



Spotlight – episode 1

Podcast transcript

Domestic abuse and older people: how can services reach more older victims?

Rachel Ozanne (RO): Welcome to Spotlight, the podcast for the domestic abuse sector. I'm Rachel Ozanne from the SafeLives Knowledge Hub and, over the next six weeks, SafeLives will be shining a spotlight on older victims of domestic abuse.

Older victims are still one of the largest groups of vulnerable people who are not accessing domestic abuse services. Typically, those aged 61 and above are much more likely to experience abuse from an adult family member or current intimate partner. They are significantly more likely to have a disability, and are much more likely to be living with the perpetrator after getting support.

With this in mind, I spoke to Rachel Nicholas, Safety Interventions Manager at Camden council, about their recent campaign, Know It's Not Too Late, which aimed to address the specific aspects of abuse that affect older victims. But, as you might expect, the success of their campaign didn't come without a few challenges.

RO: Can you tell us a little bit about the campaign?

Rachel Nicholas (RN): Okay. So one of our main motivations for doing this particular campaign – which was called Know It's Not Too Late – the motivation really behind that was that in the two years preceding this campaign, Camden had had two domestic homicides, both of which were of women who were over 50.

One was the murder of a woman which had taken place in her home, by her husband, who later killed himself. The other one took place, spookily, almost exactly a year later. And that was a son who killed his mother. So the homicide reviews are both now complete for both of those and there were a number of recommendations that came out from those. One was about the fact that actually neither of those women had accessed any domestic violence services. And so looking at that, thinking about – actually – how do we increase the likelihood of people of that age group even knowing that services exist for them. We also then looked at the kind of background information and research nationally that we had in relation to the different age groups that were being referred to services.

RO: Was that common then, that even within the Camden domestic abuse services, there weren't so many clients of that age group?

RN: Yeah, within the Camden services - so particularly Camden Safety Net, which is where the bulk of our data comes from about referrals-

RO: That's your Idva service?

RN: Yes. And the bulk of the referrals are from people aged 20-25, up through to around 40. On one level, that makes total sense because you're more likely to be in a relationship during that stage of your life. You're more likely to have children – small children particularly – at that stage of your life and you're more likely to be engaging in different services anyway, particularly if you've got small children. So that made sense, to see that pattern of referrals in terms of age groups.

So the previous year we'd run a campaign called Know This Isn't Love, which was aimed at young people, because we knew from both our own data in Camden but also national data that young people just don't really see domestic violence in the same way that adults do. There are relationship complications, it's quite acceptable [to them] – there's some quite shocking data out there about young people and their acceptance of violent behaviour in relationships. So that was our first area of target and that campaign was really successful, it produced a two minute video that went into cinemas, it was on bus stops etc and as a result of that, looking at the same period the year before, we'd seen a 44% increase in referrals for young people aged 16-25 so we knew that we'd kind of touched on something that could make a difference.

RO: Did you find out with that what bits of the campaign worked? Whether it was social media or the cinema? Were you able to find that out?

RN: One of the things we did in order to look at how that worked was design a web page for it to be accessed on. So with young people, they're far more savvy than somebody like me, and as we found out - you also Rachel - in terms of technology [both laugh]. And they use social media in ways that actually, I'm only just starting to get to grips with. And so we asked people to retweet, to put on Facebook, to share the video on Facebook, so it was deliberately only a 2 minute video that had a shorter 30 second edit so there are different versions of it which could be very easily shared on social media. I don't have the figures with me right this second but we were monitoring actually how many hits the web page got and also how many retweets and whatever the re-postings are on Facebook -

RO: Sharing?

RN: Sharing, there you go. See you know more than I do! So we were looking at that kind of thing and that worked for young people. We didn't necessarily think that was going to work with our older communities.

RO: So how did you go about thinking how you would approach older people?

RN: So there were a number of different stages to it really. The first bit was to look at a) what our homicides in Camden were telling us; b) what the national data was talking to us about and seeing that picture both in Camden and nationally was that older people tend not to refer into services to get that specialist support. They do talk to their GPs and they do talk to some of their community groups. So the next phase was to go and talk to people who had better connections with an older generation than we did. One of the organisations I actually went to speak to was Solace Women's Aid.

RO: The Silver Project?

RN: The Silver Project. So I went to speak to them, to talk to them about how they engaged with older people and they actually ran a focus group for us who looked at some of the messaging that we were looking at, they looked at some of the scenarios that we were putting into the posters and also asking them where they would most likely go to be able to see this kind of information. So they were very keen on seeing that information on our bus stops. They said that's something that speaks to them. And also in their local shopping areas, but the transport links were a really big point for them.

RO: Oh that's interesting. You sort of automatically think that the place to campaign is waiting rooms in GPs, or libraries and stuff like that but I suppose more people are likely to be using public transport aren't they, especially in a London borough.

RN: Yes. Yep. So that was a really useful bit of work we did with them. We spoke to some of our own clients who were of that age and they helped feed that in. They weren't focus groups but they were more one-on-one interviews with those older clients.

RO: So that's quite interesting because you had, and we will post a link to this for those listening to the podcast to have a look – there was the four posters wasn't there and they showed a mix of different demographics. There was a male victim and three female victims and there was partner abuse and also like a family member and different scenarios and I was interested to find out whether those came from cases or whether that was the feedback that came directly from clients about what they would want to see or what message would reach out to them?

RN: So some of those case scenarios, particularly the family one where we've got an older gentleman being financially abused by his daughter, and that was based on two real cases that Camden Safety Net had dealt with over the years. And we wanted to kind of link in with the idea that we had started hinting at in the young people's campaign which was about, you know, domestic abuse doesn't need to be physical abuse, we're not just talking about physical abuse. We were also kind of coinciding at the same time with the definition change so that was another factor that we were bringing into this.

RO: And I thought that was really good on the posters where on each of them, you list the different types of abuse and if you're experiencing this, it's not okay and seek help to just, I guess to make that really clear to people as well as looking at that visual.

RN: So, so that one particularly was taken from actual case studies. All of them were informed by cases that the Idva team had worked with and those ideas were then tested out with our focus groups and they resonated with them and that was really important. So it was just making sure that we did have a cross section of communities, that we looked from a range of ages because whilst it's kind of aimed at the over 50s, it's very hard to target a campaign without seeming like you're being rude to people [both laugh] that you're aiming it at someone over 50. And I can remember talking to one of our police colleagues and she said "Well, that would apply to me!" and that's not the perception people have when you're talking about the older generation.

RO: You can see that, with the posters that you've done, it's a different age range isn't it within the people in the posters, those images as well.

RN: One of the other elements of one of our homicides, and one of the elements that happens as we get older, is this idea that your carer could also be your abuser, so that was one of the images that we picked up in one of the posters. That idea that actually you're dependent upon that person for your care but actually they're abusing you. That might be new abuse that might have just happened since you've become more infirm, or it actually might be part of a continuous part of violence that's been going on throughout your life and actually now it's not physical anymore: it's the refusing to give you your meds and stuff like that.

RO: And those sorts of different types of control which I think comes out in those posters. So with the domestic homicides, where those two women hadn't sought help from domestic abuse services, had they spoken to anybody else about the abuse?

RN: In the husband and wife homicide which took place in 2013, both parties had disclosed to their GPs that there was domestic abuse in their relationship. She had spoken to her GP about the violence she was being subjected to by her husband. One [incident] which actually included a broken arm. And he had also disclosed to his GP that he had been violent, he was concerned he had hurt her.

RO: Was there any follow up?

RN: No.

RO: That's quite common, isn't it, with a lot of domestic homicide reviews.

RN: Yes. And in the second case, that of the mother and son in 2014, you were looking at a son who had significant mental health issues – a really tragic case in some respects because, on the day leading up to the murder, mother and son were asking for him to go into care and that wasn't forthcoming. The urgency of that need wasn't recognised at the time. It was described as them having a 'volatile relationship'. So the domestic abuse hadn't been looked at in that context. We only really looked at that as part of the homicide review.

RO: One of the things that we've seen from our data and research is, and it's obvious really, but that older victims will tend to have different types of complex cases, but certainly in terms of their own additional issues – disability being the main one. So as an Idva, particularly if other services are involved, then you'd need to be working alongside those other agencies for the support or safety interventions that they could provide, and that's not always been easy historically, I suppose, has it?

RN: No, but I think there's been huge movement over the last few years even – where other departments and other agencies are realising that they've got to get their act together a bit about domestic abuse, and they can't ignore it because it's such a large volume of the work that they do. So

I'm just thinking, I don't know what the figures are for our adult safeguarding queries, but I know that it's over 64% of child protection cases.

RO: So it's likely to be similar so you think for adult safeguarding?

RN: Yes, you're looking at least 50% I would have thought. So it requires us to work collaboratively together because our Idvas aren't going to be able to work out what somebody might need in order to assist them with their mobility or with their medication care. But they are going to be able to look at that alongside an occupational therapist and go, actually, we need to make sure this is safe enough to do.

RO: So is one of the outcomes, do you think, from initially the homicides and then the campaign, that there's been those better relationships? Obviously alongside the Care Act and changes there, but a better working relationship?

RN: That's definitely been one of them. Whilst it was easy to be able to monitor the uplift in referrals of young people from the Know This Isn't Love campaign, it was much harder to do that for the Know It's Not Too Late because, whilst we were targeting over 50s, actually the people who were responding to that weren't necessarily over 50.

RO: That's interesting. So you saw a change in referrals?

RN: We saw a change in referrals. So what we were looking at there, actually, was whether there was a change in the number of self-referrals and the change in the number of referrals, both to and from safeguarding. So we've seen an increase there – it wasn't as big as the one for the young people, because it was a harder thing to-

RO: Quantify, I suppose, if you can't see the number of hits on a website. So there was some change in referrals?

RN: There was some change in referrals, but as you said it wasn't quantifiable. But the biggest change has been the shift in relationship between safeguarding adults and the Idva service. And also really raising the profile of domestic abuse on the safeguarding adults' board and their agenda, and it then becoming one of the cross-cutting issues of both the adults' safeguarding board and the children's safeguarding board. [They] were asking questions about, you know, were wanting to know what kind of targets we were setting, and how we were meeting those targets in terms of addressing what was happening in terms of domestic abuse.

RO: Which is really important then for the ongoing change if that then continues in terms of looking at that. Was it a challenge, I suppose if you're an Idva or a domestic abuse worker, it's more rare for you to work with an older client. Is that then a challenge for workers on what they do and how they respond? Because I think one of the other things we have seen from our data and research are differences with staying in relationships; that older victims tend to stay in relationships and that might affect risk reduction, or what they need for their safety planning or support is slightly different from a lot of the usual stuff that Idva might do. So has that been a challenge for workers?

RN: I think there's two big challenges there. One is around when it's not actually the partner or ex-partner who is the perpetrator, but it's the child – the adult child – and they are just notoriously difficult to deal with in terms of putting in any real safe interventions that are long-lasting, because there are so many other things that are mixed up with that.

Particularly when we look at the second homicide, is that actually this was a mother who felt very responsible for her adult child who she felt wasn't receiving the right kind of support and services for their mental health, and so part of her was putting up with his behaviour towards her; his anger towards her. [Believing that] it's her fault he's like this, and part of that is internalised. And that makes it very difficult, because then when you are saying "in order to safeguard you, it would be better if you were removed from this situation," and that's not a realistic prospect. And similarly you will get that in other relationships as well, you know when you have got to those later stages of your life where you are reliant on one another, or where your accommodation choices are rather diminished – particularly if you are reliant on the state.

So therefore it is harder to work with those kind of cases, but it also forces you to be more creative about what the interventions could be, and more creative with your partner agencies about what these

could be as well. So it is not unheard of in those kind of cases whereby, actually, you're looking at putting them into two different tenancies: one into sheltered accommodation and one into their own accommodation, and you wouldn't think that that is even possible when we're looking at younger families – that wouldn't even be an option on the table that housing would consider.

RO: Well that can be such a barrier. You know I can think of cases I've worked with in the past where that's happened where, as you've said, a victim will be too concerned that if they move out the perpetrator will be homeless and obviously, if there's other issues there, that sense of responsibility will just hold them in that situation. But then negotiating that with the housing department can be quite tricky.

RN: And that's where you really need that coordinated response, and you really need your colleagues from adult social care, you need your Idvas, and you need your housing to come together. And so it's interesting because what we have seen since this campaign is a huge rise in the number of adult safeguarding meetings that the Idvas are attending.

RO: Okay, that's interesting

RN: That just wasn't happening before this. You'd go to child protection conference after child protection conference, but you'd never go to an adult safeguarding meeting, and since this there has been a huge rise in that. We either go because we are engaged with that client, or also we go as the advisor as to what is safe and what is not. We're not always working directly with the adult victim. And then it is about really thinking about where are the older generation – who might have very different ideas about what domestic abuse is, and what is acceptable, and what you should still put up with – we need to be thinking about where those people access any kind of support from, and predominantly that's going to be health.

RO: So it sounds like there would be quite a lot of health-related actions from the domestic homicide reviews – potentially for health and mental health. Is that something that has then become an ongoing task in those pathways?

RN: Yes.

RO: It sounds like the adult social care pathways are working really well, but is health still-

RN: Well yes – so we've been very fortunate with our clinical commissioning group in that there are people on the CCG board who actually get domestic abuse, which I don't necessarily think is the case across the country, and they were committed to doing things like Iris [Identification and Referral to Improve Safety] before we had the recommendations telling us that we should have them. And I went back to them at the beginning of this year to ask them to further fund the Iris project, and also the project that we have with Idvas in hospitals, and they've agreed to do that for a further two years.

RO: Fantastic.

RN: That's their commitment to domestic abuse and the reason why that was compelling is that, prior to those projects being commissioned, Camden Safety Net and Solace Women's Aid (the two organisations who have been working in Camden predominantly) had only ever received between them three referrals from any health professionals in any one year.

RO: Wow.

RN: Those projects now have been running since October 2013 and we've seen over 800 referrals from health, so the argument is rather compelling.

RO: Yeah it couldn't be more stark, could it? I mean – so those Iris and the hospital Idvas they're the kind of stuff?

RN: Yeah, so they're the conduits – having a go-to person in health seems to be really, really important. Doctors are very used to making referrals to 'ears, nose and throats' or a radiologist or what have you. But it's a completely different way of working than working with the police or social services – you know, very different? Because health has a way of working in terms of – they make a referral, they expect a letter back from their referrer to say 'we've seen this patient' etc, and that's quite different from the way an Idva works. So that's been a bit of a culture change for both the domestic violence sector in Camden and our GP surgeries as well. To kind of go – okay, let's work out what kind of communication we need

to have, what information we're going to be giving you because we've both have this whole idea of patient/client confidentiality going on – but ultimately they are making those referrals. That's not a sudden surge of 800 people who have suddenly become victims of domestic abuse. That's 800 people who weren't being recognised and identified before; who, by simply asking the question, have said "actually yes, and I would like to be referred onto services."

RO: Rachel thank you very much for your time – much appreciated, and we will put links to the campaign, and I'm sure if anyone has any other questions or anything they can come to you?

RN: I would be more than happy.

RO: Thank you very much.

RN: Thank you.