Ending domestic abuse

Guidance for Multi-agency forums: Cases involving victims who are black or minority ethnic

Aim of this report

Individuals who are black and minority ethnic (BME) who are experiencing domestic abuse have historically formed part of a 'hidden' group, by which we mean a group which is less well served by the response available in the UK. There is therefore a need to focus on their particular experiences and additional barriers they can face when identified as victims (or perpetrators) and being provided with safe and appropriate services.

There are a number of reasons why those who are BME are not receiving a consistent, high quality service across the UK. Some specialist services do exist, but these are often small and under considerable pressure. In general, services are typically set up without specialist knowledge or awareness of the issues someone who is BME might experience, and the connections between those agencies and the existing specialist services are not strong enough. Whilst auditing cases for the Scrutiny panel we found common threads and themes arising which we have captured below. A number of these also arose during our recent **Spotlight** on 'honour' based abuse. We include below points of guidance when dealing with these cases in relation to the Marac process.

The UK has an increasingly diverse population. The term 'BME' is not necessarily an adequate one, as it lacks nuance and can often be taken as synonymous with a single community or group together individuals within that community who themselves have very different experiences. This document is the product of sampling a number of cases from around the country, but should be taken as *indicative*, not comprehensive.

Common themes arising

- There is a transient lifestyle for many victims and family members in BME communities. This makes cross border issues, where one or more family members is moving from one Marac/local authority area to another, prevalent. Marac to Marac transfers were common throughout our case sampling work for the panel, creating additional challenges to the work of putting together appropriate safety and support plans.
- Sexual exploitation risks appeared in many of the cases we looked at, sometimes including more than one perpetrator.
- Mental health issues or drug and alcohol were present in many of the cases. There appeared to be a lack of proactive assessment, or follow up work in particular, for those involving mental health issues.
- Isolation was exacerbated by factors such as a lack of knowledge of available services, reluctance to engage with services for cultural reasons or because of lack of trust, language barriers and insecure immigration status.
- Individuals from more recently arrived groups faced different issues to those that had been here for more than one generation, including a lack of any form of support network.
- There appeared a general reluctance on behalf of the CPS to prosecute; and lack of expertise/ knowledge. This included a tentativeness to be involved or follow procedure.
- Issues of so called 'honour' based abuse were compounded by a lack of awareness and confidence on the part of many agencies, including a lack of recognition of these issues being present in a number of communities, not being the exclusive preserve of one community or ethnic group.
- The perpetrator's history in his or her country of origin, where not the UK, was usually unknown to services and/or it proved challenging to clarify this information.

- There were recurring threats to remove the children or victim out of UK. In some cases this had actually occurred.
- Other criminal activity appeared frequently in the cases we audited, including links to human trafficking, modern day slavery, CSE and moving goods into the UK illegally. This offered a good opportunity to potentially use disruption techniques in the action planning stage, with enforcement agencies able to take action against a perpetrator for multiple offences.
- Victim/survivor attitudes to public services were informed by the practice in their country of origin, where not the UK. For example, a longstanding expectation that the police will be corrupt and therefore cannot be trusted.
- The attitude of certain agencies gave us cause for concern. There was a misconception, for example, that moving the victim would automatically make them safer, without proper recognition that the community to which both they and the perpetrator belonged was fluid and highly networked across different parts of the UK. Though the sample size was small, it was also apparent that some agencies either lacked awareness, knowledge and understanding of these communities and that they were not seeking appropriate specialist guidance to improve their response. Compared with the many other cases we have scrutinised there appeared to be a tangible difference in the lack of input, care, follow up or general interest in these victims, children or families. If this is not improved, individuals within this group will continue to be treated as 'hidden', and be let down by the response to abuse.

What the data shows

- In the last 12 months from April 2016 to March 2017 13,686 cases were discussed at Marac where the victim was from a black or minority ethnic group. This was 16% of all cases discussed, which is similar to the proportion of the population covered from BME groups (18% nationally); Though these figures are broadly representative of the BME population in the UK, some areas are identifying an extremely low number of BME victims at high risk. This is not explained by the demographic of that local area in every case, so all Maracs should check their performance relative to the latest data on their local populations.
- When studying our Insights dataset it was found that victims from BME communities typically suffer abuse for 1.5 times longer before getting help than those who identify as White, British or Irish.
- The barriers to accessing services and abuse experienced is complex for victims of black and minority ethnic groups; A third of BME clients are at risk of "honour" based violence, and they're three times more likely to be abused by multiple perpetrators. A quarter of BME victims say that they need the aid of an interpreter to communicate effectively. And 1 in 5 has no recourse to public funds.

Child protection issues

Child protection issues/risks were raised in almost every case we addressed. Children were often not assessed or actions concerning them followed up. In some cases it transpired they had not been seen or located. The issue of transient communities or victims/perpetrators moving area added to this challenge, with a lack of clarity or communication between different authorities. There was a lack of joined up working; with, on some occasions, a reluctance to take any responsibility once the child had left the area. There was also a general lack of awareness of specific issues which might arise when working with children in BME communities who were living in domestic abuse situations.

Financial and housing issues

In more longstanding communities, the victim and perpetrator may have jointly owned a home for a long time. This can be challenging, making it harder for the victim to move away, especially if she/he has long term support networks nearby. Financial issues can exacerbate this situation, with the victim never having been financially independent, or the perpetrator controlling the finances as part of the abuse. Financial and benefit issues also related to immigration status, which in some cases will be unresolved or dependent on the perpetrator(s). Housing risks may include the need to consider and respond to larger households, with some victims/survivors sharing living space with other families. This may contravene tenancy regulations, again exacerbating the problem of a victim being able to seek help from people considered to be acting in an official capacity. In addition, they may be vulnerable to rogue landlords and employers who could further exploit their vulnerable legal status.

Health/mental health issues

These issues can have an enormous impact on both victim and perpetrator and consequently need full consideration when action planning with both parties. Professionals need to identify the victim's vulnerability if being cared for by the perpetrator, or if they are the carer. The perpetrator may be

identified as having specific care and support needs and still be able to perpetrate serious harm to the victim.

Enforcement issues

As noted above, victims/survivors in these cases may have a difficult and untrusting relationship with those who have official status, connected to previous experiences, their current immigration status or other concerns. The Chair of the Marac and participating agencies should be sensitive to these issues and develop their understanding of how to overcome any barriers to someone seeking help. They should also consider what opportunities are presented to take action against one or more perpetrators in these cases, which might differ from other cases seen at Marac.

Prior to Marac

We recommend that all Marac representatives have working knowledge of the Care Act 2014 and/or the Adult Safeguarding and Domestic Abuse Guidance, 2015 (ADASS, Association of Directors of Adult Social Services and Local Government Association).

A single point of contact with a trusted professional

This professional supports and represents the victim/survivor and leads in identifying the risks they face and addressing their needs. This is usually the Idva and in some parts of the country, the Idva service will be more representative of the diverse community it serves than local statutory agencies, giving them more effective insight into the particular issues someone might be facing. However, it may be more appropriate in some cases to appoint a different lead support worker, while keeping the Idva closely involved. This might be an adult social worker or appropriate health professional who has already formed a trusting relationship with the victim.

A strategy/professionals meeting could be convened with relevant domestic abuse professionals invited for their expertise. This can enable an immediate assessment to agree a single point of contact.

Get the right people around the table

Giving each new representative a full induction to the Marac process ensures that they have a clear understanding of their role and responsibilities. Due to the changes in the Care Act 2014 and the role Adult Social Care play in supporting vulnerable adults who are experiencing abuse, SafeLives has added this body to the eight core agencies we recommend should always be in attendance at Marac.

Adult Social Care

It is essential, as a core agency that Adult Social Care is in attendance at Marac. As with other agencies, it is important that the same representative attends on a consistent basis and is senior enough to be able to confidently make decisions and allocate resources on behalf of their organisation. They may also be the agency that takes the lead as a single point of contact, coordinating the care package for the victim/survivor, ensuring communication between the relevant agencies is managed appropriately. The Adult Social Care assessment should take into account the discussion at Marac.

Mental and physical health services

Mental and physical health services are core agencies at Marac. These agencies may have contact with the victim and/or perpetrator and/or children, due to age related physical or mental health issues. Professionals (including GPs) working in A&E may be the first to identify victims and perpetrators who present with health or mental health issues. They may also be in a good position to identify when a repeat incident has occurred. In situations where the victim is mistrustful of the police or other enforcement agencies, health professionals may well be seen as a more benign, supportive environment for someone to disclose and continue to receive help.

Housing

This organisation is essential in the Marac process and can provide vital creative input when engaging effectively. It is important to have this agency's expertise in cases where the victim is BME, due to common issues arising such as multi occupancy dwellings, tenancy issues, supporting victims or compelling perpetrators to move to a different location, rent arrears and situations where an individual has no recourse to public funds.

Children and Young People's Services

This organisation is a core agency and an essential part of the process. The representative should have the knowledge and awareness of particular issues which someone might face or work in conjunction

with those who do, in order to protect children effectively. This includes following up when children have not been seen or are known to have moved across local authority borders.

Police

It is a function of any Marac to explore appropriate action to constrain the behaviour of a perpetrator, as well as create a safety plan for the victim and any children involved. Police representatives at Marac will want to equip themselves accordingly, taking into account the additional opportunities for disruption which might be present.

If your Marac is unable to engage any of these partners in the process this should be escalated to your local governance structure to address. It is essential that each Marac, either locally or regionally, has their operational work supported by an overarching governance structure, either by a specific steering group or other relevant strategic forum. This is in order to oversee the performance of the Marac. In order to carry out this role effectively the group should consist of those senior to representatives at the Marac, and hold positions of strategic responsibility.

Other relevant agencies

In addition to the core agencies, your strategic partnership for Marac should ensure that other agencies such as A&E, Youth Offending Service, Fire Service and specialist BME services regularly attend or are reached out to by core representatives as part of their research into cases. There are also agencies who won't regularly be able to attend or who aren't present locally but are helpful to involve in the research and information sharing where appropriate and relevant. These may include local statutory and third sector agencies working with BME communities, relevant housing associations.

Do your research

Representatives should do their research *prior to the meeting*, bringing information to Marac which, wherever possible, identifies the impact the abuse is having on the victim/survivor and any wishes or views they have. Maracs must also consider any safeguarding issues relating to the children of the victim and/or perpetrator where relevant. Information regarding the perpetrator should also be brought which highlights the risks that they pose as well as risks they may face themselves. In cases where the victim/survivor and/or perpetrator is BME, Marac participants should also consider whether there is relevant and proportionate information which should be shared about other family members, given the prevalence of multi-perpetrator abuse. Representatives should offer the following:

Adult social care

- Details of any current and historical adult safeguarding proceedings, and an outline of any concerns.
- Details about the capacity of both the victim/survivor and the perpetrator, where appropriate.
- Dates of upcoming or recent adult protection conferences, strategy meetings and professionals meetings.
- Details of any current care packages in place.

Police

- Details of incident or past incidents if relevant; referrals made and action taken to safeguard.
- Relevant convictions – both recent and historical.
- Any relevant warning markers e.g. suicidal, mental health problems, weapons.
- Information from overseas if there is a potential history outside of the UK.
- Understanding of perpetrator's immigration status, through liaison with Immigration Enforcement.

Physical/mental health

- Any current and historical support and outline of any concerns, both victim/survivor and perpetrator.
- Information regarding diagnosis and medication if relevant and proportionate to share.
- Current or recent hospital admissions.
- Contact with GP or relevant health practitioner.
- Upcoming or recent strategy meetings.
- Information pertaining to mental health issues that could be linked to cultural myths.

All representatives

- Information about the victim/survivor's experience of the domestic abuse and the impact it is having on them and any relevant children.

- Child protection concerns about adolescent on parent/grandparent violence.
- Information from partner agencies who do not normally attend Marac or from agencies in other local authorities.
- Information about the perpetrator(s).

You can find more details on the type of information agencies can equip themselves with in **SafeLives' Marac toolkits**.

Effective Action planning

Some key questions to consider when action planning

- **Has entry been denied to a professional during a visit (planned or unannounced)?** Consider expedited action to visit again if appropriate
- **Has any agency had meaningful engagement with the victim?** If not, consider any opportunities for joint working to achieve this. Identify a lead agency who has built a trusted relationship with the victim for e.g. GPs, other health professionals or third sector organisations
- **Have the victim's views been expressed?** If not, ensure an organisation is identified who can engage with the victim, offer support and seek their views.
- **Is the statutory responsibility being fulfilled?** Local authorities have a duty to safeguard and promote the welfare of vulnerable adults with care and support needs and or experiencing domestic abuse.
- **Are the appropriate experts taking the lead – and a single point of contact nominated:** This will normally be the Idva, dependant on which the prevalent issue is and who has managed to develop a relationship with the victim.
- **Have the victim's finances been considered:** there may be financial implications when perpetrators or victims visa and/or immigration status are insecure or there may be no recourse to public funds.
- **Have cultural barriers or differences been identified** which are preventing access or that have influenced decisions not to intervene? Culture or tradition should never be a barrier to taking appropriate safeguarding action.
- **Are you following your local policies, protocols and procedures for safeguarding adults?**
- **Can the fire service** assist with welfare checks?
- **Could Marac agencies (such as the Idva service or Adult Social Care) facilitate engagement with victims,** particularly those within rural communities?
- **Are you taking into account issues such as other family members, the wider family?**
- **Where relevant, have you considered the impact of previous experiences of the authorities in country of origin?**
- **Have child protection issues been identified and are the whereabouts and current situation of all children known?**
- **Is a specialist support service involved, and if not can you reach out to one to ensure you're well equipped to deal with the issues presented?**

All risks identified should be addressed in a comprehensive action plan. Potential actions that may be relevant in these cases are:

- **Identify a single point of contact who is trusted by the victim/survivor**
- **Create opportunities to work jointly**: for example Idva and social workers sharing expertise or housing and health working together to ensure appropriate discharge plans are joined up.
- **Marac representatives to flag files** – and inform relevant frontline professionals of the Marac action plan.
- **Focus housing solutions around the risk and needs of the victim** in order to reduce isolation and vulnerability or to look at residential care where necessary.
- **If someone currently intends to remain in the relationship** ensure a care package is put in place with expertise of both Adult Social Care and domestic abuse services.
- **Ensure action plans are consistently SMART**
- **Agencies should continue to refer back to Marac** any repeat incidents which meet the definition.
- **The police / probation / CRC should feed relevant information into the Marac** and liaise with services to ensure perpetrator behaviour can be addressed.
- **Fire service to carry out welfare checks** as part of the routine follow up.
- **Consider using domestic disclosure scheme (DVDS) and the potential for domestic violence protection orders (DVPOs)** to be set up.

- **Find creative ways of engaging victims,** for example; making links between statutory agencies and local faith or community groups and networks –or services that are generally used by BME individuals.
- **Ensure there are easily accessible and appropriate translation services.**
- **Consider the full range of disruptive tactics available, especially if wider criminal ties/activities on the part of the perpetrator(s) are identified.**
- **Children's Social Care to follow pathways and protocols in regard to issues that cross local authority borders, upholding their duties under The Childrens Act 1989.**
- **All participating agencies at Marac to act as critical friends to each other's response, ensuring that no individual is deemed too hard to help.**

Outside the Marac meeting

If you are part of a Marac's strategic or governance group

Establish a local referral pathway with relevant agencies that is accessible to BME victims/survivors, including considering how clients who do not speak English as a first language might access support. Family members should not be used as translators when there is a risk of multiple-perpetrator situations.

Consider carrying out a case audit focused on BME victims in order to look at lessons learnt. SafeLives can provide you with tools to assist you do this and you might also want to gather input or ask for support from a service with specialist expertise. Ensure the Marac area records BME data correctly in its returns to SafeLives, in order that you are getting a true picture of your local response and to enable proper performance management.

If you are a commissioner

Support the development of domestic abuse services that are accessible to all BME victims. If it is not possible to create or sustain a specialist service in your own area, look for links that your local services could make with colleagues in other places, to ensure you are not operating locally without that input. Ensure local domestic abuse campaigns are cognisant of and respond to the needs of your own particular community, recognising the ethnic makeup of your area including more recently arrived communities. Training is an important factor in skilling up professionals to identify and support BME victims of abuse appropriately. Training should be available to people in all situations where BME victims/survivors may be engaged, for example, housing, and health.

Maracs and local safeguarding adult boards (LSABs)

Tackling domestic abuse is a key priority for LSAB business planning. To fulfil its statutory functions, it is essential that this forum sees domestic abuse and engaging with the Marac as part of its responsibility and core business. Joint governance can be shared, with the Adult Social Care representative on the Marac governance group sitting on the Adult Safeguarding Board. As a minimum, we recommend that LSABs use the data provided by SafeLives to monitor the number of BME victims/survivors being discussed at Marac. This local embedding of Maracs should assist in developing clearer working arrangements and ensure that systems are put in place around vulnerable adult referrals where domestic abuse has been identified. SafeLives has now added Adult Social Care as a core agency at Marac, requiring a representative from the local area to attend every meeting.

Marac and local safeguarding children boards (LSCBs)

In addition to the above, ensure local areas have clear, accessible pathways/ protocols to protect children who may be at risk of disappearing when moving out of area; when this has occurred these pathways should ensure clarity of procedure to ensure joined up working/handover, especially with the new area and any follow up work takes place. Ensure children's social care representatives have access to good quality training which increases their knowledge, understanding and confidence regarding children who are BME who may be living with abuse.

Health

Local hospitals and mental health units should have the appropriate domestic abuse protocol and training to support victims and regarding the management of patients who are also perpetrators. This should cover safe and appropriate communication with the victim and take into account the Marac action plan and victim's wishes.