WEST MIDLANDS REGIONAL ADULT SAFEGUARDING LEADS
DEVELOPING POLICIES AND PRACTICE ACROSS THE REGION

Using the DASH in Adult Social Care

There is no doubt about the usefulness of the DASH (Domestic Abuse, Stalking, and 'Honour' based abuse) risk assessment when used with working age victims of domestic abuse (who usually have no adult social care needs).

However, when used with adults who have social care needs (and there may not be children in the household) then the questions in the DASH may not be so relevant and scores can often come out as medium or low, reducing the likelihood that domestic abuse cases involving adults with social care needs will be referred to a MARAC.

There is a box on page 5 of the DASH where the professional can enter consideration of the victim's situation in relation to disability; mental health; and other factors.

It is this area that Adult Social Care (ASC) need to be ready to convey specific matters that would otherwise not be addressed in the set questions. Most local MARACs will respect referral to them based on Professional Judgement within the DASH (even though the score is low).

One of the main points ASC want to be able to convey is not that the source of risks' behaviours are escalating (unless they are, in which case convey that) - but that the vulnerability of the person with social care needs is increasing and it is this increase in vulnerability that means the risk has now increased (and continues to be dynamic – to the point that any domestic abuse could increase the vulnerability of the victim). ASC should consider factors such as:

If the source of risk is a family carer:

- If the adult is reliant on the source of risk for personal care this represents a significant point of vulnerability/ point of intimidation/high risk of coercive control
- Is there a claim that food or drink is being withheld or otherwise manipulated?
- Is there suspicion that weight loss may be due to food being withheld?
- Is medication administration controlled by source of risk and is there a concern it is not being administered correctly; used to overdose, etc
- The adult is dependent on the source of risk at key times and comments are heard, for example 'adult is a burden' or intimidation at these points (e.g. when the adult needs any aspect of support outside of the planned home care calls)

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- The source of risk can control or mediate contact with professionals and there have been instances where care staff calls have been cancelled/ care staff turned away/ health appointments not attended or cancelled

- Where the person is self-funded and/or a support plan is reduced/ cancelled by the source of risk amid claims that it is not needed/ too expensive/ care staff never turn up on time/ care staff do nothing

- There are concerns that the source of risk is not acknowledging the increased care needs of the adult and this is aggravating the situation by making them angrier/short tempered

- The source of risk is mocking the adult since the adult has periods of confusion/ incontinence/ general reliance on the family carer

For some adults there may have been a history of domestic abuse before Adult Social Care became involved. It could be that the victim found a way to manage the abuse. The abuse may have been intermittent. As the adult develops care and support needs this can have a dual aspect – the adult's previous strategies to manage domestic abuse events may now be no longer an option; at the same time the appearance of care and support needs in their partner may trigger the source of risk to initiate new domestic abuse events as they seek to re-establish control.

Increased vulnerability of the adult could include:

- The increased frailty/ reduction in mobility of the adult means that they are no longer able to protect themselves (even by moving into a different room)

- The adult's social network of support has now reduced through bereavement, isolation and /or siblings/friends are equally frail and unable to support

- The dependence of the adult on the source of risk is such that there is an oppressive atmosphere in the household - they are not able to make meaningful choices relating to staying or leaving

- Due to the level of dependency and the cared for/carer relationship there is little or no access to the adult

- Where finances have been entwined for so long the adult cannot envisage how they can be financially independent and this stifles their sense of alternative options

- The adult has a level of confusion which means they may not be able to reliably report abusive events

- The adult has, or appears to have, care & support needs that impact their ability to understand they have choices and their ability to take steps to protect themself.

Research evidence shows that of all women murdered aged 60 or more (in a domestic violence event) the source of risk was a son or grandson in 28% of these murders[1]. There are a small number where the source of risk is the daughter. Where the source of risk is a child or grandchild, consider these and related matters:

- The adult's bond to their child/grandchild may mean they are normalising the intensity and frequency of abuse, and minimising the level of risk.

[1] Bows, H (2018) *Domestic homicide of older people in the UK (2010-2015)* British Journal of Social Work.

- The adult is attributing the behaviour of the child/grandchild to alcohol/drug use or mental health issues (or autism, ADHD, etc)

- The adult fears their child/grandchild will be homeless or they will self harm if evicted from the parent's home

- Related to the above – the child/grandchild is dependent on the adult either for housing or financially (this can generate resentment in the relationships from the source of risk towards the parent)

- The child/grandchild has the potential to be physically intimidating just due to their relative youthfulness and physical agility

- The adult wants to maintain relationships with any grandchildren and so aims to maintain the relationship with the source of risk

- There is a sense that the source of risk resents the changes that have occurred (in the sense they are now a carer). Consider the impact of all the above and the nature of this potential hidden harm.

Safety Planning

Safety planning in a domestic abuse situation is about working alongside the adult at risk to identify risk and plan in advance what strategies and support they can access to keep themselves safe if the risk escalates. Safety planning can be done at any stage of contact with an adult, and should start from an early point. As with all safeguarding work, engagement and involvement with the adult in all decisions about their lives is key.

The safety plan can include the following:

- Refer to an Independent Domestic Violence Advocate (IDVA) if the adult consents. IDVAs are skilled at safety planning in domestic abuse situations. IDVAs are only allocated to high risk victims and their involvement is short term. But Women's Aid can be contacted for advice as needed by the adult

- Agreement with adult and GP practice that on all visits to health professionals in GP health centre the health professional will ask an open question about home situation
- An agreement with GP practice and adult that if home situation deteriorates adult can make appointment to go to GP surgery specifically to relay home situation (and health professional can make onward referrals to domestic abuse services and/or adult social care with consent of the adult).

- An agreement with GP surgery and adult that if the adult contacts GP surgery then GP surgery agree to make a home visit, or the other way round – invite the adult into the surgery

- Where the adult has need for regular (even if not frequent) District Nurse (DN) visits that this can be assured by DN Team to occur and if missed or blocked this is escalated

- With the consent of the adult, liaise with local Policing to see how the adult can be supported or a level of monitoring provided by Safer Neighbourhood Teams.

- Adult Social Care to consider the use of community resources and ways to extend community support networks if the adult is being isolated from others.

- Is there a ‘safe space’ in the local community (where the adult could go without raising suspicion of source of risk) so adult can declare pressure of home situation. Onward referrals to domestic abuse services and/or adult social care can then be made.

- Is there a family member or friend of the adult who the adult will agree they will speak with once a week/once a fortnight and it is agreed the family member / friend will try to initiate contact?

- Consider broader uses of how technology and telecare can add to safety planning since it provides option of direct contact with professionals if the adult feels unsafe and needs an emergency response. With the consent of the adult, share information and agree with the telecare team what their response will be.

- With the consent of the adult, to share information with local key services to flag the adult’s record or address, e.g. Police, Ambulance, GP surgery.

The Eight Stage timeline of events before domestic abuse homicide

With an increase in domestic abuse homicides being reported across the globe, a light is being shed on a crime that in 'normal' times causes the death of 2 women a week in the UK. This post explains the 8 step timeline that typically precedes domestic abuse homicides and how this relates to risk assessment and safety planning.

https://www.dvact.org/post/do-you-know-the-8-step-timeline-in-domestic-abuse-homicides (Ref July 2020)

In research published in 2018, Dr Monckton Smith reviewed domestic violence killings in the UK which showed an 8 stage timeline of events before a homicide takes place.

- Pre relationship history: criminal record, allegations
- Early relationship behaviours: early commitment
- Relationship behaviours: risk markers
- Potential homicide trigger: separation, ill health, financial problems, threats or rumours
- Escalation – frequency, seriousness, stalking, persistence
- Change in thinking
- Planning – buying weapons, grave digging, manipulate meetings, letters, organize papers
- Homicide – homicide/suicide, confession, missing person, denial, accident, multiple victims

Supplementary guidance from SafeLives can be accessed via this link

Please see the film link to 'Domestic Abuse; it happens to us too which was commissioned by Sandwell but available for all to use.

Case Study - Maggie

Maggie is a 56 year old woman who has lived with Multiple Sclerosis since first experiencing symptoms and being diagnosed when in her 30's. Her care needs have increased over the past 4-5 years as she has experienced increasing difficulties with her mobility and muscle stiffness. She now spends much of her time in bed, and needs support from one person to get out of bed and transfer to a chair.

Maggie has been in a long-term relationship with her partner Karl, who has been her main carer now for several years. They have one daughter, who is grown up and has left home. Maggie reports that throughout their relationship, Karl has had times when he drinks too much alcohol, and when he is drunk, he can be a "different person" and be abusive towards her. When they were younger, Maggie used to "stay out of his way" when he had been drinking, and even left and stayed at a hotel on a couple of occasions, but she chose to return to the relationship when Karl promised to change.

Maggie reports that things have been getting worse over recent years, since Karl gave up his job to care for her full time. His drinking is becoming more regular, and she feels he is more unpredictable more of the time, with Maggie feeling afraid a lot of the time. Maggie thinks Karl is stressed from his caring role, but takes out his frustrations on her. She says that he will shout and be short tempered with her when she has difficulties with word finding or she "loses the thread" of what she means to say – sometimes he can mimic and laugh at her which she finds cruel. Although Karl has never hit Maggie, she thinks he can be purposefully rough when helping with care if he is cross that she has said or done the "wrong" thing. A few months ago, Maggie made a mistake with her medication, and since then Karl has taken it over, keeping it out of the bedroom where Maggie can reach it. There have been times where Karl has "missed" giving Maggie her pain medication at the right time, causing her discomfort, and Maggie thinks this is done as a punishment.

Carers assessment and carers support has been offered to Karl, but he has declined any support.

As part of adult safeguarding enquiries, the social worker was able to complete a DASH risk assessment with Maggie. The DASH gave 8 *Yes* responses (a moderate score), but the social worker decided to make the referral to MARAC as high risk on the basis of professional judgement for the following reasons-

- There is a history of domestic abuse in the relationship that pre-dates Maggie developing needs for care and support.

- Maggie's care and support needs are increasing as her MS progresses, and she is not able to use the safety strategies she used when she was younger, such as staying away from Karl when he is drinking, or even leaving.

- Karl's drinking and the abusive behaviour that tends to follow is becoming more regular, and Maggie feels his behaviour is more unpredictable. Maggie is feeling afraid of Karl.

- Karl is using aspects of her care and support to control and "punish" Maggie; being rough when helping with care, withholding medication.

- Maggie is becoming more dependent on Karl, who is becoming more stressed with his caring role, which could be a further trigger for increased abusive behaviour as her dependence. increases, and her ability to protect herself decreases. Karl is declining any support with his caring role.