Section 15 – MARAC and High Risk IDVA Commissioned Support

The national VAWG strategy states the following comments on MARAC and IDVAs with regard changes to funding from 2017/18 and local provision to meet local needs:-

'In 2016/17, we will…continue to fund a network of community based support through IDVAs…and MARAC co-ordinators, and through our support package for local commissioners we will ensure these services are firmly embedded in the local landscape according to local need.

From April 2017 onwards, local service provision will be supported through a new VAWG Service Transformation Fund[1]'.

Multi-Agency Risk Assessment Conference (MARAC)

The aim of MARAC is **to reduce domestic abuse risk** by holding a case conference attended by all key support services together to discuss and share information on each high risk case. The role of those attending is to identify what is happening in each case, where each service is supporting the individual, identify gaps in support and generate key actions to be undertaken so risk is mitigated.

MARAC can be time consuming for all key services represented, as it is an administration heavy process. Indeed the SafeLives *'DV MARAC IMPLEMENTATION GUIDE'*[2] cites that for the agencies that attend MARAC regularly such as the IDVA, Social Services, Police, Probation etc. the cost is roughly equivalent to one to one and a half days work per meeting, of which half a day is at the meeting. This is significant because in Sheffield MARAC is held three weeks out of every four, the meeting is more than half a day in duration due to the usual volume of cases and therefore agency time could be around 4.5 to 6 days every four weeks for key agencies in attendance. SafeLives research does however report significant benefits to the victims following MARAC intervention.

- 74% of victims had a reduction in abuse risk level and that 63% of all victims who were supported by an IDVA had a cessation to the domestic abuse[3][4].

- The long term impact on the victim was measured by the change in the number of police incidents reported in the 12 months after the case went to MARAC[5]. 45% of victims experienced no further police call out, 20% of victims reported fewer incidents and 14% reported an increase.

- For every £1 spent on MARAC then £6 was saved on direct costs to supporting agencies.

- SafeLives estimates it costs £18,730 to support a high risk domestic abuse victim each year (health, police housing and children's services costs), but following MARAC intervention the annual cost per case will reduce by £6,100[6]. The most significant savings (compared to the services own investment in MARAC) are the Criminal Justice system, the police service and the health service.

The key findings from the VAWG review of MARACs (2011) identified ten key principles to a successful MARAC[7]: - information sharing, appropriate agency representations, IDVA engagement and victim

[1] https://www.gov.uk/government/publications/strategy-to-end-violence-against-women-and-girls-2016-to-2020, page 31
[2] DV MARAC IMPLEMENTATION GUIDE' http://www.cscb-new.co.uk/downloads/policies_guidance/national/DV%20MARAC%20Implementation%20Guide.pdf
[3] A Place of Greater Safety, SafeLives report, February 2015 http://www.caada.org.uk/policy-evidence/policy-and-research-library
[4] Based on
[5] CAADA enews (2012) based on 15 MARAC and 350 cases
[6] SafeLives Saving Lives, Saving Money – MARAC and high risk domestic abuse, February 2015, http://www.caada.org.uk/policy-evidence/policy-and-research-library
[7] http://www.safelives.org.uk/node/361

representation, a strong leader (Chair), good co-ordination, strong partnership work and the availability of training and induction. The MARAC co-ordinator for South Yorkshire has recommended that each area chooses three of the 10 principles to scrutinise. Sheffield has yet to choose their three to focus on.

MARAC and IDVAs are a national approach but with locally agreed processes.

The MARAC model in Sheffield

The MARAC model in Sheffield is as follows:-

1. MARAC in Sheffield has a roughly four weekly cycle. A MARAC is held on three consecutive weeks (the exception being if this pattern is disrupted by bank holidays). The fourth week is a 'fallow' week, but the model is responsive to volumes of referrals and therefore the fallow week is occasionally used as a MARAC week. There were a total of 37 meetings in 2015/16, with an average of 26 cases per MARAC.
2. The MARAC is always held on the other three weeks regardless of the volume of cases. For example one week it was held in 2015/16 and there were 16 referrals and on another week there were 29 referrals.
3. The conference is chaired alternately by the police and by a DACT manager. All those who chair the meeting have received specific training for the role.
4. The conference has an agreed and signed up to information sharing protocol which means information of a personal nature can be shared between all agencies that is pertinent to the domestic abuse.
5. All agencies attending the meeting should have researched their case management systems for the history of the victim, children and perpetrator. This information is at their disposal to share at MARAC. Electronic access to software is also used at the meeting but is not the norm for most services. Information is not shared in advance with the Chair or administrator.
6. The MARAC administrator was a post held in Sheffield city council based in the domestic abuse coordination team (DACT). The MARAC administrator receives all MARAC referrals, generates the list of cases going to conference each week, communicates with services attending so they can prepare in advance of the MARAC and takes full minutes at the meeting. The administrator role will be contracted out into a commissioned service in due course. The advantages of this strategic change are that the administrator would be in direct contact with the high risk service and the police service, due to location. This is likely to improve communication and may allow for quicker adjustments or changes to be made to the MARAC model in the future.
7. All meetings are audio recorded.

The model is unique to Sheffield and is under constant review. The latest MARAC co-ordinator report[8] from South Yorkshire Police explained how Sheffield is different to the rest of South Yorkshire;-

- Full minutes are not taken but a summary of the key points and outcomes for each case discussed, this is called a 'risk and action' log.
- A summary in writing is provided by each attending agency prior to the meeting.
- These two go hand in hand, and together provide a full 'picture'.
- Agencies who do not attend are on a list of non-attending agencies

One of the main reasons why Sheffield differs from the rest of South Yorkshire is due to the high volume of the number of cases referred, as it has the largest population. Therefore some of the actions taken by the other areas have been determined to be too time consuming (e.g. Preparation in writing prior to the meeting and as a result the Sheffield model remains different).

It is understood that Leeds holds a daily MARAC, hosted by the police and attended mid-morning by relevant agencies.

The recent MARAC co-ordinator's report (September 2016) states that *'Sheffield MARAC runs well and*

[8] MARAC Co-ordinator's Report Gemma Robinson, acting SYP MARAC Coordinator / PPU intelligence researcher, September 2016

needs little input' (from the South Yorkshire wide co-ordinator) which is encouraging to hear[9].

The SafeLives recommendations on the number of cases to MARAC

- Sheffield – Estimated 920 MARAC referrals per annum based on a rate of 42 cases per 10,000 populations[10]).
- South Yorkshire - Estimated 2,240 cases based on a rate of 43 cases per 10,000 populations.
- Most similar Forces - Estimated 18,710 cases based on a rate of 41 cases per 10,000 populations.
- National - Estimated 98,510 cases based on a rate of 33 per 10,000.

In 2015/16 Sheffield had a total of 941 cases, which is 21 cases (2.1%) higher than the SafeLives recommendation. The MSF (1.4%) and South Yorkshire force (7.8%) totals were also higher but the national figure is underachieved by 17%.

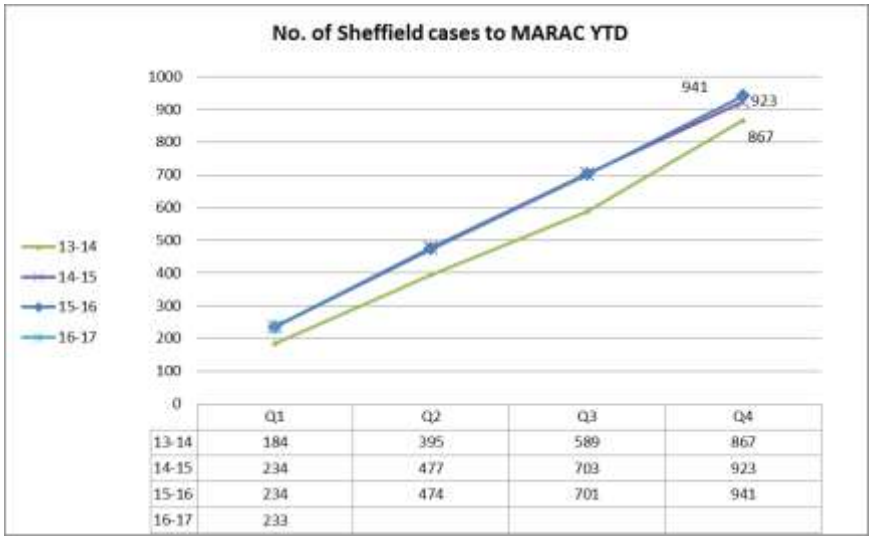
The latest MARAC performance is for the 12 month period January to December 2016.

Indicator	National figure	Most similar force group	SafeLives recommends	Police force	Sheffield
Number of Maracs	287	51	-	4	1
Cases discussed	85,504	20,103	-	2,277	942
Recommended cases	100,070	18,710	N/A	2,240	920
Cases per 10,000 population	34	43	40	41	41
Children in household	107,887	27,227	N/A	2,608	1,219
Year on year change in cases	5%	8%	N/A	-5%	2%
Repeat cases	26%	31%	28% - 40%	36%	43%
Police referrals	64%	69%	60% - 75%	62%	53%
Referrals from partner agencies	36%	31%	25% - 40%	38%	47%
BME	15%	12%	11%	14.8%	24.0%
LGBT	1%	1%	5%+	0.9%	1.3%
Disability	5%	4%	17%+	4.6%	8.8%
Males	5%	5%	4% - 10%	5.0%	3.8%
Victims aged 16-17	1,441	374	-	73	31
Cases where victims aged 16-17	1.7%	1.9%	-	3.2%	3.3%
No. harming others aged 17 or below	877	198	-	16	7
Idva (recommended volume)	923	212	N/A	24	10
Idva (current volume)	1,058	197	N/A	23	10
Admin (current volume)	275	51	N/A	6	2
Admin (recommended volume)	243	56	N/A	6	2

MARAC data - in-depth

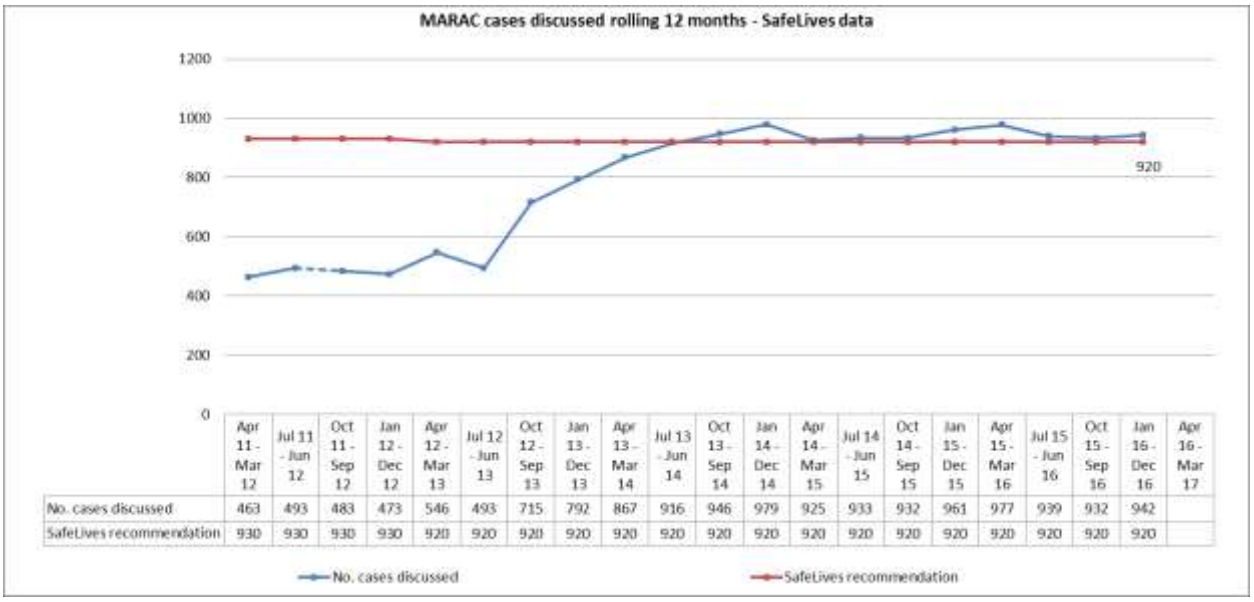
Locally held Sheffield data shows that **a total of 941 cases went to MARAC in 2015/16**. This was similar to that observed in the previous year in 2014/15, when 923 cases were heard (an increase of only 18 or 1.9 percentage points) but significantly higher (9% or 74 cases) than two years ago in 2013/14 when 867 cases were referred, see the Graph below.

[9] MARAC Co-ordinator's Report Gemma Robinson, acting SYP MARAC Coordinator / PPU intelligence researcher, September 2016
[10] SafeLives database



	Q1	Q2	Q3	Q4
13-14	184	395	589	867
14-15	234	477	703	923
15-16	234	474	701	941
16-17	233			

The graphs show that referrals to MARAC are stabilising, around the SafeLives recommended rate[11], which is encouraging.



	Apr 11 - Mar 12	Jul 11 - Jun 12	Oct 11 - Sep 12	Jan 12 - Dec 12	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16	Jan 16 - Dec 16	Apr 16 - Mar 17
No. cases discussed	463	493	483	473	546	493	715	792	867	916	946	979	925	933	932	961	977	939	932	942	
SafeLives recommendation	930	930	930	930	920	920	920	920	920	920	920	920	920	920	920	920	920	920	920	920	

Sheffield is more likely to have a case referred to MARAC than other areas. The SafeLives estimate has been over achieved for the last 10 reporting periods; however it is not in other areas. In 2015/16 South Yorkshire were estimated to have 2,415 MARAC cases but had 2,240 actual cases and nationally the 81,764 actual cases were well under the expected 98,510.

This is encouraging and is a result of work completed in Sheffield to increase the number of referrals to MARAC from a wide range of services over the last four years. Nationally 62% of referrals are referred to MARAC by the police whereas this is 56% of MARAC referrals in Sheffield.

This has included rolling out the ACPO DASH assessment tool citywide, holding a comprehensive review of MARAC using the SafeLives model and implementing the subsequent action plan and a change to MARAC frequency and administration. In addition, there has been and still is specific training commissioned for workers citywide in domestic abuse identification, disclosure, referral and the DASH risk assessment tool. This means referrals from partner agencies are much higher in Sheffield, which

[11] SafeLives database

has resulted in a higher than the SafeLives estimated number of referrals into MARAC. This is extremely encouraging and is evidence that the profile raising and training undertaken in Sheffield has had a positive impact.

Based on the locally held data, **it is anticipated that the number of referrals will continue to increase slowly and in a similar way to that observed in the last year (2% uplift, 18 cases actual). If this does happen then it will be another three to four years before the number of MARAC cases meets 1,000 which is the current contracted service provision for the Sheffield IDVA service.**

Action - A review of the service provision of commissioned places in the high risk contract will be required (using the latest MARAC activity data available at the time) for the next contract period.

Repeat referrals to MARAC

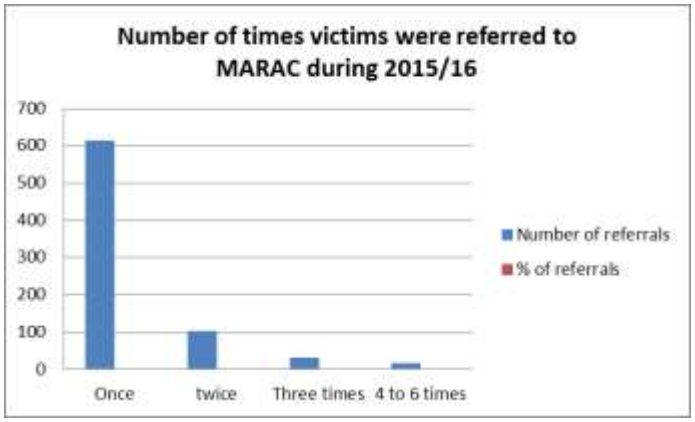
One of the key measures of MARAC is the proportion of referrals in the latest 12 month period that have been referred back to MARAC.

SafeLives recommend the repeat referral figure is between 28% and 40% of all cases in the last 12 months. Nationwide there were 25% of repeat cases to MARAC, 30% in the most Similar Force Group and 43% of cases in Sheffield during 2016. The Sheffield repeat referral percentage has increased for the last years, from 23% in 2013, 30% in 2014 and 33% in 2015, 35% in the 2015/16 financial year and 43% in 2016[12]. It is now above the expected range. One of the reasons for the repeat increase could be that a recent case study[13] completed as part of the annual MARAC review process found that more and more services were advising the victim to report any subsequent incidents to the police.

Significant action is not yet required, but the increasing repeat rate has been recognised and action has started. This includes reviewing further case studies and a focus on serial repeat cases.

More in-depth MARAC data on repeats

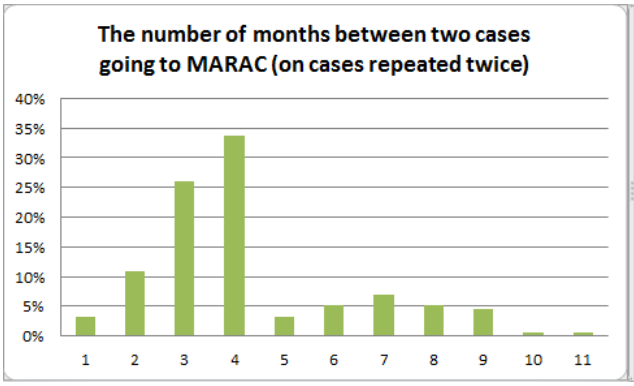
In Sheffield we know that the majority of cases will have a 'successful' outcome, there were a total of 762 unique individuals in the 941 cases at MARAC in 2015/16. A significant 614 or 80% were only referred once which suggests for these individuals that the MARAC has been successful. However 13% or 102 victims were referred two times, 4% or 31 victims were referred three times and 2% were referred between four and six times during the 12 month period.

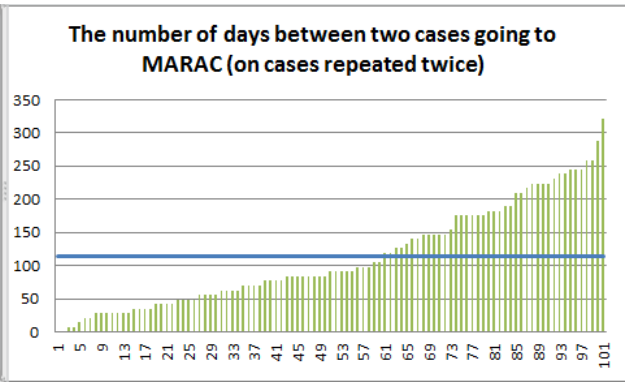


[12] All taken from the SafeLives database
[13] DA Civil & Criminal Justice Sub-Group, MARAC Case Audit Review, Minutes of Meeting 04/04/2016

If we look more longitudinally, over the last 26 month period[14], a total of 1,472 unique individuals have gone to MARAC. Of these individuals 514 have been referred once, which is 34.5%. Therefore it is observed, that whilst a referral may not happen for 80% in a fixed 12 month period (2015/16 cases), when a longer period of 26 months is viewed, one third will be referred back into MARAC at some point during this time.

Of cases that have been to MARAC twice in the last 12 months, it is found that the average time between the two cases being heard is 3.6 months or 114 days, with a range of between 0 months and 10 months. When outliers are removed there is little difference, the average is 3.3 months.





Only a very small proportion (just over 1%) have been to MARAC in all three financial years (the last nine months of 2014/15, 2015/16 and the first three months of 2016/17). A review of the brief information on these cases finds that these cases have been to MARAC on 121 occasions, all were female, there were a noticeable number of victims who had children in care, were pregnant, had two perpetrators (on different occasions) and perpetrators in prison or on remand. Information presented here suggests there will always be a small proportion of ongoing year on year repeat cases.

Action – Consider the effectiveness of current approaches where cases are continuing to be referred to MARAC without resolution.

Repeat, repeats initiative - Super MARAC

A recent development in South Yorkshire has introduced a 'The Super MARAC'. Focusing on cases which have been to MARAC four or more times in the last 12 month period, there is some thought that these are potentially 'stuck' and may need a more concentrated focus than the usual MARAC format.

To date 19 cases have been reviewed and the trends observed are as follows – *there is a noticeable number of looked after children, issues with transition of the victim to adult mental health services, engagement issues –for young people evidence that there is a need for more intensive support from the initial referral, both practical and emotional (hand holding), there is a need for multi-agency meetings outside of MARAC, plus substance misuse, Mental Health and sex work*[15]*.*

The ongoing plan is to hold the repeats, repeat review annually.

Action - Continue to hold the Super MARAC on all repeat, repeat cases, to better understand the full extent of issues and re-occurring themes.

Action – Review the super MARAC's effectiveness in terms of actions completed and repeat MARAC referrals of cases thereafter.

[14] July 2014 to September 2016
[15] Alison Higgins, Domestic Abuse Strategy Manager, DACT

Action – Review the themes presented in repeat, repeat cases and see if any learning can be applied on new cases to the MARAC to implement focused preventative action to them becoming a repeat, repeat. E.g. if a case has a young victim, perhaps focus more on transition of services, engagement with support services and multi-agency meetings.

As with any process however, there are always issues to address and MARAC is no different. Below is a list of issues that have been raised during the needs assessment process about Sheffield MARAC. It is unlikely that these issues are unique to Sheffield (and where these issues are wider this is cited).

1. Attendance at MARAC - All services working with victims and the perpetrators should be represented at MARAC. Time is of an essence and attendance has become an issue over the last year. For example
    i. National changes in the probation service have resulted in probation not attending for the whole meeting or sending apologies (CRC). This is not unique to Sheffield and is based on a National Probation report on involvement in MARAC.
    ii. Some agencies attend for cases where it is known they are working with the victim or perpetrator but once these cases have been discussed they leave. However later on in the meeting an issue is raised relevant to the agency no longer present and this leaves an information or expertise gap.
2. The meeting is a long meeting in Sheffield and very time-consuming for those involved.
3. The quality and amount of preparation completed by services prior to the meeting can vary. The recent case study review identified that some services contributed more than others.
4. The responsiveness of MARAC – how soon following a referral to MARAC is soon enough?
5. Agreed actions completed - Each agency is required to ensure the actions agreed at MARAC are completed. In Sheffield there is no routine monitoring of completion of actions agreed. On occasion a central 'audit' is completed by the MARAC administrator and case studies are undertaken, but this does not ensure all actions agreed are completed and updated. This has also been observed in the MARAC coordinator's report as South Yorkshire wide.
6. Repeat referrals to MARAC – SafeLives recommend the repeat referral figure is between 28% and 40% of all cases in the last 12 months, it was 36% of cases in Sheffield during 2015/16.
7. Information presented is not always up to date.
8. It is three years since the last full MARAC review was undertaken in Sheffield.

MARACs are not statute, this means they do not have to happen by law. SafeLives[16] recommends that this does become a statutory requirement of local authorities. However Steel et al (2011) observed mixed opinions (supported by MARAC chairs and co-ordinators and IDVAs) but not by all in the MARAC steering Group). However it needs to be noted, that some of the issues listed for Sheffield are made more complicated, because full engagement of services does not at present, have to happen.

Action – Complete a MARAC review in the next two years, review the current model and models from other areas. The review should be done in time to commission the next high-risk contract. The current contract will end on 31st March 2018 unless it is extended.

MARAC Case Studies and MARAC issues

The annual MARAC case review helps to identify areas of good practice and analyse if the MARAC is achieving its aims. The process has identified good practice *'agencies are taking a more proactive stance regarding reporting incidents and are encouraging the victims to report incidents to the police'*. However the meeting also identified a number of improvements that could be made to the MARAC process.

- Not all agencies provided an update to the case for the meeting; this suggests agencies vary in their involvement and engagement with the process.

[16] Saving Lives, saving Money: MARACs and high risk domestic abuse – SafeLives 2015

- Substance misuse (victim and/or perpetrator) was mentioned in all three cases, but no action had been taken on this at the time of the MARAC (e.g. at the time it was unknown if it was a problematic issue, consent to refer to support services is required, issues with the criminal justice system and the impact this may have on the perpetrator defence), sharing of information between services can be a stumbling block to key actions being completed,
- The DASH had not being completed at the first inkling that domestic abuse may be involved.
- The time frame for keeping cases open by IDVAs has been identified as not being long enough; therefore this is to be changed.
- Amending the Case review template to include more information on repeats in the past.

Given the amount of issues raised, case reviews should be undertaken at least once a year and actions followed through.

Action – Use the CCJ Group once a year to hold a case review audit of a sample of MARAC case studies as a way of working to continually improve the MARAC process.

MARAC Funding

Funding towards MARAC Coordinators is in part from Central government but in 2017/18 the central government contribution will be included in the VAWG Transformation Fund. This fund is to support services to provide early intervention, establish and embed the best ways to help victim and families and prevent perpetrators from re-offending. Therefore only successful bids to the Fund will continue to receive this funding.

Action –Mainstream funds for MARAC Coordination

Independent Domestic Violence Advocacy (IDVA)

All high risk referrals and therefore all cases that go to MARAC are offered the opportunity to have an advocate, an IDVA. IDVAs are the primary point of contact for high risk victims. They develop safety plans, collaborate with all services involved with the victim and are a key role in MARACs where they represent the victim[17]. IDVAs can refer to MARAC and here in Sheffield are the points of referral for all cases going to MARAC, ensuring the DASH is completed, preparing the case for MARAC and confirming the level of risk.

Evidence[18] finds that when a victim chooses to engage with an IDVA, then the outcome is more likely to result in cessation of abuse (57%) and that 79% of victims felt safer following IDVA intervention. Whilst not all victims accept the offer of support, the IDVA continues to work on the case and represents all cases at MARAC (in 2015/16 100% of all high risk referrals in Sheffield were represented by an IDVA at MARAC).

Commissioning of the IDVA service in Sheffield

Sheffield DACT commissioned the IDVA service as part of the high risk contract. The contract started in 2015/16 and is a three year contract, which ends on 31st March 2018. The commissioned service is Action, which is a voluntary sector service.

The overarching objective of the IDVA service is to reduce the risk level of all those assessed as high risk (at high risk of serious harm or homicide). This thereby increases the victim's safety. The service therefore contributes to the city's aim of *'reducing repeat victimisation, violent crime and fear of crime, and maintaining a low level of domestic homicide rates in Sheffield where domestic abuse has been disclosed by the victim and risk assessed'*[19].

[17] *Supporting high-risk victims of domestic violence: a review of Multi-Agency Risk Assessment Conferences (MARACs)* Steel, N, Blakeborough, L, and Nicholas S. (2011)
[18] Howarth, E. Stimpson, L. Barran, D. and Robinson, A. (2009) *Safety in Numbers: A Multi-site Evaluation of Independent Domestic Violence Advisor Services*. London: CAADA. www.henrysmithcharity.org.uk
[19] Service specification, Part B for the High Risk Domestic abuse contract, Sheffield City Council 2015/16

The high risk contract has the following expectations – that it is closely aligned with the MARAC process, it fits into the commissioned domestic abuse pathway in Sheffield by providing the high intense[20] and high risk support service, it works in partnership and collaboration with the Medium/Standard Risk Service, women's refuge, the Floating Support Service and others to actively encourage identification of high risk cases.

The IDVA service should meet the diverse needs of all high risk individuals, working to reduce risk for all clients, including those who choose to stay with the perpetrator.

Number of IDVAs (SafeLives Estimate)
There are 9.5 IDVAs commissioned in Sheffield (the number of IDVAs required is the recommended number by SafeLives based on the recommended number of cases that should go to MARAC each year for Sheffield. The estimate is based on a 12 week support period provided in the contract for each victim and each IDVA having a caseload of 25 at any one time, thereby 1,000 high risk cases are commissioned each year.

IDVA Activity

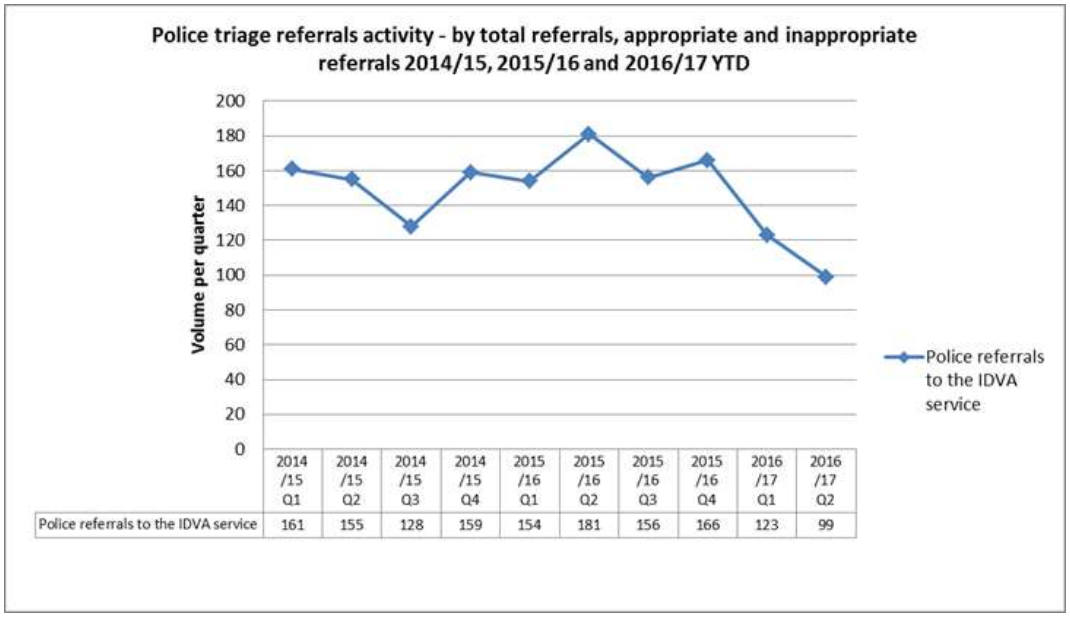
In 2015/16 the IDVA service received a total of 1,019 referrals but 11% of these were medium risk, therefore 908 were risk assessed using the DASH assessment tool and remained high risk following further investigation. This is a significant uplift (3.4%) on the previous financial year when a total of 957 referrals resulted in 878 high risk referrals in to the service and within the 1,000 capacity for the service.

IDVA Referrals come from a wide range of services (21 in total), but the most significant referrals come from the police (64%), housing (8%), health (8%) and other domestic abuse support services (7%). The main referral sources are those expected – the police and other DA services are the most likely to refer as it is more likely that they will identify a victim of abuse.

Police referrals to MARAC / IDVA
The latest performance in Quarter 2 2016/17 from the high risk service reveals that police referrals to the IDVA service have significantly reduced in 2016/17 compared with 2015/16. The graph shows that activity does fluctuate by quarter; however there were a total of 603 referrals in 2014/15, which increased to 657 in 2015/16 and have now reduced to 222 in the first two quarters of 2016/17.

In the latest quarter there were only 99 referrals, compared with the average of 160 in the last year and compared with the 181 experienced in the same period last year. Work has been initiated to understand the issues around the reduction.

[20] Other areas offer lower intensity but Howarth et al (2009) finds these less effective in terms of outcomes, www.henrysmithcharity.org.uk



	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4	2016/17 Q1	2016/17 Q2
Police referrals to the IDVA service	161	155	128	159	154	181	156	166	123	99

Action – Work is ongoing to ensure the police complete a DASH assessment and refer to MARAC when attending high risk domestic abuse incidents. Activity will be continually monitored.

Health referrals to MARAC may be underrepresented as the 8% health referrals include all GP practices, mental health services, A&E, maternity and health victors. The last 12 months has seen a significant decrease in high risk health referrals; e.g. from 54 to 34 for A&E which is of concern as the specification is to receive 165 health referrals per annum. Quarter one data suggests this will be similar in 2017/18.

Action – High risk health referrals and health worker training: Continue to monitor referrals from health services in line with the performance management of the contract. Focus on the high risk contract part B - Training to be focused on health workers in 2017/18; with the aim of increasing high risk referrals to meet the 165 target.

Action - There is an on-going need to monitor high risk referrals into IDVAs and subsequent engagement to ensure the IDVA service has the capacity to support all high risk victims.

Victim Engagement with the IDVA Service

Local data reviewed regarding victim engagement and the capacity of the service to respond and provide support within one week of referral has found the following:-

- **77% or the majority of victims accept the support of the IDVA** in 2015/16 and 2016/17 Q1 to Q3[21]. The numbers of victims who engaged with the service has improved since 2014/15 when 67%[22] chose to engage with the IDVAs. The increased and stabilising level of engagement is encouraging and within the required 75% commissioned target. Feedback from the service about the reasons that victim's do not engage included limited contact details or victim being unwilling to accept support.
- **96% of victims, who accept IDVA support, start in support within one week of referral date** in 2015/16 and 2016/17 Q1 to Q3[23].

[21] 2015/16 PMF and PMF 2016/17 year to date for the first three quarters of 2016/17. This provides seven quarters (of one year and three quarters worth of evidence.
[22] 2014/15 PMF
[23] 2015/16 PMF and PMF 2016/17 year to date for the first three quarters of 2016/17. This provides seven quarters (of one year and three quarters worth of evidence.

The data shows that the service is quick to respond to referrals and the majority of victims are engaging in support.

The Profile of High Risk Victims in Support

The minimum dataset contains data for a total of 1,683 victims who have received support in the last two financial years (2016/17 and 2015/16).

In 2016/17 there were **842** cases listed on the minimum dataset open to the High Risk Service. **692 were unique victims**, which means that 82% of all cases on the MDS in 2016/17 were on the IDVA caseload once during the 12 month period, 102 had been on the caseload twice, 16 had been three times to MARAC and a few had been four times.

33 of the unique high risk victims had been on the IDVA caseload and had also been in medium risk support and 14 had been on the standard risk caseload during the same 12 month period.

The table below shows the details of victim's profile for high risk victims compared to all victims accessing specialist commission support[24].

	All		High/ Very High		Medium		Standard	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
Total number	1776	1684	841	842	687	572	197	258
Average age	34.1	33.7	33.1	32.9	34.6	34.1	35.7	35.2
% aged 60+	2.1%	3.2%	2.2%	3.5%	2.2%	1.8%	1.0%	5.1%
X % are aged 16-17	1.1%	1.9%	1.2%	1.8%	0.9%	1.8%	1.0%	2.7%
% aged 16 to 25 years	26.5%	27.6%	30.7%	31.5%	23.3%	25.2%	19.1%	23.0%
X % are BME (not "White British")		24.0%		23.7%		24.0%		24.0%
X % are LGBT	1.7%	2.1%	2.3%	2.6%	1.3%	1.8%	1.1%	1.4%
X % are male	5.7%	4.0%	4.7%	5.6%	5.7%	2.1%	8.6%	3.5%
X% had children	60.8%	62.1%	57.8%	57.7%	66.5%	67.0%	57.4%	66.7%
% drugs issue	7.5%	6.4%	9.0%	13.0%	8.9%	5.5%	5.8%	6.3%
% alcohol issue	13.3%	14.8%	19.8%	22.2%	12.7%	8.8%	1.5%	5.9%

- The average <u>age</u> of high risk victims is 33 to 34 years old.
- 2016/17 has observed a slight increase in the proportion of high risk victims aged 60 years and older and victims aged 16 to 17 years (1.2%), which has resulted in an increase in the number of young people aged 16 to 25 years. This age group accounted for 31.5% of all high risk cases in 2016/17 (nearly one in three, whereas medium and standard risk cases finds that one in four age in this age group (25% medium and 23% standard).
- 24% of high risk victims are BME which is higher than the 17% BME population in Sheffield and this is similar for all risk levels in support.
- 2.6% of high risk victims are LGBT, similar to the 2.1% for all victims, lower than the estimated 6% of the Sheffield population who are likely to be LGBT but marginally higher than in 2015/16.
- 5.6% of victims are male, which is higher than the proportion of medium (2.1%) and standard (3.5%) risk victims. Again a marginal increase for high risk caseload on the previous financial year.
- High risk victims are likely to have dependent children, with 57.7% having children, this is however marginally lower than the 62% for the total.

<u>Vulnerabilities</u>

- 26% of high risk victims cite a disability; the overall percentage is 28%.

[24] Information is taken from the Full Minimum Dataset for Domestic Abuse and filtered for the commissioned services in 2015/16 and 2016/17. The percentages for each data field are based on the total answers completed for that field.

- 23% of high risk victims cite a mental health issue; the overall percentage is 25%.
- 6.4% of all victims in support and have the drugs field completed report a drug issue and 14.8% report an alcohol issue.
    - 22% of all high risk victims reported an alcohol issue compared with 9% of medium and 6% of standard victims.
    - 13% of all high risk victims reported a drugs issue compared with 5.5% of medium and 6.3% of standard victims.
- 20 had no recourse to public funds in 2015/16 and 15 in 2016/17.
- Less than 10 high risk victims were pregnant.
- 43% had previously attended a support service, compared to the 39% for victims of all risks.

Perpetrator data; see table below

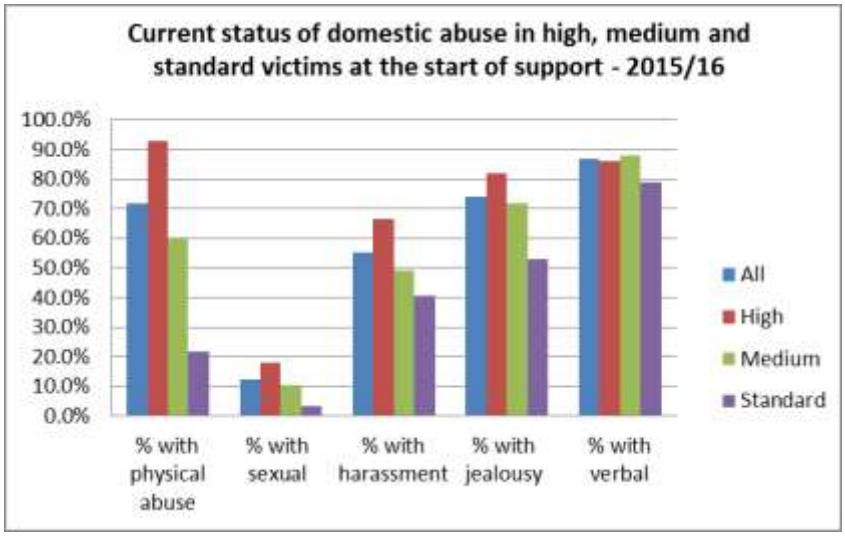
	All		High/ Very High		Medium		Standard	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
% where per was spouse / partner	24.9%	22.3%	26.8%	26.1%	24.6%	22.4%	16.2%	21.2%
% where perp was ex spouse / ex partner	64.7%	64.4%	60.4%	60.3%	66.8%	67.2%	67.7%	71.4%
% where perp was other	10.4%	13.3%	12.8%	13.6%	8.6%	10.3%	16.1%	7.4%
X were living with perp	23.8%	22.8%	22.7%	22.7%	26.3%	22.6%	17.4%	21.9%

- 86% of victims were abused by their current (26%) or ex (60%) partner / spouse in high risk cases and 17% are another relation and this has not changed in the two years of data.
- The proportion of perpetrators being the Current/ex-Spouse/partner increases as the risk reduces; 83.9% of medium victims and 92.6% of standard victims. As the risk reduces there are a higher proportion of victims reporting the perpetrator as an ex-spouse/partner.
- 22.8% of high risk victims are currently living with the perpetrator, which is similar to the total (22%) and all risk levels.
- 69% of high risk victims who had the data recorded had attempted to leave the perpetrator at least once in the last 12 month period; this was higher than for the medium (64%) and standard risk (55%) victims. Of the high risk victims 29% had attempted to leave on two or more occasions compared to the lower 16% of medium risk victims and 18% of standard risk victims.
- 71% had one perpetrator, 18% had two perpetrators and 5% had three or more perpetrators. The higher the risk, the more likely the victim was to have more than one perpetrator; 76% of medium victims and 83% of standard victims had one perpetrator.

Abuse reported at the start of support

	All		High/ Very High		Medium		Standard	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
% with physical abuse	71.9%	67.2%	92.7%	87.6%	59.8%	49.5%	21.9%	23.5%
% with sexual	12.5%	14.0%	18.1%	19.5%	10.6%	11.6%	3.2%	2.3%
% with harassment	55.3%	56.0%	66.4%	68.3%	49.1%	50.8%	40.6%	31.9%
% with jealousy	73.9%	71.3%	82.1%	81.1%	71.6%	68.7%	52.8%	41.9%
% with verbal	86.7%	88.6%	86.2%	93.8%	87.9%	87.4%	78.9%	72.0%
Source - Minimum dataset 2015/16 and 2016/17								

- 88% of high risk victims report current physical abuse, 19% report sexual abuse, 68% harassment, 81% report jealousy and 93% report verbal abuse. The percentages reporting these forms of abuse are all higher than for the medium and standard risk victims see table above for full data and the chart below, using 2015/16 data.



Analysis of the 2015/16 abuse data observed the following:-

- The majority of high risk victims reported three (37%) or four (31%) forms of violence
- 10% of all high risk victims stated they were a current victim of all five forms of abuse.
- 21% were a victim of physical, harassment, jealousy and verbal but not sexual
- 10% stated they were a current victim of sexual, harassment, jealousy and verbal abuse but not physical.

Accessing support services in the last 12 months - Analysis of the 2015/16 data

- In the last 12 months 80% had reported at least one incident to the police, in total 443 had reported to the police and collectively they informed the IDVA service of over 900 incidents (ranging between reporting one and 34 incidents).
- 254 reported going to their GP in the last 12 months (for any reason). In total these victims had gone to the GP 1,585 times or averaged five times a year (range was 0 to over 50 attendances).
- 105 high risk victims on the IDVA caseload had attended A&E as a result of domestic abuse in last 12 months, and between them visited A&E a total of 146 times.

Outcomes of the high risk service intervention

A target in the current contract is that 75% of victims will engage with the IDVA. In 2015/16, just over three quarters (77%) of victims who were offered support then accept and engage with the service. This is similar to the previous year (2014/15, 79%). Achievement of the target is encouraging, however it does also mean that a significant number of individuals referred did not engage with the IDVA and the main reasons for this include the service being unable to contact the victim due to lack of contact details, calls not being answered or the service is refused when offered. Given the target has been achieved, it shows that the IDVA service are successful in contacting and offering their service, and that the percentage of victims who will accept the offer of support is increasing.

Of those who choose to engage with the service in 2015/16 it is found that:-

In 2015/16 the majority or 71% of HIGH risk victims[25] who were supported by the high risk service had a successful outcome. This means these victims had a planned exit from support and had completed their support plan. This is encouraging as it is above the contractual target of 50% of victims to have a successful exit which therefore aims to have one in two victims exiting successfully. Conversely, it does however mean that just less than one third (29%) of victims did not have a planned exit and dropped out of IDVA support[26]. Evidence shows that the risk rating is more likely to remain the

[25] High risk PMF 2015/16
[26] Of high risk cases with an exit form 694 out of 491

same with these victims; therefore it is imperative that the target for planned exits remains over achieved and perhaps reviewed to create a more stretched target in the forthcoming financial year.

62% of all high risk cases had a reduction in risk rating (100% were high at the start, 38% high at exit, 59% medium and 2% standard) however a reduction in risk was more likely for those who complete support. For example; 27% remained high risk as opposed to 38% of the total high risk caseload.

Successful outcomes here are measured in the change in risk level and reduction in the forms of abuse the victim suffers at exit compared to that at intake.

Information taken at intake and exit on the nature of the abuse provides some insight into the change in the abuse following engagement with the IDVA service and MARAC system. Overall the forms of abuse remain, so those who were victims of physical abuse are still likely to be a victim of this abuse but victims are less likely to be on the receiving ends of extremely severe abuse and the abuse was less likely to escalate. Further detail on each form of abuse is found below:

Physical abuse -
17% of those who disclosed physical abuse at intake were not a victim of this abuse at exit, this means the majority were still a victim but for just under one in five victims the physical abuse had stopped.

More significant differences were observed in the severity and escalations of the abuse, so even though the majority were still being physical abused, the abuse was less likely to be reported as highly severe (93% compared to 96% at the start) and less likely to be escalating (50% said it had been getting worse at the start compared to 1% at exit, and for 82% of victims the escalation had reduced).

Sexual abuse -
18% of those who disclosed sexual abuse at intake were not a victim of this abuse at exit. This means for around one in five sexually abused victims on the high risk caseload, the sexual abuse had stopped at exit.

More significant differences were observed in the severity and escalations of the abuse, so the abuse was less likely to be reported as highly severe at exit (77% compared to 82% at the start) and less likely to be escalating (40% said it had been getting worse at the start compared to 4% at exit, and for 87% of victims the escalation had reduced).

Harassment abuse -
14% of those who disclosed harassment at intake were not a victim of this abuse at exit. This means for the majority the harassment continued.

More significant differences were observed in the reductions in severity and escalation of the abuse, so the abuse was less likely to be reported as highly severe (89% compared to 95% at the start) and less likely to be escalating (46% said it had been getting worse at the start compared to 3% at exit, and for 84% of victims the escalation had reduced).

Jealous and controlling behaviour abuse -
20% of those who disclosed jealous and controlling behaviour at intake were not a victim of this abuse at exit. This means for one in five victims this form of abuse stopped.

More significant differences were observed in the reductions in severity and escalations of the abuse, so the abuse was less likely to be reported as highly severe (83% compared to 90% at the start) and less likely to be escalating (39% said it had been getting worse at the start compared to 2% at exit, and for 84% of victims the escalation had reduced).

Verbal abuse -
17% of those who disclosed verbal abuse at intake were not a victim of this abuse at exit. This means for around one in five victims this form of abuse stopped.

More significant differences were observed in the reductions in severity and escalations of the abuse, so the abuse was less likely to be reported as highly severe (85% compared to 94% at the start) and less likely to be escalating (43% said it had been getting worse at the start compared to 2% at exit, and for 85% of victims the escalation had reduced).

Review of effectiveness targets

The effectiveness targets within the current domestic abuse contracts are for the successful exits, the percentage with a positive change in their assessed risk and the percentage that drop out/disengage.

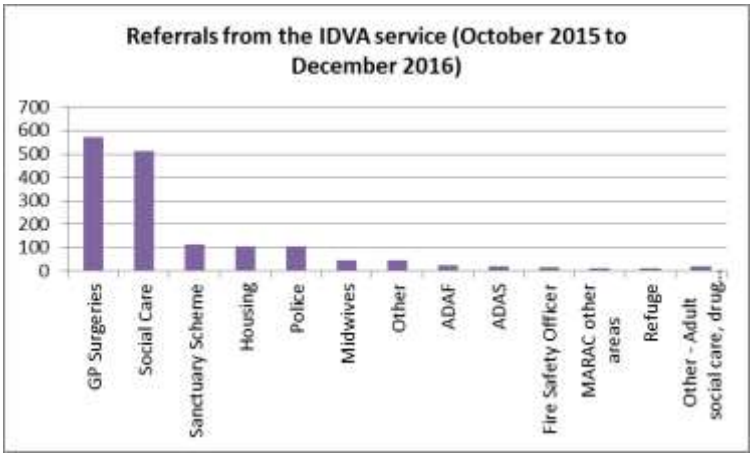
A review of these targets will be required for the new contract period and consideration should also be taken to introducing more outcome based targets, including service user satisfaction information/ feedback. For example *'since starting with the service do you feel less safe, safer than you did before starting, the same as before or more safe?'*

Service user feedback targets have been introduced to other contracts in Sheffield City Council (e.g. Homecare) and are also included on contracts for domestic abuse support services in other areas (e.g. Leeds[27] which has a target on the level of service user satisfaction with the service received).

Action - Introduce effectiveness targets for commissioned services based on service user feedback. This would be a DACT produced questionnaire working with the support services and services users. It would be completed with current service users accessing the service every six months, for a set number of service users. This would be tested for the first six months to 12 months to create a baseline and then targets introduced for the next contract period.

Referrals from IDVAs to other support services

The IDVA services make a significant number of referrals to other services for victims (1,620 between October 2015 and December 2016, which works out at around 110 per month. The data provides some insight into the other organisations who are involved with high risk and victims of domestic abuse; either at the end of successful engagement in support but also for victims who remain high risk and either did not accept support or dropped out of support.



The list includes referrals made to specialist domestic abuse support services but the majority of referrals are to wider support services that are not specialist in domestic abuse (32% to social care,

[27] Leeds Contract, Michelle De Souza, Manager - Domestic Violence Team

36% to GP, 3% midwives and 7% housing etc).

Current issues with the IDVA service

Focus on the capacity of the service and the long term support provided in the current commissioning model.

1. **Capacity - Although capacity for 1,000 high risk victims is commissioned, the service rarely has the full 9.5 IDVAs available, thus caseload capacity is higher than the 25 SafeLives recommend.** This is due to worker attrition within the commissioned service[28] (e.g. two posts vacant in Q4 2015/16), and the time taken to recruit and police vet the posts. This is an ongoing issue and an area of focus during the contract period to ensure capacity is available for victims to receive the high intense service commissioned.

2. **Time limited support - 12 weeks of support is provided to victims (as per the commissioned contract and SafeLives recommendation). This has limitations for some victims, and combined with the waiting list for medium and standard risk support which creates a gap in support**.

- Latest activity shows that the average time in support is 34.5 days for those who exit support in 2016/17 (Q1 to Q3) and this includes the 44% of victims that exit within one month of starting support. The data here is encouraging compared to the previous year (2015/16) when there was an average of 28.4 days and 55% left support within one month of support starting.
- Some victims do receive longer periods of support e.g. the average of the longest period of time in support in the last 21 months activity is 3.2 months or 91.7 days, with a range from 54 days to 137 days.
- 8% of all victims exiting the service were referred or signposted to the standard and medium risk service in 2016/17 (Q1 to Q3)[29], although data from the medium and standard risk service suggests this maybe higher (77 referrals in the first nine months of 2016/17[30]). Thus showing that there is a need for some victims to have a longer period in support, although further work is required to better understand the impact this has on the support model.
- Service users have explained that having a referral elsewhere within the commissioned system has its issues:

1. There is no key worker service commissioned to support victims from one service to another which would remove the need for the victim to explain their situation to a new worker.
2. For those undergoing court cases, the support provided by the IDVA ends at the point the IDVA support ends regardless of when the court date is.
3. How effective is the process at referring from high risk to medium and standard risk? Data shows the medium and standard risk service have waiting lists for all support (see medium and standard risk service section). Data from the medium and standard risk contract for 2016/17 Q1 to Q3 also finds that only 12.6% of victims referred had a desktop assessment within 3 weeks[31]. This means for victims who want support to continue seamlessly, there is currently a gap between the two forms of support provided.

There is a need for the above factors to be considered when considering the future of the commissioning model in Sheffield and perhaps there is a need for pilot initiatives to be undertaken prior to the commissioning of the next contract period. – see action in the Commissioning of domestic and sexual abuse support services in Sheffield Section 11.

[28] High risk PMF 2015/16
[29] High risk PMF 2016/17 year to date for the first three quarters of 2016/17, 246 and 21 referrals and signposting's to ADAS.
[30] Medium and standard risk PMF 2016/17 year to date for the first three quarters of 2016/17
[31] Ibid