



Responding to adults at risk who need care and support and who are experiencing family violence

This position paper provides an overview of the issues associated with (mis)identifying adults at risk. The aim of this paper is to draw attention to the need to look carefully at situations where the capacity, capability and wellbeing of both the carer and the adult at risk are in question. The paper also highlights the limitations of current approaches when responding to people who need care and support and who are experiencing family violence.

This paper builds on the concept of a duty *to care*,¹ where professionals maintain the standards of their role and creative solutions are developed to respond to a person in need of additional support.

The paper is presented with a case study, drawing on different (but common) experiences to highlight problematic practice.

Like many of the cases reviewed by the Family Violence Death Review Committee, a limited response from one agency is compounded by further limitations in subsequent agency responses. To identify options for changing the trajectory of an exacerbated likelihood of violence, we provide alternate narratives that highlight the potential to effectively respond to the situations described.

The committee acknowledges the input of Sue Hobbs and Delia McKenna in developing this composite case study and highlighting common mistakes made when responding to adults at risk.

Lived experience case study

Dean is a disabled man in his mid-40s with chronic health difficulties. Dean is non-speaking and is mobile with assistance and the use of an electric wheelchair. He receives disability support services through individualised funding.² Using this funding, Dean employed a family member as his primary support person/carer.

Dean lives in the family home with his carer, who is in their 70s. His carer has experienced mental distress, physical decline and cognitive impairment, which are impacting on their decision-making about Dean's daily support.

¹ Health Quality & Safety Commission. 2022. *Seventh report: A duty to care | Pūrongo tuawhitu: Me manaaki te tangata*. URL: www.hqsc.govt.nz/resources/resource-library/fvdr-c-seventh-report.

² Individualised funding is a type of person-directed funding from Whaikaha that gives disabled people and their family and whānau more choice in how they are supported to live their lives fully. See: Whaikaha Ministry of Disabled People. *Individualised funding: what is individualised funding (IF)*. URL: www.whaikaha.govt.nz/assessments-and-funding/types-of-funding/individualised-funding.

Dean's complex support requirements enhance his vulnerability, which is compounded by a lack of access to adequate support services; in addition, his carer's coercive, controlling behaviours make his environment more unsafe.

Dean's carer has threatened that he will lose their support and have to move out of the family home if he doesn't agree with their care and support decision-making.

As a result, Dean agrees with his carer about what his support should look like. He is estranged from his younger siblings and has no support network.

An independent advocate for supported decision-making was engaged to support Dean to retain his decision-making capacity and make choices about his life and supports. However, Dean declined to engage with the advocate or the process.

When Dean's health deteriorated because of lack of effective support, he was admitted to hospital. While there, he was physically assaulted by his carer.

The assault was witnessed, and his carer was subsequently charged by police. Dean's carer was bailed to the home address to continue to provide support for Dean and was warned not to 'offer violent acts'.

No assessment was requested by the court to ascertain whether the carer's mental distress and cognitive impairment affected Dean's health, safety and wellbeing.

While in hospital, Dean agreed to a capacity assessment regarding the undue influence his carer appeared to hold over him, but he was discharged home before the assessment was completed.

The incomplete assessment did find that Dean lacked capacity to make decisions in relation to living with his carer because of the undue influence held by his carer.

Dean was already living back with his carer, who refused to allow Dean to leave the residence. Dean agreed with their decision.

Dean has now been left in this unsafe situation.

It is important to note that cultural nuances will often be required for an effective response. For example, *if Dean were Māori*, there may be an extended whānau network with which services could engage.

The whānau network may already have concerns about Dean's caregiver, they may have voiced those concerns, and those concerns may not have been heard. If so, the services working with Dean will need to rebuild trust.

If Dean were Pasifika, culturally held norms could be considered critical for identifying who could provide him additional care and support. It is important that services do not trade on this cultural capital (whereby daughters may be charged with the responsibility of providing care) but seek to strengthen and assist those who can provide additional support for Dean and his carer.

These cultural nuances aren't exclusive to Māori or Pasifika people but should be considered as part of effective service delivery for culturally diverse populations.

Identifying ‘vulnerable adults’ and responding to changes in the Crimes Act 1961

Changes introduced in 2012 to the Crimes Act 1961 (the Act) mean that certain people are legally responsible for protecting vulnerable adults from serious harm. The Act defines a vulnerable adult³ as a person who is:

unable, by reason of detention, age, sickness, mental impairment, or any other cause, to withdraw himself or herself from the care or charge of another person.⁴

People responsible for protecting vulnerable adults are:

- (a) a member of the same household as the victim; or
- (b) a person who is a staff member of any hospital, institution, or residence where the victim resides.⁵

Dean’s experience	Alternate scenario
<p>Dean could not remove himself from his caregiver’s care.</p> <p>Nobody in the services that engaged with Dean and his carer felt sure about how to progress the situation. It seemed that Dean would be punished for his carer’s actions.</p> <p>Once within the criminal court, actions were taken to understand Dean’s situation more fully. The court sought and obtained input from the hospital and Dean’s siblings. It became apparent that Dean had become increasingly isolated because of his carer and that the family were concerned about the wellbeing of both the carer and Dean.</p> <p>The court obtained further input from Dean’s social workers about Dean’s carer’s wellbeing and the need for the carer to obtain independent support. The complexity of the situation became apparent, and it was clear that a number of people held concerns that had not been captured.</p> <p>It took many months to achieve a capacity assessment and for the hospital to agree to seek direction through personal orders from the family court. No policy was available to</p>	<p>Once within the criminal court, actions were taken to understand Dean’s situation more fully. The court sought and obtained input from both the hospital and Dean’s siblings. It became apparent that Dean had become increasingly isolated because of his carer and that the family were concerned about the wellbeing of both the carer and Dean.</p> <p>The court obtained input from Dean’s social workers about the wellbeing of Dean’s carer and the need for the carer to obtain independent support. The complexity of the situation became apparent. It was clear that a number of people held concerns that had not been captured.</p> <p>The hospital and other adult-facing services (including community support services and Older Adult Mental Health Services) were aware of their joint responsibilities and – supported by legislation, guidelines and an understanding of their role in this situation – accessed a timely assessment for Dean through the health system. The process increased their confidence about bringing this situation before the family court. They worked with family members to raise concerns about the support provided by the</p>

³ ‘Vulnerable adult’ is a contested term. Throughout this paper, we use the preferred term, ‘adults at risk’. This term refers to any adult who needs care and support, is at risk of abuse and is unable to remove or protect themselves because of those needs. All three parts of this definition need to apply. A key element of the definition is that it is situational and does not apply to any specific population group.

⁴ Crimes Act 1961, Section 2(1)

⁵ Crimes Act 1961, Section 195A(2)

<p>guide processes to respond to adult abuse across the lifespan.</p> <p>No consideration was given to asking the court to require assessment of the ongoing capacity of Dean’s carer.</p>	<p>carer, seeking a supportive outcome for both Dean and his carer.</p> <p>With jurisdiction to do so, the social worker requested an assessment of the ongoing capacity of Dean’s carer. The family court recommended actions that were necessary to keep Dean safe. Recommendations were also made to support Dean’s carer to attend to their cognitive decline and the coercive behaviours used.</p>
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Protecting adults at risk requires an integrated response to adult safeguarding and family violence

Adult safeguarding is defined as ‘protecting an adult’s rights to live in safety, free from abuse and neglect’.⁶ It is an interagency approach to reporting, investigating and responding to alleged or identified family harm and other forms of abuse, neglect or harm for adults at risk.⁷

The threshold for statutory intervention is high and often does not occur until the adult at risk has been exposed to multiple risks over time.⁸ As a result, individual agencies cannot address the immediate and holistic needs of the adult and their family or whānau.

Protection for adults at risk requires a framework that supports different agencies working together. Along with elder abuse and neglect, abuse of adults aged under 65 years needs to be recognised as a form of family violence. This requires a whole-of-system response, integrating family violence responses with adult safeguarding responses. Safeguarding responses have been shown to enhance agency understanding of, and response to, adults at risk. Further, a safeguarding response can lead to improvements in the accountability of support services for maintaining the safety of adults at risk.⁹

Dean’s experience	Alternate scenario
<p>Dean had multiple admissions to hospital with critical health issues because he did not receive the physical support he needed. Without the consent of Dean or his carer to provide interventions and support, services were unsure how to assist.</p>	<p>Hospital staff knew that repeat hospital admissions could be a sign of violence or trauma at home. When there were repeat admissions for Dean, concern was raised about the need for more holistic wellbeing</p>

⁶ UK Department of Health. 2014. *Care and support statutory guidance. Issued under the Care Act 2014*. URL: www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf.

⁷ Office for Disability Issues Te Tari Mō Ngā Take Hauātanga. 2017. *Outcome 4 – rights protection and justice*. URL: www.odi.govt.nz/assets/Uploads/ODI-SIA-6-Rights-SAFA-Aug18.pdf.

⁸ The standard of care required to avoid criminal prosecution for carers is set out in s150A of the Act. It requires ‘a major departure from the standard of care expected of a reasonable person to whom that legal duty applies’. While the standard was raised to avoid prosecutions for manslaughter as a result of medical misadventure, this does not necessarily mean exposing the person in need of care and support to a number of risks. One assault is a ‘major departure from the standard of care expected’.

⁹ Appleton-Dyer S, Soupen A. 2017. *Rapid review of the Waitemata Safeguarding Adults from Abuse (SAFA) pilot: report for the Waitemata police*. URL: nzfvc.org.nz/sites/nzfvc.org.nz/files/Synergia-final-report-of-the-SAFA-Pilot-5-April-2017.pdf

	<p>support to be offered to both Dean and his carer.</p> <p>Hospital staff had also noted that Dean’s carer was becoming increasingly distressed and had noted their cognitive decline. They sought the input of community-based carers as well as legal representation to understand what was required if the carer held enduring power of attorney. There was concern that his carer was no longer adequately fulfilling that role and that the carer’s own health concerns were putting both of them at risk.</p> <p>Taking a collaborative approach, it was possible to work alongside the carer to provide the help that they needed. With the carer able to trust this approach, they were also able to understand how enabling additional support for Dean would enhance the wellbeing of both of them.</p>
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Recognising adults at risk experiencing family violence requires a skilled workforce

- The experience of psychological abuse for adults at risk, perpetrated by family members who are also their primary carers, is often not understood. Withholding aids, medication or devices that support day-to-day activities may not be recognised as abuse. A lack of accurate framing prevents people from understanding this as a form of control.
- All systems that intersect with adults, including police, health, disability and family violence sectors, need to be able to identify and respond to adults at risk.
- Highly skilled workers who understand abuse as it is experienced throughout adulthood are required to work in this field.
- Trusted, safe and skilled workers need to be able to work alongside family or whānau for as long as needed.

A lack of understanding of the nature and context of violence experienced by adults at risk prevents an effective response from individuals, agencies and systems designed to prevent and protect people from violence. It is critical to understand when adults at risk are unable to protect themselves from harm because of their need for care and support. Consideration should be given to developing services that can address:

- training for workers likely to have contact with adults at risk
- emergency safe housing
- providing specialist care, including access to communication specialists and devices
- cultural support
- specialist counselling for adults at risk traumatised by abuse or neglect.

Safeguarding adults from abuse cannot be achieved by individuals or individual agencies acting alone

Safety for adults at risk requires collective action. Agencies need to work alongside the adult and their family or whānau to provide support and services that embody a duty to care and to supplement this caring with action. A ‘safeguarding adults from abuse’ coordinated multi-agency response is required to create safety and promote wellbeing. Workforce capability is required to recognise violence, see the intersection between family violence and safeguarding adults and consider supportive actions to maximise the safety of adult victims.

Dean’s experience	Alternate scenario
<p>Dean’s carer was referred to Older Adult Mental Health Services because of their declining cognition, their coercive and aggressive behaviour and the risk they posed to Dean’s wellbeing. The carer declined to see the service. They were discharged without intervention because the risk they posed to Dean was not perceived as sufficient to meet the threshold of ‘serious harm’.</p> <p>Dean was exposed to multiple risks over time. The individualised funding process did not respond to any abuse or safety concerns in the relationship. Nobody monitored or reviewed the contract for the safety of the relationship throughout the process.</p>	<p>When Dean’s carer declined engagement, the Mental Health Service communicated directly with the criminal court and expressed concern about the lack of engagement. They were aware that charges had been laid against the carer and were concerned that lack of engagement would enhance the risk posed to Dean.</p> <p>As the court had already established links with Dean’s siblings, they sought to determine whether other family carers could support Dean. Once it was established that other temporary options for his care were available, Dean’s carer was arrested for a breach of bail because of their ongoing coercive and aggressive behaviour. Dean’s carer was again provided with an opportunity to engage with Older Adult Mental Health Services to understand their own needs.</p> <p>While Dean was initially unsettled by the change in carer, effective community support was established to ensure Dean’s sibling was able to help him through this time.</p>

Consequences of misidentifying adults at risk for experiencing family violence

Adults who rely on others for their day-to-day living entrust their support people with their lives. Safeguarding adults from abuse is everyone’s responsibility to ensure adults in need of care and support can live the life they choose free from violence, abuse and neglect. An adult with such needs becomes an adult at risk when they experience family violence or any other form of abuse and neglect. Because of their need for care and support, they are unable to remove or protect themselves from harm or the risk of further harm.

Coercive control outside of intimate partner violence is not being identified as family violence. Coercive, controlling behaviours increase a victim/survivor’s risk of vulnerability through the inadequate provision of support or when supports are withheld. Individuals, agencies and the family violence system need to recognise adults at risk and what constitutes ‘serious harm’ in situations of adult abuse. There is a current lack of understanding about how an adult’s care and support needs will limit their ability to escape violence and keep themselves safe.

The criminal and family jurisdictions of the district court may need to consider developing processes to identify and work with adults at risk. The development of mechanisms to share information between the criminal and family courts can contribute to enhanced safety for adults at risk.

When concerns arise that the mental distress and/or cognitive impairment of primary support people is impacting the health, safety and wellbeing of disabled family members, health assessment opportunities are limited. Social norms about the ability to care for family members may make carers reluctant to seek support or may result in feelings of guilt or inadequacy when seeking respite care. Inadequate services or high thresholds for service provision may reinforce these views.

The individualised funding model supports disabled people to have choice and control over how support is offered and by whom. However, it does not provide safeguards where those arrangements become unsafe.

When an adult is at risk, there will be an ongoing need for professionals and support people to be sufficiently aware of and to raise concerns where situations arise that further enhance risk (such as when an independent advocate is thought to be needed or where advocacy is declined). However, expecting individual professionals to identify and respond to concerns without a system in place for safeguarding adults from abuse can cause far-reaching harm to the adult and their families and whānau, further isolating them from appropriate support services and strategies. In situations such as that described, where an independent advocate for supported decision-making has been declined but is necessary, more creative solutions may be required to promote their human right to safety and to legal capacity. As described in the alternate scenario below, creative solutions include understanding what is driving the unsafe behaviours of caregivers and developing an appropriate response to address the behaviour while ensuring the safety of the adult at risk. Partnership between agencies is vital to ensure this is undertaken effectively.

Dean’s experience	Alternate scenario
<p>Throughout the district court process described in this case study, Dean’s carer’s cognitive decline was evident. The court did not require assessment, and no consideration was given as to the carer’s ability to provide consistent and safe support for Dean. In this situation, the family court could only make orders in respect of the care of the adult at risk.</p>	<p>Dean and his carer had a number of ‘touch points’ within the family violence system, including the hospital, police and the criminal and family jurisdiction of the district court. Dean’s high and complex needs also ensured that he had regular contact with a social worker.</p> <p>Following the assault charge, Dean’s case was brought to the local family violence safety assessment meeting. The professionals involved were able to clearly articulate a growing concern for Dean’s</p>

	<p>wellbeing. It was highlighted that Dean had declined support from an independent advocate, and further concerns were raised that his carer might have undue influence over Dean’s decision-making.</p> <p>A plan was made for the social worker to meet with Dean’s carer, with police involved. The team decided it was important that the carer was informed that there was the potential for additional criminal charges because of their chronic neglect of Dean. A difficult conversation was had that allowed the social worker and police officer to outline what would happen if the carer continued to prevent Dean from making his own choices. As a result, Dean’s carer provided an opportunity for the advocate to work alongside Dean. While it took some months, it was eventually possible to garner Dean’s trust and to develop a care plan for Dean in which he would be supported and stay safe.</p>
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