Section 7 Diversity

This section focuses on the demographical and diversity information of Domestic Abuse victims looking at national research and comparing the Sheffield service user profile to the Sheffield demographical profile.

The aim is to build a better understanding of the current service user profile, ascertain if services are accessible to victims of all demographics and understand where there may be barriers to accessing support.

Gender

Gender is a widely discussed issue. Some call domestic abuse a 'gender based crime', affecting as it affects significantly more females. This statement is based on the evidence that females are more likely: - to be a victim, experience more incidents and suffer a higher level of abuse than males.

Karen Bradley MP, Minister for Preventing Abuse, Exploitation and Crime acknowledges that domestic and sexual abuse are 'disproportionally gendered' which is why the national strategy is specifically gender based and focused on *Violence Against Women And Girls*. However Bradley acknowledges that men can also be victims of domestic abuse and that the actions of the (national) strategy will benefit all genders[1].

Female victims

The data shows that women are more likely to be victims of both domestic and sexual abuse:-

- Women (8%) are twice as likely to be a victim of domestic abuse than men (4%) in the last 12 months[2]
- Women (2.7%) are nearly four times more likely to be a victim of sexual abuse than men (0.7%) in the last 12 months

However the CSEW prevalence estimates **do not show** that there is greater variation between genders in terms of the level and extent of the abuse. Only when other research is considered does this become clearer.

- **Women are more likely to be more 'highly victimised' compared with men victims.**

Walby et al[3] (2015) considered the number of reported crimes and how this differed between men and women. The CSEW findings were reviewed for the number of reported violent crimes recorded as domestic abuse. In the survey there is a 'cap', which means that the number of individual victims does not change, but the number of crimes reported by each victim is only reviewed up to five crimes. Therefore if a victim reported 10 crimes of DA VAP in the last 12 months, only five of these crimes would be counted. Capping is not unique to the CSEW, indeed similar crime surveys are undertaken in other countries (e.g. Canada and the USA) and it is done to smooth out any anomalies and fluctuations that may occur in relation to a few individuals having a significantly high number of incidents.

The capping however hides the full extent of domestic abuse victimisation because the study found that 5% of all DA respondents are high frequency victims (6 or more incidents) and their total incidents are removed when the cap is in place. Walby et al (2015) also suggests that capping is '*gendered'* and hides the full extent of victimisation of women more than men as more women are higher frequency victims than men.

[1] VAWG 2016-2020
[2] ONS Chapter 4 Intimate personal violence and partner abuse February 2016
[3] Walby, S. Towers, J. Francis, B '*Is violent crime increasing or decreasing? A new methodology to measure repeat attacks making visible the significance of gender and domestic relations'*. British Journal of criminology (2015)

When the 'cap' was removed the research found that:-

- Violence against women by intimate partners increases by 70% and violence by acquaintances to women increases by 100%[4].
- Violent crime has in fact increased since 2009 however the capping hides this and with the cap in place violent crime shows a decline.
- Despite a reduction in the number of both female and male victims of violent crime the increase in violent crime is influenced by more high frequency female victimisation which is becoming more hidden as the cap remains in place.
- Domestic abuse is one form of violent crime, and when this is considered on its own:-
    - There is an increasing female rate of domestic abuse VAP offences against women.
    - All forms of violent crime against men have fallen with the exception of domestic abuse VAP offences against men which have stabilised.
- Therefore trends in domestic abuse related violent crime against men and women do (1) differ to other forms of violent crime and (2) differ by gender; with increasingly more DA VAP crimes reported by female victims[5] than by male victims per annum.
- The study created a rate of domestic abuse violent crime for a three year period and found that the volume of female victim crime was significantly higher than for males.
- The number of victims remains the same as that reported on the CSEW but there are higher volumes of DA related crime than is currently reported due to the cap.
- Walby writes that *'Violent crime is increasing against women, increasingly perpetrated by domestic abuse relations and decreasingly against men[6]'.*

- **Female victims are more likely to be more severely injured than male victims of DA**
    - Professor John Archer, University of Central Lancaster (cited in the Guardian, July 2012)[7] found that men were less likely to be injured or killed during a domestic assault (women were twice as likely to be).
    - The CSEW found that of those who said they had been a victim of DA in the last 12 months 23% of men and 83% of women sought medical attention

- **Females are more likely to be a victim of a domestic homicide than male victims**
    - 112 of the 176 domestic homicides in 2014/15 were female victims[8].
    - 72% of female domestic abuse victims in 2014/15 were killed by their ex or current partner compared with 29% of male victims.

Therefore it is expected that a significantly higher ratio of women to men will present to support services, than the one third of men and two thirds of females that the CSEW prevalence statistics imply: *'twice as likely to be a victim of DA in the latest 12 month period'*. So when the prevalence estimates of 7,000 male and 14,500 female victims in Sheffield per annum are quoted, proportionally **the 14,500 women are more likely** to be assessed as at high risk of domestic abuse, more likely to attend health services and more likely to seek specific domestic abuse support than the 7,000 men.

Therefore, the proportion (94.3%) and volume of women seen in Sheffield Domestic Abuse support services is significantly higher than that of males victims (5.7%) and the majority of victims in incidents reported to the police are female (86%)[9]. The female proportions here are both higher than the two thirds female to one third male ratios of victims observed in the CSEW prevalence figures. Sheffield's female to male ratios in support services and police incidents are not dissimilar to the rest

[4] Neate, P (11 June 2015) *'Domestic abuse could not be further from gender neutral. Wake up Britain'*. The Telegraph,
[5] This stop is detected no matter which unit of measurement is used. No other form of violent crimes shows a consistent trend as domestic violent crime across all units.
[6] Walby, S. Towers, J. Francis, B 'Is violent crime increasing or decreasing? A new methodology to measure repeat attacks making visible the significance of gender and domestic relations'. *British Journal of Criminology* (2015), Page 23
[7] Graham-Kevan, N 'The invisible domestic violence – against men', *The Guardian*, Tuesday 7 June 2012
[8] CSEW 2015, Appendix table 2.05a: Offences currently recorded as homicide for all victims by relationship of victim to principal suspect and sex of victim, numbers, year ending March 2005 to year ending March 2015
[9] The proportion of female victims is likely to be higher in police incidents due to some abuse being from both in the relationship. See the perpetrator section for more on the 'primary perpetrator' definition, when it is explained that even when there is violence on both sides there is usually a primary perpetrator and this is usually the male.

of the country.

Male victims

The most recent Walby et al (2015)[10] research included a review of crimes against men data. The research reveals that between 1994 and 2013/14 there has been an observed year on year reduction in violent crime against men, both of acquaintance crime against men and stranger against men crimes. However the trend is different for domestic abuse crimes against men. Until 20106/07 domestic abuse crimes against men followed this reducing trend however it has since stabilised. This same stabilising trend is observed in the three year moving average, the capped rates against crime and victim prevalence rates year by year.

Data sources provide an insight into male victims of domestic abuse. Compared to females, males are

- less likely to a victim of domestic abuse (2.7% prevalence rate compared to 7.5% of women aged 16 to 59 years old)[11]
- less likely to be the victim of higher risk domestic abuse crimes (SafeLives estimates 4 to 10% of all high risk MARAC cases will be male victims[12])
- Slightly more likely to be physically injured (29% of males said they were physically injured (e.g. cut, bruised compared to 25%[13] of women but less likely to be killed by their abuser (117 between 2012/13 and 2014/15 compared with 315 female victims[14].
- less likely to seek medical attention following an incident (27% of male victims sought medical attention following an incident compared to 73% of women)[15]
- less likely to recognise they are a victim of domestic abuse (19% men compared to 31% women)[16]
- Less likely to talk to someone about their situation (61% compared to 88% of women)[17].

The **research findings show that males can be and are victims of abuse**. Some males will be a victim of domestic homicide, some men will be high risk victims of abuse, some male victims will be accessing the same wider services that female victims are (health services) and will be reporting to the police (e.g. in Sheffield 16% of victims of domestic abuse crimes are male[18]).

An article by Ippo Panteloudakis the Men's Advice Line Helpline manager, (charity providing the national men's helpline) explains that more men are approaching their service for support a lot of men are too embarrassed, ashamed and concerned that they will not be believed and the police won't take it seriously.

Panteloudakis considers that male needs are the same as female victims – *'working with male victims is not very different to working with female victims: making it clear they are not to blame, reminding them that they have the right to a life free of violence and abuse, highlighting the effects of domestic violence on children, encouraging them to report incidents, and providing practical advice and emotional support'*[19]. This is certainly considered the approach in the VAWG strategy,

[10] Walby, S. Towers, J. Francis, B 'Is violent crime increasing or decreasing? A new methodology to measure repeat attacks making visible the significance of gender and domestic relations'. British Journal of criminology (2015), page 21
[11] Domestic abuse statistics data tool 2016
https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/domesticabuseinenglandandwalesdatatool
[12] SafeLives MARAC data
[13] Focus on: Violent Crime and Sexual Offences, year ending March 2015 - Appendix Tables, CSEW 2015,
[14] Domestic abuse statistics data tool 2016
https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/domesticabuseinenglandandwalesdatatool
[15] Focus on: Violent Crime and Sexual Offences, year ending March 2015 - Appendix Tables, CSEW 2015
[16] Ibid
[17] Ibid
[18] Please note that in this statistic there will be some male victims who are also the primary perpetrator. But there will be some male victims who are the primary victim and the sole victim in the relationship. See perpetrator section for the definition and explanation of primary perpetrator.
[19] Domestic violence happens to men too – and they must talk about it
Ippo Panteloudakis The Guardian, 12 March 2014 https://www.theguardian.com/commentisfree/2014/mar/12/domestic-violence-male-victims-embarrassment

where male victims are referred to only fleetingly, but in the context that all victim orientated actions in the strategy will benefit male victims. The ministerial foreword by Karen Bradley writes *'I recognise that men can also be victims of violence and abuse and the approach set out in this strategy will benefit all victims of these crimes*[20]*.*

However, specialist domestic abuse services have to be cautious when male victims present as some male perpetrators can and do approach services. Some perpetrators do this deliberately as part of the abuse (finding out what the victim is up to), some because they feel they are the victim (primary perpetrator scenario where the victim has used violence against the abuser but they are the main perpetrator or there is mutual violence). The Respect Toolkit provides insight into this and also provides a tool to use when assessing male service users (used by all commissioned support services).

The Sheffield response - there is specialist domestic and sexual abuse provision for male victims in Sheffield. The provision is within generic specialist domestic abuse services and available citywide and for male victims of all risk levels.

The DACT commission for 10% of the medium and standard risk provision to be for male victims. 7% of the high risk caseload and 9% of the sexual abuse caseload. These targets are with a view of increasing the cohort of males in support services throughout the duration of the three-year contract period. If the targets were achieved this would not restrict provision for females and any under capacity is used by female victims.

However, if the male caseload percentages were achieved this would mean that in a given year 128 male victims would have been on the caseload of support services in Sheffield. 128 is a small portion of the estimated 6,866 prevalence of male victims in Sheffield for the latest 12-month period however this provision is sufficient for the current demand for services from male victims.

Whilst refuge provision in Sheffield is female only, males can access temporary accommodation in order to flee from domestic abuse.

We also know that 9% of victims sharing their data with the MDS from the helpline were male[21] and that in a given quarter there are around 30 male victims in or who have received specialist abuse support.

Of male victims on the MDS in 2015/16[22] there were a total of 99 male victims engaged with support services (38 high and 56 medium and standard and the rest had no risk status listed). This was very similar to the volume in 2014/15 and similar levels were experienced in both services. Based on the information available on these victims we know that:-

- 5.7% of the total minimum dataset data were male victims in 2015/16.
- 60% were abused by their ex or current partner/ spouse
- 35% were a parent
- 40% were high risk, 41% medium risk, 18% standard risk
- 53% were physically abused
- 6.5% sexual abuse, 38% harassment, 57% jealous/controlling, 80% verbal abuse

Therefore, in 2016/17 it is expected that similar levels of male victims to those in 2014/15 and 2015/16 will seek support.

[20] VAWG 2016-2020 Ministerial foreword by the Minister for Preventing Abuse, Exploitation and Crime, page 6
[21] Helpline minimum dataset 2015/16
[22] Minimum dataset 2015/16

Action – Continue to commission male service provision at the current volume and work with providers to encourage more male victims to disclose and increase referrals into support services.

Lesbian, Gay, Bisexual and Transgender (LGBT) victims

LBGT individuals may be more likely to be a victim of domestic abuse in the last 12 months compared with the general population. Evidence is taken from a recent Freedom of Information request of the Office of National Statistics. The caveat from ONS is *'Please note that this table may not be suitable for all analytical purposes as it was produced in response to an ad hoc request on 14/06/2016'*[23].

The Freedom of information request using CSEW from 2015 and 2016 found that:-

- 8.8% to 9.3% of gay or lesbian and 12% to 15% of bisexual individuals aged 16 to 59 years olds in 2015 and 2016 are estimated to have been a victim of domestic abuse in the last 12 months compared to 6.1% of the general population.
- 29% percent of gay or lesbian and 40% of bisexual individuals aged 16 to 59 years old have been a victim of domestic abuse since the age of 16 years old.
- The information is insightful, as it gives more confidence to the data provided. In each of the years LGBT individuals were 3% of the sample reporting domestic abuse.

Additional research is quite limited but the following is also available and provides further insight, and builds on the ONS information:-

Stonewall's[24] *research shows that*

- *One in four lesbian and bi women have experienced domestic abuse in a relationship. Two thirds say the perpetrator was a woman, a third a man.*
- *Almost half (49%) of all gay and bi men have experienced at least one incident of domestic abuse from a family member or partner since the age of 16.*
- *There is limited research on how many trans people experience domestic abuse in the UK, and the best studies have small group samples. However, these figures suggest it is a significant issue. A report by The Scottish Transgender Alliance indicates that 80% of trans people had experienced emotional, sexual, or physical abuse from a partner or ex-partner.*
- Research by Henderson (2003) found in their sample that 22% of Gay and Bisexual women had *ever* experienced abuse from a same sex partner and 19% had experienced repeat abuse[25]. 29% of men reported ever having experienced abuse from a same sex partner, with 24% citing repeat abuse.
- The Respect toolkit shows that 5.9% of all callers to their Men's Advice Line helpline and from England were an LGBT male victim (Victim identified by the Respect call handler based on details given) (the majority, 5.6% were gay)[26].
- SafeLives found that of those with details on the national dataset 1.3% or 189 cases of high risk victims at MARAC identified as LBGT[27].
    - Their data finds that LBGT high risk victims are more likely to be a victim of high level

[23] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/adhocs/005900prevalenceofintimateviolenceamongadultsaged16to59bycategoryandsexualidentityofthevictimyearendingmarch2015crimesurveyforenglandandwales

[24] http://www.stonewall.org.uk/help-advice/criminal-law/domestic-violence

[25] Henderson, L (2003) Prevalence of Domestic Violence among lesbians and gay men. http://www.sigmaresearch.org.uk/files/report2003.pdf the report used a questionnaire to survey a total of 3,302 LGBT individuals. Women were consulted via community based events in 2000 via an anonymous questionnaire and returned the questionnaire on the day of being handed out. Men were consulted via the 2000 National gay Men's Sex Survey and via health promoters working with gay, Bisexual and Transgender individuals with both sources containing the same six questions.

[26] The respect Toolkit, 2013 edition, page 64 http://respect.uk.net/wp-content/themes/respect/assets/files/respect-toolkit-for-work-with-male-victims-of-dv-2nd-edition-2013.pdf.

[27] Practice briefs for IDVAs – engaging and working with lesbian, gay, bisexual and transgender (LGBT) clients http://www.safelives.org.uk/sites/default/files/resources/LGBT%20practice%20briefing%20for%20Idvas%20FINAL.pdf

sexual abuse (13%) compared to the national dataset of 8% and are more likely to be high risk victims of harassment (57% compared to the 30% in the full dataset). Physical abuse and controlling behaviour data did not show much variation.

- The dataset found that LGBT service users were more likely to have complex needs however the data is very limiting due to the size of the LBGT population in the dataset and therefore should be used with caution. (19% of LBGT high risk victims were using drugs compared to the 6% of the full dataset, 32% using alcohol compared to 11%, 49% with mental health issues compared with 29%),

The variation between research findings is highly likely to be due to the sources of the information and the relatively small sample sizes.

The estimated number of LGBT victims of domestic abuse in Sheffield

Estimating the number of LGBT victims of domestic abuse in Sheffield is complex because it is worked out using an estimated figure for the number of people who are LGBT in Sheffield. Therefore these estimations need to be used with caution.

The latest Lesbian, Gay, Bisexual and Transgender (LGBT) community report for Sheffield shows that between 27,635 and 38,689 in Sheffield are LGBT using the Stonewall estimate of between 5-7% of the population[28].

If ONS domestic abuse data[29] for lesbian and gay individuals is applied to these LGBT population estimates for Sheffield, then around 2,400 to 3,400 LGBT individuals may have been a victim of domestic abuse in the latest 12 month period.

Previous LBGT population estimations in the needs assessment have used a 6% LGBT population rate whilst SafeLives suggests a 10% rate for cities based on national research by Weeks, Heaphy and Donovan (2001) which found that LGBT people are more likely to be in bigger cities due to homophobia, isolation and discrimination[30], therefore perhaps using the higher end of this range is more appropriate for estimations of LBGT victims in the last 12 month period.

LGBT access to support services in Sheffield

SafeLives recommends a 5% LGBT client base on the MARAC caseload nationally; however the MARAC Performance results show that both nationally and locally the LGBT SafeLives recommendation is not met. For example 1% of Sheffield LGBT victims are heard at MARAC[31] which is the same as the England Average, Sheffield's most similar forces and South Yorkshire Police Force. The percentage for Sheffield has remained the same over the three year period (2013, 2014 and 2015) and the average for the other areas has also remained at the same 1% rate.

The current DACT contracts for the sexual abuse service, the high risk and medium & standard risk services all have a target that 5% of the caseload is LGBT. The previous contracts had a 1% LBGT target which were not being achieved at the start of that contract period but were at the end of the three year contract period. Year to date activity data in 2016/17 finds that 9.7% of the SRASAC caseload, 2.3% of the medium and standard risk caseload and 1.1% of the high risk caseload are LBGT, which is encouraging. This means there is more work to be done in this area to encourage more referrals of LGBT individuals into support.

[28] Sheffield Community Knowledge Profiles - Lesbian, Gay, Bisexual and Transgender (LGBT) community report (August 2015) https://www.sheffield.gov.uk/dms/scc/management/corporate-communications/documents/government-politics-admin/sheffield-profile/community-knowledge-profiles/untitled/LGBT-Community-Knowledge-Profile-2015/LGBT%20Community%20Knowledge%20Profile%202015.pdf.

[29] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/adhocs/005900prevalenceofintimateviolenceamongadultsaged16to59bycategoryandsexualidentityofthevictimyearendingmarch2015crimesurveyforenglandandwales

[30] As cited in Practice briefs for IDVAs – engaging and working with lesbian, gay, bisexual and transgender (LGBT) clients http://www.safelives.org.uk/sites/default/files/resources/LGBT%20practice%20briefing%20for%20Idvas%20FINAL.pdf

[31] SafeLives 2015/16

18% of victims on the MDS did not have their sexual orientation recorded. This is an area that requires improvement as part of the Equalities Act (2010) requirements and to ensure quality data is available for analysis purposes.

The minimum dataset contains information on service users who have reported to the domestic abuse service they are LGBT. Whilst the data is not enough to draw concrete conclusions from, we know that 25% had children (less than the 60% observed within the total caseload), that there was a more even gender split (42% were male compared to 5.7% of the total caseload), that 50% had previously received support from a specialist domestic abuse support service, that a significant number had multiple perpetrators (a higher proportion than heterosexual victims) and that the majority were not living with the perpetrator (again a higher proportion than heterosexual victims).

Action – Continue to work towards increasing the percentage of LGBT victims on the Domestic and Sexual Abuse commissioned services caseload; continue to improve the recording of LGBT information as part of the minimum dataset. Consult with LBGT victims and services working with LBGT victims and perpetrators to better understand the support needs of LGBT domestic and sexual victims. Feed this into training material in order to educate workers when working with LGBT victims.

Ethnicity

The term Black, Minority and Ethnic groups refers to all individuals who would not identify themselves as White British. The term BME is therefore a broad term and includes people from a wide range of ethnic groups, including black African, Asian, Eastern European. The term also includes individuals who are migrants and immigrants to the UK.

The Domestic Homicide Review H had an action to review whether there were any barriers to BME victims of domestic abuse accessing support services.

The Census data of 2011 reveals that 17% of individuals aged between 16-59 years old in Sheffield are of black or minority ethnicity (BME) and 83% of individuals are of white British ethnicity.

One would expect there to be a slightly higher proportion of BME individuals being referred and engaging with support compared with the BME proportion in the general population but not necessarily to a large degree of difference. The reason is because the 2016 CSEW suggests some ethnicities have a higher likelihood of being a victim of domestic abuse than others. Prevalence rates for BME individuals are higher for those individuals of a mixed/multiple ethnicity (14.3% compared with the average of 8.2% for all ethnicities). However the CSEW also suggests that some ethnicities have a lower rate of domestic abuse than the average, (e.g. Asian/ Asian British (2.8%) which includes Indian (2.8%), Pakistani (4.8%) and Chinese ethnicities (0.7%), see the column to the right on Table below.

<u>Engage with support</u>

In 2015/16 the proportion of BME service users receiving either high risk or medium and standard risk structured support was 24% which is higher than the 17% in the Sheffield population (for the age group 16 to 59 year olds[32]. This would suggest that an appropriate proportion of BME individuals are accessing support. See table below.

[32] PMF data from Action and DAOS in 2015/16 for high risk and medium and standards risk services.

Ethnic Group	Ethnicity	% of high risk service users by ethnicity	% of medium & standard risk service users by ethnicity	Total DA service users by ethnicity	Sheffield ethnicity - all age groups. Census 2011	CSEW CSEW - estimated prevalence for the ethnic group for females	CSEW 2016 - estimated prevalence for the ethnicity for females
	White British	75%	77%	76%	80.8%		8.90%
	White Irish	0%	0%	0%	0.5%		8.90%
White	White Other	2%	1%	2%	2.4%	8.60%	
	Asian or Asian British (Bangladeshi)	1%	1%	1%	0.6%		
	Asian or Asian British (Indian)	0%	3%	1%	1.1%		2.80%
Asian/ Asian British	Asian or Asian British (Pakistani)	7%	6%	6%	4.0%		4.80%
	Asian (Other)	3%	2%	2%	2.30%	2.80%	
	Black of Black British (African)	3%	2%	2%	2.1%		7.50%
	Black or Black British (Caribbean)	3%	1%	2%	1.0%		8.30%
Black/ Black British	Black (Other)	1%	3%	2%	0.5%	7.80%	
	Mixed White and Black African	0%	0%	0%	0.2%		14.30%
	Mixed White and Black Caribbean	2%	1%	1%	1.0%		
	Mixed White and Asian	0%	1%	1%	0.6%		
Mixed/ Multiple Ethnic Groups	Mixed Other	0%	1%	0%	0.6%	14.30%	
Other Ethnic Group	Other Ethnic Background	2%	3%	3%	2.2%	6.40%	
Source - High risk and Medium & Standard risk services, Action PMF and DAOS PMF. Source - CSEW 2016 Source - 2011 Census data, Sheffield City Council							

The table shows:-

- That there are marginally lower proportions of white British service users in support, compared with the 80% of the total population group and the 83% of the 16 to 59 year old age group.
- Service engagement and individual risk level does not appear to prevent access to support based on ethnicity. For example 75% of all high risk service users were White British which is similar to the 77% of medium and standard services users and the 76% overall in commissioned support services.
- Of the BME ethnicities;-
    - There is a slightly higher proportion of Asian or Asian British in support compared to the percentage of this ethnicity in the total Sheffield population (4%),
    - There is a greater proportion of Black (Other) in support – 2% compared with the 0.5% of this group in the Sheffield population. This is also encouraging because the Black/ British group has a prevalence rate similar to the 8.4% average observed nationally.

Therefore the access to support services by BME communities is encouraging and does not appear to show any barriers to accessing support services for any community (based on the ONS ethnic groupings).

Helpline contacts

28.5%[33] of helpline contacts who gave consent to use their data were BME, which suggests the helpline is accessible to BME individuals.

Sheffield BME Activity

- 19% of all cases going to MARAC in 2015/16 had a BME victim[34] which is higher than the 10% recommendation by SafeLives, and higher than the 17% BME population group for those aged 16 to 59 years old. Sheffield is also higher than the national average of 15% and higher than the 11% Most Similar Force average and the average for South Yorkshire Police Force. This suggests BME is not a barrier to high risk domestic abuse being identified in Sheffield.

Table – MARAC BME data for Sheffield compared to the national figure, the most similar force,

[33] Helpline dataset.

[34] SafeLives report activity for the 12 months 2015/16 for cases seen at MARAC

SafeLives recommendation and SY police force – 2015/16.

Indicator	National figure	Most similar force group	SafeLives recommends	Police force	Sheffield
BME	15.00%	11.00%	0.10%	12.00%	19.00%

- South Yorkshire Police incident data in 2013/14 found that the ethnicity of victims in crimes flagged as domestic abuse were White: 82%, Asian: 8.4%, Black: 7%, SE Asian: 0.5%, Middle Eastern: 0.9% and 1% south European[35].

- Refuges - 47% of the total refuge population during 2015/16 were BME women, compared to the 53% white British, see the table below[36]. Thus showing that refuges work with a significantly higher proportion of women who are BME than the commissioned high risk and medium and standard risk domestic abuse support services. This suggests BME women have a greater need for refuge than White British women if they are a victim of domestic abuse.

2015/16 Floating support and Refuge data	% floating support	% refuge	% total
Asian or Asian British: Bangladeshi	1%	1%	1%
Asian or Asian British: Indian	1%	2%	1%
Asian or Asian British: Other Asian Background	2%	3%	2%
Asian or Asian British: Pakistani	12%	11%	11%
Black or Black British: African	7%	5%	6%
Black or Black British: Any Other Black Background	1%	0%	1%
Black or Black British: Caribbean	1%	2%	1%
Gypsy, Romany, Irish Traveller	0%	1%	0%
Mixed Other	1%	0%	0%
Mixed: Any Other Mixed Background	1%	1%	1%
Mixed: White & Black African	1%	0%	0%
Mixed: White & Black Carribean	1%	1%	1%
Not Stated	6%	13%	10%
Other Ethnic Origin: Chinese	1%	0%	0%
Other Ethnic Origin: Other Groups	2%	4%	3%
White British	61%	53%	57%
White Irish	1%	1%	1%
White: Any other white background	2%	3%	3%
Source - Housing Independence Service, Sheffield City Council			

- Floating support – 39% of the total floating support services caseload were BME women during 2015/16 compared to the 61% who were White British, see the table above. Thus showing that the floating services work with a significantly higher proportion of women who are BME than the commissioned high risk and medium and standard risk domestic abuse support services. This suggests BME women have a greater need for floating support services than White British women if they are a victim of domestic abuse.

<u>Referrals into the medium and standard risk support service</u>

More detailed research was completed into referrals into the medium and standard risk service and what the outcome was following referral based on ethnicity. It was found that there are little differences in the outcome following referral, see the table below.

<u>Positive outcomes following referral into medium and standard risk service</u>

- Both ethnicity groups had similar percentage who had completed support (29% BME compared with 25% White British).
- BME referrals appear to have a greater likelihood of a positive or a neutral outcome following referral compared to White British referrals:-.
    - For example of the positive outcomes (currently in support, completed support, in YANA group) a total of 43% BME referrals have a positive outcome and 10% a neutral outcome (referred to IDVAs, waiting for Power to Change programme and moved), or 52% overall.

[35] South Police data, Lisa Street, Police Analyst 2015 report.
[36] Data from HIS team, Lucy Hagan and Beatrice Maloni

- This is higher than the 34% White British referrals with a positive outcome and 9% with a neutral outcome, or 43% overall.

Of the total referrals into service the number who have…		Of the total BME referrals, the percentage for each referral outcome	Of the total White British referrals, the percentage for each referral outcome
Positive outcomes	Completed Support	29%	25%
	Currently in Support	12%	9%
	YANA Only	2%	0%
Neutral outcomes	Under 18, IDVA referral	5%	3%
	Waiting for Power to Change	0%	5%
	Moved	5%	1%
Negative outcomes	Unable to contact	5%	8%
	Disengaged	7%	12%
	No longer wanting support	17%	17%
	No response for PTC	19%	20%
Source - Action, Standard and medium risk service			

Negative Outcomes following referral into medium and standard risk service

- Of the negative outcomes (no response for Power to Change, no longer wanting support, disengaged with the service and unable to contact) a total of 47.6% BME referrals had a negative outcome compared to 57.1% of White British referrals.
- 12% of White British services users disengaged compared to the lower 7% of BME service users.

This data shows:-

- That there are very few differences in outcomes between the engagements of BME referrals compared to White British referrals in the medium and standard risk support service.
- The main differences are found in the positive and neutral outcomes, where BME referrals are more likely to have a positive outcome following referral.

Therefore the support and response provided by the medium and standard service appears to be appropriate for BME individuals.

Refused service

When a report on the minimum dataset for domestic abuse was undertaken, there was a specific field for service users who refuse support following referral. These are often referrals for high risk victims (who as per the high risk process do not have to consent to a referral being made) or referrals between IDVAS and the medium and standard service, where the service user then declines further support.

Of the 120 service users who refused a service in 2015/16[37], 65% were White British and 35% BME, which would suggest that if you are BME you are more likely to reject support.

A more detailed look was taken into the risk level and the form of domestic abuse that White British and BME service users were a victim of to ascertain whether the abuse of those accessing support services differed based on ethnicity. It was found there was little difference in risk level, and that the forms and severity of the abuse was slightly different, but this was not conclusive, as some forms were more likely to be experienced by White British service users than BME service users and other forms more likely to be experienced by BME service users than White British service users.

This is outlined in more detail below: -

The risk level at the start of support (Intake form)

[37] Domestic abuse Minimum dataset for 2015/16

There is little difference in the risk level at the start of support, with 49% assessed as high risk, which was the same for both BME and white British individuals. The difference was slightly more pronounced for those assessed as medium and standard, with a slightly higher proportion of BME individuals assessed as standard (14%) compared with White British (10%).

Risk level of BME service users – at the end of support

Of the service users who remain in support and have the exit form completed, there is no difference between the risk levels at exit for BME compared to White British individuals.

High risk at intake and risk level at exit

For those who are high risk at intake and exit support we again find that ethnicity does not appear to be a factor in risk level at exit. For example 29% of BME service users exiting remain at high risk and 70% are regarded as medium risk which is similar to the 26% regarded as high risk that are of White British ethnicity and 69% medium risk and 3.2% standard risk.

Current and historic abuse[38]

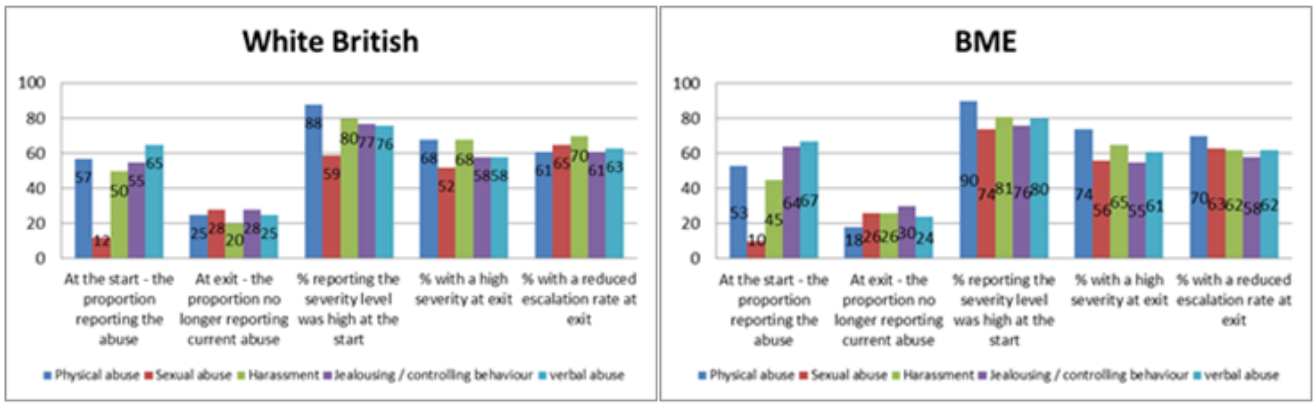
There are some differences observed when historic and current abuse is considered. The total cohort reporting current and historic abuse is seven percentage points higher for BME service users at 28% of BME cases compared with 21% of white British cases.

Current abuse

When the five different forms of **current abuse** are observed physical, sexual, harassment, and verbal abuse these are at similar levels (within five percentage points) with the exception of jealous & controlling behaviour which is higher by nine percentage points for BME individuals.

Severity of the abuse at intake

For four forms of abuse (physical, harassment, verbal abuse and jealous & controlling behaviour the level of severity is within 2-4 percentage points and therefore little different between ethnic groups; e.g. BME high severity for physical violence was 90% and 88% for White British. There is however a difference for sexual abuse, with BME individuals more likely to report a high severity of sexual abuse than White British individuals.



Historic abuse & sexual abuse severity

When the level of severity and historical abuse is also factored in there are some noticeable differences observed for sexual abuse. Those who are BME report a higher severity of abuse, with 74% of those reporting current abuse also reporting the abuse as highly severe compared with 59% of White British, a difference of 15 percentage points.

Current abuse at exit

The proportions reporting current abuse at exit compared to the start of support does reduce for all five abuse types; however the level of change varies by abuse type and by ethnicity.

[38] Minimum dataset Intake and exit form 2015/16

It is found that for each abuse type the percentage who no longer reports that form of abuse is between 20% and 28% for White British individuals and for BME between 18% and 30%.

There is no significant difference between the proportions no longer reporting sexual (26% BME and 28% WB), jealous / controlling (30% BME and 28% WB) and verbal abuse (24% BME and 25% WB) at exit but there is for physical and harassment abuse:-.

- 18% of BME service users report they are no longer being a victim of physical abuse compared with 25% of White British service users.
- The opposite applies for harassment with only 20% of White British individuals stating they are no longer on the end of harassment abuse compared to the higher percentage of 26% or one in four BME service users.

Escalation of abuse

The proportion of individuals reporting a reduction in the escalation of abuse during the time in support did not differ for three of the five forms of abuse by ethnicity; for example sexual (65% WB to 63% BME reported a reduction in the escalation of abuse respectively), jealous / controlling (61% WB to 58% BME reduction) and verbal abuse (63% WB to 62% BME reduction) however for physical abuse and harassment there are differences based on ethnicity.
The proportion reporting a reduction in physical abuse escalation was 61% for WB which is nine percentage points lower than the 70% observed for BME services users.

The opposite is observed for harassment, 70% of WB reported a reduction in escalation compared with 62% BME.

Therefore:-

There are a number of similar observations made between risk level at the start and end, and abuse types experienced at the start and end, however regarding severity and escalation rate for the five forms of abuse there are some differences between BME and WB service users. There appears to be no difference in ethnicity groups for referrals, engagement and overall outcomes.

The differences are as follows: - At the start of support a higher proportion of BME services users are likely to report sexual abuse (current or historic) than WB service users, BME service users are more likely to report a higher level of severity of sexual abuse than WB service users and they are more likely to report current jealousy & controlling behaviour. However they are less likely to report harassment compared with WB service users.

This means support services have to address current and historic sexual abuse in proportionally more BME cases than WB cases e.g. the proportion who reported current sexual abuse at the start is similar for all ethnicities but has a higher severity rating for BME. But it appears that that the support received is effective because at exits both ethnicities report a similar reduction in the proportion who reports a high escalation rate (63% compared to 65% WB).

Further work is currently being undertaken to gauge feedback from BME service users with specific reference to how services are accessible to BME individuals and what barriers there might be in support. This will be extremely useful, as the data here has been taken from those referred or who have accessed support which shows that when a referral is made and support is accessed there is very little difference in outcome compared to those who are of White British Ethnicity.

Action – Review with support services why there might be a higher proportion of people from a BME background who refuse domestic abuse support and complete the consultation with BME individuals to understand if there are any barriers to accessing domestic abuse support services.

Language and Interpretation services

Local experts have stated that *'no one is refused an interpretation service'* which is reassuring and

encouraging that all victims are supported in their own language, if the need is presented. However specific feedback from the specialist BAMER service, Ashiana has revealed *that 'interpreting is a major barrier for women accessing the right support'.*

DACT contracts specifically state that interpretation services are part of the offer to victims accessing their support service *'Where the Client's first language is not English, the Provider will be responsible for booking and arranging interpreting services through a recognised provider. Family members or friends of the client are not to be considered acceptable substitutes for interpreters'.*

The MDS[39] shows that in 2015/16 a total of 128 victims required interpretation services in the following languages Arabic, Bengali, Chinese (Mandarin), Farsi, French, Mirpuri, Other (the highest volume), Polish, Punjabi, Somali and Urdu. This was a similar volume to that experienced in 2014[40] (129 victims) and the same languages with similar volumes apart from one additional language in 2014.

Local experts across a number of organisations (not just those commissioned, and particularly within the voluntary sector), raised a few challenges that working with individuals who require an interpreter bring to their services. These included the availability of female interpreters to meet the demand in some languages, a need in some situations for the interpreter to be female (often due to cultural reasons), with Ashiana specifically stating a need for a female interpreter for all female victims of sexual abuse.

Interpretation was again raised by local experts in the Provider Consultation Group in May 2017 which acted as a final consultation to the needs assessment and initial strategy discussions. Specific feedback following the meeting and provided by Ashiana highlights the interpretation challenges discussed. They included the need for:-

1. *'Interpreters to have an awareness/training in abuse & trauma and more specific sensitive issues around FGM, HBV, FM.*
2. *Interpreters to have access to counselling/support (as they are hearing and interpreting another's often traumatic personal situation).*
3. (A pool of) *suitably qualified people to meet the communication, interpretation and translation requirements of the client.*
4. *Interpreters to have a strict application of confidentiality rules.*
5. *Ensuring translators, interpreters and the individual are clear about legal and work setting requirements for the use of translation and interpretation services.*
6. *To be aware that the interpreter is not a family member, friend or from the local community*
7. *Female interpreters to interpret for females especially around sexual abuse.*
8. *Views, religion & advice of the interpreter are not relayed to the client including own background, experiences and beliefs that may have an impact on your practice and client*
9. *Non Befriending of interpreter to client.*
10. *A review with the individual and key people to the contribution that the interpreting and translation services have made to the individual's communication and wellbeing.*
11. *To ensure that the right language is also the right dialect. This can be extremely complex. The example given was that Arabic speaking countries don't all share the same dialect and in some instances some mutually understandable ways of speaking, which one might think of as "dialects" of one language, are actually treated as separate languages. At the same time, some mutually incomprehensible tongues an outsider might view as separate "languages" are thought of locally as dialects[41]'.* This means that for a victim who speaks Arabic, there is a need to know the correct dialect also and not just the country of origin, to ensure the Arabic interpreter can

[39] Minimum dataset 2015/16
[40] Minimum dataset 2014
[41] The example provided by Ashiana included a list of Arabic speaking countries in Asia (Middle East) cited from the http://www.nationsonline.org/oneworld/ website. The Arabic countries cited by Ashiana were Bahrain, Jordan, Oman, Saudi Arabia, Yemen, Iraq, Kuwait, and Palestinian territories, Syria, Israel, Lebanon, Qatar and the United Arab Emirates. Arabic is also the official language in Algeria, Bahrain, Comoros, Chad, Djibouti, Egypt, Eritrea, Iraq, Israel, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, United Arab Emirates, Yemen, Palestine, and Western Sahara.

speak and understand the Arabic dialect of the victim.

In addition a number of local experts suggested an increasing need / demand for interpretation services, which is not presenting in the MDS data but may be evident in the wider support services. An increasing demand could be viewed as a positive outcome as it suggests more people without English as a first language are accessing or presenting at wider support services. This is encouraging as it suggests that awareness of services amongst professionals working with / victims in some 'hidden' communities are increasingly aware of support services. However the converse to this (and also raised by local experts at consultation) means the support services have increasing interpretation costs.

Considerable work has been undertaken since August 2015, as interpretation services featured in a number of actions from DHR H. All the below are the actions in DHR H about interpretation services and the need to embed processes when using interpretation, and training the interpreter on safeguarding and domestic abuse.

- The Lead GP for Safeguarding Adults recommends that when using an interpreter, this should be documented in the patient's GP notes by the member of staff using the interpreter.
- Recommendation for all practices that information about domestic abuse should be displayed in the local languages of prevalent populations attending GP Practices if resources are available.
- The issue of interpreters is not exclusive to Sheffield. However those who commission interpreters within the Sheffield area, and were part of this review, need to be alerted to the issues that have emerged. Commissioners should ensure that interpreters are trained and educated in respect of the vulnerability of victims and the domestic abuse risk factors they may be exposed to. A new contract for Translation & Interpreting Service was commissioned by SCC jointly with CCG and STH. It was agreed to include in the specification that interpreters are trained and educated in respect of the vulnerability of victims and the domestic abuse risk factors they may be exposed to.
- Safeguarding training for interpreters is also to be a focus in the CCG, the Children's Foundation Trust and Sheffield Teaching Hospitals.
- New national process in the Probation Service for booking an interpreter

All these DHR actions have now been completed.

The ongoing discussion about interpretation suggests that more can be done to address these issues, and there is a need to ensure the commissioned SCC interpretation service is aware of the issues raised.

Action - There is a continued need to ensure commissioned support is available in all languages and dialects used by service users, there is a need to work with the commissioner of the SCC interpretation service to advise on the interpretation needs of victims and how interpreters could be trained and equipped when working with victims and there is a need to ensure support services have the funds to continue to meet the increasing demand.

Domestic abuse victims who have 'no recourse to public funds'

A number of domestic abuse victims have *'no recourse to public funds'*[42]. Victims may only be entitled to be in the UK because of their relationship with a British citizen or someone settled in the UK or they may have entered the UK on a visa (such as a student or visitor's visa) that has expired. This means that the victim has no '*access to benefits or services as British citizens'* would.

'*However, the government is aware of the difficulties victims of domestic violence face, in particular those who can't access public funds. Because of this, the government provides help to these victims who have been admitted to the UK with leave as spouses, unmarried partners or civil partners of a*

[42] https://www.gov.uk/guidance/domestic-violence-and-abuse

British citizen, or of a non-citizen who is settled in the UK. This allows domestic violence victims to apply for indefinite leave to remain in their own right, if they have been victims of domestic violence'.

Sheffield response - the community based services commissioned services, are contractually bound to *'offer support to people with no recourse to public funds or who are excluded from benefits and services for reasons of immigration status'*. The refuges can offer support to women with No Recourse if they are eligible to receive the Destitution Domestic Violence Concession – 26 victims in 2015/16.

Services need to have trained staff to work with these individuals including the area of accessing immigration support , language needs, advocacy and onward referral to the most appropriate support (to meet wider needs). This includes working with the victim to apply to the Destitution Domestic Violence Concession (a fund set aside for domestic abuse victims who are NRPF individuals if they have come into the country on a family of a settled person visa).

The medium and standard risk services are contracted to fundraise to establish a charitable fund to enable them to offer financial support to NRPF victims when other funding/benefits are unavailable. *The provider will be expected to use reasonable endeavours to obtain voluntary contributions in order for this service to be provided. The provider will establish criteria for access to funds that will be agreed with the purchaser. The purchaser will however limit the liability of the provider to the extent that if the provider receives an appropriate level of external funds they will then be expected to provide the service.*

The issue was raised by local experts that there *'can be a lot of problems when trying to support someone who has no recourse to public funding'* which is primarily as a result of the national legal and policy framework for people in this situation.

Religion

The DACT contract with commissioned providers states the following *'the service will ensure that it is accessible to people of all religions or none. The service will ensure that all clients are asked about religion / belief and that this information is recorded for monitoring purposes'*.

Religion can be of significance for some victims presenting at support services, for example beliefs can influence a victim's response to domestic abuse e.g. domestic abuse is accepted and perceived as a cultural norm although no religion condones domestic abuse. This can impact on whether an individual will accept support, and/ or their interpretation of their own situation therefore support services need to factor religion into their response.

Data on religion in the MDS is more complete than it was a few years ago, with 58% of service user's having this field recorded. But there remain a significant number of people (42%) who do not have their religious status recorded. Improvements are still required as recording this information is part of the Equality Act (2010)[43] data collection requirements.

The majority of victims with a status recorded were of no religion or atheist (53%[44] which is higher than the 33% on the 2011 Census for Sheffield[45]), 21% were Christian/ C of E (which is much lower than the Census 56%), 17% were Muslim which was much higher than the 8% on the Census data and other religions included; Catholic (5%), Buddhist, Hindu, Sikh and Other. Similar percentages were also observed in 2014[46].

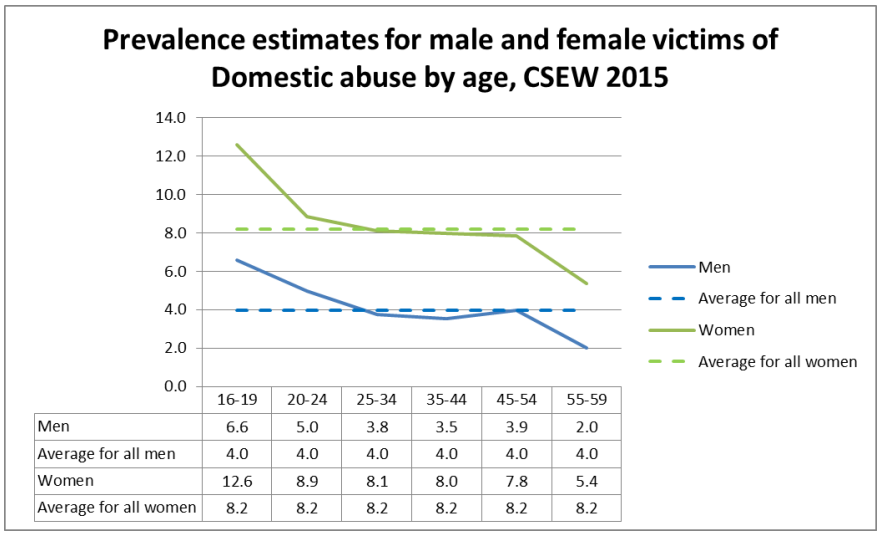
Action – Continue to increase the proportion of victims who have their religious status recorded in the MDS

[43] The Equality Act (2010) http://www.legislation.gov.uk/ukpga/2010/15/contents
[44] Minimum dataset 2015/16
[45] Religion Census Wards 2011
[46] Minimum dataset 2014

Age of victims

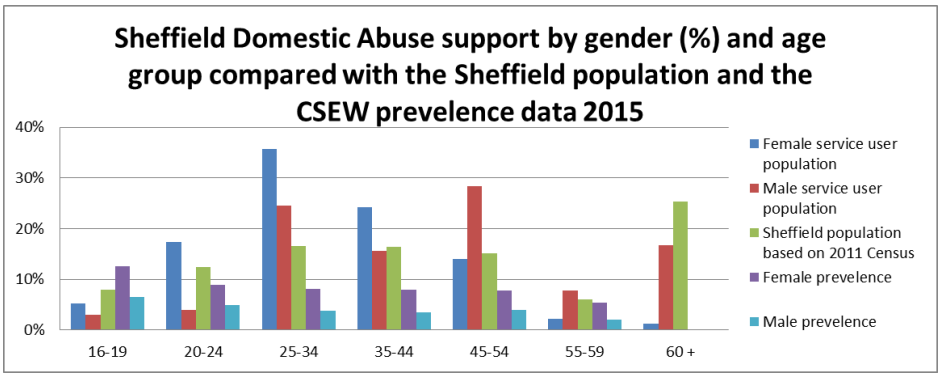
- For details of young people's domestic abuse prevalence and young people accessing support see Part 3 of the needs assessment, Children and Young People.

Age difference impacts on estimated prevalence rate - The CSEW 2015 prevalence estimates suggests that between the ages of 25-45 there is a similar prevalence rate regardless of age (prevalence is between 7.8% and 8.1% for females and 3.5% to 3.9% for men). The prevalence rates do show that there is a higher prevalence rate for young victims (see Young People Section, but data shown in the graph below) and a lower prevalence rate for older victims, those aged 55 years to 59 years old, with a rate of 2% for males and 5.6% for females in a 12 month period.



	16-19	20-24	25-34	35-44	45-54	55-59
Men	6.6	5.0	3.8	3.5	3.9	2.0
Average for all men	4.0	4.0	4.0	4.0	4.0	4.0
Women	12.6	8.9	8.1	8.0	7.8	5.4
Average for all women	8.2	8.2	8.2	8.2	8.2	8.2

Age impacts on the likelihood of accessing support services – The graph and table below shows the proportion of the Sheffield population in each age category and the estimated prevalence for females and male of experiencing domestic abuse in the last 12 month period. The graph also shows the proportion of the total service user population by gender in each category. The graph suggests there are less young people presenting for support compared to their estimated prevalence figure for both male and females proportions and less older (particularly female) victims presenting for support compared to the proportion of residents in Sheffield in the over 60 years age group.



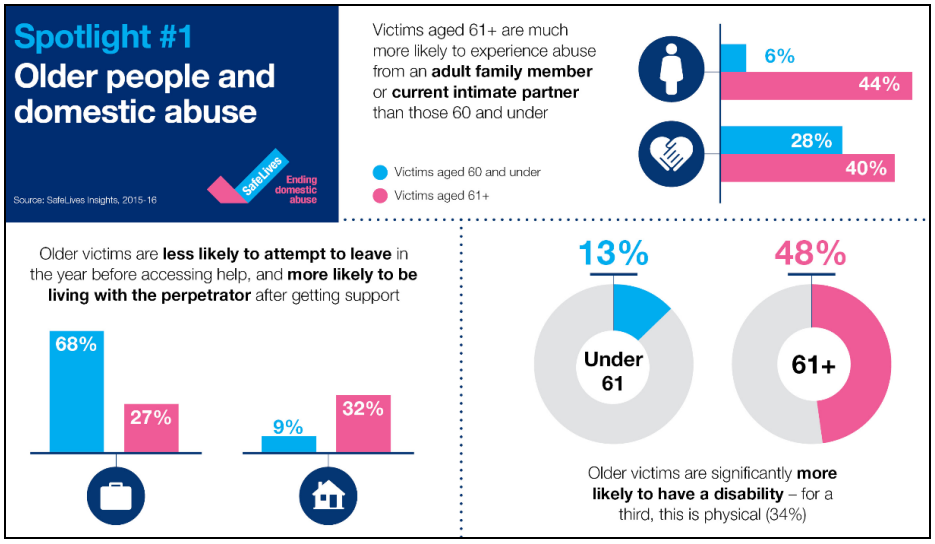
Older victims – aged 60 years or older

There no prevalence data from the CSEW for victims aged 60 years or higher but local service activity data shows that victims aged 60 and older are accessing support services, although as alluded to above, there is a suggestion that there ought to be more older female victims presenting

for support. For example the minimum dataset shows that in 2015/16[47] 1% of all females accessing support were aged 60 or older and 17% of all male service users were in this age group, whilst the most recent 2016/17 PMF data[48] shows that 4.7% of all those in structured support are aged 60 years plus. Both these percentages are low given that the 60 plus age group equates to 25% of the 16 and over Sheffield population and the prevalence estimates for the age group are lower than this (the 5% female and 2% male for those aged 55 to 59 years[49]).

	Female service user population	Male service user population	Sheffield population based on 2011 Census	Female prevelence	Male prevelence
16-19	5%	3%	8%	13%	7%
20-24	17%	4%	12%	9%	5%
25-34	36%	25%	17%	8%	4%
35-44	24%	16%	16%	8%	4%
45-54	14%	28%	15%	8%	4%
55-59	2%	8%	6%	5%	2%
60 +	1%	17%	25%	No data	No data

Differences observed between older victims accessing support compared with the total supported - SafeLives[50] have competed research into older people accessing support and have found that older people live with abuse for longer before accessing support, they are more likely to be abused by a family member than a spouse or ex, they are less likely to attempt to leave the household in the year leading up to accessing support, are more likely to be living with the perpetrator and they are more likely to have a disability. The graph below shows the data is pictorial form.



A further risk for older victims is perpetrators who are returning to live with parents – South Yorkshire CRC[51] have raised the issue of perpetrators being given bail conditions and licence conditions that mean they cannot return to the home they share with the victim. Often the perpetrator has not lived with their parent's for a long time. For some, the perpetrator who has been violent towards an intimate partner then becomes abusive to their parents, as tension in the household builds. It was explained that often the parents are older (if the perpetrator is late 30's these victims are likely to be aged 60 plus).

[47] Sheffield minimum dataset
[48] PMF for Q1 and Q2 Action high risk and medium and standard risk contracts.
[49] The theory goes that, the prevalence rates for those aged over 60 years would be similar to that of those in the age category below this one, which is lower than the citywide average for all ages.
[50] http://www.safelives.org.uk/node/861
[51] Michael Perch, South Yorkshire CRC, in attendance at the PCG in May 2017

A snap shot of older people compared to those aged 59 years old or younger has been completed using the minimum dataset and similar findings were observed to the SafeLives research.

Of the service users aged 60 years or older in support services the following differences to the total cohort were found:-

- There are a higher number of male victims – 57% female and 43% male.
    - The relationship to the perpetrator is different and is more likely to be an adult daughter or son, or step son (in 46% of cases compared the 4% of the total cohort) compared to the spouse or ex-spouse.
    - Where the perpetrator is the partner/spouse, older people are more likely to classify them as a current spouse/ partner (32%) than their ex (12%) compared to 25% current and 65% ex-spouse or partner for the total cohort.
- The victim is more likely to be living with the perpetrator (52% compared to the 23% of the total cohort).
- In 50% of older people's cases where the perpetrator is an adult son or daughter they are also living with the victim.
- The victim is more likely to have a disability (72% compared to 56% for the younger cohort)
- They are less likely to have a drug misuse problem but just as likely to have an alcohol problem
- The type of abuse reported appears to differ. For example older victims are slightly more likely to report physical abuse (56% compared with 51% of those who are 59 years or less) and verbal abuse (83% compared to 75%). Older victims are significantly less likely to report sexual abuse (either current or historic) and harassment (28% compared to 53%) and slightly less likely to report jealous / controlling behaviour (50% compared to 63% of those aged 59 years or less.
- They are just as likely to be high risk as those aged between 25 years and 59 years old[52]. The average for this group was 40% high risk and for the older age group it was 41%. The 55 to 59 age group has the lowest proportion of high risk cases, with 28% of all cases for this age group.
- Two of the eight domestic homicide reviews in Sheffield had an older victim.
- No victim aged 60 or older entered the women's refuges in 2015/16.

The 'hidden' older cohort

Older people experiencing domestic and sexual abuse are likely to be 'hidden' and less likely to be voluntarily accessing support services or disclosing abuse. A recent SafeLives report[53][54][55] on older people and domestic abuse suggested that some of the reasons why older victims may not present or disclose were as follows:-

- *Embarrassment, lack of awareness about services and options, they may also have less experience of 'self-help' models or disclosing personal circumstances to a stranger[56].*
- *Victims may be more reluctant to engage with services due to their age, as they may see services as being for younger people*
- *Health issues may mean they can't physically access support, or the health issues of the perpetrator may mean there is additional pressure to remain in the relationship and in the home*
- *There may be a cultural misconception by professionals that older victims do not experience these issues*
- *Hospitals and care settings may have a lack of awareness of the dynamics of domestic abuse within older people's relationships*
- *Older people are less likely to report to the police*
- *They may be isolated, or in the position of being the perpetrator's carer, or cared for by the perpetrator,*

[52] Action PMF for Q1 and Q2 2016/17 for the high and the medium & standard risk services
[53] Guidance for MARACs Hidden victims: older people http://www.safelives.org.uk/node/861
[54] *Association of Directors of Adult Social Services (Adass) guidance as cited on the SafeLives article What 'Domestic Homicide Reviews tell us about the abuse of older people' http://www.safelives.org.uk/practice_blog/what-domestic-homicide-reviews-tell-us-about-abuse-older-people*
[55] http://www.safelives.org.uk/practice_blog/older-people-and-domestic-abuse-completing-jigsaw
[56] *Association of Directors of Adult Social Services (Adass) guidance as cited on the SafeLives article What 'Domestic Homicide Reviews tell us about the abuse of older people' http://www.safelives.org.uk/practice_blog/what-domestic-homicide-reviews-tell-us-about-abuse-older-people*

- *The perpetrator may have financial control, Power of attorney, joint house ownership or have lived in the same house for a long period of time*

The SafeLives report finds that older victims in cases going to MARAC are likely to focus on different issues than those found in younger cases and therefore recommends that Adult Social Care becomes a standing core member of MARAC. Here in Sheffield Adult Social Care are part of the weekly circulation list for all cases going to MARAC and attend when cases include victims on their caseload. Children's Social Care Services always attend, and should the need arise can and do access the case management system.

It has been observed by the MARAC Chairs that in MARAC cases where the victim is elderly and being cared for, there are different needs to those who are not as dependent on services. The SafeLives report provides a MARAC check list of actions that may need to be considered in such cases and it is recommended that this list is reviewed by the MARAC Chairs, Adult Social Care and other Core MARAC attenders.

Action – The SafeLives report provides a MARACs check list of actions they may need to be considered in older person's cases. It is recommended that this list is reviewed by the MARAC Chairs, Adult Social Care and other Core MARAC attenders.

Action – The SafeLives report recommends that Adult Social Care are considered core members of MARAC and therefore should attend for the whole meeting. Adult Social Care to consider this finding.

The high risk and medium risk services are commissioned to provide domestic abuse support to clients of all ages and given that 4.7% of those accessing support are aged above 60 years old, then it appears the services are in a position to respond to the needs of those aged 60 and over. The services do not have age related targets in place for older people and therefore is perhaps an avenue to be explored, to give this area some focus.

There are a number of additional support services in Sheffield that work with younger victims and victims of any age, however there are no known services with specific focus on domestic abuse and older victims and no current plans for development in this area.

There are no known protocols produced by DACT or Adult Social Care that discuss identification, working with and referrals of older victims into domestic abuse support services.

The SafeLives report recommends the following for commissioners of domestic abuse services – *'Support the development of domestic abuse services that are accessible to older victims. Ensure that local domestic abuse campaigns proactively reach out to older victims. Training is an important factor in skilling up professionals to identify older people who are experiencing domestic abuse, and should be available to people in situations where older victims may be engaged – for example housing, health and older people's support agencies'.*

Sheffield has a similar disparity to the rest of the country in that the proportion of older people accessing support services for domestic abuse is lower than the proportion of people in this age group and lower than the prevalence estimates for the next age group down.

Action – Explore how support services can be promoted in 'older people services', including health, mental health and disability services. A Task and Finish Group (starting January 2017) will explore developing specific training to be offered to those working with older people and whether any specific pathways and protocols are required.

A further discussion by local experts has raised the issues of how older people living in an intergenerational family where domestic abuse is happening but not directed at themselves are likely

to be affected by the domestic abuse. This issue is considered at MARAC and by services if a person with care and support needs is living with a family member who is experiencing domestic abuse but is otherwise unquantified both nationally and locally.

Disability and/or a long standing illness

- Please note this issue is also in part discussed in the age section and the Safeguarding Adults section.

The most recent ONS CSEW data shows that disability is a factor which may make an individual more likely to be a victim of domestic abuse. The table below shows that 16% of women and 8% of men aged 16 to 59 years old will be a victim of domestic abuse in the last 12 month period. This is double the estimated prevalence for individuals with no long standing illness or disability - 8.2% of females and 4% of men.

The CSEW data also shows there are differences in the prevalence rates based on the type of disability. Separated into:

- disabilities which limit day to day activities (prevalence rate of 18.1% for females and 8.3% for men (note here the female prevalence rate is higher than the 16.0% for any disability whilst the male rate is the same)
- Disabilities which do not limit day to day activities (the prevalence rate is 8.8% for females and 9.7% for men (note here the female prevalence rate is similar to the female 8.2% prevalence for all females whilst the male prevalence is significantly higher at 9.7%).

England and Wales		
	Any domestic abuse	
	Men	Women
Percentage victims once or more[5]		
ALL ADULTS	4.0	8.2
Long-standing illness or disability		
Long-standing illness or disability	8.8	16.0
Limits activities	8.3	18.1
Does not limit activities	9.7	8.8
No long-standing illness or disability	3.2	6.8
Appendix table 4.10: Percentage of adults aged 16 to 59 who were victims of intimate violence in the last year, by headline categories, personal characteristics and sex, year ending March 2015 CSEW[1,2,3]		

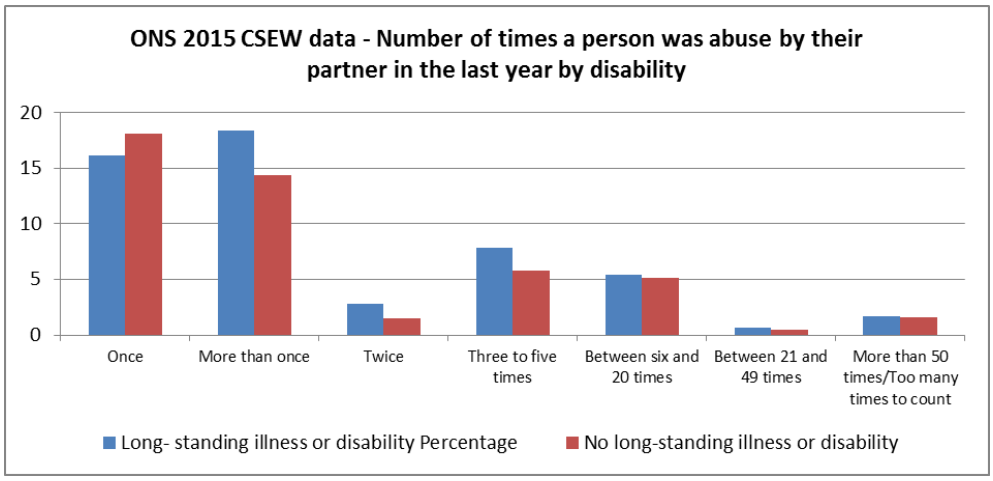
Further research finds that the domestic abuse perpetrated can be differently focussed where people are disabled: -

- The domestic violence aimed at those who have a disability can take unique forms which are different to those individuals without a disability. For example those who are reliant on a family member acting as their carer could find medicine is deliberately not provided or they are not taken to the toilet[57].
- Leaving, or disclosing being a victim of a domestic abuse situation maybe more difficult for a disabled person[58].
    - For example the victim is often supported by another when attending the GP so disclosing the situation is not possible if the perpetrator is present
    - Moving out of the situation may be physically difficult due to mobility issues or where their current property is adapted for their use.
    - The victim with a disability may be isolated and may not have anyone to share / disclose to.
- Victims who have a disability are 35% less likely to report good or excellent health compared to

[57] Ibid
[58] As cited in The Public Health England Report (2015) Disability and domestic abuse – risks, impacts and response.

those with a disability but are not a victim of domestic abuse[59].

- ONS data finds that disabled people and those with a long standing illness are more likely to be a victim of domestic abuse on more than one occasion in the latest 12-month period than individuals who do not have a disability[60].



The graph shows that 18% reported being a victim on more than one occasion compared with 14% of victims who were did not have a disability or long standing illness.

The PHE report explains that individuals with a disability may not only be more vulnerable to domestic abuse but may have more barriers to accessing support services, including domestic abuse services[61]. It adds that national provision of specialist domestic abuse support services for those with a disability is patchy, that accessibility to the actual premises can be an issue, that not all staff has disability training and that for some specialist emotional support is required[62].

Sheffield commissions support services to meet the needs of all victims including those with a disability. The DACT contracts with specialist domestic abuse support services do not have specific target or a set number of places for victims with a disability, but this information is monitored during quarterly performance monitoring meetings between commissioner and provider and the information is taken as part of the minimum dataset at assessment.

The 2015/16 data shows that around 527 victims disclosed a disability at the start of support. It is difficult to ascertain a percentage of the total as only 51%[63] of victims on the MDS had this data field recorded. Data collection is an area for improvement and correct and accurate information about disability should be considered as a priority. The volume of victims disclosing a disability is however significant, and could amount to around one sixth of the service users in support and even without further details on the level and type of disability, it is a considerable number of people to factor into support services.

The MDS data for those with and without a disability have been reviewed. This is a significant sample size (527 with a disability and 424 stating they do not have a disability). There are a number of differences noted:-

- A smaller proportion of those with a disability were employed (10% were employed or self-employed compared with 15% of those without a disability).

[59] As cited in The Public Health England Report (2015) Disability and domestic abuse – risks, impacts and response.

[60] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/adhocs/006081numberoftimesvictimsofpartnerabusehadbeenabusedbypartnersinthelastyearbyageanddisabilitystatusofvictimyearendingmarch2015crimesurveyforenglandandwalescsew

[61] Public Health England Report (2015) Disability and domestic abuse – risks, impacts and response

[62] As cited in The Public Health England Report (2015) Disability and domestic abuse – risks, impacts and response. Page 17

[63] 951 have a disability recorded on the minimum dataset, 424 had no disability and 527 had a disability. There is no further explanation to the type and severity of the disability, therefore it is not known how much the disability impacts on the victims to access support and the support received.

- A larger proportion of those with a disability had a family member as the perpetrator (17% had a perpetrator that was another family member compared with the 7% without a disability).
- Those with a disability were more likely to have been to the GP in the last 12 months (86% with a disability compared with 71% without a disability and more likely to have visited the GP on more occasions. Those with a disability visited an average of 7 times compared with 4 times per annum for those with no disability).
- A larger proportion of those with a disability have a history of the five forms of abuse compared to those without, e.g. around 60% of those reporting a historical physical, jealousy or verbal abuse had a disability and this increased to 74% for sexual abuse and 80% for harassment. This did not apply when just current abuse was observed.
- There is a marginal difference in successful completion of support (65% compared to 70% for those who did not have a disability).
- Those with a disability have a higher average of time in domestic abuse support (an average of 80 days compared to the average of 55 days for those without a disability).

The data shows that individuals with a disability are more likely to have complex needs, but the outcomes do not vary much. Therefore this suggests that support services in Sheffield are working appropriately with victims with disabilities. The data here is however limited as it focuses on those who have already accessed support. The unknown is if there are any barriers to accessing support services; the *'hidden cohort'*. The PHE report recommends that people with a disability care need are consulted on when the planning of services is undertaken, to ensure the services are responding to their needs. Therefore it is recommended prior to the services being re-commissioned (once their contract ends), that service user consultation is completed with current users of the service who have a disability and those who do not have a disability to explore how easy it was to access support services, how they were referred, whether they had any barriers to accessing support and what needs have been met and what remains unmet.

A further recommendation in the PHE report is that specialist training on disability and domestic abuse is made available for health and social care workers. With training to raise worker awareness of the higher prevalence rate for those with a disability, coercive control, perpetrators of abuse, challenging stereotypes, the complexity of the abuse, social barriers and individual impairments[64].

Action - There is a continued need to improve the recording and reporting of client disability data on the Minimum dataset in order to meet the requirements of the Equalities Act 2011 and any disability issues can be addressed accordingly.

Action – Consult with service users who have a disability (including learning disabilities) and those who do not have a disability to explore how easy it was to access support services, how they were referred, whether they had any barriers to accessing support and what needs have been met and what remains unmet. With a view of exploring how the unmet needs can be addressed and met in the new contract period.

Action – Consider training needs of health and social care workers regarding domestic abuse and disability.

[64] The full list of training recommendations is found in Public Health England Report (2015) Disability and domestic abuse – risks, impacts and response, page 20.