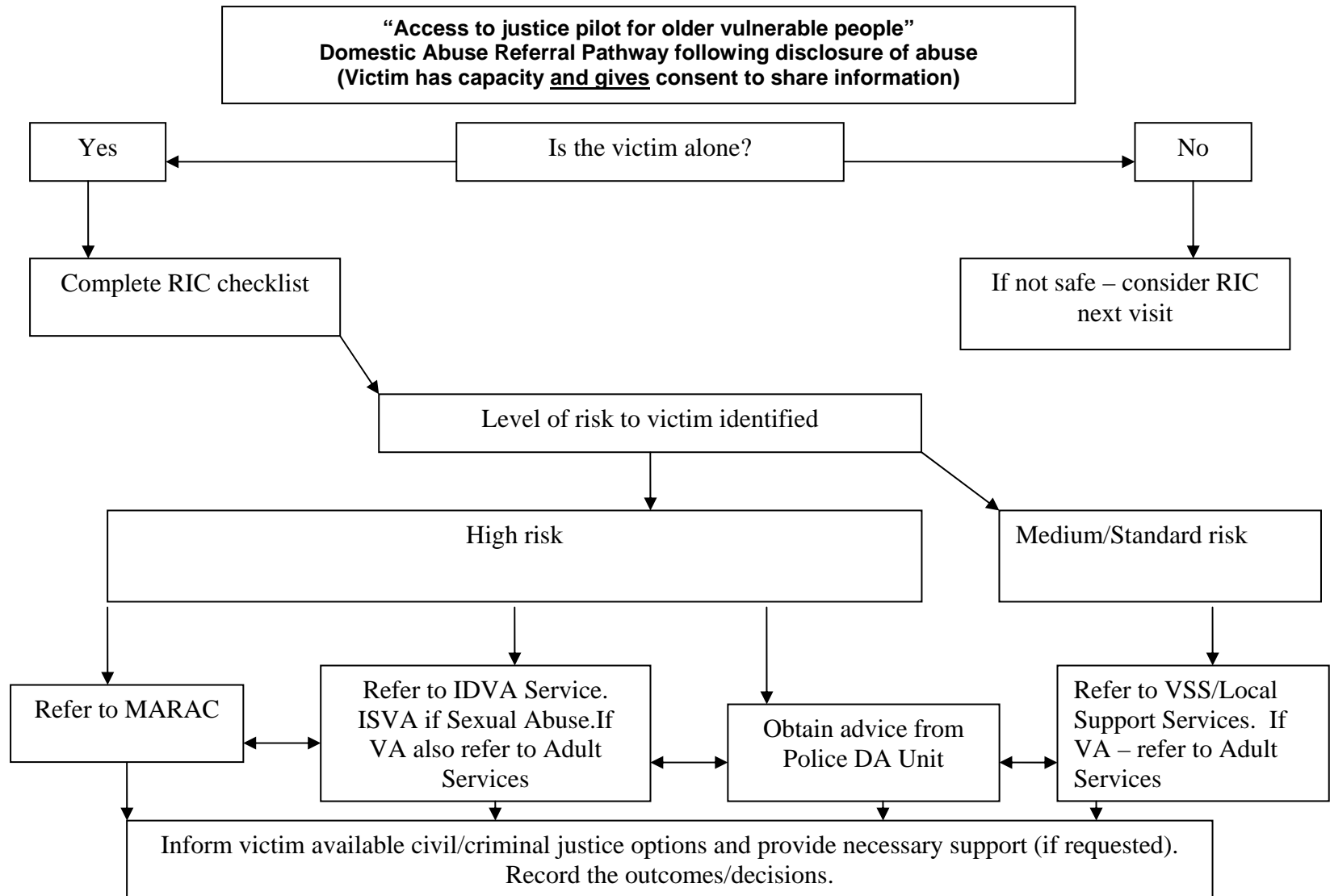
Training

- a) Training would be provided for carers, social housing agencies, tenant support groups and others on how to identify older abuse and how to make the appropriate referrals to MARAC, IDVAs, IMCA and the criminal justice system.
- b) A range of practitioners and managers do not appear to be aware of the significance of the DASH RIC, part of the role would involve targeting training and raising awareness of the DASH RIC tool, and training on domestic abuse in older people.
- c) There is limited knowledge on how elder abuse impacts on men, given elder abuse appears to be less gendered than other forms of domestic abuse, awareness raising should seek to highlight the experience of abuse for men.
- d) The role would entail producing a leaflet on safety planning for older people experiencing abuse, and informing victims of local contacts where they can obtain information and advice about the justice options available.
- e) The role should involve liaising with/and training key health professionals who work with older people (GPs, district nurses, health visitors, A&E and the Falls Clinic). Joint working with health to generate more referrals should be a priority.

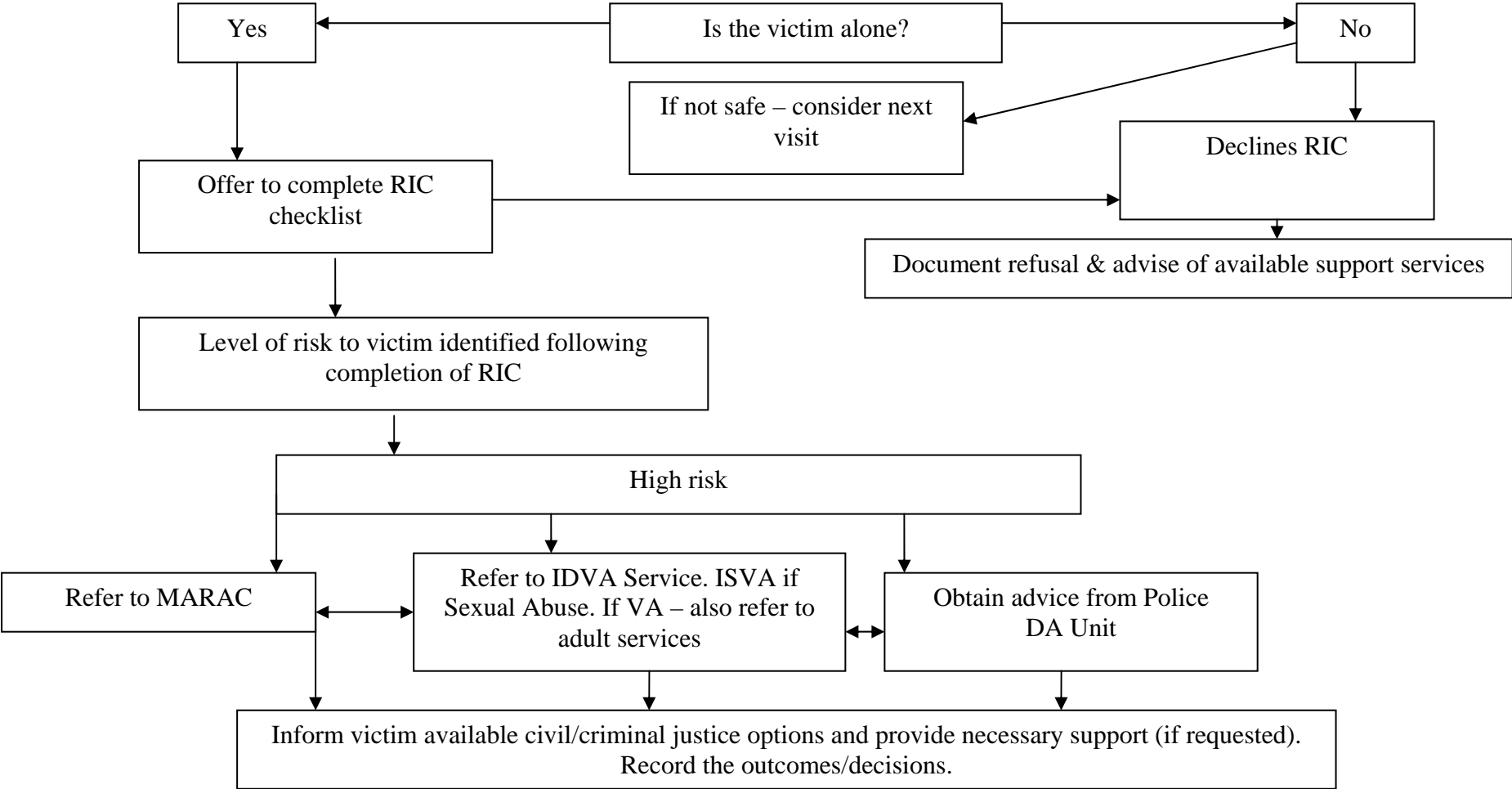
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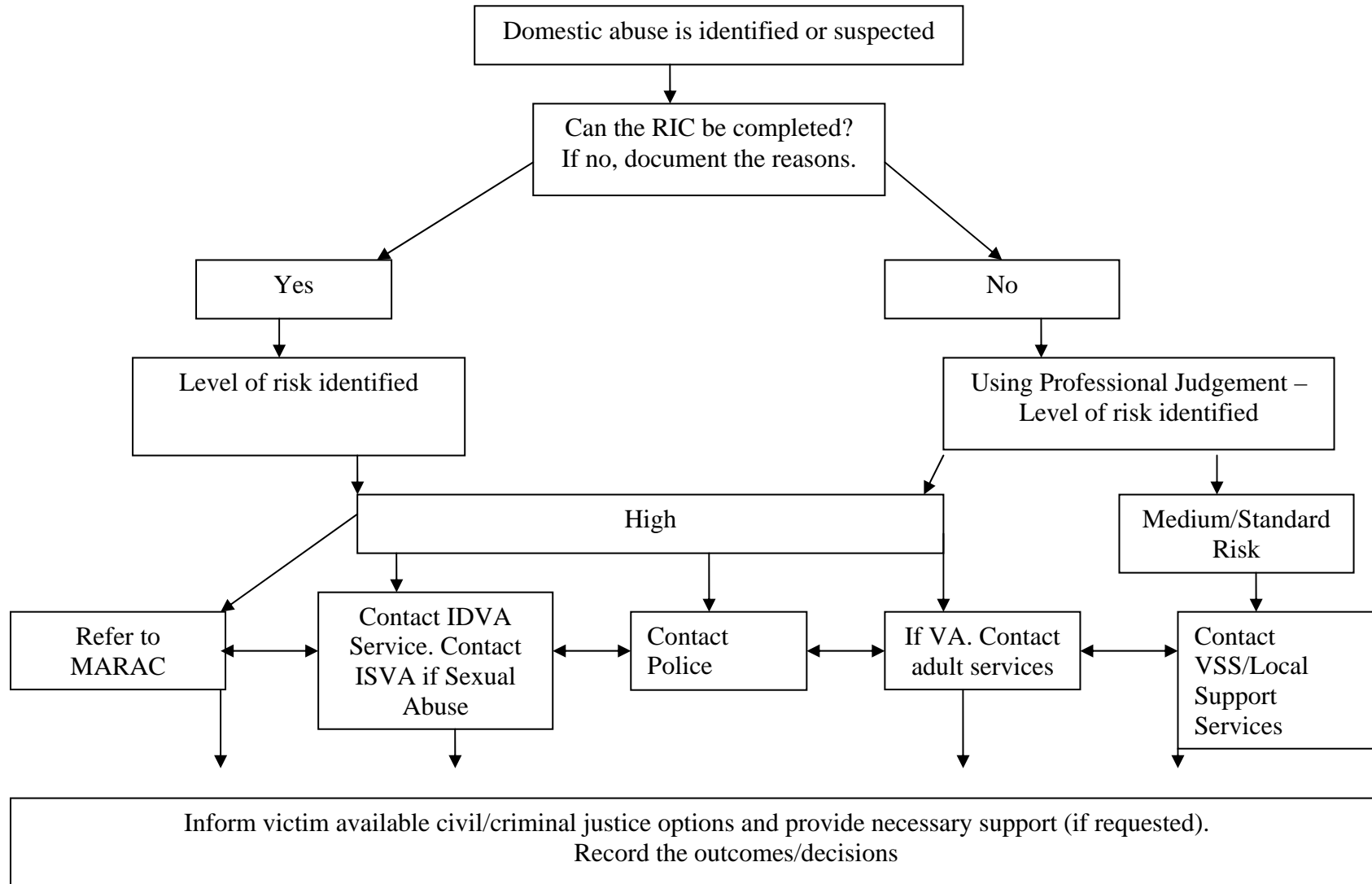
Appendix A: Referral Pathways: 'Process Maps'



**“Access to justice pilot for older vulnerable people”
Domestic Abuse Referral Pathway following disclosure of abuse
(Victim has capacity and does not consent to share information)**



**“Access to justice pilot for older vulnerable people”
Domestic Abuse Referral Pathway following disclosure of abuse
(Victim does not have mental capacity to give consent to share information)**



Appendix B: Case Management Record

EVALUATION OF THE 'Access to Justice' Pilot

PARTICIPANT CASE MANAGEMENT RECORD TO PROVIDE A SNAPSHOT ON THE EFFECT OF THE PILOT PROJECT

PART 1. POINT OF CONTACT

SECTION A: CLIENT DETAILS

Client ID. No (See data collection guidance)	
Date of initial contact:	
Organisation at point of contact:	
Gender of client:	
Female (Indicate with X)	
Male (Indicate with X)	
Client has disability: Y / N / Not Known	
BME (Indicate with X)	
LGBT (Indicate with X)	

Abuse profile at point of contact:		
Please indicate the type(s) of abuse (Indicate with X).		Yes
Physical		
Sexual		
Financial		
Neglect		
Psychological/ Emotional		

Alleged Perpetrator's relationship to victim	
---	--

Husband/Wife/Partner/Ex-Partner	
Son/Daughter	
Grandchild	
Other	

SECTION B: CONSENT AND IDENTIFICATION OF RISK

Mark with an 'X' all boxes that are applicable.	Yes	No
Client gives consent to share information.		
Form does not indicate if consent has been obtained.		
Client lacks mental capacity to give consent		
DASH Risk Indicator Checklist completed.		
DASH Risk Indicator Checklist – unable to complete.		
If unable to complete DASH please indicate reason below.		
Victim refuses to cooperate.		
Perpetrator present, unsafe to complete.		
Victim lacks mental capacity to complete.		
Level of risk identified:		
High		
Medium		
Standard		
Not indicated		

SECTION C: REFERRAL TO MARAC / OTHER SUPPORT SERVICES

	Yes	No
Referred to MARAC:		

Referred to IDVA :		
Referred to IMCA:		
Referred to Adult Services:		
Referred to Local Support Service:		
Referred to Police:		
Civil/Criminal Justice Options discussed with victim		

PART 2. OUTCOMES

1. Indicate with X in Box if No Further Action Taken

SECTION A: CRIMINAL / CIVIL JUSTICE PROCESS. ABUSE PROFILE

(TO BE COMPLETED AT CLOSE OF INTERVENTION AND SUPPORT).

2. Criminal Justice:

	Y	N	Not Known
1. Alleged Perpetrator Arrested:			
2. Alleged Perpetrator Charged:			
3. Perpetrator Convicted:			
4. Case withdrawn:			

3. Civil Justice

	Y	N	Not Known
1. Case referred to Civil Justice Process			
2. Application made to civil court			

Only complete 3 – 9 below where an application has been made to the civil court			
3. Occupational Order Application			
4. Occupational Order Application granted			
5. Non-molestation Order Application			
6. Non-molestation Order Application granted			
7. Proceedings under Protection from Harassment Act			
8. Enforcements proceedings			
9. Referred to Office of Public Guardian			

4. Abuse profile at close of intervention and support

Abuse profile at close of contact:					
Please indicate the type(s) of abuse at close of contact: (Indicate with 'X')	Don't know	Not asked	More severe	Less severe	No change
Physical					
Sexual					
Financial					
Neglect					
Psychological/Emotional					

SECTION B: CLIENT FEEDBACK

Only complete this section if you have information from the victim on the impact of the service that has been provided.

Feedback:

SECTION C: AGENCY FEEDBACK

Only complete this section if you have information/comments on the impact of the service that has been provided.

Date of closure of contact:

Organisation:

Appendix C: Interview schedules

'Access to Justice' Pilot-An independent evaluation Telephone interview schedule for practitioners

Background

1. I'd like to start by asking you a few questions about your professional background:

What is your role/job title?

How long have been in your current role?

What is your role regarding the 'Access to Justice' Pilot?

Section on Pilot implementation

2. In your own words could you please give me a brief outline of the 'Access to Justice' Scheme?

Prompt if necessary:

- How does it aim to improve current practice generally?
- Ask about uptake of DASH RIC tool/MARAC prior to the scheme.
- Does the scheme encourage better use of existing provision, if not why not, if so why?

3. Were you involved in any of the training and awareness-raising sessions during and prior to the launch of the scheme?

If yes:

- What was the nature of this involvement?
- What worked well about the process?
- What could have been improved?
- What other agencies were present at the training session?
- What was the general perception of the training?
- Were there any agencies who were perceived to be particularly supportive or reluctant to engage with the process? If so, why?
- Did anyone comment on the Referral Pathway tools, Case Management Records (CMR) etc? What were their views?

4. Once the Pilot was launched did you feel that the tools used were fit for purpose? If not why not, if so, why?

5. Have you noticed any difference in your own practice (or that of others) in the last 12 months or so as a consequence of the scheme?

Informed Consent /Capacity issues

Now I would like to discuss the issue of informed consent and whether you feel that service users are given the opportunity to explore justice seeking remedies given the information given to them by criminal justice agencies and support services.

6. Do you feel that victims feel more empowered as a consequence of the scheme?

Prompt (as appropriate):

- Has the scheme changed practice in any way? (MARAC, POVA, third sector working, record keeping, responses to potential cases)
- How the format on the CMR is useful in encouraging practitioners to consider whether they have explored options? (prompt: referral pathways and consent)
- Are service users made aware of the relevant information so they can make an informed choice about their options? (is so why, if not, why not)
- What do practitioners do if they have doubts about a service user's capacity? (Use of IMCA, understanding of IMCA role, referrals etc.)
- What if their capacity fluctuates but they wish to pursue a justice option?
- What is your opinion of current practitioner awareness on informing service users about pursuing criminal /civil justice options?

7. Are there any changes you feel could be made to improve the process? (Prompt: multi-agency working, DASH Tool, POVA)

8. CASE EXAMPLE: Please talk me through an example where you feel the service user was empowered by the process and what it was that you feel enabled them to feel they were put in a position to make an informed decision.

Future development

9. What do you think are the most important aspects of the 'Access to Justice' Scheme that our evaluation should be focusing on and highlighting?

Final comments

10. Do you have any other comments that you'd like to make about domestic abuse services delivery, locally/nationally?

Many thanks for your time and assistance.

END OF INTERVIEW

‘Access to Justice’ Pilot-An independent evaluation Telephone interview schedule with OPAN members

Background

1. Could you first of all tell me little about yourself and why you felt you would like to take part in this study?

Scenarios

2. I am going to read out a brief scenario of someone’s experience of elder abuse and then ask you for your opinion on what you think the victim may want:
 - in terms of services generally;
 - in terms of justice ;
 - Also what would a victim/ or victims (if partners) want from the process and as an outcome

Scenario A

A call was made to the police by the neighbours reporting that they can hear arguments next-door and it sounds like there are sounds of smashing and shouting. When the police arrive the alleged perpetrator (son) leaves. The victim (mother) refuses to cooperate with the police and claims that they had a minor dispute. The victim looks much shaken up and has redness down the one side of her face and has lost a tooth. She claims that this was caused through walking into a door, denying any accusation that it was her son.

Prompts :

- What do you feel the victim may be thinking?
- What do you think the police can do?
- Are there any other agencies you feel would help support the victim?
- What do you think the victim wants? Why?
- How would the victim feel towards the son if she knows he wants money to buy alcohol to support his addiction?

Scenario B

The victim is very vulnerable and has limited mobility as a consequence of a stroke. The perpetrator is the wife of the victim and is his sole carer. Social Services have received a phone call stating that they believe the wife is suffering from 'carer stress' and is neglecting her husband and emotionally and physically abusing him. There have been known (by the children) occasions for the wife to lash out at the husband, but none of these have been reported to the police.

Prompts:

- What do you feel the victim is thinking ?
- What do you think the social services can do/ explore other agency involvement?
- What do you think the victim wants? Why?
- How would the victim feel towards his wife if he knows she is struggling to cope, what if the victim/perpetrator has dementia?
- What do you feel can be done to help adults who lack capacity in using justice/welfare options?

Equality

3. How do you think the gender of the victim may influence their decision-making?
(Prompt: disclosures, service response, time and relational influences)
4. Now I would like to explore whether you feel that older people are given the same opportunities to explore justice seeking remedies as other sections of society (do they have any differing needs? How can services cater for these needs?)

Future development

5. How should older people be supported by the criminal justice system and other support agencies when they are experiencing elder abuse

Final comments

6. Do you have any other comments that you'd like to make about service delivery for older people, delivery locally/nationally?

Many thanks for your time and assistance.

END OF INTERVIEW

Appendix D: Proposed model of practice to link 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.

Domestic Abuse	Adult Protection
<p><u>Abuse disclosed or suspected</u></p> <ul style="list-style-type: none"> 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). <p><u>Completion of CAADA DASH Risk Identification Checklist</u></p> <ul style="list-style-type: none"> Follow Domestic Abuse referral Pathway for completion of RIC. 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) <p><u>MARAC</u></p> <ul style="list-style-type: none"> 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). A Social Services representative may attend MARAC. If the alleged victim or perpetrator is 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 	<p><u>Referral</u></p> <ul style="list-style-type: none"> Should include information about whether the alleged perpetrator is a partner/ex partner or otherwise related to the alleged victim. Referral should include information about any previous domestic abuse and any action taken. <p><u>Initial evaluation</u></p> <ul style="list-style-type: none"> 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. If the alleged victim is a vulnerable adult determine if the alleged abuse meets the threshold for adult protection. 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. Take immediate protective action if required. If there is possible domestic abuse this may involve accessing domestic abuse services, e.g. refuge. <p><u>Strategy discussion</u></p> <ul style="list-style-type: none"> If alleged perpetrator is a partner, ex-partner or otherwise related to victim identify the incident as domestic abuse.

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 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.

- 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, e.g. 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, e.g. 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.

	<p><u>Investigation</u></p> <ul style="list-style-type: none"> • Request specialist domestic abuse involvement as required – e.g. perpetrator risk assessment. <p><u>Final Strategy meeting</u></p> <ul style="list-style-type: none"> • 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). <p><u>Case conference</u> (This is where information about the investigation is shared with the alleged victim and/or their representative and the Protection Plan is agreed).</p> <ul style="list-style-type: none"> • Domestic abuse professionals to participate in or lead case conference as appropriate. <p><u>Review of Protection Plan</u></p> <ul style="list-style-type: none"> • Domestic abuse professional to participate if they have had continuing involvement or if it becomes appropriate for domestic abuse services to be involved.
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Richards, M. and Kaye, A. (2011) *Adult Protection and Domestic Abuse: Strengthening the Links*, Interim Report, Powys Pilot Project.

Appendix E: Roles of the MARAC, IDVA and IMCA

Multi-Agency Risk Assessment Conference (MARAC)

The MARAC is part of a multi-agency strategy to tackle domestic violence and comprises representatives from the local police, health, social services, housing, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. Its primary aim is to reduce the risk of serious harm or homicide in the case of victims of domestic abuse. Local agencies meet to discuss the situation of those victims at highest risk and decide what actions need to be taken to ensure their safety. Information is shared to create individual risk management plans.

Independent Domestic Violence Advisor (IDVA)

The main role of the IDVA is to address the safety of victims at high risk of harm from intimate partners, ex-partners or other family members. They are the victim's primary point of contact and normally work with clients to assess the level of risk and construct safety plans. These plans will include actions from the MARAC as well as sanctions and remedies provided by criminal and civil courts and other organisations which can provide support with housing and social welfare.

Independent Mental Capacity Advocate (IMCA)

IMCAs work within the framework of the Mental Capacity Act 2005 to promote the interests of people who lack capacity to make their own decisions. Typically they are involved when significant decisions, such as moving into a care home, have to be taken and the person is what is referred to as 'unfriended'. This means that the person has no one to speak for them or nobody that is suitable (for example, the perpetrator may be the closest relative). In cases of suspected abuse there is discretion to involve an IMCA where the victim lacks capacity.